

# Chapter 16

## Urgent and emergency care

### 16.1 Key audiences

Primary care trusts:

- commissioners of acute medical services including older people
- commissioners of services for older people in the community
- commissioners of accident and emergency services
- directors of public health
- Director of performance
- GPs and practice-based commissioners.

NHS trusts and NHS foundation trusts:

- managers of acute medical services for older people
- medical directors
- directors of nursing
- directors of duality and safety
- managers of A&E services.

Nursing homes:

- managers.

Older people voluntary sector organisations:

- chief executives.

Ambulance services

## 16.2 Key issues and concerns

### Summary

Older people, and in particular those over 80, make up a significant proportion of those who attend accident and emergency departments (A&E). They are also more likely to be admitted to hospital from A&E than are younger people. Reducing inappropriate emergency admissions by providing targeted care and assessment for older people in A&E departments, intermediate care and better support in the community leads to a better experience for older people and is cost-effective.

If older people are urgently admitted to hospital it is important that they get the maximum benefit. This includes having a comprehensive assessment leading to appropriate access to specialist facilities such as intensive care and specialist clinicians. [Also see Chapter 5 High quality care for all.](#)

It is particularly important that discharge is planned throughout the older person's stay in hospital and that they, their carers and all those involved in their care collaborate to ensure that they are fully prepared to be discharged to the most appropriate place with the support they need. The rate of readmission to hospital within a month of discharge is relatively high amongst older people, and is highly variable between hospitals, which suggests that more could be done to improve the quality of their care and discharge planning.

### Key points

- Older patients can experience poor care in A&E departments.
- Older patients are more likely than younger patients to be admitted to hospital if they attend A&E.
- Addressing the continuing rise in emergency admissions is likely to have economic benefits and improve the experience of older people.
- Comprehensive assessment of older people being admitted in an emergency can improve the quality of their care and reduce lengths of stay in hospital.
- The rates of hospital readmission within 28 days of discharge for older patients are high and increasing.
- Discharge planning is often not adequate for older people.
- Intermediate care can prevent unnecessary admission, expedite appropriate hospital discharge and avoid long-term admission to care homes.
- Old age specialist teams can considerably improve outcomes.

### ***Older patients can experience poor care in A&E departments***

Evidence of age discrimination in the provision of hospital accident and emergency services is unclear, but individual high profile examples of poor care in Accident and Emergency departments, particularly affecting older people and resulting in the deaths of patients, can and do occur.<sup>464</sup>

### ***Older patients are more likely to be admitted to hospital from A&E***

Older people are increasingly frequent users of A&E departments and often have complex medical and social needs over and above the clinical cause of attendance.<sup>465</sup> There is no convincing evidence that older people use A&E inappropriately, although social isolation and chronic disease are associated with an increased risk of attendance.<sup>466</sup>

Older patients are much more likely than younger patients to be admitted to hospital from A&E due to their reduced functional reserve which may result in significant impairment of daily living activities following relatively trivial illness or injury.<sup>467</sup>

Studies report 46-48 per cent of over 65s are admitted to hospital from A&E compared with 14-20 per cent of younger patients.<sup>468 469 470</sup>

### ***Addressing the continuing rise in emergency admissions is likely to have economic benefits and improve the experience of older people***

Reducing emergency admissions would have benefits for older people and for the health economy. However, the number of emergency admissions is still rising in many parts of the country.<sup>471 472</sup>

Improved multidisciplinary assessments in A&E departments, including psychiatric assessment (see [Chapter 14 Mental health including dementia](#)),

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<sup>464</sup> *Investigation into Mid Staffordshire NHS Foundation Trust*, Healthcare Commission, 2009 [www.cqc.org.uk/\\_db/\\_documents/Investigation\\_into\\_Mid\\_Staffordshire\\_NHS\\_Foundation\\_Trust.pdf](http://www.cqc.org.uk/_db/_documents/Investigation_into_Mid_Staffordshire_NHS_Foundation_Trust.pdf)

<sup>465</sup> *Repeat attendance by older people at accident and emergency departments*, Bentley J, Meyer J, *J Adv Nurs*. 48: 149-56, 2004

<sup>466</sup> *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 Revised March 2008), British Geriatrics Society, 2008 [www.bgs.org.uk/Publications/Compendium/compend\\_3-2.htm](http://www.bgs.org.uk/Publications/Compendium/compend_3-2.htm)

<sup>467</sup> *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 Revised March 2008), British Geriatrics Society, 2008

