IMPROVING THE CARE OF FRAIL PATIENTS

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1.0 Background

There is an increasing amount of evidence suggesting that improving the identification and management of patients with frailty can improve both patient and service outcomes.

On commencement of this work the Basingstoke and North Hampshire Hospital (BNHH) had no frailty pathway or processes to recognise, assess or manage the needs of frail patients. As a result some patients were being admitted unnecessarily or staying longer than they medically required.

3.0 Project approach

❖ A multiagency, multidisciplinary project group was established, meeting bi-weekly to agree changes ideas and monitor progress.
❖ In the early stages the group developed a driver diagram to understand the influencing factors and help develop the change ideas (Fig 1).
❖ The improvement work has been undertaken using plan-do-study-act (PDSA) testing cycles.

Figure 2: New frail patient pathway process map

2.0 Aim and objectives

Aim:
At BNHH we will reduce the time frail patients stay in hospital by 10%, by September 2017.

Objectives:
❖ To systematically identify frail patients soon after arrival
❖ To carry out specialist assessment and care planning
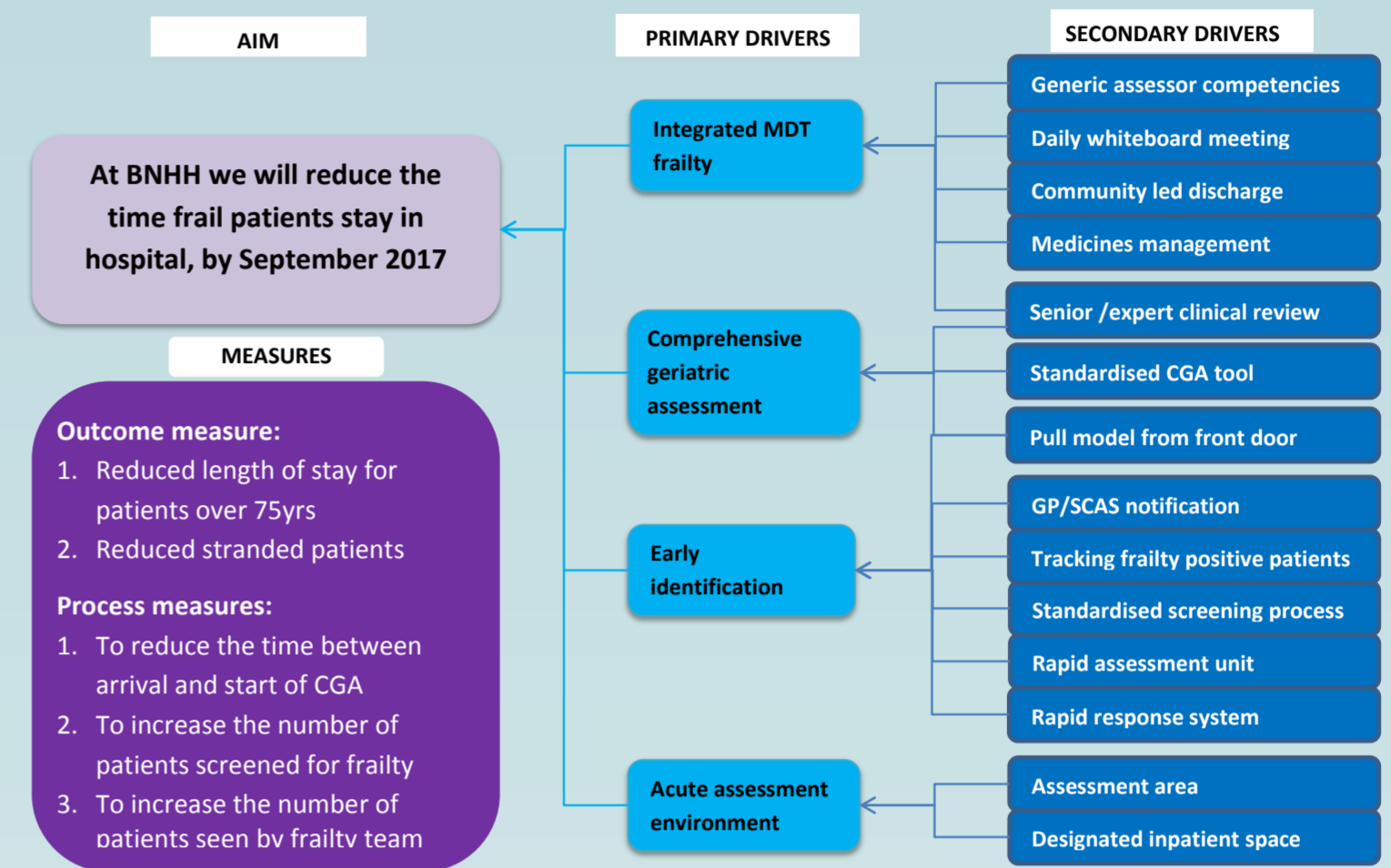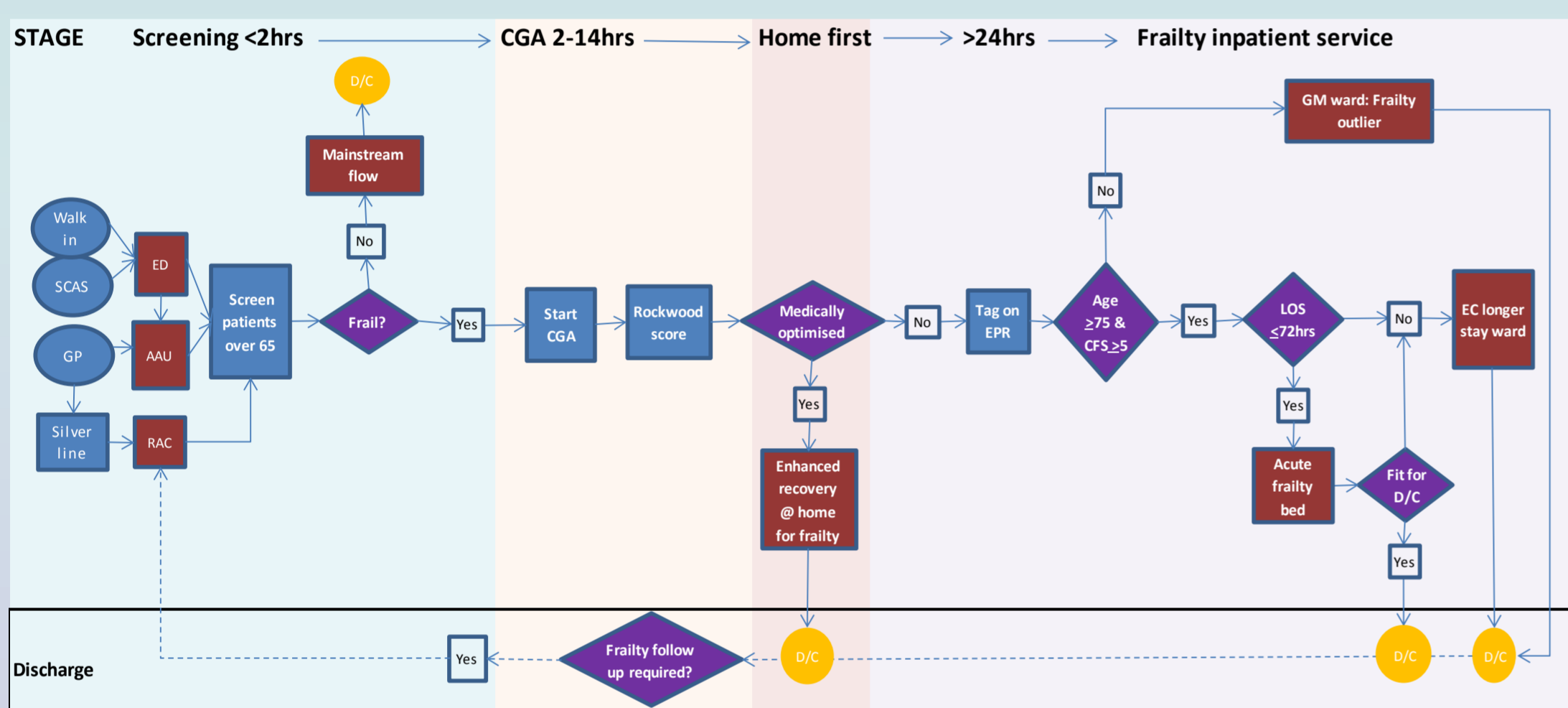❖ To stream patients to the right place for the right care
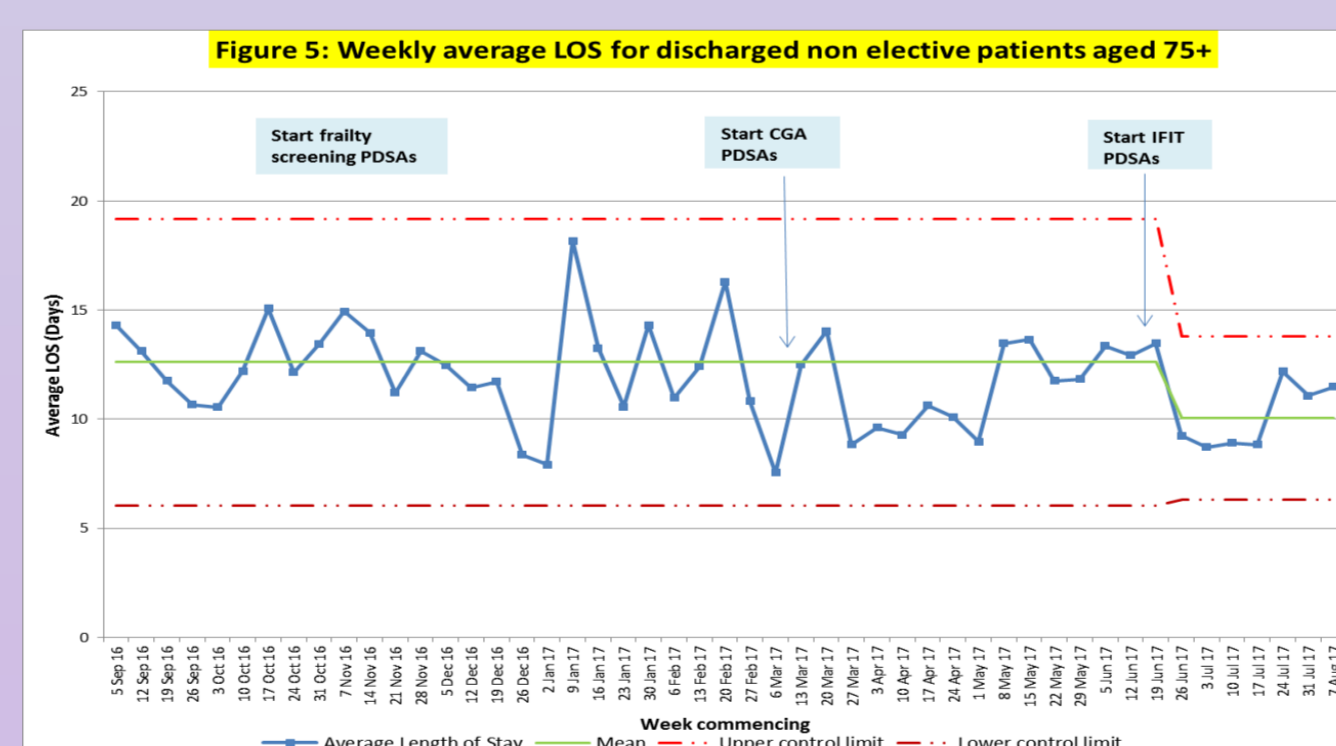
Figure 1: Driver diagram

