The role of the specialist nurse in an acute assessment and liaison service

Paula Harvey and Dan Wilson discuss a service that ensures the complex needs of frail patients are not overlooked in a busy acute environment

Summary

This article explores the work of an acute assessment and liaison service for older people, including the role of the older people's specialist nurse in the service. The service screens all patients admitted who are over the age of 75 for problems specific to a frail population and to identify where ongoing specialist support, referral or advice is indicated. Patients with complex problems undergo a comprehensive geriatric assessment. The service has reduced length of stay and resulted in better care for older people.

Keywords
Acute care, assessment, older people

ABOUT TWO thirds of patients admitted to acute hospitals in the UK are aged over 65 (Department of Health (DH) 2001) and the number of extremely old people with multiple physical and mental health problems is increasing. Therefore, it is becoming increasingly important that these patients are served well in what is often a challenging, fast-paced environment. Pressures to improve efficiency, especially by reducing length of stay, sometimes sit uncomfortably alongside the need to provide thorough assessments, enough time for full recovery and adequate rehabilitation.

Older people present with multiple diagnostic challenges and complex interactions between their health problems and the social environments in which they live. In addition, older people are at greater risk of coming to harm while in hospital, for example, because of falls, delirium, drug interactions or from greater known risk of procedures. This is particularly so for those who are deemed frail. The concept of frailty and its definition have been increasingly studied in recent years (Rockwood *et al* 2005). The recognised characteristics of frailty are of an older person who has reduced reserve capacity and is at increased risk of health problems, although there is as yet no universally accepted scoring system.

The *National Service Framework (NSF) for Older People* (DH 2001) identified the need to ensure early access to the care and advice of a specialist team for older people admitted to general acute hospitals. It stated that older people's care in hospital should be delivered by staff who had the right set of skills to meet their needs (DH 2001). The NSF highlighted that this was particularly important for emergency admissions, but also for frail older people who were vulnerable to complications as a result of elective surgery.

Specialist teams

Nurses should ensure that the needs of older people are recognised and addressed in acute care. All hospital nurses should be competent in this area, but nurses also have a role in specialist teams as envisaged in the NSF. Harwood *et al* (2002) demonstrated that specialist nurses could select patients suitable for rehabilitation, identify those who required ongoing acute inpatient care and make arrangements for supported direct discharges where appropriate. In the literature, the role of the older people's specialist nurse has been identified as that of an expert clinical practitioner working with older people and their families, with the role additionally encompassing clinical research, consultation, teaching and leadership (Royal College of Nursing and British Geriatrics Society 2001).

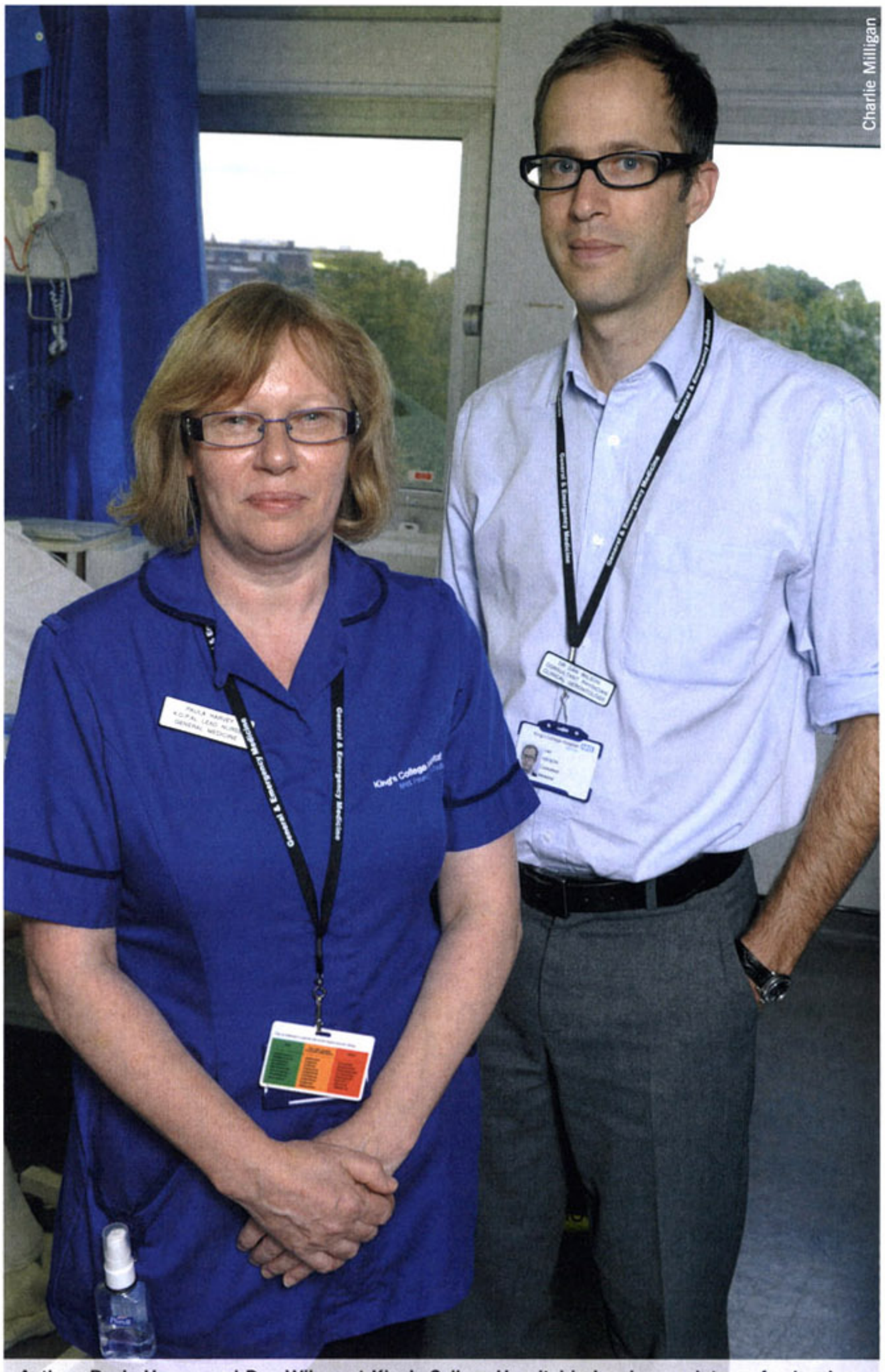
The provision of specialist advice for older people in hospital pre-dates the NSF by some time. Geriatric medicine as a specialty was founded on the principle of holistic assessment of individuals and active treatment of conditions that were once believed to be part of an inevitable decline into old age. This is the cornerstone of specialist care for older people today and is also embraced by nursing and other health professions. As clinicians in their multidisciplinary teams tried to define and then research the processes that they had developed, the concept of comprehensive geriatric assessment (CGA) arose.

