Post Discharge Frailty Support (PDFS)

Dr Angelene Teo, Hazel Wright NP
Geriatric Medicine, Lancashire Teaching Hospitals NHS Foundation Trust

Background:

- In response to the COVID pandemic when new robust discharge criteria were introduced to facilitate early discharge to optimise hospital capacity, Post Discharge Frailty Support (PDFS) was established[3]. This presented an opportunity for innovation with nurse-led telephone follow up for patients discharged primarily from the Emergency Department (ED) and the Acute Frailty Assessment Unit (AFAU).
- We adopted a Continuous Improvement methodology for constant review and learning. The aim was to provide continuity of care for frail elderly patients at home, by reviewing their medical, functional, and social progress post discharge with the aim to reduce readmissions.

Feedback from our patients:

"I am very impressed with the aftercare my husband had. It has made a big difference."

"You kept in touch and listened carefully. The service is just right."

"Professionalism and reassurance"

"Amazing team – floored by the service"

"Everything was explained – I am happy with the referral that led to equipment being installed – that has been fantastic"

Results:

Results:	Year 1 01.04.20 – 31.03.21	Year 2 01.04.21 – 31.03.22
Number of new referrals	598	297
Referrals to therapy	93	49
Referrals to community frailty	73	32
Referrals to other community services (dietitians, continence, podiatry)	91	76
Discussions with GP to avoid hospitalisation	112	41
30 day readmission	14%	11%
Patients discharged	547	224

Methods/ The Service:

- The service is overseen by the Lead Frailty Practitioner, supported by Consultant Geriatricians.
- Patients are issued with a leaflet prior to discharge detailing the service and providing important contact numbers.
- The case load is split up into 3 categories with levels of priorities – 1: At least weekly calls; 2: Fortnightly calls; 3: Monthly calls.
- Calls are made to patients by a team of Specialist Nurses who complete a mini comprehensive geriatric assessment and formulate a problem list and management plans. Any concerns are escalated to the geriatricians as required.
- This service engages closely with community partners such as the community frailty service, social care, district nurses and general practitioners. The service has access to Frailty HOT clinics for clinical review.

Use of Continuous Improvement Methodology:

We used quality improvement methodology to help us design and test our way to developing the PDFS. A Big Room is a weekly meeting consisting of stakeholders from across the clinical pathway who come together to work collaboratively to identify changes which can be made. Our approach to change was through the Flow Coaching Academy[2] and we used our weekly Frailty Big Room to create our aim, establish measures of success, and design a series of Plan-Do-Study-Act cycles to try and enact change for our patients. Due to the nature of weekly meetings, this created an opportunity to test ideas at pace, allowing the Big Room to learn and iterate future tests until we made improvement.

Conclusion:

PDFS is an effective service that has helped to reduce length of stay of frail elderly patients in an acute hospital setting, maintaining patient safety and prevent hospital re-admission, liaising closely with community services. Our service has been highlighted in the 2021 GIRFT report[1] on improving clinical practice.

References:

1. Hopper, A. (2021). Geriatric Medicine GIRFT Programme National Specialty Report. Available at: www.gettingitrightfirsttime.co.uk
2. The Health Foundation. (2019) Flow Coaching Academy. Available at: https://www.health.org.uk/funding-and-partnerships/programmes/flow-coaching-academy
3. Dept of health and social care 2020, Coronavirus (COVID –19) Hospital discharge service requirements. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/911541/COVID-19_hospital_discharge_service_requirements_2.pdf