The Frailty Journey

Emergency Department
Royal Berkshire Hospital
2015-2018

16th March 2018

Dr Ruth Weldon, Anna Puddy

Frail Elderly Revolution

– Over the next 20 years the number of people 85+ is set to by 2/3

– 20% ED attendances 65+ years = CORE BUSINESS

– Prof Oliver describes ageing and frailty as a GAME CHANGER

– 4 hour target skews decision making in this complex group
Frailty is the no. 2 research priority in EM

Royal Berkshire NHS Foundation Trust

Aim “To provide the best healthcare in the UK for our patients in our community”

- **POPULATION:** 500,000 patients in Berkshire, South Oxfordshire.
- **CHALLENGES:**
  - Older patients attending ED ↑ 25% in 4 years
  - ED lack of flow, trolley waits, busy staff
  - No priority for frail patients, no time to care
  - Vacancies in Interface Geriatrics
Low risk Obs Bay was High Risk

Assessing for Cognitive Impairment in Older People
Clinical Audit 2014-15

Standard

1. All patients over the age of 75 are assessed for cognitive impairment in the ED.
2. Assessments are done using a structured tool.
3. The findings are provided to the inpatient teams.
4. The findings are provided to the patient’s GP.
5. Information is given to the patient’s carers.
6. All patients over the age of 75 have at least one Early Warning Score assessment.
The purpose of the Acute Frailty Network is to optimise acute care of frail older people in England, but no one model will fit all systems, although the guiding principles can be derived from the existing evidence base, and locally adapted.

Professor Simon Conroy, Dr Jay Banerjee, Leicester

- 10 pilot sites
- 12 month collaborative improvement programme
- Regular national workshops, masterclasses & webinars
- Local working group ED, Interface Geriatrician, OT, Physio, Manager
- Site visit and peer review

What does good look like in frailty care?

1. Early identification of people with frailty
2. Comprehensive Geriatric Assessment (CGA) within the first hour
3. Rapid response system for frail older people
4. Clinical professional standards to reduce variation
5. Measurement mind-set
6. Strengthen links with services inside and outside hospital
7. Education and training for key staff
8. Identify clinical change champions
9. Patient and public involvement
10. Identify an executive sponsor and underpin with a robust project
2015: RBH data - Seeing more patients, and they stay less time...

ED OT

EDOT Activity by Type

- Total Patients Discharged (admissions avoided)
- Unable to Discharge (no community capacity)
- Unable to Discharge (no SS capacity)
- Referrals to Community Services
- Referrals to Social Services
Clinics for the Older Person

RACOP
- Rapid Access Clinic for the Older Person!
- Multi-disciplinary assessment, led by Dr. Wearing to assess, treat and avoid admission
- 4 clinics a week, seen within 7 days or 48 hours if urgent
- Need to transfer with 1, may take up to 3 hours

Bleep 510 in hours
Fax 6704 Out of hours

FALLS CLINIC
- Consider in all falls presentations
- Weekly, led by Dr. Pearson
- Nurse, Physio and OT review
- Not suitable if have cognitive impairment
- Review patients medications before referral

FAX referral to 6544

Frailty Awareness

All patients 65 years and over
Is this patient at risk of frailty?

<table>
<thead>
<tr>
<th>Assessment</th>
<th>When?</th>
<th>By? (name &amp; grade)</th>
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<tbody>
<tr>
<td>Cognition</td>
<td></td>
<td></td>
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<tr>
<td>Mobility</td>
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<tr>
<td>Function</td>
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<tr>
<td>Continence</td>
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<tr>
<td>Medication review</td>
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If YES to any of the above, the patient is at risk of frailty, and would benefit from a CGA. Please record completion of CGA on all frail patients.
12 Days of Geriatric ED

- 12 ladies falling
- 11 bit confused
- 10 men collapsing
- 9 trolleys waiting
- 8 fractured hips
- 7 short of breaths
- 6 angry relatives
- 5 UTI's
- 4 found on floor
- 3 can't walk
- 2 broken wrists
- 1 Obs Bay that is full up

Recognising Frailty in ED Audit 2015

- Audit of current practice based on silver book recommendations
- Documentation of basic aspects of CGA and frailty syndromes

- RESULTS: Poor documentation of all aspects of CGA and frailty

- CONCLUSIONS: Poor recognition of frailty in older patients
- ACTION PLAN: Standardising frailty identification
  Continue education sessions about frailty
2016: Increasing national focus on frailty
   Diploma in Geriatric Medicine
   First Geriatric Emergency Medicine Conference, Leicester
   Frailty at the Front Door, RCP

TEAM ENGAGEMENT IN ED WAS A CHALLENGE

ELDERLY CARE TEAM HAPPY WITH THEIR SERVICE in AMU

Where is the Front Door?