Comprehensive geriatric assessment

While a concept such as CGA may be too broad to define, most trials examining its effects share core features which are recognised as the backbone of the assessment process. It is not only a diagnostic process in which multiple facets of an individual's health are examined by a multiprofessional team, but it also informs a co-ordinated treatment plan delivered across a range of physical, psychological and functional domains (Ellis and Langhorne 2005), often with an acknowledgement of the need for long-term follow up (Stuck *et al* 1993). CGA is compatible with nursing models of care because it focuses on a multidisciplinary way of working with the individual, which is holistic and examines frailty, functional ability, cognition and social circumstances. Nursing models such as Roper *et al* (1980) and Orem (1991) examine similar criteria for assessment.

CGA has been shown to reduce short-term mortality (Stuck *et al* 1993), length of stay (Harari *et al* 2007a, b), readmission to hospital (Caplan *et al* 2004) and likelihood of entering long-term care. In addition it has been shown to improve mental health, reduce delirium (Inouye *et al* 1999) and support more independent living at home (Stott *et al* 2006). It has measurable effects on improved morbidity and quality of life. Its success depends not only on addressing many of the facets of care alluded to above, but also in the selection of those assessed and treated. Used as a tool to apply unselectively to all older people it tends to fall flat, but when individuals are screened for particular diagnoses or disabilities associated with frailty it is more robust. The environment in which the care is given is also important, and for inpatients, delivering that care in specialist inpatient settings seems more effective than delivering a consultative peripatetic service (Ellis and Langhorne 2005).

Recently a number of UK hospitals have developed services that specifically seek older people who have been admitted and who might benefit most from CGA. They have started to develop care pathways that enable them to access specialist inpatient multidisciplinary care for older people after admission to an acute medical unit (Harari *et al* 2007b) and even before they come into hospital for elective surgery (Harari *et al* 2007a). These services have further demonstrated reductions in morbidity and length of stay in trial settings (Harari *et al* 2007a,b) and through audit of practice (King's Older People's Assessment and Liaison service, unpublished audit data).



Authors Paula Harvey and Dan Wilson at King's College Hospital in London say interprofessional communication is essential for the smooth running of the assessment and liaison service

The KOPAL service

The King's Older People's Assessment and Liaison (KOPAL) service at King's College Hospital, London aims to screen all people aged over 75 years within 24 hours of admission to general medical wards to identify where ongoing specialist support, referral or advice is indicated.

The service was established in 2006, in response to an increase in admissions of people aged over 75 and a reduction in the general medical and specialist bed pool. In an unpublished pilot study at King's College Hospital, screening admissions demonstrated that approximately two thirds of patients aged over 75 years had complex problems with an indication for further specialist input. A business case was developed for the service to improve efficiency and appropriate bed use by rapid specialist assessment and review of patients, case management and the smooth and safe transfer of care.