4.0 What we did

❖ Introduced a frailty screening tool using PDSA cycles.
❖ Developed a comprehensive geriatric assessment (CGA) tool with the multidisciplinary team.
❖ Redesigned the frail patient pathway through process mapping (Fig 2) to stream patients to the right ward for their needs.
❖ Developed an electronic patient tracking system.
❖ Set up the Integrated Frailty Intervention Team (IFIT): a multidisciplinary team with members from acute and community services

5.0 Results

Following the changes we have introduced, we now screen an increasing number of patients over 65 years for frailty (Fig 3).
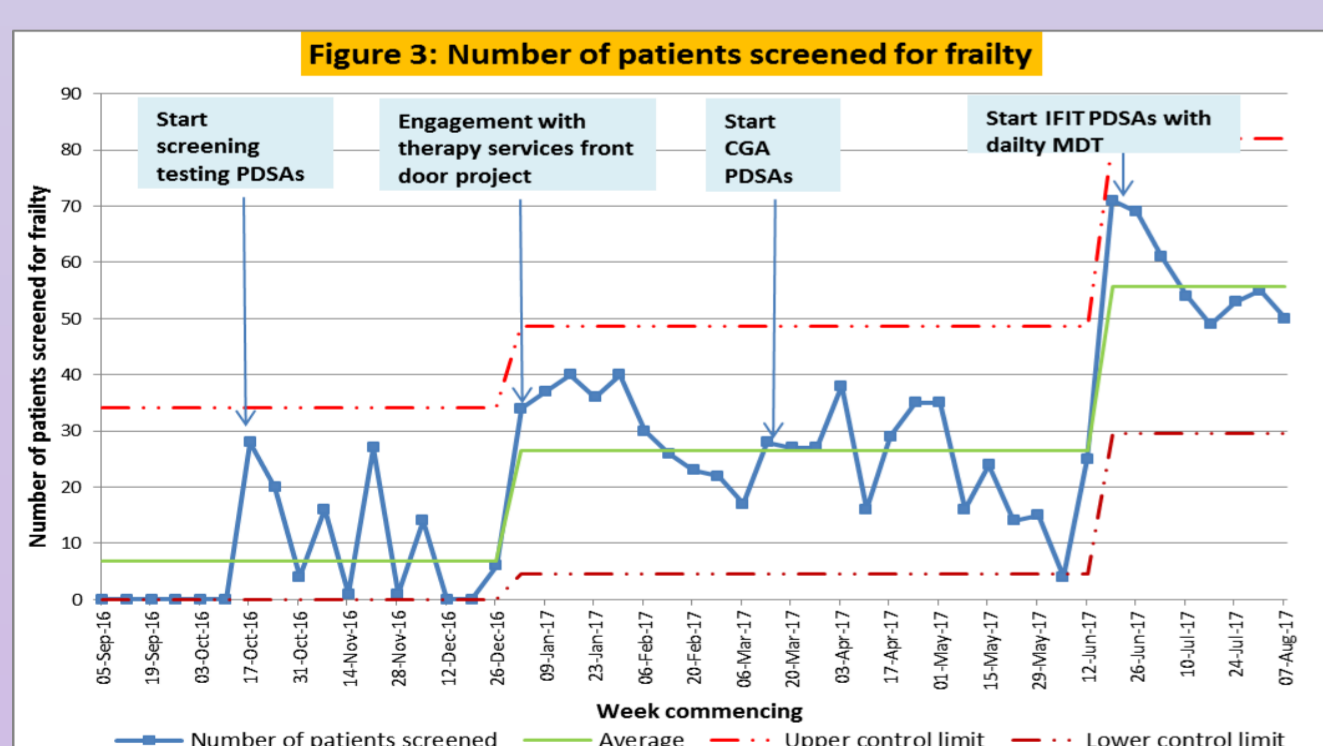
We have started to see improved patient outcomes. Average lengths of stay of patients, over 75 years, have reduced by 21% from 12.6 to 10 days (Fig 5).
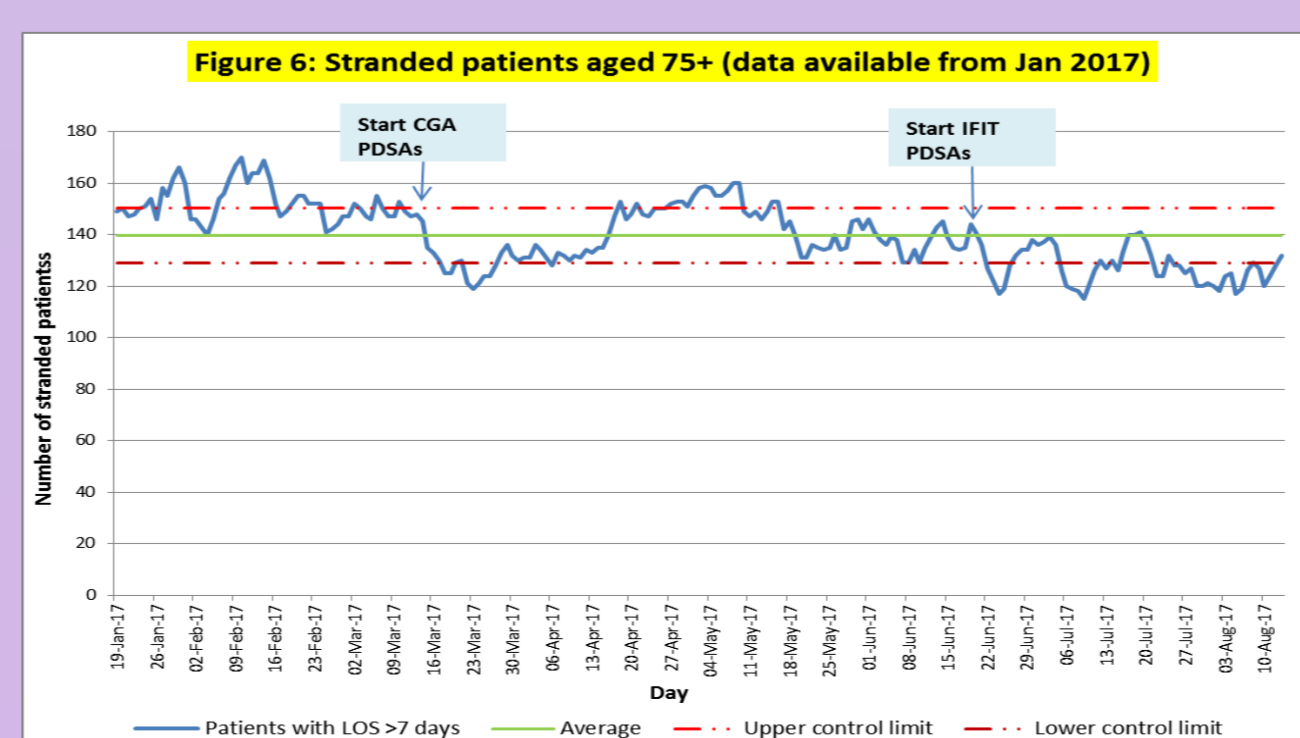