<sup>468</sup> *Transforming emergency care in England*, Alberti G, Department of Health, 2004

<sup>469</sup> *Older people's use of Accident and Emergency services*, Age and Ageing, Downing A and Wilson R, 34 (1): 24 – 30, 2005

<sup>470</sup> *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 Revised March 2008), British Geriatrics Society, 2008

<sup>471</sup> *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 revised March 2008), British Geriatrics Society, 2008 [www.bgs.org.uk/Publications/Compendium/compend\\_3-2.htm](http://www.bgs.org.uk/Publications/Compendium/compend_3-2.htm)

<sup>472</sup> *Rise in admissions will be unsustainable for PCTs*, Health Service Journal, HSJ 21.1.10, 2010

and the availability of intermediate care alternatives can help to reduce emergency admissions and ensure older people receive the most appropriate care. In addition, services in the community can help prevent A&E attendances and emergency admissions. The evaluation report of the Partnership for Older People Projects (POPPs) concluded that projects designed to promote the health, wellbeing and independence of older people in the community can reduce overnight hospital stays by over 40 per cent and A&E attendances by nearly 30 per cent.<sup>473</sup> The report also concluded that POPPs services appear to have improved users' quality of life.

### ***Comprehensive assessment of older people being admitted in an emergency can improve the quality of their care and reduce lengths of stay in hospital***

A study found that comprehensive screening and assessment of older people who had been admitted to hospital in an emergency improved clinical effectiveness and reduced lengths of stay.<sup>474</sup> Falls and delirium are both common causes of A&E attendance for older people and of subsequent admissions.<sup>475</sup> Delirium is often not recognised by clinicians and is poorly managed.<sup>476</sup>

### ***The rates of hospital readmission within 28 days of discharge for older patients are high and increasing***

Concerns have been expressed at the increasing proportion of hospital patients aged 75 and over who are readmitted as emergency admissions within one month of discharge.<sup>477 478</sup> There was a 27 per cent increase in the numbers of older people being readmitted within a month between 1998/9 and 2006/7. It is not clear how much of the higher rate for older people results from increased frailty and how much from poorer standards of care or from premature or insufficiently well-planned discharge procedures. However, the high, and increasing, rates of hospital readmission within 28 days of hospital discharge, for older patients, is a clear indication of problems with the hospital care or discharge procedures for this group. This would appear to be a case of indirect discrimination, where universally applied policies are particularly disadvantageous to older people.<sup>479</sup>

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<sup>473</sup> *National Evaluation of Partnerships for Older People Projects – Final Report*, Windle et al, PSSRU, Department of Health, 2009

<sup>474</sup> *The older persons' assessment and liaison team 'OPAL': evaluation of comprehensive geriatric assessment in acute medical inpatients*, Harari D, Martin FC et al, *Age and Ageing*. 2007, November;36 (6):670-5, Epub 2007 Jul 26

<sup>475</sup> *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 revised March 2008), British Geriatrics Society, 2008  
[www.bgs.org.uk/Publications/Compendium/compend\\_3-2.htm](http://www.bgs.org.uk/Publications/Compendium/compend_3-2.htm)

<sup>476</sup> *The prevention, diagnosis and management of delirium in older people*, BGS and RCP, 2006

<sup>477</sup> *One voice: shaping our ageing society*, Age Concern and Help the Aged, 2009

<sup>478</sup> Harrop A, Jopling K and contributors

<sup>479</sup> *Ageism and age discrimination in secondary health care in the United Kingdom*, CPA, October 2009

### ***Discharge planning is often not adequate for older people***

In 2006 the Healthcare Commission found that “*Rapid discharge was only achieved at the expense of proper planning with the older person concerned*”. Studies of hospital discharge from the older person’s perspective find that older people do not fully participate in planning their discharge and feel disempowered in terms of exercising any real choice in decisions about their transfer to the community.<sup>480 481</sup> Risk management and safety are often priorities for staff planning discharge, and matching plans to existing services, but they fail to take into account longer term life-planning issues of importance to older people.<sup>482</sup>

A national report on rehabilitation and remedial services for older people stressed the importance of comprehensive assessment for older people who may require additional support to regain their best possible functional independence and confidence, compared to younger adults, to reduce the risk of readmission to hospital or being ‘misplaced’ in long term care.<sup>483</sup> An audit of nursing home placements in England and Wales found 90 per cent of records contained no physiotherapy or occupational therapy reports of pre-admission assessments.<sup>484</sup> Older patients, aged 81 and over, are much less likely than younger patients to feel they have been given adequate information about what to do if they are worried about their condition after leaving hospital.<sup>485</sup>

