Frailty Nursing in Primary Care: Introducing a Practice Frailty Nurse

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FRAILTY & PRIMARY CARE

✧ May not be apparent unless actively sought

✧ May be overlooked if the focus is on disease-based long-term conditions

✧ May not be known to primary care until they become immobile, bed bound, or delirious as a result of an apparently minor illness or injury

A person-centred, goal-orientated comprehensive approach reduces poor outcomes and may reduce hospital admission
Comprehensive Geriatric Assessment

- Multidisciplinary diagnostic process...to determine frail older person’s medical, functional, and psychosocial status + limitations to develop plan for treatment and follow-up

- CGA can lead to improved function and quality of life, and reduce admission rates and institutionalisation.

- All staff involved in assessment and examination must have competence in older peoples care needs and have an in depth understanding of the long term condition management

Gold Standard Care in Frailty
Why?

Local Intelligence - Gateshead Care Home Initiative [Vanguard]
Evidence Based Care — Frailty Focus
Integrated Delivery — Primary Care, Community Health Services, CCG
PROJECT AIMS

• OLDER PERSONS SPECIALIST NURSE

• PROACTIVE CASEFINDING

• MULTI-DISCIPLINARY WORKING

• CGA & PERSON CENTRED CARE PLANNING

Collaboration, Networking, Sharing
CASE MANAGEMENT

94 Patients case managed

- Average Age : 85 yr
- 67%F: 33% M
- 88% resident own home

REFERRALS

- 39% GP
- 26% Proactive case finding
- 25% Practice based staff

STATUS PROJECT END

- 14% RIP
- 4% Left practice
- 2% Care Home admission
Measures

Use of Unscheduled Care

A&E Attendance
➢ 54% reduction

Admissions
➢ 54% reduction

House Call Requests
➢ 81% reduction
More Measures

MDT REFERRALS

- Occupational Therapy
- Geriatrician
- Physiotherapy
- Old Age Psychiatry
- Dietician
- Home Loans
How was it for The Practice?

- Continuity, follow up, single and point of contact are important. They give confidence and reassurance to patients making them feel they well looked after/supported Practice Nurse

- Good impact on MDT working, which supported planning and care coordination across a range of organisations GP

- Productivity is higher when practitioners work very closely with a practice ... employment by a separate organisation not an issues if the practitioner is based in the practice. Practice Manager

All of these advantages should be able to be rolled out to other practices. The more a practice is willing and able to work with OPSN including hosting them, the more they and their patients will benefit GP
Some Challenges!

- Avoiding duplication of current community nursing roles

- Cross organisational working highlighted issues relating to information governance

- Case management = a reduction in the need for GP input via house-calls. This can have a practical impact on EOL issues

- The need for referral criteria and stratification of the varying needs of the caseload needs further exploration in terms of managing workload pressures and meeting the expectations of patients and carers.
What did we recommend?

Four suggested options to recognise this vision for Primary Care:-

- Investment in the development of the practice nurse workforce ..... with the support of a clinical expert such as a Nurse Consultant Role

- The introduction of practice aligned nurses specialised in the care and management of frailty

- Utilising the existing community matron workforce but base them directly in practices to work as a more integral part of the PHCT

- A fundamental transformation of community and practice nursing to move from a task based approach to a patient centred approach, that enables integrated working and the right skills assembled around the needs of the patient and their carer.
Practice based frailty nurse within a complex care team

Karen Smithson
Frailty Nurse Specialist
Oxford Terrace Rawling Road Medical Group
WHY HAVE A FRAILTY NURSE

- Two sites
- 15,200 Patients
- 2,500 high admission risk
  - All long term conditions
  - Hospital stay longer
  - Deaths earlier etc etc
- Culture of continuous quality improvement
- Test and Tweak every day
The Problem

Gateshead CCG:QIPP - Urgent Care Review

Emergency Admissions Trend

Urinary tract infection
COPD
Acute lower respiratory infection
Asthma
The Solution

- Older Peoples Specialist Nurse
- Secondment (substantive)
- Comprehensive Geriatric Assessment
- Based In Practice
- Using Emis Web
- MDT
Team Set Up At OTRR

• Practice Based (Standardised Care/Systems)
• Part of MDT Weekly and 6 Weekly
• Embedded in Practice – (core work)
• Complex Care Team
  – Frailty nurse practitioners (now having a part time OPNS for care home patients
  – OT
  – Navigator
  – Care Home Nurses
  – Administrator
  – Sponsorship/Support from GP and PM
  – Link With Practice Nurses – housebound long term conditions
• Same IT System
• Control Over Case Load
• Co-Located
• Single Point of Contact (unplanned admissions)
• Community Engagement Events
Who do we refer to

Carers Association

Community Based Services

District Nurses

GP

Intermediate care unit

Consultants Geriatrician

Old age psychiatrist

Community Pharmacy

CPN's

Age Concern

Physiotherapists

Frailty nurse

OT

OPNS

Patient

Urgent Care Team/Rapid response team

Alzheimer's Society

Nurses

Queen Elizabeth Hospital

Community Matrons

Occupational Therapists

PCN.

