Acute Frailty Network

Restoring health and independence: a hospital's role and responsibilities

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Defining and developing the frailty pathway at Addenbrookes Hospital

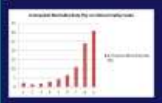
In collaboration with partners at the local CCG, we decided to try to identify all vulnerable elderly patients admitted to the acute trust. This was initially undertaken under the auspices of a CQUIN project.
We chose the Clinical Frailty Scale for its ease of use, and set up a project to score and record Clinical Frailty Scores for all patients admitted as an Emergency aged 75+

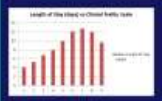
We achieved very high concordance with frailty scoring, demonstrating the ease of use of the scale and the ability to utilise the scale in an acute hospital setting

With the help of the Acute Frailty Network, we opened an Acute Frailty Assessment Unit, using frailty scoring to help determine those most appropriate for admission. This proved the most difficult process we have undertaken as part of our frailty work, as the effectiveness of the pathway was materially affected by the recent opening of a new Medical Decisions Unit.

We have developed a team of senior nurses and therapists (the SAFE team) who are able to view frailty scores in real time on a bespoke dashboard, and who will review all vulnerable adults admitted to areas outside the Department of Medicine for the Elderly, offering advice, gaining collateral history, helping with discharge planning, and repatriating to Elderly Care beds where appropriate.

Having embedded frailty scoring into our Emergency Pathway, we wanted to test whether scoring of this nature had clinical relevance.
We undertook a clinical study of the use of the scale in hospital.





We have shown that frailty scoring can provide us with valuable information about which patients may be vulnerable to adverse hospital outcomes

As part of our work with the Acute Frailty Network, we have developed a number of Trust-Wide and Departmental initiatives.

We have a working group developing nursing protocols to identify and manage 'stranded patients' around the Trust, we have developed a collaboration between all local voluntary services, providing information and a single point of contact, and we undertake weekly long-stay patient reviews in the department. We anticipate that all these initiatives will have a positive impact on length of stay and patient satisfaction for vulnerable adults.

We have reconfigured our IT systems, so that frailty scores are reported back to primary care on discharge summaries.

Junior medical staff were provided with training and advice on frailty factors which the primary care team would like to be informed about

Ongoing work.

We have learned a lot from our experience within the Acute Frailty Network and have a number of ongoing workstreams arising from the working groups and network meetings.

We have two key aspirations which have been driven by the Network and by learning from the experiences of our peers.
Our key aspirations are to re-develop our acute frailty pathway, fitting it in to the new Medical Decisions Unit model, and to generate more robust models of statistical analysis with which we can monitor progress into the future.

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OXFORD

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Original paper

ORIGINAL PAPER

Association of the clinical frailty scale with hospital outcomes

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Imperial College Healthcare NHS Trust

