Health Education England

Portsmouth Hospitals NHS
NHS Trust

Frailty

Improving the recognition and management of frail older patients in acute care

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1. Aim

- Improve recognition and management of those who are frail (75+ years) presenting to the Emergency Department (ED) measured by reducing admission to hospital from the ED, increasing patients being discharged by 72 hours without increasing re-attendances at ED or time spent in ED

2. Background

- Frailty is a health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people living with frailty are at risk of adverse outcomes after an apparently minor event eg infection, new medication (British Geriatrics Society)
- Identifying older people with frailty is recommended by national guidance. There is not one prescribed way to do this in a secondary care setting
- Comprehensive Geriatric Assessment (CGA) is multi-domain assessment (medical, social, environmental, functional, psychological) by one or more specialist health care professionals
- Improving recognition and management is of those who are frail is recommended by national guidance & led to better outcomes for patients, and the urgent care system, elsewhere

3. Project design

- Data available, audit, patient and carer experience, multi-disciplinary and departmental professional opinion to consider potential improvements
- Screening at presentation for frailty and development of early management identified as key first step to achieving improvement

Fig 1. Driver diagram

Aim	Primary Drivers	Possible Interventions
Timely, effective and safe care for frail older patients admitted through the Emergency Department/Acute Medical Assessment Unit medical pathway Frail – presenting with confusion, reduced function (new or usual), immobility, fall in last 3 months Older – 75 and over (65 and over from care home)	Consistent identification of frail older patients (1)	Working definition and identification tool (1)
		Screening at presentation (1), (2), (3), (4)
		Staff education/awareness of frailty
	Providing safe care – delirium management, continence management, cannulae and devices, falls management and assessment, prevention of pressure sores, VTE prevention, assessing and managing for nutritional requirements (2)	Recognition of delirium and management
		Staff education delirium/catheters/VTE
		Processes/screens for routine assessment and management (2)
		Provision of equipment where required within a short time frame (<4 hours)
	Comprehensive geriatric assessment (mutli-disciplinary) (3)	CGA document/pathway (3), (2), (4)
		Mobility/physiotherapy assessment and plan (3)
		Collateral history (3), (4)
	Patient and carer involvement early (4)	Awareness of any end of life/advanced care plans (3)
	Ability to discharge patient with appropriate community input (5)	Identifying care home patients early (1), (3)
		Community in reach(pull model) and information – locality based (3)
		Ambulatory FUP/Community response (5)
		Discharge to assess (5)

4. Changes made

- Frailty screening tools adapted and implemented in the Emergency Department using Plan Do Study Act (PDSA) cycles – more than 80% of patients are now screened by ED nursing staff (Fig.2)
- Proactive input by Frailty and Interface Team to do early initial CGA – 38% (compared to baseline of 0%) of those screened positive for frailty now receive an initial CGA in the ED
- CGA document developed and implemented in the Medical Assessment Unit (MAU) for patients seen by the frailty team
- Patient experience - as a result of the initial work done to understand this there is a link nurse for frailty in the ED
- Education sessions for ED and MAU nurses and doctors

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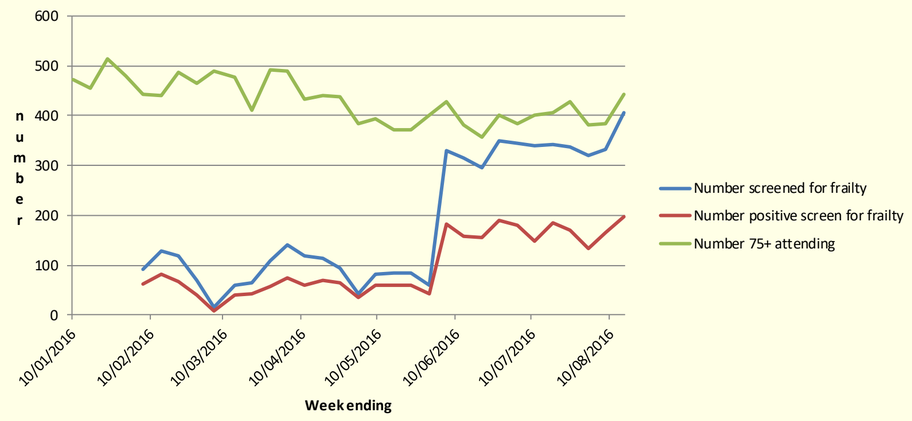
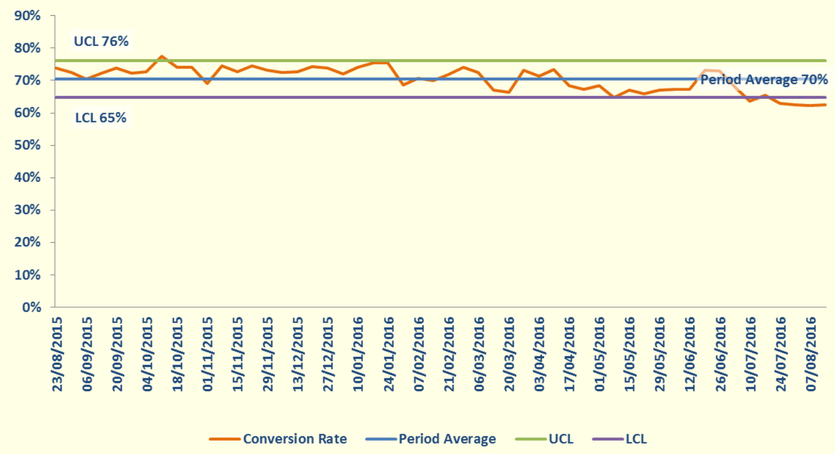
Fig.2 – Frailty Screening in the ED for 75+ years patients



5. Outcome

- The conversion rate (numbers of patients admitted from the Emergency Department has fallen (see Fig 3.) – other pathway changes may have contributed but temporally there is a reduction from the introduction of the screening and team from February 1st 2016
- <72 hour length of stay has not reduced to date
- Time in ED and re-attendance has been stable

Fig. 3 Conversion rate (% of patients aged 75+ years attending the ED that are admitted)



6. Sustainability

- Frailty screening routine in the ED and frailty flag on bed management system – will be utilised for development of outreach assessments to other areas
- Regular training for ED and MAU staff planned to continue
- Acute frailty group with multi professional & organisational representation will be continued
- Frailty measurement dashboard now in place and utilised

7. Lessons Learned

- Measurement helpful in PDSAs (eg time taken to do a screen) and sharing data important for engagement
- Small scale PDSAs can be powerful – don't make them too big (numbers and time to do)
- Process measures were challenging to capture for frailty – no routine ones in use prior - use less measures and define them more precisely
- Wide engagement including staff in ED/MAU, external to the hospital (eg ambulance service, adult social care, community providers) was helpful – understand what is happening already, what is needed and active, regular communication
- Patient experience work helped support the changes

8. Next Steps

- Frailty screening and input of outreach team across the hospital (eg SAU, AMU direct admits)
- Further development of CGA processes and documentation
- Education and training strategy for frailty
- Development of short patient experience videos to use with staff