

# 2022 Frailty and Urgent Care Meeting

8 July 2022

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## Book of Abstracts

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## **CQ - Clinical Quality - CQ - Improved Access to Service**

### [1104 An Evaluation of a Geriatrician-Led Acute Medical Admission Unit at Morryston Hospital, Swansea](#)

A Yusoff; E A Davies; D J Burberry; N Jones; C Walters; C Beynon Howells; D Davies; P Quinn

Department of Geriatric Medicine, Morryston Hospital, Swansea Bay University Health Board (SBUHB)

#### Introduction

The medical intake at Morryston Hospital is accepted on two units; Rapid Assessment Unit (RAU) and Acute Medical Assessment Unit. Both were acute physician-led until July 2021 (Phase 1). From July 2021, RAU became geriatrician-led (Phase 2). This evaluation concerns the performance of RAU.

**Phase 1 (Acute Physician-Led Unit)** Between 01/08/2020-30/06/2021, there were 3102 admissions with a median length of stay (LOS) of 2 days on RAU. 37.2% of patients were discharged directly from the unit. (SBUHB data). A detailed analysis of 496 patients consecutively assessed between November 2020–January 2021 showed a median LOS on RAU of 1, 28.8% were discharged directly from RAU. Overall health board (HB) median LOS for the cohort was 7. In over 70 years, median LOS on RAU was 1, overall HB LOS 9.

**Phase 2 (Geriatrician-Led Unit)** 1237 patients were assessed July-December 2021, with a median LOS of 2 days. 42.8% of patients were discharged from RAU. (SBUHB data). A detailed analysis of 566 patients consecutively assessed between September-November 2021 showed a median LOS on RAU of 2, 41.7% discharged directly from RAU.

Overall HB median LOS for the entire cohort was 5. For the > 70 years, median LOS on RAU was 2, overall HB LOS was 7. Patient flow through assessment areas is dependent on the function of downstream medical wards. Mean LOS within medicine at Morryston increased 1.5 days between Phase 1 and Phase 2.

#### Results

Acute geriatricians have delivered the 72hr LOS standard that SBUHB has set for assessment areas. The unit has achieved a reduction in overall LOS for the cohort of patients evaluated ( $p < .01$ ), especially for the > 70 years ( $p = .007$ ). This data supported a change in practice; RAU has taken a frailty specific intake since January 2022.

# AN EVALUATION OF A GERIATRICIAN-LED ACUTE MEDICAL ADMISSION UNIT AT MORRISTON HOSPITAL, SWANSEA

Dr A Yusoff; Dr EA Davies; Dr DJ Burberry; N Jones; C Walters; C Beynon-Howells; D Davies; P Quinn

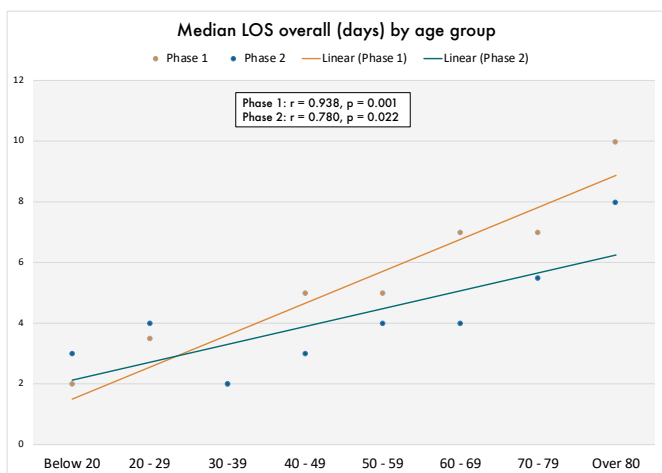
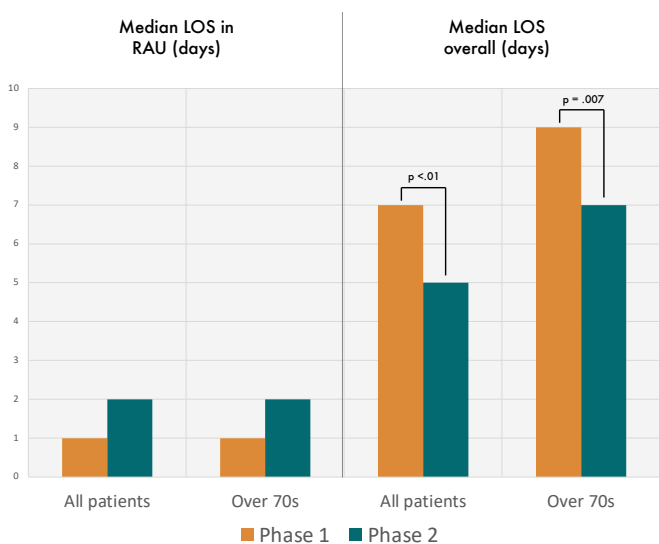
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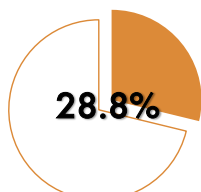
## INTRODUCTION

- The medical intake at Morriston Hospital is accepted on two units; Rapid Assessment Unit (RAU) and Acute Medical Assessment Unit.
- Both were acute physician-led until July 2021.
- From July 2021, RAU became geriatrician-led.
- This evaluation concerns the performance of RAU.

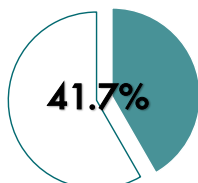
## RESULTS



% Discharged directly from RAU



Phase 1



Phase 2

## METHODOLOGY

### Phase 1

- Acute Physician-led Unit
- 496 patients between Nov '20 - Jan '21 analysed

### Phase 2

- Geriatrician-led Unit
- 566 patients between Sept - Nov '21 analysed

## SBUHB DATA

Period	Aug '20-June '21	July '21-Dec '21
No of admissions	3102	1237
Median LOS in RAU	2 days	2 days
Discharged directly from RAU	37.2%	42.8%

## DISCUSSION

- Patient flow through assessment areas is dependent on the function of downstream medical wards.
- Mean LOS within medicine at Morriston Hospital increased 1.5 days between Phase 1 and Phase 2.

## CONCLUSION

- The unit has achieved a reduction in overall LOS for the cohort of patients evaluated ( $p < .01$ ), especially for the  $> 70$  years ( $p = .007$ ).
- Acute geriatricians have delivered the 72hr LOS standard that SBUHB has set for assessment areas.
- This data supported a change in practice; RAU has taken a frailty specific intake since January 2022.

## **CQ - Clinical Quality - CQ - Patient Safety**

1161 Improving staff awareness of frailty in the emergency department: a multi-disciplinary quality improvement project.

GP May<sup>1</sup>; LA Bennett<sup>1</sup>; JP Loughrey<sup>1</sup>; N Littlewood<sup>1</sup>; L Mitchell<sup>2</sup>.

<sup>1</sup>Emergency Department, Queen Elizabeth University Hospital (QEUH), Glasgow; <sup>2</sup>Department of Medicine for the Elderly, QEUH, Glasgow.

### Introduction:

Comprehensive Geriatric Assessment (CGA) improves outcomes for frail older adults in acute hospitals. Patients aged 75 and over admitted into the Emergency Department (ED) at the QEUH will automatically generate a "frailty icon" on their electronic record. The number of frail people accessing emergency care is increasing. This Healthcare Improvement Scotland (HIS) frailty tool prompts staff to assess for frailty and refer to the local Frailty Pathway if appropriate. We designed a multidisciplinary quality improvement project (QIP) to increase completion of the frailty icon and the number of referrals to the frailty service from the ED.

### Methods:

Both medical and nursing staff in the ED were targeted for intervention. Weekly data was collected on the percentage of patients aged 75 and above who were discharged from the ED with a "frailty icon" completed over a 3-month period. Our main intervention was to hold a frailty awareness month. This involved multiple sub-interventions such as; announcements at handovers, e-mails, word-of-mouth, and posters.

### Results:

The weekly percentage of completed "frailty icons" increased from 28% 2 weeks pre-intervention (n = 283) to 48% in 1 month (n = 258). A peak of 57% (n = 293) completed icons was achieved immediately after our intervention. These increases were then sustained for a further 6 weeks with a weekly average baseline of 45.2% completion (average n = 281). Increased "frailty icon" completion in the ED led to a 100% increase in referrals to the frailty pathway.

### Conclusion:

Increasing awareness of frailty amongst ED staff results in increased front door assessment for frailty, and subsequent referral to the frailty team. This allows for more patients to receive a CGA. Multidisciplinary QIPs utilise the skills of diverse staff groups to best achieve sustainable change.

# Improving Staff Awareness Of Frailty In The Emergency Department: A Multi-Disciplinary Quality Improvement Project.

Dr G May<sup>1</sup>, Nurse LA Ingram<sup>1</sup>, Dr JP Loughrey<sup>1</sup>, Dr N Littlewood<sup>1</sup>, Dr L Mitchell<sup>2</sup>  
<sup>1</sup>Emergency Department, Queen Elizabeth University Hospital, Glasgow  
<sup>2</sup>Dept of Medicine for the Elderly, QEUPH, Glasgow

## Background

Comprehensive Geriatric Assessment (CGA) improves outcomes for frail older adults in acute hospitals<sup>1</sup>.

CGAs are performed by the Acute Frailty Team in the QEUPH on all new admissions identified as frail.

Patients aged 75 and above admitted into the Emergency Department at the QEUPH will automatically generate a "frailty icon" ● on their electronic record.

This icon prompts ED staff to assess for frailty and refer to the local Frailty Pathway if appropriate.



**Royal College of Physicians & Society of Acute Medicine 2020**  
*guidance on acute care for older people living with frailty.*  
**Recommendation:** ensure a system is in place to identify older people with frailty as they attend hospital<sup>2</sup>.

## Results

Weekly percentage of completed frailty icons ● pre-ED discharge rose from **28% (n = 283)** pre-intervention **to 48% (n = 258)**.

**Peak of 57% completed frailty icons in 1 week** for all adults aged 75 and above pre-ED discharge.

Baseline 45.2% (average n = 281) per week ● completion **sustained for 6 weeks post-intervention.**

## Aim

To use quality improvement methodology to increase the number of completed frailty icons for patients aged 75 and above before discharge from the ED.

## Importance

The Healthcare Improvement Scotland frailty icon tool ● allows for quick and **easy assessment of frailty at the front door.**

If the patient is for admission and identified as frail in the ED, they are **prioritised for a Medicine for the Elderly bed, frailty team review, and a CGA.**

Early CGA can lead to a **reduced length of in-patient stay** and more likely to **be living independent at home**<sup>3</sup>.

ED staff have an important role to play **in ensuring frailty is identified** and patients are promptly referred to the frailty team.

Frailty icon completion can be improved by using QI methodology to **raise departmental awareness** of this important issue.