Curriculum

Geriatric EM Bootcamp

Resuscitation Department, Mint Wing, St Mary's Hospital
October 17th 2016

Topic		Speaker(s)	Time
Registration and Breakfast			8.30
Introduction	Overview of the day	Rosa McNamara Kate Sendall	9.00
Check-in and Assessment			
Communication	*Short Presentations, each 15 minutes long with Panel discussion to follow*		
	How do I talk to my patient?	Rita Freyne *OT Dementia Team*	9.15
	What should families know? What should I tell them?	Claire Solomon *Interface Geriatrician*	9.30
	Community care agencies-Who do I talk to and how?	Jordan Pearton *OT Emergency Department*	9.45
	Panel Discussion	Milica Stojanovic	10.00
Investigating and Managing			
Work Shops	*4 interactive workshops running concurrently, each 15 minutes. Participants choose 3 to attend.*		10.30
Workshop 1	Not 'just' older adults – An overview of changes in physiology and pharmacology in older age	Suham Jama *Lead Pharmacist – Emergency, Acute and Elderly Medicine*	
Workshop 2	Why Continence matters in the ED	TBC	
Workshop 3	What is Frailty?	Claire Solomon *Interface Geriatrician*	
Workshop 4	Confusion- A pragmatic approach in the ED	David James *Lead Geriatrician Dementia Care*	
Grab a Coffee			11.15
Managing complexity in the ED (Lecture) *Rosie Belcher* *Interface Geriatrician, Imperial College Healthcare NHS Trust*			11.45
Work Shops	*4 interactive workshops running concurrently, each 15 minutes. Participants choose 3 to attend.*		12.30
Workshop 1	Falls in the ED	Claire Solomon	
Workshop 2	Skin Care/Pressure sores	TBC	
Workshop 3	IT IS NOT A UTI... diagnosing UTI when it is there.	Rosa McNamara *Consultant in Emergency Medicine*	
Workshop 4	How do I know what my patient can do? Simple Functional Assessment in the ED.	Sarah Montgomery- OT *Emergency Department/* Mallissa Turner – *Community Falls Therapy Link Worker*	
Lunch			13.15
Learning Lunch	Activities are spread across the lunch break so that participants can learn over lunch – maximising learning opportunity and allowing local staff to join in on their lunch break!		
Topic 1	Parkinson's Disease and medication s *Soham Jama*	Topic 4	Quality Improvement in the ED *Lara Ritchie*
Topic 2	Meeting Patient Nutritional Needs *Josh Perrin/ Jo Jones*	Topic 5	Transitioning Care Safely *James Jenkins*
Topic 3	CEM Curriculum and older adults *Ruth Brown*	Topic 6	Community/ Service Links TBC
Process			
Managing process under time constraint - Delivering excellent care in a chaotic environment (Lecture) *Wendy Mathews* *Emergency Department, St Marys Hospital*			14.30
Work Shops	*4 interactive workshops running concurrently, each 15 minutes. Participants choose 3 to attend.*		15.15
Workshop 1	Getting care right at the end of life	Mary Dawood *Nurse Consultant Emergency Department*	
Workshop 2	Older persons trauma care	Nicola Batrick *Trauma Lead Imperial College*	
Workshop 3	Keeping patients safe in ED	Sarah Pearse *Matron Emergency Department St Marys*	
Workshop 4	Managing Challenging Behaviours	Jules Knight *Mental Health Nurse, Dementia Team*	
Wrap-up *Roza McNamara & Kate Sendall*			16.00
So what now?			
How can I integrate what I've learned into my practice			
How could we change the course to meet our department's needs? Feedback and Certificates.			

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RACE Unit ethos

- Triage of referrals
- Triage of arrivals
- Assessment v admission
- Comprehensive Geriatric Assessment

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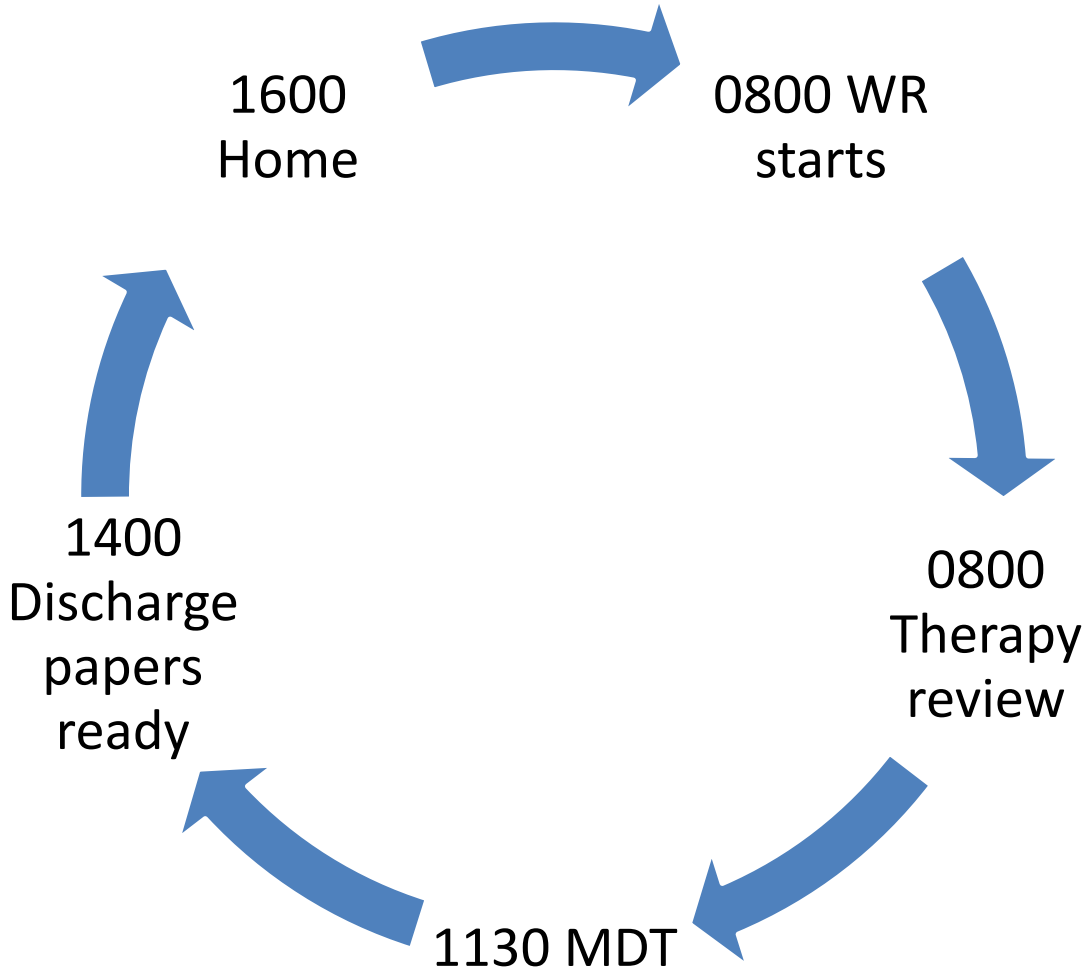