### ***Intermediate care can prevent unnecessary admission, expedite appropriate hospital discharge and avoid long-term admission to care homes***

Evidence that the intermediate care function is effective has begun to emerge from a number of major research programmes, although conclusions are mixed. It has been shown to reduce the use of acute hospital admissions in some areas and to enable people to regain skills and abilities in daily living, thus enhancing their quality of life.<sup>486 487</sup>

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<sup>480</sup> *Delayed transfer from hospital to community settings: the older person's perspective*, Swinkel A and Mitchell T, *Health and Social Care in the Community* 17 (1): 45-53, 2008

<sup>481</sup> *Using qualitative research in systematic reviews: older people's views of hospital discharge*, Fisher et al, Social Care Institute for Excellence (SCIE), 2006

<sup>482</sup> *Using qualitative research in systematic reviews: older people's views of hospital discharge*, Fisher et al, SCIE, 2006

<sup>483</sup> *The way to go home: rehabilitation and remedial services for older people* (Promoting independence 4), Audit Commission, 2000

<sup>484</sup> *Ageism and age discrimination in social care in the United Kingdom*, CPA, October 2009

<sup>485</sup> *Ageism and age discrimination in secondary health care in the United Kingdom*, CPA, October 2009

<sup>486</sup> *Early discharge hospital at home*, Shepperd S and Doll H et al, *Cochrane Database of Systematic Reviews* 2009, Issue 1 Art. No: CD000356 DOI: 0.1002/14651858.CD000356.pub3

<sup>487</sup> *Intermediate Care – Halfway Home: Updated guidance for the NHS and Local Authorities*, Department of Health, 2009

### **Old age specialist teams can considerably improve outcomes**

The early involvement of old age specialist teams, when a hospital admission is being considered, improves outcomes, reduces lengths of stay and avoids inappropriate admissions.<sup>488 489</sup> This is also preferred by patients.<sup>490</sup> Old age specialists can also coordinate care for older people and help to ensure that they access other appropriate specialist health professionals.

## **16.3 Drivers and policy imperatives**

### **Emergency care**

The Department of Health's 10-year strategy, *Reforming Emergency Care* (October 2001), is driving the changes in emergency care. The strategy is based on six key principles:

- Services should be designed from the point of view of the patient.
- Patients should receive a consistent response, wherever, whenever and however they contact the service.
- Patients' needs should be met by the professional best able to deliver the service needed.
- Information obtained at each stage of the patient's journey should be shared with other professionals who become involved in their care.
- Assessment or treatment should not be delayed through the absence of diagnostic or specialist advice.
- Emergency care should be delivered to clear and measurable standards.

Transforming Emergency Care<sup>491</sup> highlights the need to pay particular attention to older people in A&E.

The British Geriatrics Society's *Best Practice Guidance on the Older person in the Accident and Emergency Department* (latest version 2008) sets out how to deliver high quality care to older people in A&E departments. These guidelines stress the need for a comprehensive, multidisciplinary assessment of older people in A&E and following an admission from A&E.

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<sup>488</sup> Urgent care pathways for older people with complex needs – *Best Practice Guidance*, Department of Health, 2007

<sup>489</sup> *The Older Person in the Accident and Emergency Department – Best Practice Guide*, British Geriatrics Society, 2008

<sup>490</sup> *The Older Person in the Accident and Emergency Department – Best Practice Guide*, British Geriatrics Society, 2008

<sup>491</sup> *Transforming Emergency Care*, Department of Health, 2004

## Intermediate care

The *National Service Framework (NSF) for Older People* (Standard Three) stated that:

*“Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care”.*

The NSF also noted that:

*“An essential component of intermediate care services is that they should be integrated within a whole system of care including primary and secondary health care, health and social care, the statutory and independent sectors.”*

The most recent Department of Health Guidance on intermediate care<sup>492</sup> updates the 2001 Guidance.<sup>493</sup> This provides a definition and clarification of intermediate care and renews the emphasis on those at risk of admission to residential care. It also stresses the need to include people with dementia or mental health needs, adds the need for timely access to specialist support as needed and focuses on the need for joint commissioning of a wide range of services to fulfil the intermediate care function including social care reablement.