The KOPAL service consists of one whole time equivalent (WTE) older people's specialist nurse, 0.5 WTE consultant geriatrician, 0.5 WTE physiotherapist and 0.5 WTE occupational therapist. All members of the service contribute to the screening process for people aged over 75 years who are admitted to general medicine. From Monday to Friday, the service ensures that this group of patients have swift access to specialist assessment within 24 hours of admission and at weekends, on the next working day. The service is hands-on and sees between approximately 150 and 170 patients per month. Data are collected to evaluate the service and monitor length of stay in hospital. Referral is also accepted for advice on patients who are younger than 75 but have complex needs. This patient group are assessed in the same way but are not included in data capture.

In-house screening tool

The KOPAL service uses a screening tool that was designed in-house (Box 1). This triggers the need for more in-depth assessment and is also a means of collecting data which are subsequently kept on a web-based server. Information on demographics, presenting and past diagnoses and detailed background social history are collected. This requires detailed conversations with the patient, family members, carers, social services and anyone who has close contact with the patient. The tool was developed using a CGA approach in an acute setting which includes identification of comorbidity, frailty and the 'geriatric giants' of confusion, falls, incontinence and mobility impairment and their effect on health and function. The tool is used as a prompt to inform the assessor's clinical judgement. Where decisions cannot be made by the individual making the assessment it provides a useful structure to aid case presentation to the multidisciplinary team which then decides on the direction of care for the patient.

Screening is carried out with the usual admission procedures and enhances, rather than replaces, the usual multidisciplinary assessment process. Consideration of the person's mental capacity and consent are fundamental to the process and ensure that a person-centred approach is adopted from the outset.

Latest audit figures for September 2009 show that since the introduction of the full KOPAL service in February 2006, total mean length of stay has reduced on the acute general medical wards (adults of all ages) from 13 days to 10.5 days. The most significant effect has been on the health and ageing unit, the hospital's specialist older adults' inpatient wards, which excludes the stroke unit, where mean length of stay has fallen from 33 days to 21 days. This has occurred without a negative effect on length of stay for younger adults, which has remained static over this time. Therefore this does not appear to have been at the expense of other acute medical services, nor does it seem to have occurred as part of broader attempts to drive down length of stay

Box 1 Areas included in the King's Older People's Assessment and Liaison screening tool

- Reason for admission.
- Readmission history.
- Falls.
- Polypharmacy: taking four or more medications daily.
- Mental health including presence of dementia, delirium or depression.
- Pressure ulcers.
- Chronic pain.
- Social circumstances including whether the person is housebound.
- Mobility impairment.
- Functional dependency.
- Urinary incontinence.
- Constipation/faecal incontinence.
- Poor nutrition.
- Unmet social needs.
- Visual or hearing impairment.

The screening tool provides a useful structure to aid case presentation to the multidisciplinary team

across the whole medical division. Readmission rates have not risen significantly over this period and mortality has not been negatively affected. Staff satisfaction with the service has been high. Many of the principles of early assessment and specialist intervention leading to care by specialist older adult teams have informed the more recent development of a medical admission unit at King's, and are being adopted by other specialties.

Good teamwork

The multidisciplinary nature of the KOPAL service allows the team to offer CGA to patients to help improve their health and functional status and reduce length of stay. This is achieved not just through early intervention on the wards but by having rapid access to specialist outpatient appointments with the KOPAL consultant and other members of the department of gerontology at King's. Although KOPAL members screen individually, a daily meeting is held to discuss any complex issues with new patients, and once a week a longer team meeting is held to ensure that all patients are being managed appropriately.

A member of the old age psychiatry liaison team also attends the meetings for new referrals and feedback. Other teams or individuals with whom the KOPAL service has close links include those responsible for end of life care such as the palliative care team and cancer clinical nurse specialists, the trust's falls service and the dementia clinical nurse specialist. With this type of service, excellent interprofessional working is essential and close working relationships, good communication and mutual respect are key to the smooth running of the service. Each team member is managed in their professional departments and is not managerially accountable to any other member of the KOPAL service. The KOPAL therapy staff are on rotation, which sacrifices a degree of stability in the team but allows the service to educate more staff about CGA. They then take these skills with them to other posts.

Older people's specialist nurse

Although full time, the older people's specialist nurse role is non-managerial and requires flexibility and understanding of all roles in the service. It is important that the older people's specialist nurse informs and supports front line nurses who also need to know about the principles of CGA. Every nurse should be aware of the potential comorbidities of older adults and should recognise atypical presentations. For example, nurses should be able to recognise and manage syndromes that can present in a wide variety of ways, such as delirium, but may require the support of the older people's specialist nurse to assist with complex care plans that may be needed. In addition, CGA will help to identify risk factors for delirium, some of which may be modifiable thus reducing the chance of it occurring in the future.