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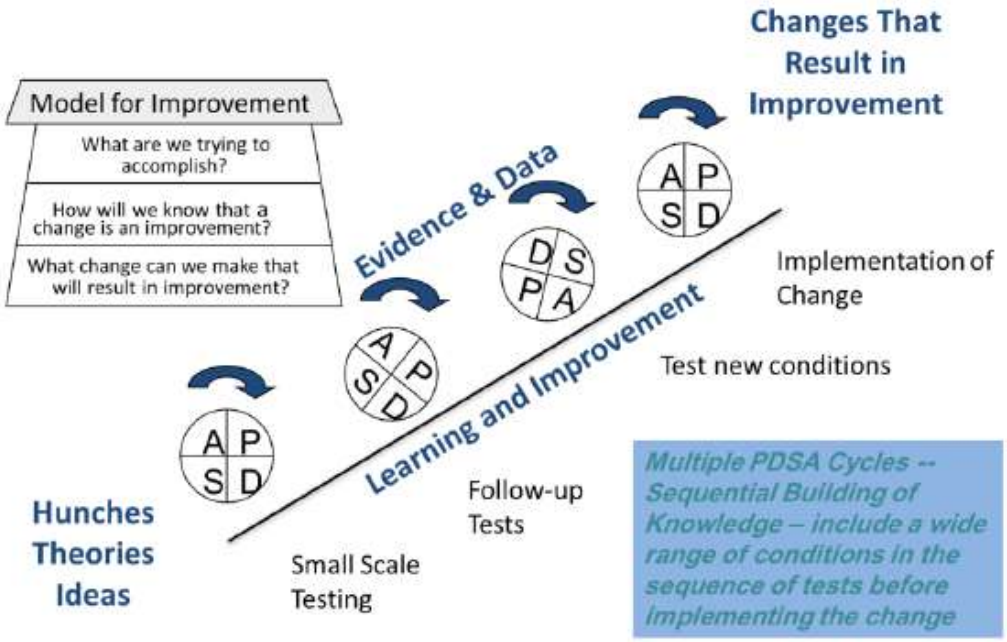