## Method

### PLAN

- Will raising ED staff awareness of frailty increase frailty icon completion pre-discharge?
- Inaugural QEUPH ED Frailty Awareness Month June 2021
- Weekly percentage of completed frailty icons collected

### DO

- ED medic and nurse ran frailty awareness tests together
- Baseline 28% completion of frailty icons pre-discharge
- Initial barrier to change as perceived "not ED work"

### STUDY

(see results section for run chart)

- As awareness of frailty increased, so did frailty icon completion pre-ED discharge
- Results sustained for a further 6 weeks

### ACT

- Awareness not sustainable in long term as requires regular interventions
- Next PDSA cycle to focus on education, "myth-busting" and understanding importance of frailty, CGAs and role of ED staff

## Future Direction

A 2<sup>nd</sup> PDSA cycle involving education sessions on acute frailty with geriatricians and flow coordinators was planned, but unfortunately due to staff rotation was not implemented.

Email: Gareth.May@ggc.scot.nhs.uk

### References:

- Healthcare Improvement Scotland. Ihub: Improving acute care for people living with frailty. Accessed 20 Apr 2022. [Improving acute care for people living with frailty - Improving acute care for people living with frailty \(Ihub.scot\)](#).
- Royal College of Physicians. Acute care toolkit 3: Acute care for older people living with frailty. Accessed 20 Apr 2022. [Acute care toolkit 3: Acute care for older people living with frailty | RCP London](#)
- Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O, Harwood RH, et al. Comprehensive geriatric assessment for older adults admitted to hospital. Cochrane Database of Systematic Reviews 2017, Issue 9. Art. No.: CD006211. DOI: 10.1002/14651858.CD006211.pub3

## **CQ - Clinical Quality - CQ - Improved Access to Service**

### 1162 Improving access to Same Day Emergency Care for older patients

A Stephens; M Memon; S Honour; C Spice

Queen Alexandra Hospital, Portsmouth Hospitals University NHS Trust

#### Introduction

National guidance indicates Same Day Emergency Care (SDEC) should be available for older people. Every week over 200 people aged 85+ years attend Portsmouth Hospitals University NHS Trust (PHUT) Emergency department (ED). A Frailty and Interface Team (FIT) in the ED support admission avoidance but we had no specific medical SDEC service for older people (OSDEC). Previous work identified a need for access to this service for at least 6-10 patients daily (focused on 85+ years, 75+ years with Parkinson's Disease) particularly those with frailty. An OSDEC unit opened December 2021. We describe our improvement work to increase access to OSDEC.

#### Method

We used short weekly multi-professional Plan Do Study Act (PDSA) meetings, a focused Rapid Improvement Week (RPIW) and data review to identify changes and support achievement of aims. Metrics included number seen in OSDEC and proportion discharged same day. We measured patient experience using the AFN Patient Survey Tool.

#### Results

Our initial pull model by a Specialist Registrar in Older Persons Medicine identified patients but not the numbers anticipated. Between the unit opening in mid-December and the subsequent 10 weeks the numbers accessing OSDEC were increased from 0 to 42 per week. We achieved same day discharge in 41% (30-62% range). Changes included escalation of barriers to discharge, increased focus on care home patients, criteria for ED staff to prompt discussion for suitability. The change to enhance identification of patients with severe frailty resulted in a 50% increase in care home patients accessing OSDEC. FIT for discharge direct ED discharged patient numbers remained stable. Patient experience surveys for 64 patients demonstrated good experience but also identified opportunities for improvement.

#### Conclusions

SDEC access for older people, including those with frailty, has been improved using a multi-professional improvement approach including a willingness to test and evolve criteria and communication.



# Improving access to Same Day Emergency Care for older patients.

Alice Stephens<sup>1</sup>, Muntaha Memon<sup>1</sup>, Samuel Honour<sup>1</sup>, Claire Spice<sup>1</sup>

<sup>1</sup>Medicine for Older Persons Department, Portsmouth Hospitals University NHS Trust, Queen Alexandra Hospital, Cosham, Portsmouth, UK

## Introduction

National guidance indicates Same Day Emergency Care (SDEC) should be available for older people<sup>1</sup>. Every week over 200 people aged 85+ years attend Portsmouth Hospitals University NHS Trust (PHUT) Emergency department (ED). A Frailty and Interface Team (FIT) in the ED support admission avoidance but we had no specific medical SDEC service for older people (OSDEC). Previous work identified a need for access to this service for at least 6-10 patients daily (focused on 85+ years, 75+ years with Parkinson's Disease) particularly those with frailty. An OSDEC unit opened December 2021. **We describe our improvement work to increase access to OSDEC.**

## Method

Data was collected from patients seen through the 8 bed space OSDEC unit over a 10 week period (13/12/21 to 20/02/22).

We included data from patients identified as being suitable for this service; those 85+ years and 75+ years with Parkinson's disease. See figure 1 below for the inclusion criteria.

**OSDEC STREAMING STICKER** Portsmouth Hospitals University NHS Trust

For people >85, or >75 with Parkinsons Disease

	YES	NO
• Is their Covid result positive?	<input type="checkbox"/>	<input type="checkbox"/>
• Does the person need isolation?	<input type="checkbox"/>	<input type="checkbox"/>
• Is there a new clinical O <sub>2</sub> requirement?	<input type="checkbox"/>	<input type="checkbox"/>
• Is there a NEWS2 score ≥ 5 on either of 2 sets of vital signs?	<input type="checkbox"/>	<input type="checkbox"/>
• Does the person need 1:1 care?	<input type="checkbox"/>	<input type="checkbox"/>
• Does the person need a Resus Care Space?	<input type="checkbox"/>	<input type="checkbox"/>
• Is there a suspected fracture requiring treatment?	<input type="checkbox"/>	<input type="checkbox"/>
• Is the person having a suspected stroke?	<input type="checkbox"/>	<input type="checkbox"/>
• Is there acute MI/Ischaemic limb/surgical problem?	<input type="checkbox"/>	<input type="checkbox"/>
• Is the person actively dying?	<input type="checkbox"/>	<input type="checkbox"/>

If all answers are "NO" then person may be OSDEC suitable

Please refer to OSDEC streaming criteria

Feb 2022 Medical Illustration ref: 22-01118

Figure 1: OSDEC streaming sticker which was used to identify suitable patients from ED

- ❖ Weekly Plan, Do, Study, Act (PDSA) meetings were held to review progress and identify new changes.
- ❖ Attended morning Frailty and Interface Team (FIT) meetings and ED handovers to communicate changes.
- ❖ Held a Rapid Process Improvement Workshop (RPIW).
- ❖ Metrics included number seen in OSDEC and proportion discharged same day.
- ❖ Patient experience measured using the AFN Patient Survey Tool<sup>2</sup>.

## References

1. NHS Improvement, NHS England. Same-day acute frailty services. May 2019.
2. AFN Patient Survey Tool. Acute Frailty Network. NHS Elect. 2015.

We would like to acknowledge that this work was a team effort and would like to thank all members of the OSDEC unit, the FIT, therapy team and nursing staff.

## Results

374 patients were identified and reviewed during the 10 week period. Over this time **we saw a steady increase in the numbers accessing OSDEC**, figure 2.

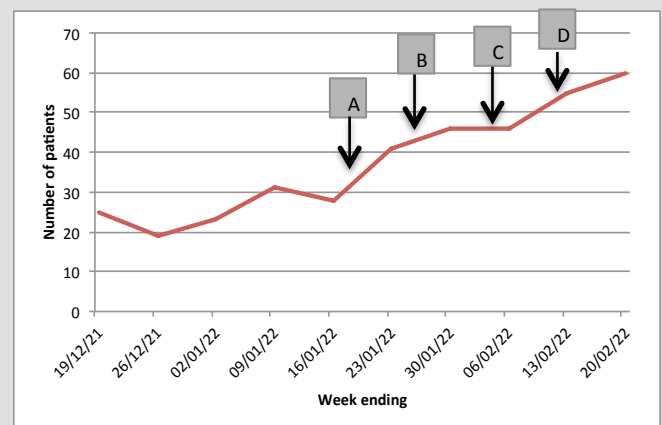


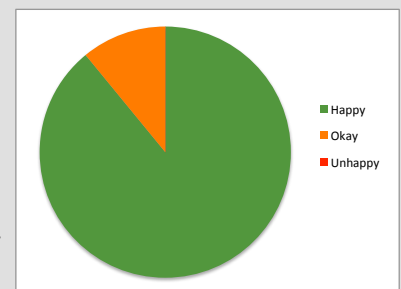
Figure 2: Total number of patients seen through OSDEC per week, indicating key changes made at different time points.

A) Increase focus on those from RH/NH. B) Flagging need for covid POCT to get patients from ED into the unit earlier. C) Review of take list by SpR to see OSDEC suitability and discuss with ED to increase pull. D) Introduction of identification sticker for ED to focus on a cohort of patients as potential OSDEC before being seen fully in ED.

**We achieved same day discharge in 41%** (30-62% range).

**Overall patient experience was good**, figure 3.

Figure 3: Patient experience surveys for 'How you felt after your first assessment' (n=64).



## Conclusions

**SDEC access for older people, including those with frailty, has been improved using a multi-professional improvement approach** including a willingness to test and evolve criteria and communication.

## **CQ - Clinical Quality - CQ - Clinical Effectiveness**

### [1171 Creating a Frailty Friendly Front Door: a QI Approach to Screening for Frailty and Delirium in the Emergency Department](#)

A Armstrong

Emergency Department, Royal Infirmary of Edinburgh

#### Introduction:

Early recognition and targeted evidence-based interventions for frailty and delirium are key to delivering better patient outcomes (and experiences) for those presenting to unscheduled care. Despite this, screening for frailty and delirium is not routine in many emergency departments, including RIE ED. Baseline data suggested <2% of patients being screened for frailty and around 4% for delirium.

#### Aim:

To increase screening for frailty and delirium from a baseline figure of <5% to 75% for patients aged over 75 years of age (or over 65 if living in a residential care facility) attending RIE ED by the end of May 2021.

#### Method:

A stakeholder meeting was held and following this a project driver diagram produced. A stakeholder analysis, process map and Cause-and-Effect diagram produced to guide change ideas. These were then tested by the ED frailty team using the Model for Improvement approach. Change ideas included the complete redesign of our nursing care plan, comprehensive programmes of nursing and medical education and appointment of frailty nurse champions within the nursing team structure.

#### Results:

In summary, a total of 72% of patients sampled during our tests of change were screened for frailty, whilst 68% of patients sampled had a 4AT completed.

#### Conclusion:

The results described above represented a significant improvement, though still fell short of the project aim. Further analysis revealed significant variation in daily results. It is hypothesised that further staff education and training is required to reduce this variation. Similarly, consistent use of the plans across all areas is felt likely to help this become more ingrained in our departmental culture. These hypotheses form the basis of the change ideas for our next planned PDSA cycles.

# Creating a Frailty Friendly Front Door: a QI Approach to Screening for Frailty and Delirium in the Emergency Department



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## Background:

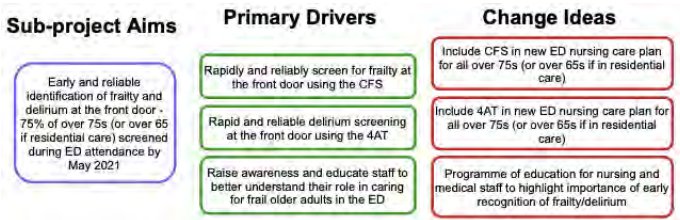
Early recognition and targeted evidence-based interventions for frailty and delirium are key to delivering better patient outcomes (and experiences) for those presenting to unscheduled care. Despite this, screening for frailty and delirium is not routine in many emergency departments, including RIE ED. Baseline data suggested <2% of patients being screened for frailty and around 4% for delirium.

