Older Person's Assessment & Liaison service

NHS
Salisbury
NHS Foundation Trust

# OPAL Referral checklist

## Your patient could benefit from referral to OPAL for specialist services for the frail older person.

**Referral criteria**

Aged 65+ with moderate to severe frailty who would benefit from early intervention from the elderly care team to support an early discharge.

**Consider if one or more of the below criteria is met:**

| | |
|---|---|
| 1 | Potential for early discharge/same day discharge |
| 2 | Falls |
| 3 | Decreased mobility |
| 4 | Not coping at home/Social issues/Nursing home/Residential home |
| 5 | Medication management review |
| 6 | Delirium/dementia |
| 7 | New onset/worsening incontinence |

**The OPAL team operate Monday to Friday to assess, treat and review patients in ED, SSEU and MAU.**

# Referral: Bleep 1129

Monday - Friday 8am – 4pm

*(see OPAL pathway for further details of the process)*

Older Person's Assessment and Liaison team
OPAL

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# OPAL Pathway

## Referral

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**ED/SSEU/MAU staff refer patient to OPAL by BLEEP 1129 to put on pathway within 1hour**

## Assessment

**OPAL will see the patient within 2 hours of the referral** and initiate the CGA and PCP.
A Geriatrician will be available to advise within 24 hours of the referral.
**The patient remains under the care of the admitting specialty**

### Discharge

Appropriate patients will be **referred to IDB team** for discharge home supported by community teams or discharged to an intermediate care or community bed

**OPAL will support discharge** through liaison with the patient's GP, Frailty Lead or Care Coordinator verbally or by Electronic Discharge Summary (EDS) within 24hrs of admission. This will hand over the patient's PCP

**Direct clinic referrals can be made by OPAL** to: RACE clinics/ falls clinic/ other medical specialist clinics/ specialist nurses in community

### Inpatients

The aim is that patients who need admission will be admitted directly to Durrington or Winterslow wards **within 24hrs**

The aim is that patients will be discharged from Durrington **within 5 days** or moved to Winterslow for ongoing medical/ therapy input

Winterslow will provide ongoing care and proactive discharge plan for patients with an **LOS (>5 days)**

Appropriate patients will be supported by the OPAL team for **safe and timely discharge, through close working with integrated community services**

**OPAL will aim to give low level support at home** as necessary with discharge home visit, therapy assessment & re-ablement care

*Delivering an outstanding experience for every patient through joined up working*