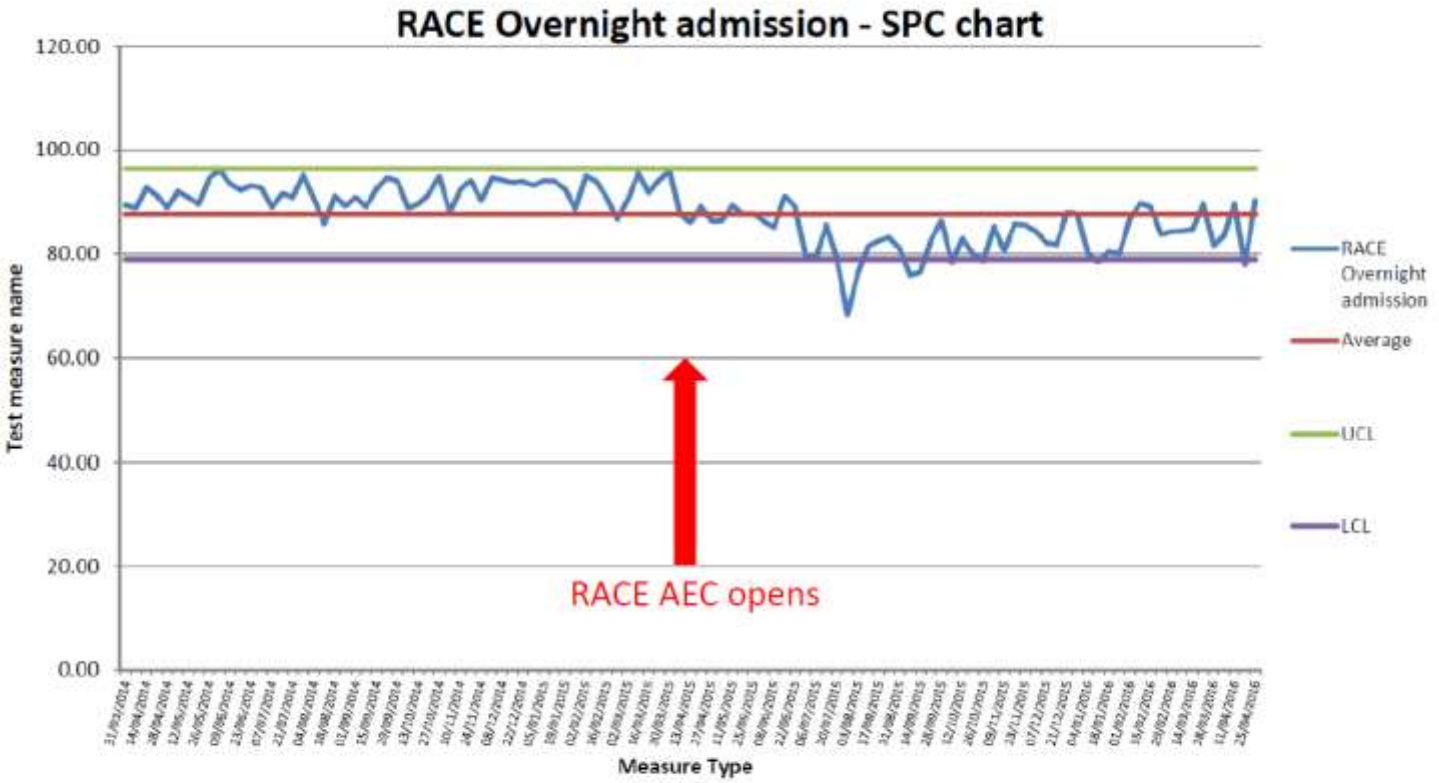

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Orthogeriatrics

POPPS

Oncogeriatrics

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