## Discharge

Standard four of the *NSF for Older People*<sup>494</sup> stresses the need to pay particular attention to discharge planning for older people in hospital.

The Department of Health Guidance *Discharge from hospital: pathway, process and practice*<sup>495</sup> provides the most comprehensive guidance on hospital discharge and updates and builds on the 1994 guidance and workbook. This guidance notes that particular attention should be given to assessments of older people’s needs when being discharged from hospital and stressed the use of the Single Assessment Process (SAP) for older

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<sup>492</sup> *Intermediate Care – Halfway Home: Updated guidance for the NHS and Local Authorities*, Department of Health, 2009

<sup>493</sup> *Intermediate Care – Health Service/local authority circular HSC 2001/001*, Department of Health, 2001

<sup>494</sup> *National Service Framework for Older People*, Department of Health, 2001

<sup>495</sup> *Discharge from hospital: pathway, process and practice*, Department of Health, 2003

people. This has recently been updated with good practice guidance on discharge for older people:<sup>496</sup>  
The Government's carers strategy<sup>497</sup> introduces a new commitment to run pilots looking at the ways in which primary care trusts can better support carers. These include examining good practice in actively involving carers in diagnosis, care and discharge planning.

## 16.4 What good age-equal practice might look like

Also see Chapter 8 Prevention and health promotion.

In order to promote age equality, primary care trusts might work to improve:

- The quality of care and level of dedicated expertise available to older people in A&E departments and the early stages of acute admissions.
- The availability of intermediate care to meet the needs of older people including those with dementia and mental health problems.
- The high level of readmissions of older people after one month.
- The experience of discharge for older people and their carers.

### Emergency care

The British Geriatrics Society provides a best practice guide on the care of older people in A&E.<sup>498</sup> This states that clinicians should ensure that the clinical care provided for older patients is based on clinical need and not arbitrary age-defined criteria and that there should be equity of access to the full range of investigation and treatment facilities. It also stresses the need for emergency care to be patient-centred and makes the following recommendations:

- Patients who come to A&E will want to be seen promptly and have the opportunity to be assessed by a doctor in private, in surroundings which take account of their hearing as well as their physical, emotional and cognitive states.
- There should be an understanding of the particular health problems of elderly patients from ethnic minority groups, particularly with reference to linguistic, cultural and religious differences.

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<sup>496</sup> *Ready to go – Planning the discharge and transfer of patients from hospital and intermediate care*, Department of Health, 2010

<sup>497</sup> *Carers at the Heart of 21<sup>st</sup> Families and Communities*, Department of Health, 2008

<sup>498</sup> *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 revised March 2008), British Geriatrics Society, 2008

- If admission is to be arranged, patients and their carers should be informed of their management plan and prognosis.
- Where applicable, advance directives and lasting powers of attorney should be respected and in cases where patients lack capacity, carers, next of kin, friends and independent mental capacity advocates may be consulted as outlined in the Mental Capacity Act.

These guidelines also recommend that local commissioners and providers should ensure the following:

- Minimal delays for older people in A&E prior to assessment.
- Adequate facilities available to make patients feel comfortable in A&E e.g. food, drink, appropriate chairs/beds for the elderly.
- Adequate toilet facilities.
- Timely transfer from A&E directly to acute geriatric medicine wards, acute medicine units, geriatric medicine rehabilitation or specialist stroke beds.
- Appropriate admission of patients with acute mental health problems.
- Admission areas for overnight observation where discharge may be unsafe.
- Referral from A&E for urgent multidisciplinary assessment to provide care support, based on the level of need, either at home or in a residential home, nursing home or interim care facilities.
- That responsibilities for meeting the needs of older patients are clear and comprehensive so that individuals do not fall between services.

Whilst no single model of care has been shown to be the most effective, 'fast-track' systems for older patients with fractured neck of femur and stroke are examples of beneficial developments.<sup>499</sup>

It is also effective to site staff in A&E who can provide initial assessment for frail elderly patients. This may be a physiotherapist, occupational therapist, social worker, specialist nurse or any combination of these individuals who can then access/pass the referral on for further assessment in the appropriate setting including:

- primary care
- falls clinic
- transient ischaemic attack (TIA) clinic

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<sup>499</sup> *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 revised March 2008), British Geriatrics Society, 2008  
 Achieving age equality in health and social care – NHS practice guide | May 2010  
 Chapter 16 Urgent and emergency care | [www.southwest.nhs.uk/age-equality.html](http://www.southwest.nhs.uk/age-equality.html)