## Aim:

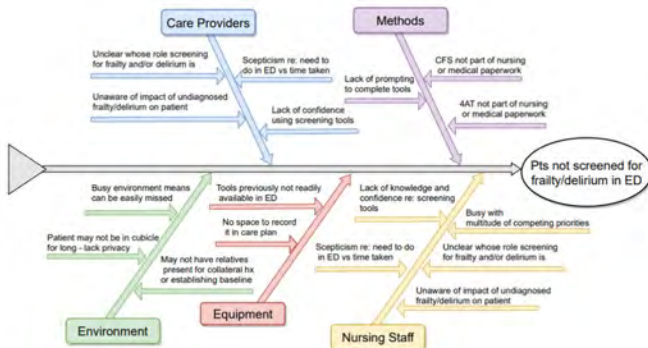
To increase screening for frailty and delirium from baseline figures of <2% and 4% respectively to >75% of all patients aged over 75 (or over 65 if in residential care) attending RIE ED by the end of May 2021.

## Method:

A stakeholder meeting was held and a project driver diagram produced, which can be seen below (Figure 1).



A stakeholder analysis, process map and Cause-and-Effect diagram (Figure 2) were produced to guide/focus change ideas. These change ideas were then tested by the ED frailty team using the Model for Improvement approach.



### 1) What are we trying to accomplish?

At the outset, the project aim was very broadly 'to improve outcomes and patient experiences for older adults living with frailty who attend RIE ED'. To be achievable, this initial goal clearly required further refinement. This was achieved using Doran's SMART criteria to break down this overarching aim into attainable component parts, and then choose one specific area to focus on (namely screening), resulting ultimately in the aim as stated above.

### 2) How will we know a change is an improvement?

A combination of measures were used within the QIP. The main outcome measure was the % of patients aged over 75 attending RIE ED who were screened for delirium or frailty. A sampling approach was used for ease of measuring.

### 3. What changes can we make which will result in an improvement?

Combining information gained from the pre-intervention nursing survey, the Cause-and-Effect diagram and Process Map, the decision was made to pursue a full redesign of the ED care plan to include screening with the CFS and 4AT, as well as making it more focussed by removing time-consuming parts of the document that were rarely used.

A 'Standard ED Care Plan' was also produced for for 'non-frail' patients, in an attempt to reduce the documentation required for this group. A carefully considered and targeted programmed of education was delivered to meet the training need identified in our pre-intervention survey results.

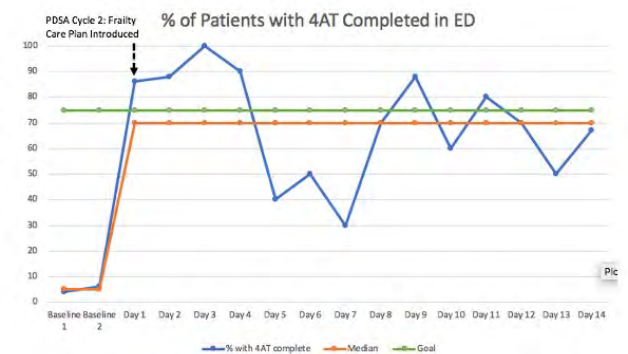
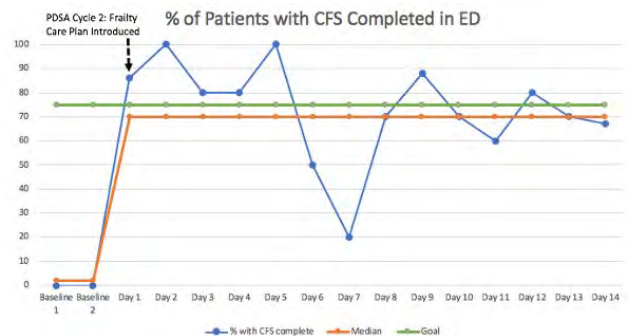
**PDSA 1.1 -1.4** (May 2020 – Mar 2021): multiple redrafts of proposed new ED 'Frailty' and 'Standard' care plans – circulated to ED CNM, SCNs, and CNs, as well as geriatricians, RIE ED Frailty Team (SIG) and ED QI lead for comments/feedback and refined accordingly.

**PDSA 2** (Mar-May 2021): introduction of Frailty (V5) and Standard (V2) ED care plan - 2 week departmental trial/test of change following handover 'Brief Educational Intervention' strategy.

**PDSA 3:** (May 2021 – current) ongoing works to convert RIE Frailty and Standard care plans to electronic/paperlite versions and update to reflect new NHS Lothian Accreditation & Care Assurance Standards. Proposal ongoing to embed frailty/delirium teaching into regular departmental teaching/induction.

## Results:

In summary, a total of 72% of patients sampled during our tests of change were screened for frailty, whilst 68% of patients sampled had a 4AT completed. This can be seen graphically on the run chart below.



## Conclusion/Discussion:

These results were obviously encouraging but still fell short of the target of 75%. Additionally, it was noted that there was significant variation in performance between days (range for CFS 20%-100%; range for 4AT from 40%-100%). It is hypothesised that further staff education and training is required to reduce this variation. Similarly, consistent use of the plans across all areas within the ED is felt likely to help them to become more ingrained in departmental culture. These hypotheses form the basis for ongoing works as detailed in PDSA Cycle 3 above.

**N.B. Due to space constraints I have been unable to include the ED Frailty Care Plan within my poster. I would be delighted to share it with any interested party – please do not hesitate to contact me by email to request a copy.**

## CQ - Clinical Quality - CQ - Patient Centredness

### 1183 Acute Frailty intervention reduces length of stay and readmission rates

L Mitchell 1; E Mackay 1; J Rimer 1; L Munang 1

1. Department of Medicine of the Elderly, St John's Hospital, NHS Lothian

#### Introduction

Outcomes for frail patients are improved when they are cared for on dedicated Medicine of the Elderly (MOE) wards, with Scottish Government standards recommending that older patients presenting with a 'frailty syndrome' have access to comprehensive geriatric assessment (CGA) and specialist management in a timely manner (Care of Older People in Hospital: Health Improvement Scotland standards, June 2015). The inaugural Frailty Advanced Nurse Practitioner (ANP) at St John's Hospital (SJH) was appointed in July 2020 with subsequent establishment of the front-door Frailty team to facilitate early CGA, identification for ongoing care in the acute Frailty ward and appropriate utilisation of community services including Hospital at Home.

#### Method

All patients admitted  $\geq 65$ -years-old into the SJH Medical Unit are screened within 24 hours by a member of the Frailty Team and scored according to the Rockwood Clinical Frailty Scale (CFS); those with a CFS  $\geq 4$  have a subsequent nurse-led Frailty assessment. A proportion of patients with the highest burden of multimorbidity and polypharmacy are reviewed on the Frailty ward round by the Frailty consultant or clinical fellow. In May 2021, one of the general MOE rehabilitation wards was reconfigured as an acute Frailty ward, with appropriate patient identification by the Frailty Team particularly for those with a shorter predicted length-of-stay.

#### Results

In the 12-month period December 2020–December 2021 there has been a reduction in the median length-of-stay of patients aged  $\geq 65$ -years-old, with a larger reduction in patients identified as frail. There has also been a reduction in the 30-day readmission rate of frail patients aged  $\geq 65$ -years-old over the same time period.

#### Conclusion

Targeting of Frailty resources to appropriate patients has ensured timely access to CGA, with improved patient care and appropriate utilisation of acute Frailty ward care and community resources. This has led to reduced average length-of-stay and readmission rates.

# Acute Frailty intervention reduces length of stay and readmission rates



Dr Lee Mitchell, Elaine Mackay, Dr Jane Rimer, Dr Latana Munang  
Department of Medicine of the Elderly, St John's Hospital, NHS Lothian

## INTRODUCTION

- Outcomes for frail patients are improved when they are cared for on dedicated Medicine of the Elderly (MOE) wards.
- Scottish Government standards recommend that older patients presenting with a 'frailty syndrome' have access to comprehensive geriatric assessment (CGA) and specialist management in a timely manner<sup>1</sup>.
- The inaugural Frailty Advanced Nurse Practitioner (ANP) at St John's Hospital (SJH) was appointed in July 2020 with subsequent establishment of the front-door Frailty team to facilitate early CGA, identification for ongoing care in the acute Frailty ward and appropriate utilisation of community services including Hospital at Home.

## METHODS

- All patients admitted ≥65-years-old into the SJH Medical Unit are screened within 24 hours by a member of the Frailty Team and scored according to the Rockwood Clinical Frailty Scale (CFS)<sup>2</sup>.
- Those with a CFS ≥4 undergo nurse-led Frailty assessment.
- A proportion of patients with the highest burden of multimorbidity and polypharmacy are reviewed on the Frailty ward round by the Frailty consultant or clinical fellow.
- In May 2021, one of the general MOE rehabilitation wards was reconfigured as an acute Frailty ward, with appropriate patient identification by the Frailty

Team, particularly for those with a shorter predicted length-of-stay.

## RESULTS

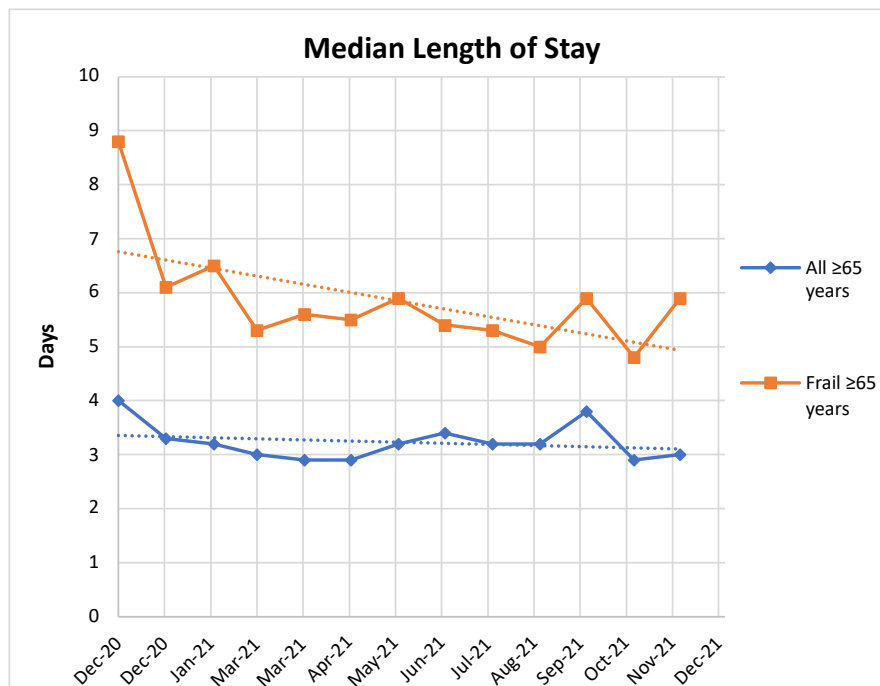
- In the 12-month period December 2020–December 2021 there has been a 25% reduction in the median length-of-stay of patients aged ≥65-years-old (n=6855), with a 33% reduction for patients identified as frail (n=3472).

