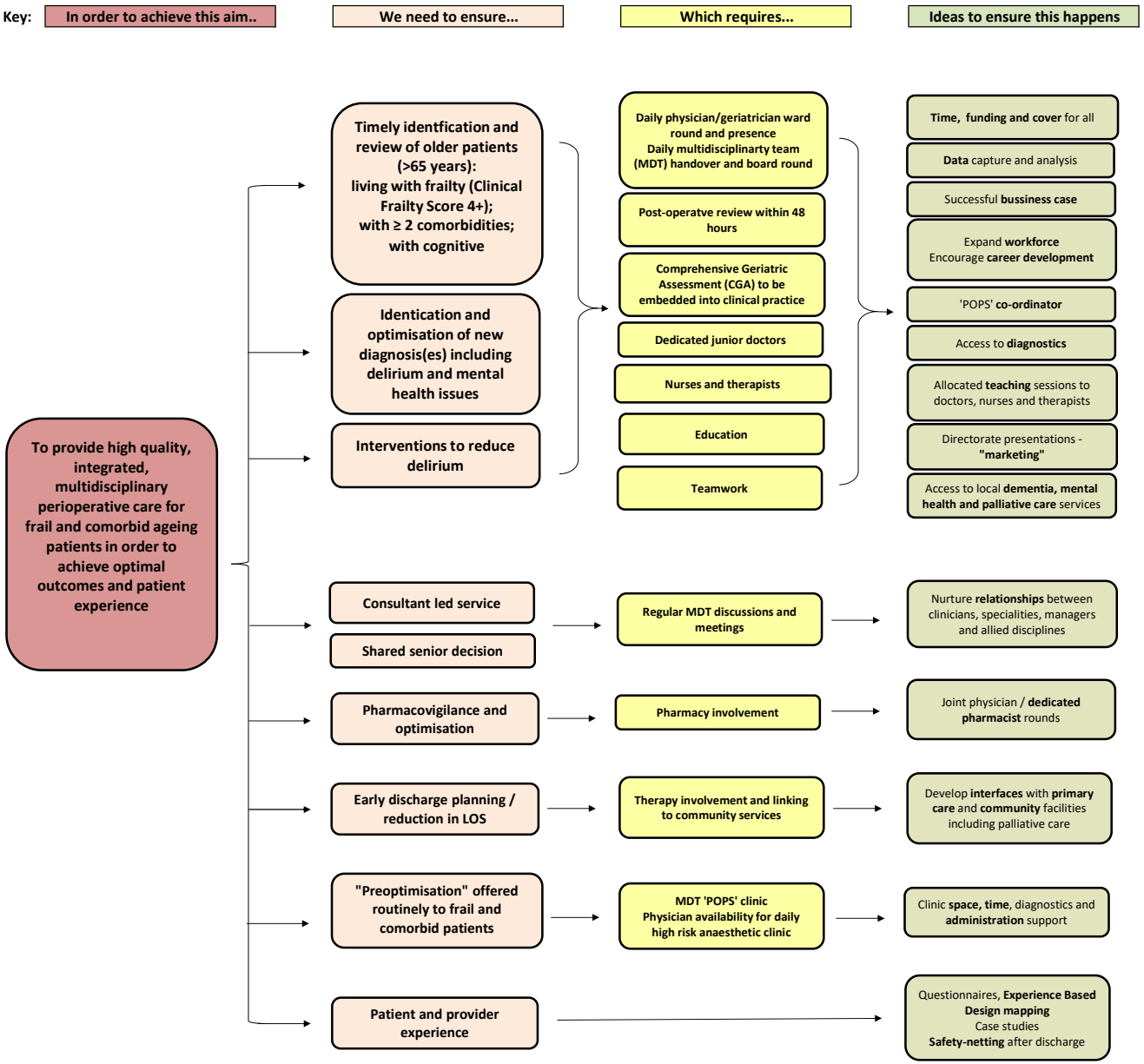
Key:
In order to achieve this aim..
We need to ensure...
Which requires...
Ideas to ensure this happens
To provide high quality, integrated, multidisciplinary perioperative care for frail and comorbid ageing patients in order to achieve optimal outcomes and patient experience
Timely identfication and review of older patients (>65 years): living with frailty (Clinical Frailty Score 4+); with ≥ 2 comorbidities; with cognitive
Identication and optimisation of new diagnosis(es) including delirium and mental health issues
Interventions to reduce delirium
Daily physician/geriatrician ward round and presence
Daily multidisciplinarty team (MDT) handover and board round
Post-operatve review within 48 hours
Comprehensive Geriatric Assessment (CGA) to be embedded into clinical practice
Dedicated junior doctors
Nurses and therapists
Education
Teamwork
Time, funding and cover for all
Data capture and analysis
Successful bussiness case
Expand workforce
Encourage career development
'POPS' co-ordinator
Access to diagnostics
Allocated teaching sessions to doctors, nurses and therapists
Directorate presentations - "marketing"
Access to local dementia, mental health and palliative care services
Consultant led service
Shared senior decision
Regular MDT discussions and meetings
Nurture relationships between clinicians, specialities, managers and allied disciplines
Pharmacovigilance and optimisation
Pharmacy involvement
Joint physician / dedicated pharmacist rounds
Early discharge planning / reduction in LOS
Therapy involvement and linking to community services
Develop interfaces with primary care and community facilities including palliative care
"Preoptimisation" offered routinely to frail and comorbid patients
MDT 'POPS' clinic
Physician availability for daily high risk anaesthetic clinic
Clinic space, time, diagnostics and administration support
Patient and provider experience
Questionnaires, Experience Based Design mapping
Case studies
Safety-netting after discharge