Figure 3: Number of patients screened for frailty

Figure 5: Weekly average LOS for discharged non elective patients aged 75+

We have reduced the time taken from arrival to commencement of CGA by 85% so frail patients are receiving specialist care planning earlier in their stay (Fig 4).
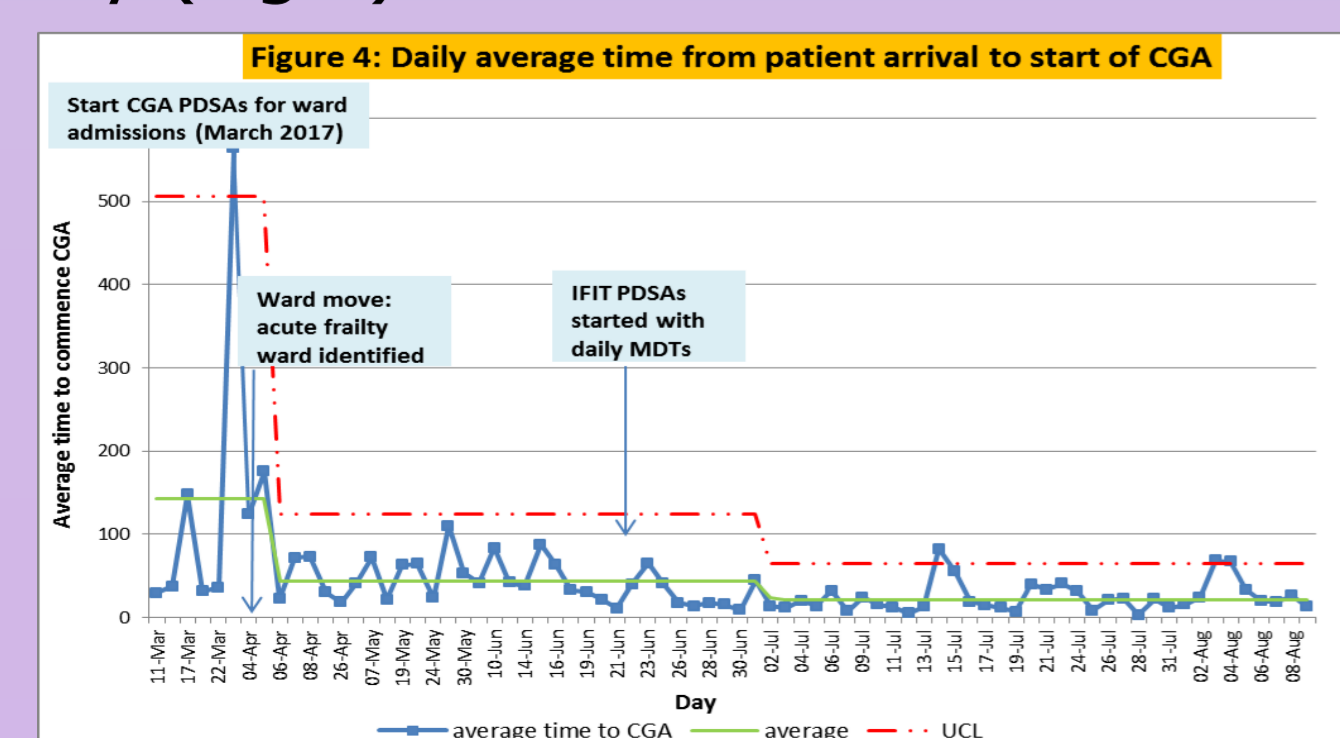
We have seen an 18% reduction in the number of patients staying more than 7 days (i.e. stranded patients) since the start of the year (Fig 6).

Figure 4: Daily average time from patient arrival to start of CGA

Figure 6: Stranded patients aged 75+ (data available from Jan 2017)

6.0 Learning

❖ Small scale PDSA cycles are a really effective way of finding what really works for you. We have discovered solutions we may otherwise have missed by only testing small changes.
❖ Expect plenty of 'false starts' and 'misfires'. They offer valuable learning.
❖ Data collection is challenging and requires a lot of testing.
❖ Just measure what you really need to keep things manageable.
❖ Be adaptable and look out for new opportunities and threats that may emerge.

7.0 Next steps

❖ The frailty journey continues. We have embedded solid foundations for sustainable improvements and developed an improvement mind-set amongst the team.
❖ Going forward there will be an increased focus on acute frailty in ED and further staff engagement.
❖ We also hope to seek feedback from service users through an experience based co-design approach.

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