- day hospital
- rapid assessment geriatric clinic
- intermediate care and social care to provide urgent support and/or rehabilitation when indicated.<sup>500</sup>

The Department of Health provides guidance on a care pathway for older people with complex needs caused by falls, confusional states or hip fracture.<sup>501</sup>

## Intermediate care

The Department of Health has recently updated guidance on the development and provision of intermediate care.<sup>502</sup>

Factors that have been shown to lead to the successful development of the function of intermediate care are:

- good clear leadership
- good co-ordination
- a single point of access to the service
- the capacity to accept risk.<sup>503</sup>

It is important that intermediate care is accessible and appropriate for people with dementia. It is good practice to ensure that there is mental health support for intermediate care teams.

## Discharge

Recent Department of Health guidance on discharge puts forward 10 key steps to achieving safe and timely discharge. These steps are based on the good practice previously identified and evaluated by practitioners.<sup>504</sup>

→ [www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh\\_103146](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146)

## Readmissions

Suggestions for reducing the readmissions rate include:

- agree outcomes for target group, such as reduced attendance at A&E with robust data collection and evaluation

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<sup>500</sup> *The Older Person in the Accident & Emergency Department* (Best practice guide Document 3.2 revised March 2008), British Geriatrics Society, 2008

<sup>501</sup> *Urgent care pathways for older people with complex needs*, Department of Health, 2007

<sup>502</sup> *Intermediate Care – Halfway Home: Updated guidance for the NHS and Local Authorities*, Department of Health, 2009

<sup>503</sup> *Intermediate Care – Halfway Home: Updated guidance for the NHS and Local Authorities*, Department of Health, 2009

<sup>504</sup> *Ready to go – Planning the discharge and transfer of patients from hospital and intermediate care*, Department of Health, 2010

- have an integrated care coordination service to deliver case management alongside statutory and voluntary partners
- incentivise GPs to use simple case-finding systems
- demonstrate financial impact of reduced admissions – care coordination pays for itself.<sup>505</sup>

## 16.5 Case studies of illustrative / good practice

### **Reducing emergency admissions using the Methodology for Ensuring Seamless Healthcare (MESH) Birmingham**

NHS Birmingham East and North has been working with Healthcare at Home to redesign patient care pathways and deliver services to adult patients in the community. These services provide an enhanced supported discharge team, long-term and ambulatory care, sensitive condition care, home chemotherapy and a family liaison service to support patients who are at the end of life. The services are all unique in their design but are also supported by a 24-hour nurse triage telephone and rapid response team, with the aim to support patients and their relatives during difficult times.

This is a pilot which is supported by robust IT systems to provide up-to-date information on progress and audit results to the NHS. Evidence suggests that for older people, who are more likely to experience adverse events in hospital, home-based healthcare has the potential to avoid exposure to infection and gives the benefit of offering care in familiar surroundings. The care pathways provided by these teams are designed with these benefits in mind.

#### **Further information**

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<sup>505</sup> *Health Service Journal*, 5 November 2009

## **Reducing emergency admissions South Staffordshire**

An Accident and Emergency Diversion and Discharge Support Service is provided in seven hospitals across South Staffordshire. Most of the referrals are from Social Care and Health through their access teams. The service was developed to reduce emergency admissions to hospital, to support older people on discharge from hospital, and to prevent unnecessary admissions to hospital, respite or care homes. Amongst services provided is an initial assessment, linked to SAP and including risk of falling.

### **Further information**

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## **Brent POPP Integrated Care Coordination Service**

The Integrated Care Coordination Service (ICCS) is an extension of an existing care coordination service, which became a fully integrated team of staff from social and healthcare agencies, and voluntary and community sector organisations (VCOs). The aim of the ICCS is to move from reacting to case referrals to proactive case-finding to maximise prevention.

It is a 'holistic' service targeted at older people over 65 who may be at risk of avoidable hospital admission, premature admission to institutional care, or simply causing concern due to medical, physical, emotional or social issues. It uses the Emergency Admission Risk Likelihood Index (EARLI) tool to proactively 'case find' older people in need of some help. It address people's needs by undertaking assessments and then coordinating a range of interventions responding to identified needs – operating across health, social care and other organisational boundaries as required. The involvement of the service can typically extend to three months.

Interventions include odd jobs around the home, assistance with moving into more appropriate accommodation, benefits and pensions advice or referrals to health and social care providers, podiatrists, occupational therapists etc.