Administrator.

Community Based Services

Director of Social Care

Emergency Department

District Matron

District nurses

Frailty nurse

Intermediate care unit

Consultants Geriatrician

Old age psychiatrist

Community Pharmacy

CPN's

Age Concern

Physiotherapists
Complex care team register

There are 486 patients
All have care plans and being reviewed

210 live in their own homes or non linked care homes
Age ranges between 20 - 104 years of age
With majority between 70 - 95 yrs of age

- Oxford terrace /Rawling road mg

- Have 37 patients over the age of 95
- ( only 16 currently on the register for complex care )
- Housebound Patients
- 62% F : 33%M

Remain on register for as long as required .Most remaining currently by choice
Practice Based Frailty Nurse role

- Meet with people in their own homes and carry out a holistic Geriatric Comprehensive Assessment {gold standard}

- Build up a relationship work with them to provide a health care plan and aim to prevent avoidable admissions to hospital

OR

Ensure admissions will be more acceptable and safe
Practice Based Frailty Nurses Role

• Gaining confidence and trust to gain information

• Monitor health and social status at home

• Care planning and goal setting including MDT workings and referrals

• Work Closely with GPs in practice shared view with long term conditions and medication reviews

• Considering reversible medical conditions and social care
Practice Based Frailty Nurse Role

- Work closely other Older Person Nurse Specialists and Geriatricians (Dr Crabtree)
- Look at immunisation and preventative medicines
- Networking with Nurse Specialist in Secondary Care assessing mental health issues
- Supporting carers
- Using clinical skills and monitoring health issues
- End of life planning and DNACPR
- AVOIDING ADMISSION

..........but never say never if best care can only be provided in hospital admit
Case history

Mr J presented to Gp with daughters who were concerned he was lethargic tired always asleep and hallucinating. Concerned re falls and confusion

• GP referred to frailty nurse complex care as for further assessment
• CGA With daughter present and good history from all

Issues
• Diabetes not under control
• Nutrition poor
• Fluid intake extremely poor
• Review of medication in own home showed non compliance
• Hypotension and blood abnormalities
Case history continued

MANAGEMENT PLAN

• Medication review with Heart Failure Nurse and discontinuation of diuretics
• Nutrition monitored and dietician review
• Daughters monitored fluid intake and medication compliance after pharmacist sorted correct dose the system
• OT reviewed independence in home and outdoor mobility
Positive ending for all

OUTCOMES

• Ongoing monitoring from frailty Nurse over 4 weeks
• Lead to this man being able to go to Benidorm for his holiday which had been planned for many months

Thank you letter sent
The Team-the whole is greater than the parts!
Frailty Summit

LAURA MAITRA BSC(HONS) DIP(HE) RGN
FRAILTY NURSE SPECIALIST
5TH DECEMBER 2016
Case Identification

- Electronic Frailty Index (EFI)
  - 72 Frail patients reviewed by community matron or frailty nurse specialist

- Referral sources
  - Secondary care
  - District Nurses
  - Community Matrons
Patient Profiles

- Demographic differences between locality practices
- Service Use
- Length of time on Frailty Caseload
- Rockwood Frailty Index
Claire Laing
Business Intelligence Lead
Care Home Vanguard
NHS Newcastle Gateshead CCG
Background to introduction of Frailty Nurse

• Gateshead has a rapidly aging population
• Currently, around 20% of the population is aged 65 or over

• However, frailty is not exclusively seen in the elderly, and this cohort needs proactive case management too
Patient profiles

<table>
<thead>
<tr>
<th></th>
<th>Frailty nurse input:</th>
<th>No nurse input:</th>
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</thead>
<tbody>
<tr>
<td>% over 50:</td>
<td>38.80%</td>
<td>38.30%</td>
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<tr>
<td>Average IMD score:</td>
<td>29.9</td>
<td>28.0</td>
</tr>
<tr>
<td>No. LTCs (average):</td>
<td>1.91</td>
<td>1.88</td>
</tr>
<tr>
<td>EoL register (ave):</td>
<td>24.8</td>
<td>15.1</td>
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**Note:** both cohorts have similar levels of unscheduled secondary care usage
Rate of A&E attendance for over 50s per 1000 population

Introduction of first frailty nurse post working in one practice (merged)

Introduction second frailty nurse working into a further four practices
Rate of NEL admission for over 50s per 1000 population

Introduction of first frailty nurse post working in one practice (merged)

Introduction second frailty nurse working into a further four practices
THANK YOU