## CONCLUSION

- Targeting of Frailty resources to appropriate patients has ensured timely access to CGA, with improved patient care and appropriate utilisation of acute Frailty ward care and community resources.
- This has led to reduced average length-of-stay, particularly in frail patients.

## REFERENCES

1. Care of Older People in Hospital: Health Improvement Scotland standards, June 2015.
2. Rockwood K, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, Mitnitski A. A global clinical measure of fitness and frailty in elderly people. *CMAJ*. 2005;173(5):489-495.



	<b>1</b>	VERY FIT
	<b>2</b>	FIT
	<b>3</b>	MANAGING WELL
	<b>4</b>	LIVING WITH VERY MILD FRAILTY
	<b>5</b>	LIVING WITH MILD FRAILTY
	<b>6</b>	LIVING WITH MODERATE FRAILTY
	<b>7</b>	LIVING WITH SEVERE FRAILTY
	<b>8</b>	LIVING WITH VERY SEVERE FRAILTY
	<b>9</b>	TERMINALLY ILL

Rockwood Clinical Frailty Scale (CFS)<sup>2</sup>

## **CQ - Clinical Quality - CQ - Clinical Effectiveness**

1185 An audit to investigate the accuracy of Clinical Frailty Scores from ED compared to OPAU

P TANNIRANDORN 1; A ALI 1

1. Nottingham University Hospitals (NUH)

### Introduction

The Clinical Frailty Scale (CFS) is a scoring system used to measure the severity of frailty, with grades ranging from fitness to terminally ill. The CFS does not identify components of frailty. The Edmonton Frail Scale (EFS) is an alternate scoring system which enables the definition of the components of frailty. The CFS was introduced in the Emergency Department (ED) of Queen's Medical Centre during the Covid-19 pandemic. All patients over 65 are assessed and their score recorded in MEDWAY. This audit was conducted to investigate whether the ED team are able to accurately recognise frailty and tag appropriately to in-patient frailty services.

### Methods

Frail elderly patients are admitted to the older person frailty unit (OPAU) via ED. We repeated the CFS assessment on 22 consecutive admissions under the care of the elderly based on their circumstances 2 weeks prior to admission. We then compared the results to the ED CFS score as to whether they reflected on how the patient was prior to coming into hospital. We also performed the Edmonton Frailty Scale on the same group of patients to explore possible correlations between scoring systems.

### Results

Overall, we found discrepancies in both the CFS and EFS score. The results were different in more than half the cases when ED and OPAU scores were compared. The numbers are small to make any statistical conclusions. The CFS score was shown to be overestimated by ED by 13.6%. EFS indicated difficulties in assessing frailty well unless at the extremes of frailty such as severe frailty.

### Conclusion

In conclusion, it is recommended that staff in ED be reminded on the use of CFS scores and the need to explore patient functional status prior to coming into hospital. The Edmonton Frailty Score is also unlikely to be of use in ED.

# An audit to investigate the accuracy of Clinical Frailty Scores from ED compared to OPAU

Puntrika Tannirandorn; Dr Aamer Ali  
Nottingham University Hospitals (NUH)

## INTRODUCTION

The Clinical Frailty Scale (CFS) is a scoring system used to measure the severity of frailty, with grades ranging from fitness to terminally ill. This system summarises and allows clinicians to screen and roughly quantify an individual's overall health status. The CFS does not identify components of frailty (1). An electronic version of CFS scoring was introduced with a teaching package at the time of introduction.

The Edmonton Frail Scale (EFS) is an alternate scoring system which enables the definition of the components of frailty. This system was developed as a practical tool for healthcare providers to create an individualised care plan for patients (2).

The CFS was introduced in the Emergency Department (ED) of Queen's Medical Centre during the Covid-19 pandemic. All patients over 65 years are assessed and their score recorded on the digital patient records system used in ED called MEDWAY.

## OBJECTIVES

This audit was conducted to investigate the accuracy of CFS scores between ED staff and the frailty team on the older person admission unit (OPAU) in recognising frailty accurately as it had implications for tagging to inpatient frailty services.

## METHODS

Frail elderly patients are admitted to the older person frailty unit (OPAU) via ED. We repeated the CFS assessment on 22 consecutive admissions under the care of the elderly based on their circumstances 2 weeks prior to admission. We then compared the results to the ED CFS score as to whether they reflected on how the patient was prior to coming into hospital.

To explore possible correlations between the two scoring systems, we also performed the Edmonton Frailty Scale on the same group of patients and divided them into categories of mild, moderate and severe frailty instead of scores for ease of comparison.

## RESULTS

Overall, we found discrepancies in scores of CFS in ED vs CFS in OPAU for assessed patients. The results were different in more than half the cases when compared between both groups. However, the numbers are too small to make any statistical conclusions. The CFS score was shown to be overestimated by ED by 13.6%.

There was limited correlation between EFS and CFS scores unless at the extremes of frailty such as severe frailty.

## CLINICAL FRAILTY SCALE

	<b>1</b>	<b>VERY FIT</b>	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	<b>2</b>	<b>FIT</b>	People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.
	<b>3</b>	<b>MANAGING WELL</b>	People whose medical problems are well controlled, even if occasionally symptomatic, but often are not regularly active beyond routine walking.
	<b>4</b>	<b>LIVING WITH VERY MILD FRAILTY</b>	Previously "vulnerable," this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up" and/or being tired during the day.
	<b>5</b>	<b>LIVING WITH MILD FRAILTY</b>	People who often have more evident slowing, and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

	<b>6</b>	<b>LIVING WITH MODERATE FRAILTY</b>	People who need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
	<b>7</b>	<b>LIVING WITH SEVERE FRAILTY</b>	Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
	<b>8</b>	<b>LIVING WITH VERY SEVERE FRAILTY</b>	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
	<b>9</b>	<b>TERMINALLY ILL</b>	Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise living with severe frailty. (Many terminally ill people can still exercise until very close to death.)

## SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.



Clinical Frailty Scale ©2005-2020 Rockwood, Version 2.0 (2020). All rights reserved. For permission: www.geriatricmedicine.ca  
Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. *CMAJ* 2005;173:489-495.

Figure 1: The Clinical Frailty Scale (3)

## DISCUSSION

EFS is not suitable to be used in ED and there is no correlation between EFS and CFS in patients presenting with frailty in ED.

The use of CFS will need continuous teaching reminders as the initial use was introduced with a teaching package but message has been lost due to the huge turnover of staff within the department.

## CONCLUSIONS

In conclusion, the CFS is a useful score to identify frailty in ED. It is recommended that staff in ED be reminded of accurate history taking in regards to the level of frailty prior to acute illness or deterioration. Our audit has shown that ED is currently overestimating the score by more than one point which has implications downstream for bed management. There is also a limited role for EFS in the acute setting.

## REFERENCES

1. Rockwood, K., 2005. A global clinical measure of fitness and frailty in elderly people. *Canadian Medical Association Journal*, 173(5), pp.489-495.
2. Rolfson, D., Majumdar, S., Tsuyuki, R., Tahir, A. and Rockwood, K., 2006. Validity and reliability of the Edmonton Frail Scale. *Age and Ageing*, 35(5), pp.526-529.
3. Dalhousie University. 2022. *Clinical Frailty Scale*. [online] Available at: <<https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html>> [Accessed 22 June 2022].

## ACKNOWLEDGMENTS

I would like to thank my supervisor, Dr Aamer Ali for his valuable feedback, patience and encouragement throughout the entire project as well as the OPAU team for allowing the conduction of this audit.

## CQ - Clinical Quality - CQ - Improved Access to Service

### 1188 Managing Emergency Laparotomies in Frail Patients

R Caldwell<sup>1</sup>; M Alam<sup>2</sup>; A Casey<sup>3</sup>

1. General Practice, Aintree University Hospital; 2. Upper Gastrointestinal Surgery, Royal Liverpool Hospital; 3. Emergency Department, Aintree University Hospital

#### Introduction:

The National Emergency Laparotomy Audit (NELA) and the British Geriatric Society (BGS) both outline recommendations for managing patients over 65 undergoing emergency laparotomies. Our study aims to evaluate whether our trust is concordant with this guidance and is appropriately identifying and managing frail patients to minimise adverse outcomes following surgery.

#### Methods:

Both retrospective and prospective data have been collected from January 2019 to June 2021 on patients who are >65 and 'frail' (Clinical Frailty Score [CFS] >5 or aged >80) who have undergone an emergency laparotomy. Outcome measures included: whether frail patients were identified and received a geriatric review, length of stay, post-operative complications, mortality, discharge destination and re-admission.

#### Results:

Of our prospectively collected data, only 0.02% of patients had their frailty score documented (NELA standard 91.8%) and of the frail patients identified by our audit, 0.05% were reviewed by a consultant geriatrician (NELA standard 27.1%). The average length of hospital stay was 10.2 days (NELA standard 15.1).

#### Conclusion:

There is certainly room for improvement with regards to identifying and documenting patient's frailty to assess whether geriatric involvement is warranted. We aim to re-audit the incorporation of mandatory CFS documentation and geriatric assessments- if this demonstrates significantly improved outcomes for emergency laparotomies in the elderly and frail population, the ultimate aim would be to provide a multidisciplinary unit for frail patients who may require or are undergoing emergency laparotomies.



Caldwell, Robyn 1; Casey, Anna 2; Alam, Mushfique 3  
Aintree University Hospital

## BACKGROUND

The National Emergency Laparotomy Audit (NELA) and the British Geriatric Society (BGS) both outline recommendations for managing patients over 65 undergoing emergency laparotomies (ELs). Both guidelines state all patients over 65 undergoing ELs, should:

- Be assessed using a clinical frailty score (CFS)
- Have a consultant geriatrician review if over 80 years old or have CFS >5

Current evidence suggests having a geriatric-led comprehensive geriatric assessment and optimisation reduces mortality, length of hospital stay and postoperative medical complications.

## AIMS

- Evaluate whether our trust is concordant with both NELA and BGS guidance.

## METHODOLOGY

- Prospective data was collected between May-July and October-November 2021 on all patients over aged 65 being considered for an emergency laparotomy.
- The primary outcome measures were:
  1. % of patients aged >65 who had their frailty assessed
  2. % of patients identified as frail who received a geriatric review.
- Secondary outcome measures included: length of hospital stay (LOS), post-operative complications, mortality, discharge destination and re-admission.
- These were compared to the data documented in NELA's 7<sup>th</sup> report

## RESULTS

- Figure 1 outlines the primary outcome measures. It compares data collected from the Emergency General Surgery Department (EGSU) with data from the 7<sup>th</sup> NELA report.
- CFS was calculated in 0.02% of EGSU patients aged >65 and considered for EL, compared to NELA's average of 91.8%
- Of those patients meeting the frailty criteria, EGSU data demonstrates only 0.05% received geriatric input compared to NELA's average of 27.1%.
- Figure 2 outlines primary and secondary outcome measures and compares to NELA averages.
- The average LOS in our study's cohort was only 10.2 days compared to NELA's average of 15.1.
- Patients aged >65 and classed as frail had a 0% 30-day mortality in EGSU.
- Patients aged >80 had a 30-day mortality of 28.6% (NELA average 14.2%).

