Using Date to Inform How to Set Up a Front Door Frailty Service

Aim: to better understand the population of older people attending a district hospital emergency department, to identify how a front door frailty team could be utilized and estimate the potential impact this could have on admissions and length of stay.

Method: an emergency medicine higher trainee with additional training in frailty was based in a district hospital ED for 4 consecutive Thursdays (0800-1600) and attempted a rapid review all patients over the age of 65.
During this assessment patients were screened for delirium, geriatric giants and were asked about their reason for ED attendance.
After each review, they were assigned into a hypothetical category for frailty team input (ED review, SDEC review, ward follow up, or no input).
Following this case notes were reviewed detailing their 7- & 30-day outcome and, if admitted, their length of stay.

Results:

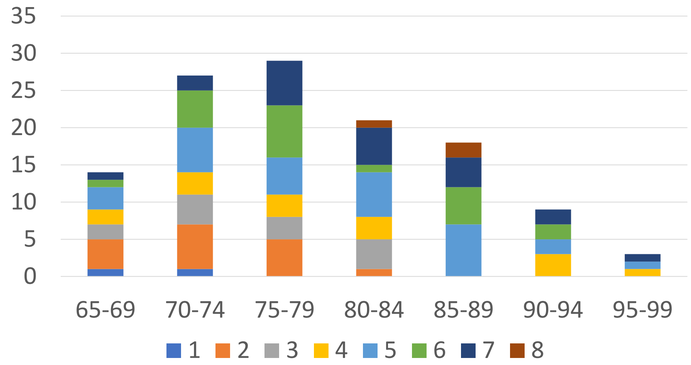
121 patients were included in this thought experiment (aged 65 to 97.)

Of 121 patients, 48 were assessed as likely to benefit from front door frailty team involvement with a view to discharge. 28 of those 48 patients were admitted to an acute hospital bed following full assessment by the ED clinician. Tracking the subsequent journeys of these 28 patients showed that they accumulated a total 161 bed days between them.

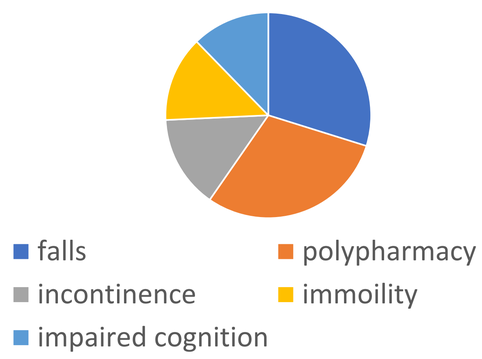
Of the admitted patients 26/28 patients spent an additional 61 days in hospital after being declared medially fit by their clinical team.

Hospital admission and prolonged length of stay has a huge impact on patient's welfare and associated hospital-acquired harms, as well as on hospital flow and resources. One of the 28 admitted patients was considered medically suitable for discharge with essential D2A by the therapy team, but before this was available, unfortunately he deteriorated and subsequently died in hospital. His preferred place of death was home.

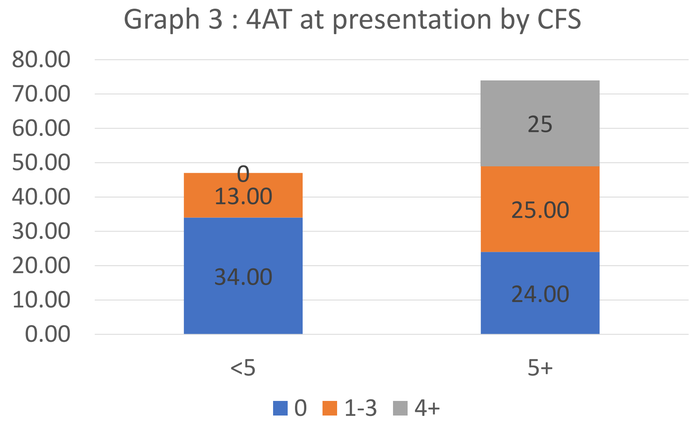
Graph 1 : CFS by age



Graph 2 : Geriatric syndromes



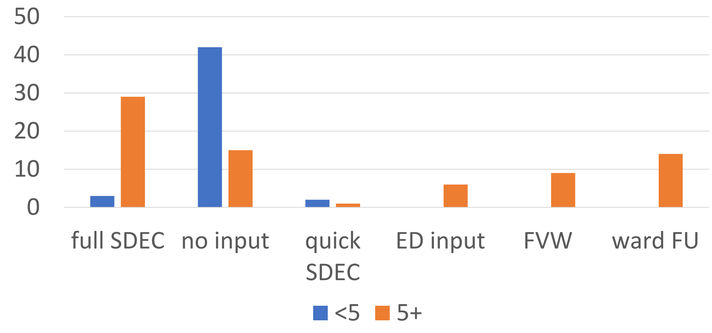
Graph 3 : 4AT at presentation by CFS



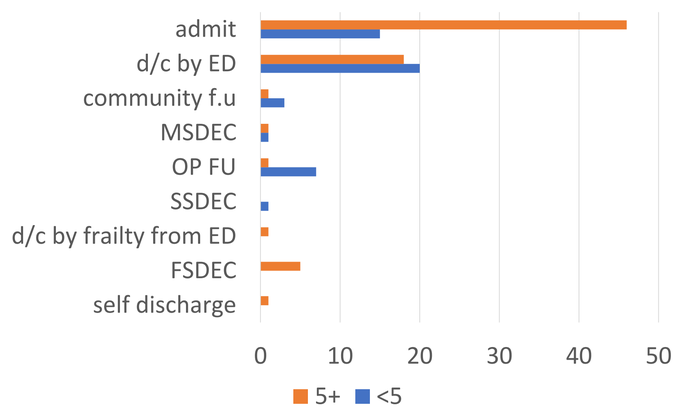
What have we learnt?