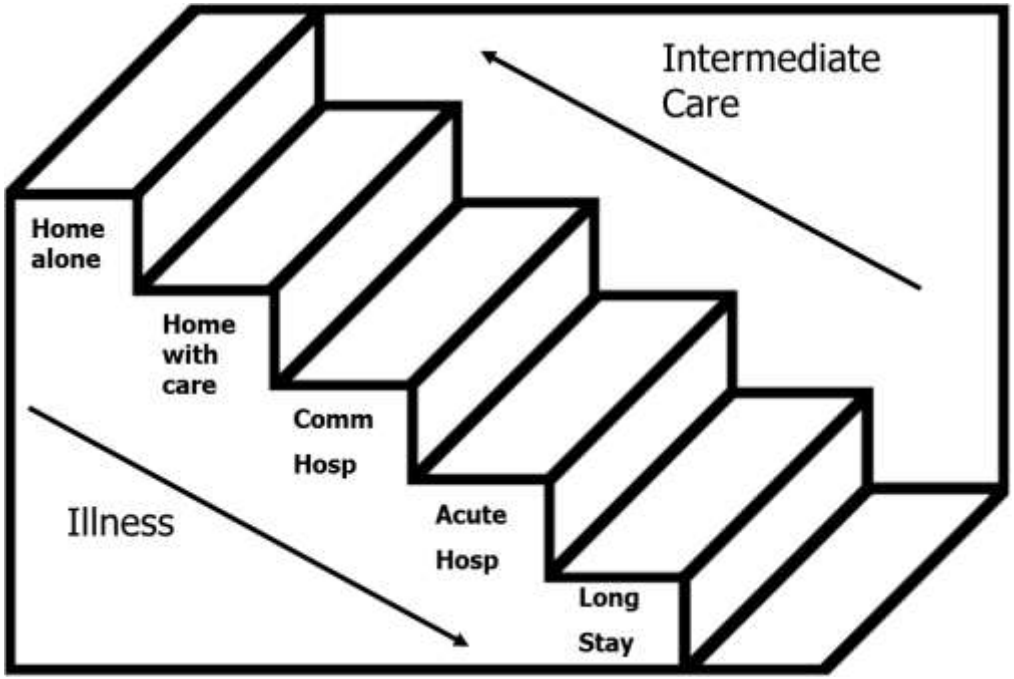
Collaboration



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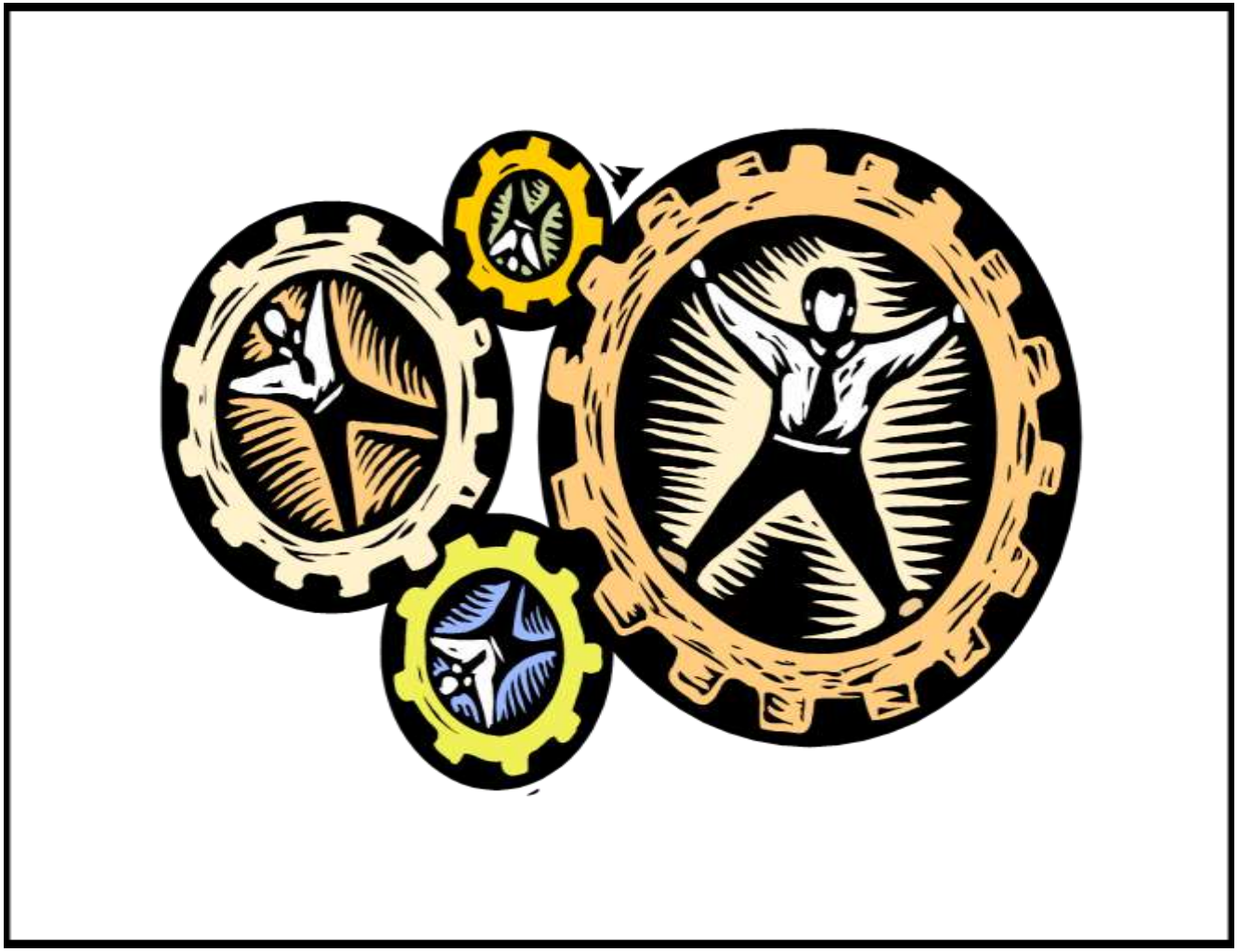

