Identification of a Frail Patient on the Acute Medical Unit

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Quality Improvement Initiative

AIM: To reduce the length of time taken by 20%, (for patient’s targeted as frail on their Rockwood score), to be referred to appropriate services. For health care professionals on the Acute Medical Unit to follow a devised pathway.

Ultimately to improve upon patient flow, enabling quicker assessment and implementation of the required needs for discharge.
‘Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparent minor event which challenges their health, such as an infection or new medication’ (British Geriatric Society, 2014).

‘It is estimated that one third of older patients admitted to acute hospitals as a medical emergency no longer require a hospital bed’ (NHS confederation, 2013).

Implementing an innovative project to detect frailty, support and interventions can be planned for once they are medically fit for discharge.
Process to Achieve the Aim

Baseline Measures

Average time for referral

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Process to Achieve the Aim

Frailty Audit % of Pts 75yrs + that have had their frailty score done 22/12/16

Across AMU A & B
Implementation Method

1) Increase urgency
2) Build guiding teams
3) Get the vision right
4) Communication for buy-in
5) Enable action
6) Create short-term wins
7) Don’t let-up
8) Make it stick

Creating a climate for change

Engaging & enabling the organization

Implementing & sustaining the change
Test of Change — Improving Compliance

% Fraility Score completed AMU

A

B

% completed

29/03/2017 30/03/2017 31/03/2017 01/04/2017 02/04/2017 03/04/2017 04/04/2017 05/04/2017 06/04/2017 07/04/2017

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Benefits

• Build professional relationships with community teams
• Increase the quality of engaging with the patient and assessing their needs
• Anticipate improvement in patient experiences
• Improve patient flow
• Identify patients early who will require a supported discharge
• Improves on green days and reduce red days
• Potentially reduced length of stay – therefore reduces financial implications
• CQUIN Targeted
What’s Next??

Frailty Care Pathway Acute Medical Unit

Identifying a Frail patient:
- Gain an in depth Collateral History on admission
- Define the patient's usual baseline
- Identify ongoing medications
- Identify if the patient receives any input from community services prior to their admission – have their needs changed? If so

Common indicators:
- Falls
- Cognitive Impairment
- Mobility
- Nutrition
- Polypharmacy
- Low mood
- Social Isolation
- Social problems

Rockwood 6
- Refer to Physio/OT/RATS/IHSS
- If needs of the patient have deteriorated
- If the patient's diagnosis be supported at home to aid an earlier discharge
- Discharge letter to identify GP patient required a Comprehensive Geriatric Assessment
- If remaining an IP – highlight to pharmacy patient requires a personalised medication review

Rockwood 7
- Discharge letter to identify GP patient required a Comprehensive Geriatric Assessment
- Discharge letter to identify Advanced care planning is required (if appropriate for that patient)
- Refer for extra community support if required
- If baseline has declined and can be managed at home refer to IHSS/RATS/PHYSIO/OT

Rockwood 8
- Where is this patient's preferred place of care?
  - Once deemed not acutely unwell refer to DN’s, social services and palliative care for an integrated supported discharge
  - Can the patient be managed at home for this acute admission? If so refer to IHSS/RATS
  - Advanced care planning required to be commenced as IP or via GP

Rockwood 9
- If this patient can be managed at home refer to IHSS/RATS/AMU’s Physio/OT
- Refer to palliative care
- Advise GP to commence advanced care planning in discharge letter

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Frailty So Far…

Audit results are celebrated, quality improvement teams are involved and published results into their communication emails, the monthly newsletter continue to celebrate the unit’s successes. Scoring patients for frailty is now a daily talk embedded onto the daily checklist as a compulsory task. Now progress can be made to teach staff what to do with the scores to therefore achieve the overall aim.
Thank you for listening