Feb 2017: Think PD in ED

- Highlight all PD patients on arrival
- PD patients must NEVER miss or delay their medication
- Do not give Dopamine Antagonists Haloperidol, Antipsychotics, Prochlorperazine or Metoclopramide (HARM)
- PD drugs available in ED Resus
- Awareness of PD Nurse, PD Guidelines and resources
On arrival to ED

- Identify PD Patient at STAT on EPR
- Establish PD drugs and timings
- Ensure drugs are given on time in ED

PD Results

<table>
<thead>
<tr>
<th>% PD patients with yellow sticker</th>
<th>% PD patients getting meds on time</th>
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<tbody>
<tr>
<td>10</td>
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<td>9</td>
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EDucate evening on PD and Frailty

We had improved PD care in ED which felt GOOD

“MY GRANNY” MEDICINE

Could we do better??

100% said YES

CEO Transformation Funds: 2017

£1million to improve services for our patients in a financially efficient way

- Successful bids demonstrate:
  - A team approach with energy and commitment
  - An innovative approach to changing the way that services are delivered for patients
  - A real cash releasing efficiency saving

Application process followed by Elevator pitches to the CEO Board
The Big Idea: To identify patients at risk of frailty in ED, and for those not medically unwell, to be assessed by Frailty Practitioners to arrange timely discharge home or to alternative pathways.

What should this achieve:

- Frailty Screening for over 65s in the ED
- Reduced average length of stay and conversion rates for frail patients in ED
- Comprehensive Geriatric Assessment at the front door
- 4AT Delirium assessments in all patients seen by frailty practitioners
- Improved awareness of Parkinson’s patients and their needs
- Improved communication with patients, relatives and carers
- Improved networking with alternative pathways: RACOP, RRAT, Falls clinic, RACU, EDOT
>340 patients a day,
60-80 patients at a time
24 trolley spaces
New career in corridor medicine

Every frail patient should get an emergency response
Right Patient, Right Place, Right Time

- Think Frailty +65s
- If not acutely unwell Frailty Practitioner review
- Decision making Plan Action

- discharges to home or appropriate community pathway
- improved liaison with ECPOD, RACOP and community teams

Paed ED Improvements in 10 years

- Paeds ED
- Paed Emergency Consultant
- Paediatric nurses
- Improved teamwork
- High quality patient care
The Frailty Friendly Front Door has gone live!

Frailty Practitioners are now in the Emergency Department

Bleep 579

8am – 8pm, 7 days a week

The team will be carrying out parallel assessments alongside the Emergency Department doctors, to expedite prompt discharge home and/or referral to alternative pathways, for patients living with frailty.
THINK FRAILTY ON ARRIVAL
IN ALL over 65s

- Falls
- Reduced mobility
- Acute/chronic confusion
- Is known Parkinson’s
- Lives in a Care Home

THINK 5 TO GET HOME FIRST

What have we achieved?

<table>
<thead>
<tr>
<th>ED (USING FRAILTY FLAG from 14th Dec)</th>
<th>BEFORE 16th Dec to 7th Jan</th>
<th>AFTER 8th Jan to 8th March</th>
<th>VARIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendances (ave day)</td>
<td>22.5</td>
<td>22</td>
<td>-0.1</td>
</tr>
<tr>
<td>Re-attendances (ave day - within 72 hours)</td>
<td>5</td>
<td>2.5</td>
<td>-2.6</td>
</tr>
<tr>
<td>Re-attendance Rate (within 72 hours)</td>
<td>22.8%</td>
<td>11.2%</td>
<td>-11.6%</td>
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<tr>
<td>Average Length of Stay in ED (mins)</td>
<td>272</td>
<td>237</td>
<td>-35</td>
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Frailty Patients - Average LoS in ED
Frailty Practitioner Activity Jan – Feb 2018

JAN: total 224 – Av 8/day

February: total 255-av 9/day

Frailty Practitioners: Patient’s Next Steps from ED

- Total Disb bus overnight
- Total admitted
- Total same day discharges
Frailty Practitioners: Patient Journey from ED

- Admitted (+/- obs bed)
- Discharged (+/- obs bed)

January
February

THINK 5 referrals - February 2018

Number of referrals:
- EDOT
- RACOP
- Falls Clinic
- THINK 5
- RMT
- RACU
Quality Benefits

Improved patient-centred care during the busiest ever ED period

- Positive patient, carer and staff feedback
- Positive feedback from RRAT, RACOP Consultants, Elderly Care Clinical Governance, Falls Clinic, ED Team
- Establishing formal patient, carer and staff feedback daily

TOP TIPS

- Team engagement – persist, smile, repeat
- Specialty Team and community involvement – persist, smile, repeat
- Grab attention and educate at every opportunity
- Board rounds, Clinical Governance, Newsletters, Posters
- Reward good practice – awards, rosettes, Frailty Doctor of the day
- Make data collection and analysts your friends
Pitfalls

- Working with non-clinical teams Finance, Payroll, HR, EPR
- Be prepared for their different timescales to ED Doctors
- Develop new skills – write a business case, job descriptions
- Data collection, data collection, data collection
- Change can be hard for some colleagues – persist, smile, repeat
- Don’t give up, make it better

Questions?