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Expanding across North West London……

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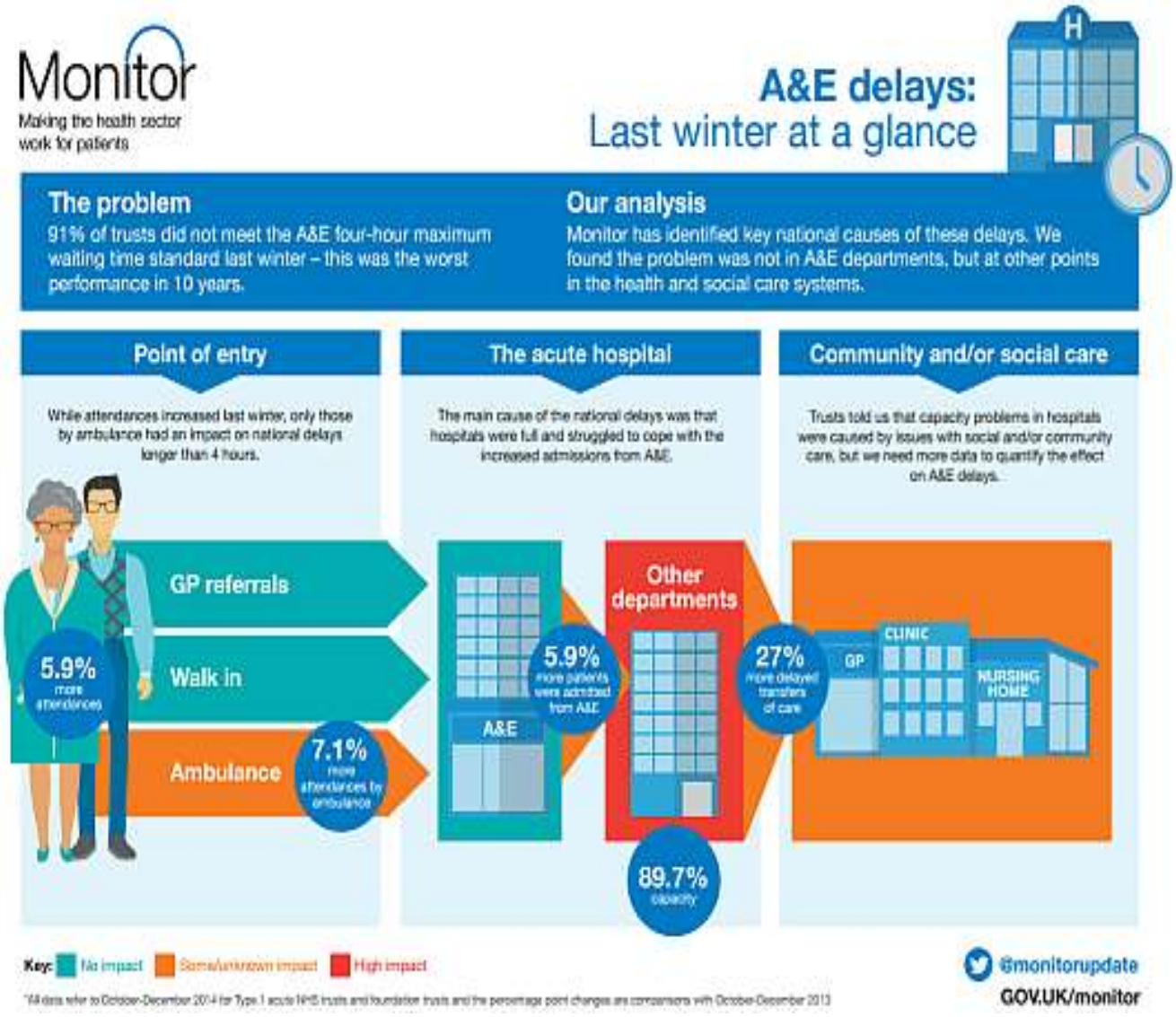

