Frailty Team on an Inpatient Ward

Health Education England

1. BACKGROUND

Frailty is seen in older patients in whom there is a loss of resilience to stressor events due to a loss of built-in reserves. Frail patients are at risk of an adverse effect on their health when faced with such stressors such as admission to hospital and risk poorer outcomes due to increased length of stay.

2. Aims : To reduce length of stay of frail patients by input from the frailty team on a non geriatrician led general medical ward .

3.Frailty Team When the project started the team consisted of a lead consultant, frailty matron, 3 band 7 frailty practitioners (nurse and occupational therapists), a registered mental nurse, a pharmacist, specialising in frailty and a speciality doctor in frailty.

4.Design and Methods

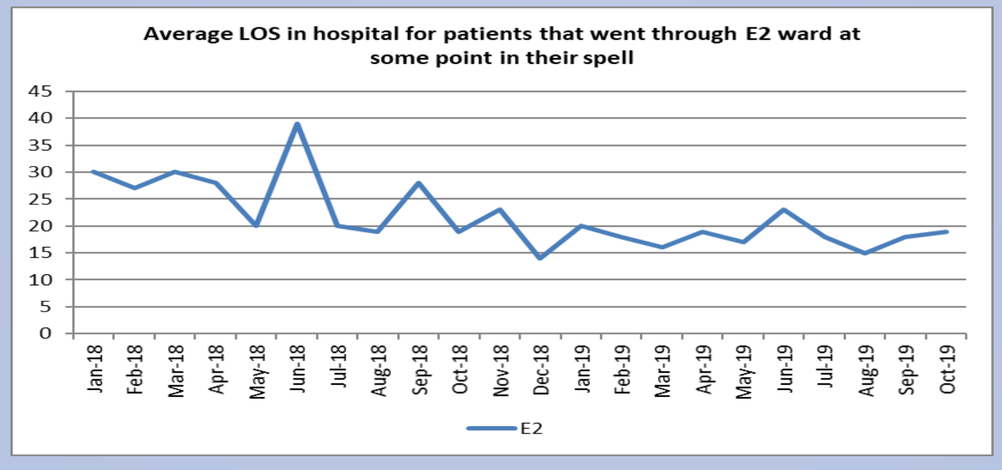
For the purpose of the study patients were classified as frail if they were over 80 years and had one or more of the following issues:

- Had a diagnosis of dementia or cognitive impairment
- Been admitted with a fall or be a recurrent faller
- Live in a nursing or residential home
- Had reduced mobility due to sarcopenia or muscle weakness.

We attended the daily (M-F) board round, reviewed patients notes to screen for frailty and excluded patients using specific criteria . Data recorded included

- the date of the patient being admitted to the ward
- discharge date, subsequently the MFFD(medically fit for discharge) , we recorded
- whether a CGA was completed and reasons why if not and if the frailty team had any input

offered valuable support in communicating with other teams



very grateful for input

Learning outcomes

- Having continuity of ward medical staff showed improved outcomes , enabling to have excellent knowledge of all the patients , and take a more holistic approach looking at other areas including advanced care planning. The continuity of care helped with reducing length of stay of the patients from the beginning of 2019.
- Education of ward staff important at the start of a project
- Addressing the cause of delays
- Increasing use of frailty pharmacist
- Recording of clinical contact input
- More joint assessments

Pronblems encountered

Staff shortages
Professional boundaries

Moving Forward

- Liaison service for patients likely to be discharged within 72 hours
- Primary- secondary care MDT to improve communication to improve on going patient care
- Improve awareness of frailty and the Frailty team across all areas of the hospital
- Frailty Clinics
- Continuing with the work in ED

that information obtained from the CGA was very helpful in identifying the patient's needs,

Other benefits to input. As well as the CGAs We were able to ensure prompt and early follow up in rapid access outpatient clinics , liaison with other services.
Some positive qualitative feedback came from therapy staff and junior doctor and relatives