Nurses should also be aware of the risk of more easily measured conditions that commonly present in older people, such as hypothermia. Here the treatment may be simple, for example, gentle warming, or sophisticated and require intensive therapy unit support. Therefore, the role of the older people's specialist nurse also includes staff training.

The leadership skills and clinical expertise of the specialist nurse mark out the role from that of the general nurse, promoting high standards of care and also providing enhanced support for processes such as assessment of eligibility for NHS continuing health care, support for end of life care and advance care planning, promotion of dignity in care and

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Members of the multidisciplinary team at the King's Older People's Assessment and Liaison service, King's College Hospital, London, assess a patient. The service ensures that patients over 75 years old have speedy access to specialist assessment

safeguarding vulnerable people. These functions are integrated in the role, through direct clinical work and provision of leadership and training to staff joining the organisation at all levels.

The role of the older people's specialist nurse is specific to the acute setting and the nature of it means that it does not just draw on academic qualifications, although for any clinical nurse specialist role, study at least to degree level is preferable. It is equally important that the older people's specialist nurse has in-depth knowledge of the ageing process and its effect on health and illness, and expertise in assessing and managing the complex care needs of older people, in conjunction with an understanding of the individual's relevant psychosocial and economic situation. In acute care, training in clinical skills in advanced assessment is an advantage. Such training is a useful way of consolidating knowledge and developing the more complex skills needed for this role.

Conclusion

Taking a CGA approach addresses the often complex health and social needs of frail older people and is relevant to the practice of all professionals working with older people in an acute setting. The principles of CGA are compatible with the nursing assessment and care planning process, providing a structure to ensure that complex needs in old age are not overlooked in a busy acute environment. An enhanced service such as that described in this article can improve efficiency, contributing to reduction in length of stay without compromising the need to use a person-centred approach and promote high quality care.

The leadership skills and clinical expertise of the specialist nurse mark out the role from that of the general nurse

The older people's specialist nurse contributes hands-on expertise, leadership and support for staff development to this multidisciplinary process. There are strong drivers for change in the delivery of acute care and KOPAL offers a model for developing services, although further evidence on a range of patient outcomes is needed.

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References

Caplan G, Williams A, Daly B *et al* (2004) A randomized, controlled trial of comprehensive geriatric assessment and multidisciplinary intervention after discharge of elderly from the emergency department--the DEED II study. *Journal of the American Geriatrics Society.* 52, 9, 1417-1423.

Department of Health (2001) *National Service Framework for Older People.* DH, London.

Ellis G, Langhorne P (2005) Comprehensive geriatric assessment for older hospital patients. *British Medical Bulletin.* 71, 45-49.

Harari D, Hopper A, Dhesi J *et al* (2007a) Proactive care of older people undergoing surgery ('POPS'): designing, embedding, evaluating and funding a comprehensive geriatric assessment service for older elective surgical patients. *Age and Ageing.* 36, 2, 190-196.

Harari D, Martin F, Buttery A *et al* (2007b) The older person's assessment and liaison team 'OPAL': evaluation of comprehensive geriatric assessment in acute medical inpatients. *Age and Ageing.* 36, 6, 670-675.

Harwood R, Kempson R, Burke N *et al* (2002) Specialist nurses to evaluate elderly in-patients referred to a department of geriatric medicine. *Age and Ageing.* 31, 5, 401-404.

Inouye S, Bogardus S Jr, Charpentier P *et al* (1999) A multicomponent intervention to prevent delirium in hospitalized older patients. *New England Journal of Medicine.* 340, 9, 669-676.

Orem D (1991) *Nursing: Concepts of Practice.* Fourth edition. Mosby, St Louis MO.

Rockwood K, Song X, MacKnight C *et al* (2005) A global clinical measure of fitness and frailty in elderly people. *Canadian Medical Association Journal.* 173, 5, 489-495.

Roper N, Logan W, Tierney A (1980) *The Elements of Nursing.* Edinburgh, Churchill Livingstone.

Royal College of Nursing and British Geriatrics Society (2001) *Older People's Specialist Nurse: a Joint Statement from the Royal College of Nursing and the British Geriatrics Society.* RCN/BGS, London.

Stott D, Buttery A, Bowman A *et al* (2006) Comprehensive geriatric assessment and home-based rehabilitation for elderly people with a history of recurrent non-elective hospital admissions. *Age and Ageing.* 35, 5, 487-491.

Stuck A, Siu A, Wieland G *et al* (1993) Comprehensive geriatric assessment: a meta-analysis of controlled trials. *The Lancet.* 342, 8878, 1032-1036.