Autumn 2017 spotlight on......Elderly Care Orthopaedic Nurses

Standard 8: Every patient who is identified locally as being frail has a Comprehensive Geriatric Assessment within 3 days of admission.

Many patients presenting with hip fractures are frail and have complex medical problems. Collaborative working with Geriatricians has been shown to improve the standards of medical care in this frail group.

There are a number of models of orthogeriatric care such as specialist nurses who provide advice on medical care on a regular basis in the orthopaedic ward and Advanced Nurse Practitioner roles are to deliver support in the identification and management of frailty, including participating in the delivery of Comprehensive Geriatric Assessment.
Diane Whiteside, Elderly Care Ortho Nurse (ECON) shares her experience in implementing a cohesive service in Glasgow.

Before coming into post in April 2015 Ortho geriatric liaison was facilitated by the Charge nurses or senior charge nurses within the ortho wards. These ward rounds were lengthy and often the complex history of the patients were unknown by the staff meaning long trails through case notes to find the appropriate information.

The investigations that were requested by the DME clinicians were often not ordered or chased due to other clinical priorities meaning longer stays for patients prior to discharge/ transfer to offsite rehab. There was a clear need for a closer collaboration between orthopaedics and DME.

We now have a system where we have 3 DME rounds a week with the ECON highlighting which patients require assessed. This has enabled the rounds to be much more efficient with most information known at that point. Investigations are ordered at the point of ward round within the scope of the ECON. Thus, eases pressure on ward doctors and nurse practitioner workloads.

Out with these days the ECON will complete a comprehensive geriatric assessment on all NOFs with the aim to meet the 72hr target and highlight any issues which may arise.

By doing this and following up on investigations promptly we have seen an improvement in the number of patients seen by day 3 from 27% in 2015 to 61% in 2016 and continues to improve in 2017.

Challenges to this post have been limited ECON weekend cover and no backfill for the post. If our NOF patients come in over a weekend most will have breached by the Monday morning. This also means during annual leave the system reverts back to the previous service.

There are plans for a 2nd ECON secondment enabling a 7 day service. Thus being able to meet the 72hr target and allowing better collateral histories and delirium work to be done.

As part of this role I have been able to incorporate becoming a dementia champion into my day to day workload focusing also on delirium and 4AT assessment. Developing quality improvement projects around AWI, 4AT and bowel management with our NOF patients.

We have looked at who requires an AWI do they have one and if so do they still need it.

We have looked at whether patients have appropriate laxatives prescribed and the use of these and finally we have looked at 4AT assessment and the implementation of the TIME bundle.

I am now part of a hip fracture forum within orthopaedics with all members of the MDT which has been developed to highlight issues around this patient group.

This post is developing and changing all the time but so far with the help from the wider team our hip fracture patients have seen a much smoother, pleasant and quicker journey home than ever before.
Susan Duffy, Ortho Geriatric nurse practitioner within NHS Forth Valley describes how her role has impacted on the care of vulnerable people with this injury.

This new role has been implemented primarily to ensure complex geriatric assessment and maximum medical optimisation of the hip # patient but has proven to have an impact across the journey from admission to discharge. I have been fortunate to shadow the full time specialty geriatrician in ensuring assessment from as early as day 0 and daily input when required using a structured ward round approach.

Achievements to date include:

- Improved the rates of Comprehensive Geriatric Assessment in Hip Fracture Patients from 52% in 2016 to 100% in August 2017
- Assessment of bone health has also improved from 72% in 2016 to 100% in August 2016 
  Standardisation of documentation to mirror current guidelines
- Structured ward round and feedback system to minimise risk of missed clinical deterioration
- Relationship building with MDT and wider local services to better understand resources
- Development of repatriation resource for streamlining in safe discharge planning to home authorities
- Assist with audit collection as part of continuous improvement
- Liaise with families/carers and patients managing expectations and setting goals for safe discharge / delivering difficult news and answering questions freeing medical staff

Challenges:

- Finding a place in the team and building trusting relationships with medical and nursing staff
- Developing a routine whilst supporting junior medical and nursing staff
- Continuing with personal development and continuing education in advanced practice

Planned work:

- Trial of My Hip folder- providing personal resource of the Hip # journey
- Trial of documentation in fluid fasting to improve recording and reduce fluid fasting times
- Continue to network and build relationships
- Continue to review and develop documentation
- Continue to attend MDT forums and share with others.

WHERE CAN I FIND OUT MORE?
Tools and resources are available on the Scottish Hip Fracture Audit website www.shfa.scot.nhs.uk.