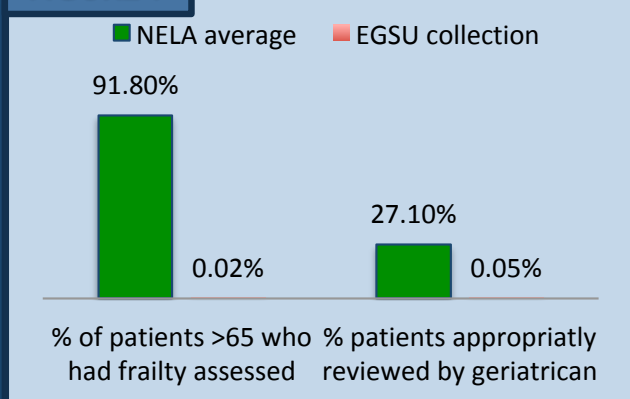
FIGURE 2

	NELA STANDARD	EGSU COLLECTION
Average length of hospital stay in those over 65	15.1	10.2
% of patients ≥80 OR over 65 with CFS ≥5, reviewed by a consultant geriatrician	27.1%	0.05%
% of patients >65 who had frailty assessed	91.8%	0.02%
30 day mortality in those over 65 and frail (CFS ≥5)	18.6%	0%
30 day mortality in those over 80	14.2%	28.6%
30 day re-admission rate	-	12%

## CONCLUSION

There is much room for improvement with identifying and documenting patient's frailty to enable geriatric involvement. We aim to re-audit following the incorporation of mandatory CFS and geriatric assessments in EGSU to evaluate if this improves outcomes for ELs in the elderly and frail population. Our ultimate goal is to establish a multidisciplinary unit for frail patients who may require or are undergoing ELs.

FIGURE 1



## REFERENCES

1. NELA Project Team (2021) 'Seventh Patient Report of the National Emergency Laparotomy Audit RCoA London.' Available at: <https://www.nela.org.uk/Seventh-Patient-Report> (accessed 24/06/22)
2. British Geriatrics Society (April 2020) 'BGS Position Statement: Older patients undergoing emergency laparotomy.' Available at: <https://www.bgs.org.uk/resources/bgs-position-statement-older-patients-undergoing-emergency-laparotomy> (accessed 24/06/22)
3. Shipway D, Koiza L, Winterkorn N et al. Embedded geriatric surgical liaison I associated with reduced inpatient length of stay in older patients admitted to gastrointestinal surgery. Future Healthcare Journal 2018; 5 (2): 108-16

**2022 Frailty and Urgent Care Meeting**

**CQ - Clinical Quality - CQ - Patient Centredness**

**1192 Falls Prevention: Community Exercise Programme; reducing risk of deconditioning, falls and loneliness in frail elderly patients**

J Butler<sup>1</sup>; L Shalev Greene<sup>2</sup>;

1. Kingston Hospital NHS Foundation Trust; Department of Elderly Care; 2. Kingston Hospital NHS Foundation Trust; Volunteering Department

**Introduction**

Covid has had a devastating effect on the Elderly, resulting in deconditioning, increased falls and loneliness. Tailored exercises can reduce falls in people aged over 65 by 54% and participation in physical activity reduces the risk of hip fractures by 50%, currently costing the NHS £1.7 billion per year in England. This 8 week intervention delivered by trained volunteers in patient's homes, aims to reduce deconditioning, loneliness and the risk, incidence and fear of falling (FOF) amongst frail patients post-discharge from hospital.

**Method**

A gap in service was identified in Frail patients discharged from hospital, at risk of falling and awaiting community physiotherapy. A steering group was set up including acute and community therapists, volunteers and carers to design a collaborative intervention to bridge the gap. At risk patients were identified and referred by ward therapists supported by the hospital volunteering team. Volunteers were trained to deliver an 8 weeks programme of progressive exercises in patients' homes with additional signposting to appropriate statutory and voluntary services. Qualitative and quantitative outcome measures were taken at week 1 and week 8 of the intervention

**Results**

91.5% total health outcomes improved or maintained by average: - FOF reduced by 22.5% - 180 degree turn improved by 43% - 60 sec Sit to Stand improved by 14.75% - Timed Up And Go improved by 15.5% - Confidence to cope at home improved by 15% - Pain / discomfort (self-reported) improved by 18.75% - Overall health (self-reported) improved by 8.5%

**Conclusion(s).**

Targeted exercise at home with skilled volunteers can improve functional fitness and health outcomes in a frail elderly population at risk of falls when discharged home from hospital. The programme increases patients' connectivity to local voluntary and community sector services. Volunteers' mental health improves by engaging in meaningful service.

# Falls Prevention: Community Exercise Programme; reducing risk of deconditioning, falls and loneliness in elderly patients

Authors: Butler, J; Shalev Greene, L, Dagnin, H, Griffith, M.

**Background & Introduction:** Covid 19 has had a devastating effect on the Elderly, resulting in deconditioning, increased falls and loneliness. Tailored exercises can reduce falls in people aged over 65 by 54% and participation in physical activity reduces the risk of hip fractures by 50%, currently costing the NHS £1.7 billion per year in England. This 8 week intervention delivered by trained volunteers in patient's homes, aims to reduce deconditioning, loneliness and the risk, incidence and fear of falling (FOF) amongst elderly patients post-discharge from hospital whilst improving quality of life.

## Aims: Proactively reduce patients' risk of falls following discharge home from an acute hospital by:

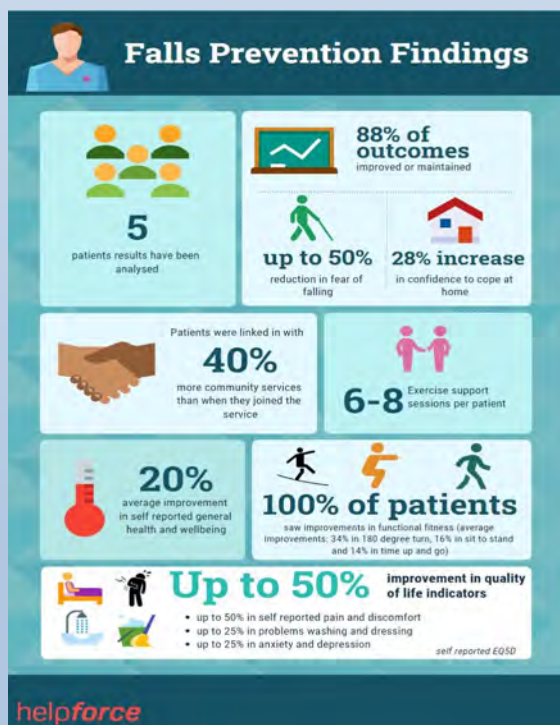
- Reducing fear of falling
- Improved balance, strength and coordination
- Increased social connectivity

## Sample Size:

Launched in November 2021 the sample size of patients who completed the 8 week programme was 5 patients. These early findings showcase promising results in a small patient cohort and a second cohort of 5 patients is underway, due to complete Summer 2022. Tests will be repeated once the sample size has increased to prove any statistical significance of these early trends.

## Overall Results:

Qualitative and quantitative outcome measures were taken at week 1 and week 8 of the intervention. We are seeing extremely promising results and positive trends.



**Method:** A gap in service was identified in elderly patients discharged from hospital, at risk of falling and awaiting community physiotherapy. A steering group was set up including acute and community therapists, HelpForce, volunteers and carers to design a collaborative intervention to bridge the gap. At risk patients were identified and referred by ward therapists supported by the hospital volunteering team.

Volunteers visit patients in their homes on a weekly basis for the first 8 weeks following discharge home from hospital, with additional telephone support in weeks 1-4. Volunteers supervise a programme of progressive exercises in patients' homes offering support, encouragement and companionship with additional signposting to appropriate statutory and voluntary services.

## Lessons learned and benefits:

- ❑ Sample size remained small due to challenges of identifying eligible patients amongst the population of unwell patients of high acuity.
- ❑ Volunteers are not a free resource – whilst they give their time altruistically, Trusts must invest significant resource into the recruitment, training and management of skilled, community based volunteers
- ❑ There is immense social and functional value in volunteers visiting patients in the home post discharge.
- ❑ Increased collaboration between primary, secondary and tertiary care has improved working relationships, putting the patient first.

*"It gave this patient a purpose, with all the benefits that mobilisation around the home and a renewed sense of self-respect and dignity." Juliet, Ward Physiotherapist*

## Conclusions:

Targeted exercise at home with skilled volunteers can improve functional fitness and health outcomes in an elderly population at risk of falls when immediately discharged home from hospital. The programme increases patients' connectivity to local voluntary and community sector services. Volunteers' mental health improves by engaging in meaningful service.

## Forward Plans:

This service is not an attempt to replace community therapy. Rather, to bridge a gap in service as patients move between hospital and home. Aligned with Helpforce's vision, Back to Health, we see potential to adapt and expand this initiative into Care Homes and areas such as pre-hab and pre assessment with future collaboration and innovation.



*"The exercises were enjoyable and there was a good variety. I liked being able to choose and tailor the programme to suit my needs. I chose what I wanted to work on which was lower body and balance, then we found the best exercises for this. The sessions went on for a good amount of time— once a week for 8 weeks felt like enough time to build up confidence. It was nice to be able to see the volunteer... it really boosted my mood and confidence." Richard, Patient.*

## **CQ - Clinical Quality - CQ - Patient Centredness**

### [1212 Improving Treatment Escalation Planning on the Frailty Assessment Unit at a District General Hospital](#)

J Gilbert 1; E Payne 1

Acute Frailty Unit, Queen Elizabeth the Queen Mother Hospital, Margate

Treatment Escalation Plans were developed during the Covid pandemic to help guide clinicians how to best respond to an individual's needs and provide personalised care.

An initial audit in September 2021 found that only 8/19 (42%) of patients on our frailty unit had a TEP in place (against standard of 100%) and even those filled in were difficult to find as they were stored in a variety of places.

To act on these findings, a checklist for TEP completion was added to our daily MDT board rounds and the team agreed on a standardised place for where they should be filed. Re-audit in December 2021 showed that TEP completion rates significantly improved to 19/20 (95%) and 72% reflected evidence of patients' wishes and engagement. The TEPs that were most comprehensive were those filled out by the frailty ACPs and Registrar who have both hospital and community experience and have received specialist training in how to complete TEPs.

Following a series of breakfast club education sessions for the whole MDT, a second re-audit in April 2022 showed sustained improvement with 15/15 (100%) TEPs completed and evidence of patients' wishes in 80%. The level of detail on the documents improved too, with pragmatic signposting and greater consideration of planning for those who did not wish to be readmitted to hospital.

Future work now needs to focus on rolling out this project to all general elderly care wards and further linking with our community colleagues to provide the best possible integrated and patient-centred care.