(Source: Partnerships for Older People (POPPS) report:

[www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_111353.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111353.pdf))

## **Reducing emergency admissions – virtual wards Croydon**

Croydon Primary Care Trust has developed and piloted the use of 'virtual wards' for people at highest predicted risk. In essence, virtual wards use the systems, staffing and daily routine of a hospital ward to provide case management in the community.

Virtual wards copy the strengths of hospital wards: the virtual ward team shares a common set of notes, meets daily, and has its own ward clerk who can take messages and coordinate the team. Each virtual ward has a capacity to care for 100 patients in their own homes. The day-to-day clinical work of the ward is lead by a community matron. Other staff include a social worker, health visitor, pharmacist, community nurses and allied health professionals.

This is a summary of a case study by Dr Geraint Lewis, previously Specialist Registrar in Public Health, Croydon Primary Care Trust.

### **Further information**

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## **Improving intermediate care for people with dementia – Bristol**

Bristol's intermediate care teams have psychiatric nurse support and there has been training on working with people with dementia. Bristol's short-term reablement service provides focused intensive domiciliary support, which includes support for people with dementia. Bristol also makes use of a specialist independent care home which provides intensive residential reablement for up to eight weeks for people with dementia, predominantly post-discharge from hospital.

Source: Regional findings from SW Review in respect of intermediate care: objective 9.

## **Discharge to care homes - Joint working between a health board, hospital trust and the independent sector Bridgend**

A number of concerns were highlighted through complaints in relation to the discharge of vulnerable older patients from hospitals back to care homes. In collaboration with the trust's dignity champion for older people, the aim was to evidence incidents of unsatisfactory discharge from wards within the trust to care homes and to improve the discharge of older people. The health board worked with care homes to collate information, including examples of poor discharge, and present these to the trust. The trust provided key staff contact

details to care homes to encourage better communication. The trust also identified areas where further training was required and a number of workshops for both care home and ward staff are planned with the aim of building improved trust and communication in relation to discharge planning.

There has been a significant reduction in the reporting of unsatisfactory hospital discharges.

#### **Further information**

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## **16.6 Suggestions for quick wins / what you can do now**

The Department of Health has produced tips for quick wins in improving responses to older people who need emergency care and in reducing that need. It is recognised that some of these actions are already in place in some parts of the country, but recommended that these become embedded as the standard mainstream approach.

- **Long-term conditions management**  
Identify patients with complex long-term conditions who are most at risk of unplanned hospital admissions. Adopt a case management approach, typically with a community matron, to anticipate, coordinate and join up their health and social care. This can improve the quality of life and outcomes for patients, prevent exacerbation of their condition(s), reduce emergency admissions and enable those who are admitted to return home more quickly.
- **Establish medicines reviews in care homes by community pharmacists or general practitioners**  
This will reduce drug side effects in residents, which account for a large number of emergency hospital admissions from care homes.
- **Care home escalation policy**  
Agree escalation policy with care homes and local general practitioners for responding to medical crises in care homes. This will improve outcomes for patients and reduce unnecessary referral to emergency departments and admission to acute hospital beds.
- **Rapid access to intermediate care**  
There should be a single point of contact for access to intermediate care services, available on a 24/7 basis. This will provide alternative admission for patients who need rehabilitation (loss of ability in activities of daily living) but do not clinically require hospital admission.

- **Falls service**  
Following a fall, all emergency patients without life-threatening illness or need for surgery should be referred to the local falls service for multidisciplinary assessment and management. This will reduce the need for hospital admission, improve outcomes for patients and reduce the risk of further falls or fractures.
- **Stroke assessment unit**  
Create a geographically-defined stroke assessment unit to which patients are rapidly transferred following an emergency response. This will minimise time in the emergency department for these patients and improve patient experience and outcomes.
- **Acute confusion**  
Emergency response staff should be trained in basic assessment of patients who seem confused, with early transfer to staff trained in managing people with confusion. This will help patients who are particularly vulnerable in emergency departments get quickly through the system.
- **Other conditions**  
Patients with falls or with multiple health problems who need admission should be fast-tracked to old age specialist teams within 24 hours of admission. This will ensure that needs are addressed, with early transfer to intermediate care if appropriate.<sup>506</sup>

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<sup>506</sup> *8 tips for quick wins – Improving responses for older people*, Ian Philp and George Alberti et al, Department of Health, 2005