Frailty
Improving the recognition and management of frail older patients in acute care
Claire Spice (Consultant Geriatrician, Portsmouth)

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 multidomain 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

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

Contact: claire.spice@porthosp.nhs.uk

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

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