# Improving Treatment Escalation Planning on the Acute Frailty Unit at a District General Hospital



Jacqueline Gilbert, ST7 SpR Geriatrics,  
Elizabeth Payne, Frailty Trainee ACP  
QEQM Hospital, Margate



## Background

Treatment escalation plans (TEPs) were introduced to empower patients to make informed decisions and guide clinical teams about the care they would like to receive. As per NHS England and BGS guidance, this should include the option for patients to receive care in their own home if they prefer. A recent quality improvement project on the frailty unit improved TEP completion rates from 42% to 95% but quality and transferability to the community were not measured.

## Aims

To assess quality of TEP documentation and optimise an individual's future care planning needs.

## Methods

Between December 2021 – April 2022 a Quality Improvement Project using Plan, Do, Study Act cycles was used to develop TEPs on the acute frailty unit. A specialist Task and Finish Group agreed 5 criteria for a good quality TEP:

- Reflects the patient's current condition and needs
- Reflects the patient's wishes
- Evidence of engagement with relatives / care home
- Includes a detailed plan for a response to a crisis
- Pragmatic plans with signposting and contact numbers if needed

### Standards

- 80% of patients should have a TEP
- 80% of TEPs should meet the above criteria

Data was gathered in a spot single day audit on the Acute Frailty Unit and a General Geriatrics Ward.



## Actions

Rates of TEP completion on the acute frailty unit remained high, as expected following recent work to raise awareness. However, the quality of TEPs still needed to be improved,

We appointed a frailty ACP with experience of both acute and community settings to be our TEP champion. Through breakfast club education sessions the whole MDT were upskilled and felt more confident discussing advance care planning with patients and their families. We also established weekly Teams meetings with our community colleagues to promote consideration of home treatment options and communication across the primary/secondary care interface. All TEPs were uploaded and the original sent home with patients at point of discharge.

## Reaudit on the Acute Frailty Unit April 2022

100% TEP completion rate with 73% of TEPs now meeting all 5 quality criteria.

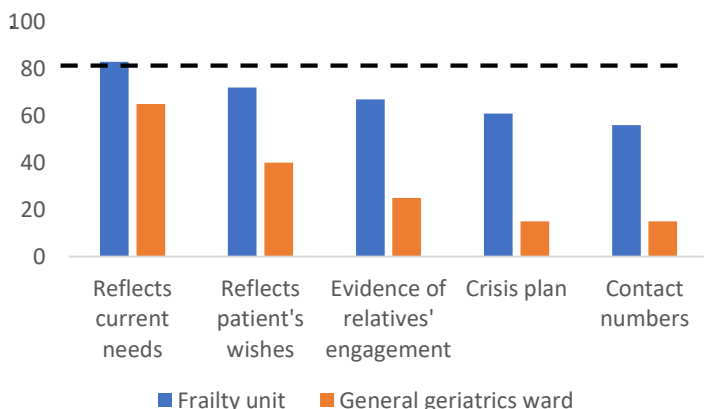
'Having a clear TEP makes decision making much easier when on-call seeing patients you don't know. It helps us to understand what they would want.' ST4

'When seeing patients in the community, TEPs advising whether they would want readmission to hospital or not are the most useful. Just saying 'ward based care' does not apply outside of the hospital and does not help us.' Frailty ACP

'I'm so glad we were listened to and can keep my dad comfortable at home. That is our priority'. Patient's relative

## Results

- On the acute frailty unit 18/19 patients (95%) had a TEP in place vs 20/29 (69%) on a general geriatrics ward.
- Of the completed TEPs, 50% on the acute frailty unit met all 5 quality criteria vs 10% on the general geriatrics ward.
- Documentation of patients' & relatives' engagement was variable and crisis planning often minimal, only relating to treatment options within hospital (eg – 'ward based care')



## Conclusions and Future Work

Whole MDT education and interface working are essential to improve the quality of TEP documentation and make plans that are of real benefit for patients. Further spot audits on the frailty unit are planned on a 6 monthly basis to ensure standards are maintained. We now plan to nominate TEP champions across all geriatrics wards to emulate the acute frailty unit's success. With their help we will undertake education at trust-wide grand rounds to raise awareness of advance care planning options for all.

## **CQ - Clinical Quality - CQ - Clinical Effectiveness**

### [1220 Improving management of Older Major Trauma Patients in the Emergency Department of Homerton Healthcare NHS Foundation Trust](#)

A Sharma<sup>1</sup>; C Vaughn<sup>1</sup>; J Rogers<sup>1</sup>; M Hughes<sup>1</sup>; A Devaney<sup>1</sup>

#### 1. Homerton Healthcare NHS Trust

##### Introduction

The Major Trauma in Older People (TARN) 2017 report highlighted falls from standing height as the most common major trauma cause. The report shows a disparity in the care of older injured patients against standards. Issues include difficulty identifying major injury in older people and lack of senior reviews in the Emergency Department (ED). The described QIP started in 2020 at Homerton ED. Our aim was an increase of 40% in primary surveys (60% total) and senior reviews ST4+ (63% total) in patients meeting the recommended criteria.

##### Methods

We conducted a process map and root cause analysis to identify obstacles through the department. Several change ideas and a driver diagram helped split our overall goal into smaller, achievable tasks. We looked at all patients over 65 attending the ED with injuries, excluding those not meeting major trauma criteria. Our team conducted three PDSA (Plan, Do, Study, Act) cycles between 01/02/2020-01/12/2021, with the fourth PDSA ongoing. Cycles included teaching, simulation sessions, clinical cases, documentation templates and a standard operating procedure (SOP).

##### Results

Baseline data was collected for 27 patients attending between 01/02/2020-12/02/2020. This showed 85% qualified for senior review, but only 30% received one. Following implementation of 3 PDSA cycles, we analysed data from 172 patients between 01/06/21-31/01/22. Data revealed clinician variability undertaking primary surveys, (range 0-100%) within a 22-week period (mean 38%). Senior reviews improved with 61% of patients qualifying and an average of 54% receiving review.

##### Conclusion

The Pan London Major Trauma Network Booklet 2021 is an important resource for management of older trauma patients. Identifying obstacles within our ED has enabled creation of teaching resources and standardised templates. We are currently writing an SOP based on the Pan London Booklet. Ongoing issues include improving senior cover out-of-hours and involving stakeholders from other specialities for cohesive patient care.

# Improving management of Older Major Trauma Patients in the Emergency Department

A.Sharma, J. Rogers, M. Hughes, C. Vaughn, A. Devaney

## Background

The Major Trauma in Older People (TARN) 2017 report highlighted falls from standing height as the most common major trauma cause. The report shows a disparity in the care of older injured patients against standards.

Issues include difficulty identifying major injury in older people and lack of senior reviews in the Emergency Department (ED). The described QIP started in 2020 at Homerton Healthcare NHS Trust Emergency Department

## Aims and Objectives

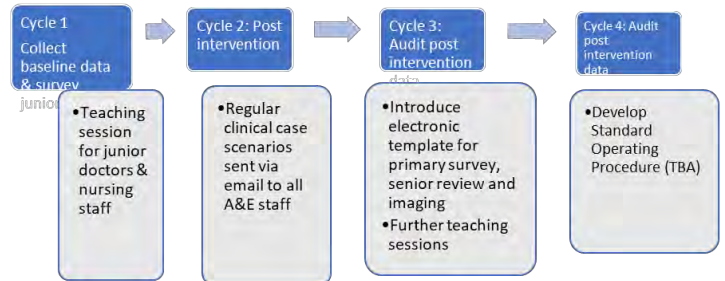
- Improving the care of patients over 65 years old presenting with a fall by ensuring early senior reviews and escalation of care including trauma calls and primary surveys.
- Our aim was an increase of 40% in primary surveys (60% total) and senior reviews ST4+ (63% total) in patients meeting the recommended criteria.

## Methodology

We conducted a process map and root cause analysis to identify obstacles through the department. Several change ideas and a driver diagram helped split our overall goal into smaller, achievable tasks.

We looked at all patients over 65 attending the ED with injuries, excluding those not meeting major trauma criteria.

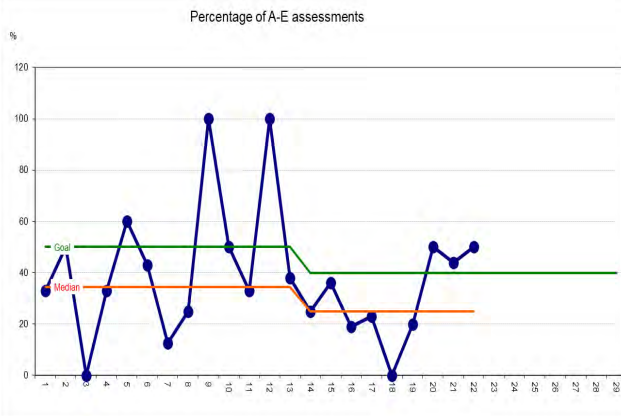
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## Results

Baseline data was collected for 27 patients attending between 01/02/2020-12/02/2020. This showed 85% qualified for senior review, but only 30% received one.

Following implementation of 3 PDSA cycles, we analysed data from 172 patients between 01/06/21-31/01/22. Data revealed clinician variability undertaking primary surveys, (range 0-100%) within a 22-week period (mean 38%). Senior reviews improved with 61% of patients qualifying and an average of 54% receiving review.



## Discussion

The Pan London Major Trauma Network Booklet 2021 is an important resource for management of older trauma patients. Identifying obstacles within our ED has enabled creation of teaching resources and standardised templates. We are currently writing an SOP based on the Pan London Booklet. Ongoing issues include improving senior cover out-of-hours and involving stakeholders from other specialities for cohesive patient care.

**Template for Primary Survey in Older Trauma**

This template is for use in patients over 65 presenting with a fall or injury meeting the following inclusion criteria:

- Time of injury
- Any hospital interventions (including haemostatic agents, splints applied, reduction of fractures)
- Current vital signs
- Presented to ED as an emergency (Trauma/Major haemorrhage/Multiple emergency services)
- Team members present with names/speciality/roles

**Examination per head-to-toe:**

- Time of injury
- Any hospital interventions (including haemostatic agents, splints applied, reduction of fractures)
- Current vital signs
- Presented to ED as an emergency (Trauma/Major haemorrhage/Multiple emergency services)
- Team members present with names/speciality/roles

**History:**

- GMCS number:
- Time taken:
- Type of fall: Details as necessary (Trauma/Major haemorrhage/Multiple emergency services)

**Examination:**

- Head
- Neck
- Chest
- Abdomen
- Extremities
- Spine
- Rectum
- Perineum
- Genitals

**Disability:**

- GMCS
- APACHE
- SOFA

## **CQ - Clinical Quality - CQ - Clinical Effectiveness**

1225 Does Frailty score predict mortality and/or prognosis in a hospital at home setting?

Dr S. Din<sup>1</sup>, Dr L. Burton<sup>1</sup>; J. Thompson<sup>1</sup>; L. Inglis<sup>1</sup>; J. Coward<sup>1</sup>; A. Flatt<sup>1</sup>

<sup>1</sup>Dundee Enhanced Community Support-Acute (DECS-A) Team, Royal Victoria Hospital

### Introduction:

The DECS-A team is aligned with the principles of “hospital at home” in frail patients over 65. Frailty puts patients at risk of adverse outcomes including falls, hospitalisation and mortality<sup>1-3</sup>. Early identification of frailty enables people to make informed decisions about their care and discuss anticipatory care planning (ACP). The aim was to assess the Rockwood Clinical Frailty Scale (CFS) in predicting mortality and guiding ACP in patients referred to the DECS-A team.

