Introduction

It has been identified that acute medical units have the advantage of access to clinical staff and rapid diagnostics but do not always cater for the need of the older person. Difficulty arises in completing a Comprehensive Geriatric Assessment (CGA) within 72 hours of admission as patients may be admitted to base wards without alternatives being considered (RCP 2007).

National guidance

The British Geriatric Society (BGS) states that all interactions between an older person and a health or social care professional should include an assessment for frailty. (BGS 2014).

In the last 20 years the number of geriatricians has almost doubled to cope with the increasing demand (Health and Social Care Information Centre 2014), they are now incorporating multi-disciplinary ward rounds into their routines to reduce referrals and length of stay.

Methodology

Frailty Liaison took place during a 2.5 hour session one afternoon a week and involved a varying range of professionals including Consultant Geriatrician, Frailty Nurse(s), Nurse Consultant Older Persons and physiotherapist.

- Patients screened by nurses for frailty using the Think Frailty tool.
- Collated information on background, baseline, presenting complaint.
- Brief CGA.
- If appropriate each patient was also screened by a physiotherapist.
- Patients identified for geriatrician assessment.
- MDT assessment.

Project Aim

‘As part of the Gateshead Frailty Strategy our aim was to identify frailty within Short Stay Unit (SSU) and evaluate the impact of a geriatrician led MDT assessment’

Specific Objectives

- Embed frailty screening using a validated tool in patients over the age of 65 in SSU.
- Ensure rapid Comprehensive Geriatric Assessment to identify medical issues, functional changes and social problems early to allow proactive care planning.
- Initiate appropriate care and treatment plan.
- Influence patient flow aimed at ensuring right place, right care the first time.
- Formulate a discharge plan which allows an accurate EDD thus reducing the risk of extended length of stay or unnecessary internal transfers, actioned in a timely fashion to prevent delays when medically fit.
- 24 – 48 hour review patient outcomes.
- Evaluate the impact of the frailty liaison team working within SSU.

Implementation

Short stay unit was the focus of the interface project, it was felt once a person has been an inpatient for 24 hours and initial treatment administered, there was a higher chance of the team being successful in discharge or improving treatment plan.

Results

The observations and outcomes detailed below relate to a 7 week period whereby 30 patients were assessed within the interface session.

Recommendations

- Ensure frail older people who need to stay in hospital receive timely Comprehensive Geriatric Assessment (CGA) and input from a specialist team.
- Acute and emergency care units should have a clearly defined pathway for the delivery of acute medical care for older people.
- Daily Frailty liaison MDT at the beginning of the inpatient journey.
- Occupational Therapist to complete the team.

Conclusion

We attempted to determine whether Comprehensive Geriatric Assessment by a Multidisciplinary Team (MDT) provides benefits in functional and health status. A common aim is to expand the team which would benefit the new approach for frail older people in terms of lower mortality, shorter hospital stays and fewer discharges to institutional care. This would follow the guidance from Safe, compassionate care for frail older people using an integrated care pathway (NHS England, February 2014) recommends that expert decision makers should be available at the front door of the acute hospital from 8 am to 8 pm 7 days per week. It also recommends that specialist assessment should be made available within 12 hours of admission, 7 days per week, which we hope to achieve with the support of the AFN aiming to improve the first 72 hours of a complex frailty elderly admission. Continue to develop and evolve our Frailty team and strategy. Improving care pathways, education and training of staff this is planned to take place early in 2017.

References:

Health Improvement Scotland (2014) Think Frailty Screening Tool. NHS Scotland


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