NHS Benchmarking network 2005 - 2013

- 22% increase in ED attendances overall
- 50% increase in people 60-79 years
- 55% increase in people > 80 years

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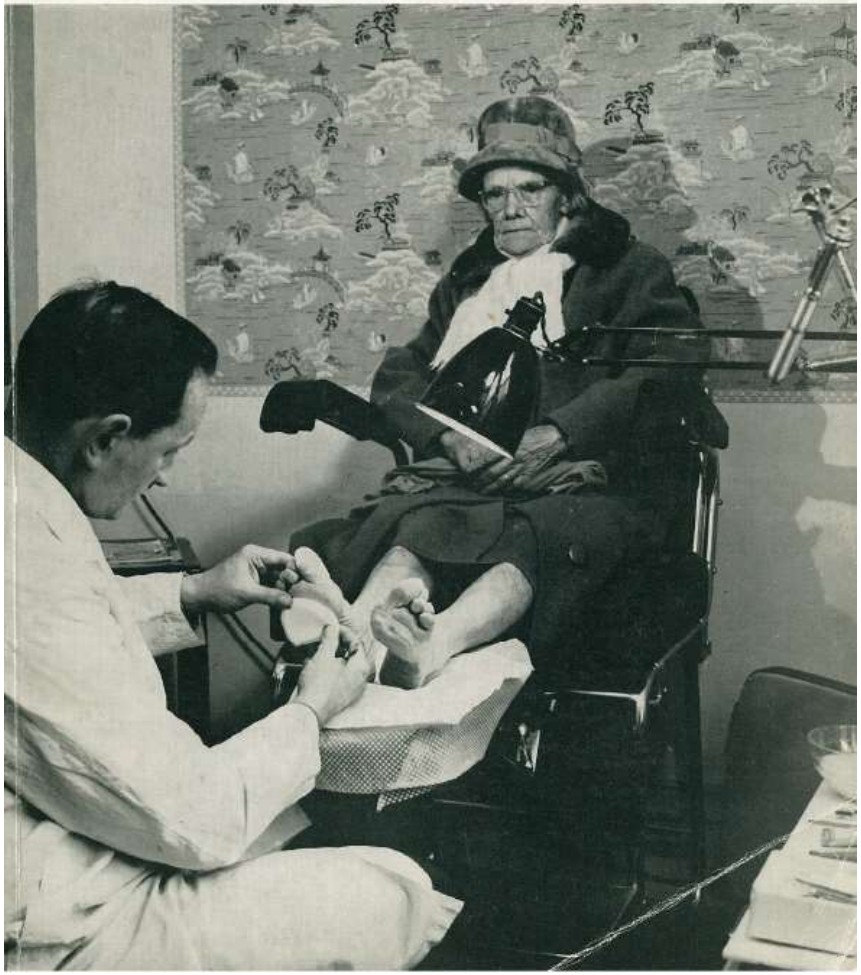
MODERN BRITISH GERIATRIC CARE



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Of course, as with other age groups, many elderly patients will be admitted as acute patients at the request of their general practitioner; but this is not the characteristic pattern of admission to a geriatric unit. The key to this is assessment, a process which looks at the patient's whole life situation, taking in his physical, mental and social circumstances. It attempts to define the need for treatment, the scope for rehabilitation, and the ultimate prognosis from the earliest contact with the patient. Frequently it starts in the patient's own home before admission. Although it may be mainly done by a domiciliary visit by a consultant in geriatric medicine it is essentially a multidisciplinary affair, involving social workers, occupational and physiotherapists as well as the general practitioner and hospital doctors.

After admission the process of assessment continues concurrently with treatment and rehabilitation. It

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When did Frances become old?

When did Frances become frail?

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