### Method:

The Rockwood CFS was recorded as part of the admission documentation and the proforma. Cycle 1: 12 months analysis of the number of times CFS was recorded and if ACP/DNACPR discussions were documented for those with CFS score of 7 or above. An additional training session was implemented and the results were captured prospectively over a consecutive 3 month period (cycle 2).

### Results:

In cycle 1; 33% (53/162) of patients had a CFS score recorded. 42% with CFS 7 and 100% with CFS 9 died within 3 months post discharge. There were no patients scoring CFS 8. ACP/DNACPR discussions were had in 100% of patients. Following the educational session in Cycle 2: 89% (51/57) had a CFS score recorded. 40% with CFS 7 and 100% with CFS 8 died within 3 months post discharge. There were no patients admitted to caseload with CFS 9. ACP/DNACPR discussions were had in 83% with CFS 7 and 100% with CFS 8.

### Conclusion:

A CFS score of  $\geq 8$  was associated with an increased risk of mortality at 3 months for patients within a Hospital at home setting. Identification of frailty can also be useful in assisting with decision making for anticipatory care planning for frail vulnerable patients in a community setting. Further research using a larger prospective cohort study would be required to validate these results.



# Does Frailty score predict mortality and/or prognosis in a hospital at home setting?

## Introduction

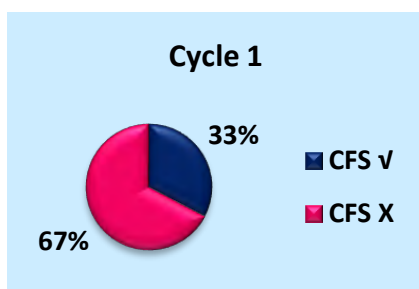
- The DECS-A team is aligned with the principles of "hospital at home" in frail patients > 65.
- Frailty puts patients at risk of adverse outcomes.<sup>1-6</sup>
- Early identification enables people to make informed decisions about anticipatory care planning (ACP).

## Aim:

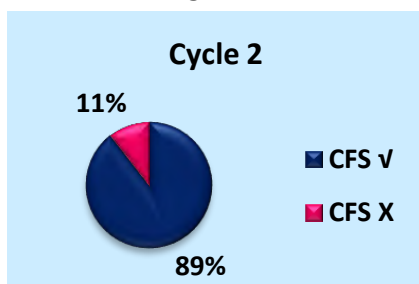
- To assess the Rockwood Clinical Frailty Scale (CFS) in predicting mortality and/or guiding ACP in patients referred to the service.

**Educational session using BGS Frailty resources ↑ frailty scoring from 33% to 89%**

## CFS Recording Pre Intervention



## CFS Recording Post Intervention



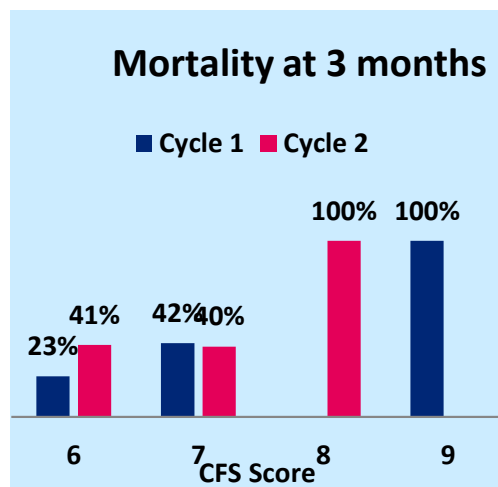
## Method:

- The Rockwood CFS was recorded as part of the admission documentation and the proforma.
- 12 months analysis of the number of times CFS was recorded and if ACP/DNACPR discussions were documented for those with CFS score of 7 or above.
- An additional training session was implemented and the results were captured prospectively over a consecutive 3 month period

**A CFS score of  $\geq 8$  was associated with an ↑ risk of mortality at 3 months within a Hospital at home setting**

## Results:

- Cycle 1; 33% (53/162) of patients had a CFS score recorded. 42% with CFS 7 and 100% with CFS 9 died within 3 months post discharge. There were no patients scoring CFS 8. ACP/DNACPR discussions were documented in 100% of patients.
- Post educational session in Cycle 2: 89% (51/57) had a CFS score recorded. 40% with CFS 7 and 100% with CFS 8 died within 3 months post discharge. There were no patients admitted to caseload with CFS 9.
- ACP/DNACPR discussions were completed in 83% with CFS 7 and 100% with CFS 8.



**ACP/DNACPR discussions completed in 100% with a CFS score  $\geq 8$**

## Conclusion:

- A CFS score of  $\geq 8$  was associated with an increased risk of mortality at 3 months for patients within a Hospital at home setting.
- Identification of frailty can support decision making in anticipatory care planning for frail vulnerable patients in a community setting.

- Further research using a larger prospective cohort study would be required to validate these results.

## References:

1. Clegg A, Young J, Iliffe S et al Frailty in elderly people. *The Lancet* Volume 381, Issue 9858, 2-8 March 2013, Pages 752-762.
2. Rockwood K, Howlett S, MacKnight C et al Prevalence, Attributes, and Outcomes of Fitness and Frailty in Community-Dwelling Older Adults: Report From the Canadian Study of Health and Aging. *Journal of Gerontology: Medical Sciences*. 2004, Vol. 59A, No. 12, 1310-1317
3. Vermeiren S, Vella-Azzopardi R et al. Frailty and the Prediction of negative Health outcomes: A Meta-Analysis. *J Am Med Dir Assoc* 2016 Dec 1;17(12): 1163.e1-1163.e17
4. Kojima G. Frailty as a predictor of future falls among community-dwelling older people: a systematic review and meta-analysis. *J Am Med Dir Assoc* 2015; 16: 1027-33
5. Kojima G. Frailty as a predictor of hospitalisation among community-dwelling older people: a systematic review and meta-analysis. *J Epidemiol Community Health* 2016; 70: 722-29
6. Kojima G, Iliffe S; Walters K. frailty Index as a predictor of mortality: a systematic review and meta analysis. *Age Ageing*. 2018 Mar 1;47(2):193-200
7. Specialised Clinical Frailty Network: Clinical Frailty Scale. 2018. <https://www.scfn.org.uk/clinical-frailty-scale>
8. British Geriatrics Society: End of Life Care Introduction and Foreword. Last updated 12 May 2020. <https://www.bgs.org.uk/resources/end-of-life-care-in-frailty-introduction-and-foreword>.
9. British Geriatrics Society: End of Life Care in Frailty: Identification and prognostication. Last updated 12 May 2020. <https://www.bgs.org.uk/resources/end-of-life-care-in-frailty-identification-and-prognostication>
10. Clinical Frailty Scale App - NHS Elect & Acute Frailty Network [Clinical Frailty Scale \(CFS\) on the App Store \(apple.com\)](https://www.bgs.org.uk/resources/end-of-life-care-in-frailty-identification-and-prognostication)

## CQ - Clinical Quality - CQ - Improved Access to Service

### 1228 Trialling extended hour's service provision of a Frailty Intervention Therapy Team (FITT) within the Emergency Department

Kara Mc Loughlin<sup>1</sup>; Chiara Reddin; <sup>1</sup>Louise McGettigan; <sup>1</sup> Carol Lyons; <sup>1</sup> Laura Burke; Grainne Maher; Aoife Roche; Michelle McDonald; Ciara Black; Grace Corcoran; Eimear Walsh; Paul Maloney; Ivan Clancy;

Beaumont Hospital, Dublin, Ireland

#### Background:

Older adults with frailty in the Emergency Department (ED) often present with complex needs requiring a holistic approach to their care. Many ED's are addressing these needs through the introduction of FITT however the majority of these teams in Ireland work standard office hours with many complex patients presenting outside of these times. The Royal College of Physicians (2020) recommends " An MDT capable of assessing and managing geriatric syndromes should be available 10 hours a day, 7 days a week" therefore to attempt to bridge the gap between current service provision and service needs an extended hours trial was completed.

#### Methods:

Over a two month period an extended hour trial was completed by existing FITT staffing to include cover until 8pm on Friday evenings & from 8am to 2pm on Saturdays. A total of 11 additional shifts were completed. Results: 112 patients were screened with 78 deemed appropriate for a FITT assessment

#### Outcomes

- Directly Home: 45
- Admission ; 33 – primarily for further medical intervention
- Average CFS 5
- 36 Additional HSCP referrals were highlighted in ED
- 51% of those discharged home required onward referral 60% of those admitted required further HSCP input at ward level

Feedback surveys were also completed with ED staff, patients and family members reported;

- 100% of service-user's were happy to be assessed & 82% were happy with the recommendations

- ED staff scored FITT an average of 9.8 for the extended hours and ease of access 100% of ED staff felt the extended hours improved patient flow
- Other feedback highlighted need for further investment for FITT and extended hours services as a priority

The provision this service allows for a larger proportion of frail older adults

# Frailty Intervention Therapy Team (FITT) Beaumont Hospital – Extended Hours Trial

Kara Mc Loughlin, Louise McGettigan, Chiara Reddin, Carol Lyons, Grainne Maher, Philip Williams, Laura Burke, Eimear Walsh, Grace Corcoran, Ciara Black, Clodagh Daly, Michelle McDonald Paul Maloney, Ivan Clancy, Beaumont Hospital, Dublin, Ireland



@fittbeaumont  
t



## Background

Older adults with frailty in the Emergency Department (ED) often present with complex needs requiring a holistic approach to their care. Many ED's are addressing these needs through the introduction of multidisciplinary teams however the majority of these teams in Ireland provide a service during core working hours only. Many complex patients present outside of these times. The Royal College of Physicians (2020) recommends "An MDT capable of assessing and managing geriatric syndromes should be available 10 hours a day, 7 days a week" therefore to attempt to bridge the gap between current service provision and service needs an extended hours trial was completed by the FIT Team in Beaumont Hospital.

## Methods

Over a two month period an extended hours trial was completed whereby the FIT Team provided a service until 8pm on Friday evenings and from 8am to 2pm on Saturdays. A total of 11 additional shifts were completed.

- o All patients presenting to the ED  $\geq 75$  years were screened by FITT and verbal referrals were taken for those under that age limit if they had frailty needs to be addressed.

## Results

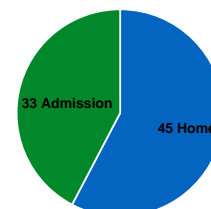
112 patients were screened with 78 deemed appropriate for a FITT assessment

### Outcomes

Direct discharge home 45

Admission; 33 –primarily for medical intervention

Average **CFS 5**



36 Additional HSCP referrals were highlighted in ED

51% of those discharged home required onward referral

60% of those admitted required further HSCP input at ward level

### Qualitative Feedback

100% of service-user's were happy to be assessed & 82% were happy with the recommendations

100% of ED staff felt the extended hours improved patient flow

Other feedback highlighted need for further investment for FITT and extended hours services as a priority

## Conclusion

The provision of this extended service enables a larger proportion of frail older adults to be assessed. For long-term sustainability further investment and additional staffing would need to be considered.