- A huge proportion (2/3, graph 3) of the frail older people presenting to the ED present with a cognitive impairment, which is largely unrecognized and poorly managed in the acute emergency setting
- There is significant morbidity and mortality associated with an Emergency Department attendance in the CFS >5 26/28 patients who were admitted had longer than necessary bed stays, which is associated poorer outcomes including inpatient mortality (graph 9).
- It is clear that an MDT front door frailty service, with a good understanding of community services and early senior decision making, is likely to significantly reduce (60%) number of admissions.
- For those who need admission, front door assessment by a frailty team is likely to reduced inpatient length of stay, with a comprehensive geriatric assessment (GCA) started much earlier in the patient's journey to facilitate this.

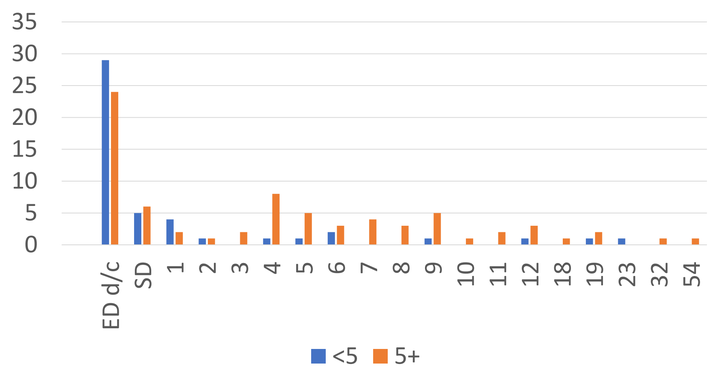
Graph 4 : proposed intervention by frailty team by CFS



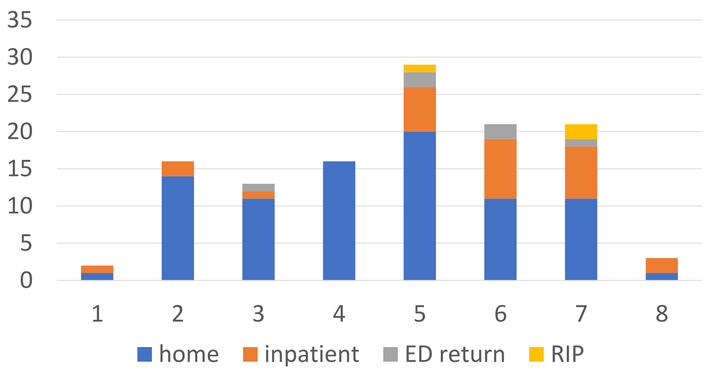
Graph 5 : ED outcome by CFS



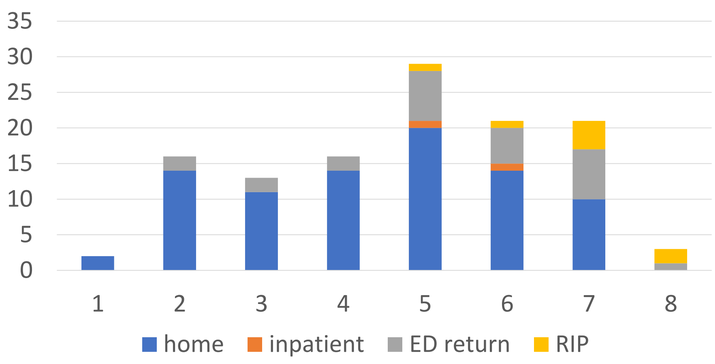
Graph 6 : Length of stay by CFS



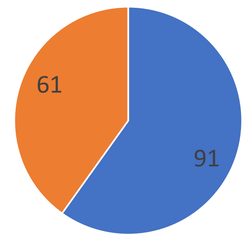
Graph 7 : 7d outcome by CFS



Graph 8 : 30d outcome by CFS



Graph 9 : Bed days of patients appropriate for review by frailty services



Graph 1: demonstrates age is a poor indicator for frailty score
Graph 2 : patients over the age of 65 presenting to the ED suffer from a spectrum of geriatric giants, but not all are reasons for ED attendances. Multiple geriatric giants can co-exist!
Graph 3 : over the age of 65, the more frail patients (CFS >5) are likely to present with dementia or delirium (approx. 66%) compared to approx. 33% of those of lower CFS score
Graph 4 : Nearly 80% of patients with a frailty score 5+ were deemed appropriate from review by the frailty team, either in ED, for review for early discharge, follow up in clinic or followed up on the ward
Graph 5 : ED are more likely to admit a patient to a ward bed instead of discharging or streaming to a same day or outpatient service.
Graph 6 : This graph demonstrates the more frail patient, if admitted, are more likely to have a prolonged stay, with some patients remaining an inpatient for up to 2 months.
Graph 7 and 8 : these demonstrate how the 7 and 30 day outcomes vary between the frail and non-frail patient, with an increase in 30d inpatient, hospital return or death increasing with increasing frailty.
Graph 9 : patients who were admitted who I believed to be suitable for an early frailty review had longer than necessary length of hospital stay. The goal of working with an MDT with knowledge of community services will hopefully reduce the unnecessary inpatient bed days

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