## **CQ - Clinical Quality - CQ - Improved Access to Service**

### [1229 Geriatric Emergency Medicine \(GEM\)' Pearls And Pitfalls'- An Interdisciplinary Approach To Education](#)

Louise McGettigan; 1 Dr Abdi Sadik Abdullahi; 1 Kara Mc Loughlin; 1 Carol Lyons; Dr Owen Keane, Chiara Reddin

Beaumont Hospital, Dublin, Ireland

#### Background

In recent years we have seen increased awareness of the terms 'frailty' and 'GEM' in many of our Emergency Departments (ED). A clear understanding of these terms within the context of ED is essential to provide a holistic care and to best meet the needs of older adults. It has been highlighted internationally that current training programmes do not sufficiently address learning needs of trainees to optimise care of this cohort of patients. The European Geriatric Medicine Society and the European Society for Emergency Medicine has attempted to address this gap through the introduction of a core GEM curriculum in 2016, however, at a local level many EDs are not utilising this resource for a number of reasons including lack of awareness and prioritisation of other local learning needs as determined by specialist training. To address the GEM learning needs at a local level an initiative idea was trialled in the form of a GEM teaching wall with dedicated monthly topics chosen from the above curriculum.

#### Methods

The initiative was led by a Senior Physiotherapist working on the Frailty Intervention Therapy Team and a Senior House Officer (SHO) working in ED with collaboration from other ED members as identified. A brainstorming session took place to identify potential topics. A poster was created by the project leads each month focusing on a core topic including an overview on the subject, national/international guidelines and top tips how to best manage in ED. Relevant team members contributed to different topics. Monthly posters were displayed in the ED.

#### Results

The project has been successfully running for 4 months with topics including Abdominal pain, Silver trauma Delirium and Falls.

**Conclusion** GEM teaching is a cornerstone of successful management of older adults presenting to our EDs. Novel MDT teaching approaches can address the identified learning gap

# Geriatric Emergency Medicine “Pearls And Pitfalls” - An Interdisciplinary Approach To Education

Louise McGettigan, Dr Abdi Sadik Abdullahi, Carol Lyons, Kara Mc Loughlin, Chiara Reddin and Dr Owen Keane, Beaumont Hospital, Dublin, Ireland



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## Background

In recent years we have seen increased awareness of the terms *‘frailty’* and *‘Geriatric Emergency Medicine’* (GEM) in many of our Emergency Departments (ED).

A clear understanding of these terms within the context of Emergency Medicine is essential in order to provide a holistic approach to patient care as well as meeting the needs of older adults presenting to the ED.

International literature refers to current training programmes that do not sufficiently address the learning needs of trainees when caring for this complex patient group.

The European Geriatric Medicine Society and the European Society for Emergency Medicine has attempted to address this gap through the introduction of a Core GEM Curriculum in 2016, however, at a many EDs are not utilising this resource owing to a lack of awareness of this evidence based practice adjunct, resource challenges and prioritisation of other local learning needs as determined by their specialist training authorities.

To address the GEM learning in our ED, an initiative was trialed in the form of a GEM Teaching Wall with dedicated monthly topics chosen from the Core GEM Curriculum.

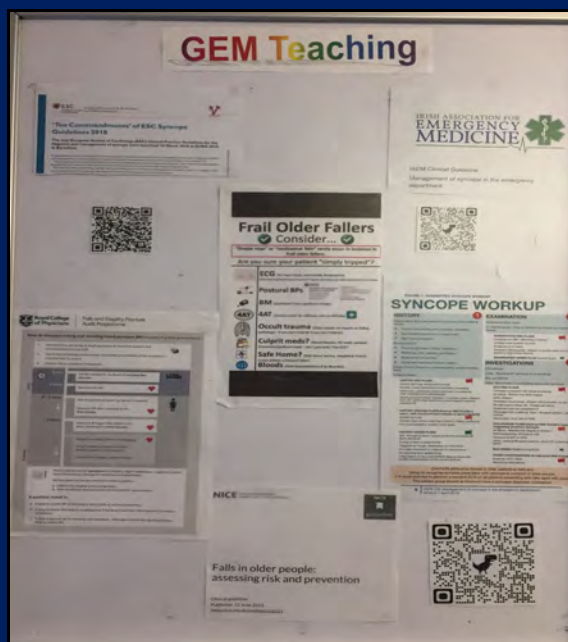
## Methods

This initiative was led by a Senior Physiotherapist working as part of the Frailty Intervention Therapy Team (FITT) and a Senior House Officer (SHO) working in Emergency Medicine with as well as collaboration from other ED members as identified. A brainstorming session took place to identify potential topics. A poster was created by the project leads each month focusing on the chosen core curriculum topic. This included an overview on the subject, national/international guidelines and top tips relevant to the ED phase of care. Monthly posters were displayed in the ED with contributions from various members of the EM Team.

## Results

This collaborative project has been running successfully for the past four months at Beaumont ED with topics covered including:

- ‘Abdominal pain in the Older Adult’
- ‘Silver trauma’ ,
- ‘Delirium’
- ‘Falls’



## Conclusion

GEM teaching is a cornerstone of successful management and practice in the care of older adults presenting to the ED. Novel MDT teaching approaches can identify and address learning gaps in this area and promote international evidence-based best practice whilst enhancing practice standards across the wider EM Team without incurring significant cost.

## **CQ - Clinical Quality - CQ - Patient Safety**

### [1236 A Retrospective Audit Assessing the Frequency and Quality of Visual Assessments in Older Patients on Admission](#)

A Gulamhussein<sup>1</sup>

1. Sandwell General Hospital; 2. Sandwell and West Birmingham Hospitals NHS Trust

#### Introduction

Poor vision is an established risk factor for inpatient falls. National guidance states that older patients should receive vision screening as part of a multifactorial assessment on admission. Despite this, only 48% of patients undergo visual assessments as per the National Audit of Inpatient Falls.

#### Methods

The aim of this project was to assess the frequency and quality of visual assessments performed by a local Frailty Intervention Team (FIT) for the period of March 2022. Electronic records of 57 patients with Comprehensive Geriatric Assessments were screened. Data collection concerned three aspects: if admitted patients underwent vision assessments, the nature of screening performed (e.g. bedside assessment vs. screening questions), and whether a fall was sustained during inpatient stay.

#### Results

38.5% of patients did not have a visual assessment. Of those who did, 85.7% of these assessments were historical (i.e. no bedside assessment was undertaken). Only 2.9% of patients who underwent vision assessments had a bedside test conducted. 7% of all patients sustained a fall either as an inpatient or after discharge. Of the patients who did not have visual assessments, 4.5% sustained a fall either as an inpatient or after discharge. Of those who did have visual assessments, 8.6% sustained a fall either as an inpatient or after discharge.

#### Conclusion

The data illustrates that over a third of admitted patients sign-posted to FIT do not undergo any visual assessment. Of those that do, the majority are simply asked if they wear glasses for near or distance vision. This highlights the need for a standardised visual screening tool for this unique patient population. Planned interventions include raising these findings at the Trust Quality Improvement meeting and introducing elements of the "Look out! Bedside Vision Check for Falls Prevention" tool into FIT CGAs.

# A RETROSPECTIVE AUDIT ASSESSING THE FREQUENCY AND QUALITY OF VISUAL ASSESSMENTS IN OLDER PATIENTS ON ADMISSION



Sandwell and West  
Birmingham Hospitals

NHS Trust

Ali Hasnain Gulamhussein

Syeda Naqvi

Sandwell and West Birmingham Hospitals

NHS Trust

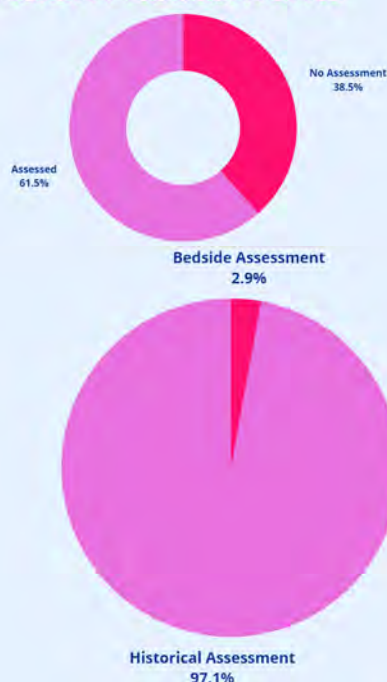
## INTRODUCTION

Poor vision is an established risk factor for inpatient falls. National guidance (NICE) states that older patients should receive vision screening as part of a multifactorial assessment on admission. Despite this, only 48% of patients undergo visual assessments as per the National Audit of Inpatient Falls.

## METHODS

The aim of this project was to assess the frequency and quality of visual assessments performed by a local Frailty Intervention Team (FIT) for the period of March 2022. Electronic records of 57 patients with Comprehensive Geriatric Assessments were screened. Data collection concerned three aspects: whether admitted patients underwent vision assessments, the nature of vision screening performed (e.g. bedside assessment vs. screening questions, also known as a "historical" assessment), and whether a fall was sustained during inpatient stay.

## Vision Assessments



Main trends identified:

**THERE IS NO STANDARDISED TOOL USED TO ASSESS OLDER PATIENTS' VISION ON ARRIVAL. THERE IS AN OVERRELIANCE ON SCREENING QUESTIONS WITHOUT AN ACCOMPANYING BEDSIDE ASSESSMENT.**

### References

- [Internet]. RCP London. 2015 [cited 31 May 2022]. Available from: <https://www.rcplondon.ac.uk/projects/outputs/naif-audit-report-2015>
- [Internet]. RCP London. 2022 [cited 31 May 2022]. Available from: <https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool>
- [Internet]. RCP London. 2022 [cited 31 May 2022]. Available from: <https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool>

## RESULTS

The average age of patients included in this study was 85.4. 45.6% of patients in this study were male, and 54.4% of these patients were female. 38.5% of all patients did not have a visual assessment at all. Of those who did, 85.7% of these assessments were historical (i.e. no bedside assessment was undertaken). Only 2.9% of patients who underwent vision assessments had a bedside test conducted. 7% of all patients sustained a fall either as an inpatient or after discharge. Of the patients who did not have visual assessments, 4.5% sustained a fall either as an inpatient or after discharge. Of those who did have visual assessments, 8.6% sustained a fall either as an inpatient or after discharge. When looking at the gender split amongst those who did have visual assessments, 60% were female, and 40% were male.

## CONCLUSION

The data illustrates that over a third of admitted patients sign-posted to FIT do not undergo any visual assessment. Of those that do, the majority are simply asked if they wear glasses for near or distance vision. This highlights the need for a standardised visual screening tool for this unique patient population. Interestingly, the group which had documented vision assessments sustained a greater proportion of falls as opposed to the group without any visual assessment. Planned interventions include raising these findings at the Trust Quality Improvement meeting and introducing elements of the "Look out! Bedside Vision Check for Falls Prevention" tool into FIT CGAs.