Comprehensive Geriatric Assessment in the Emergency Department

Author: Sarah Smith/ Dr Gaggandeep Singh Alg/ Edward Howes

Introduction

The need for providing a dedicated frailty service in the emergency department (ED) is crucial for improving outcomes for older adults living with frailty[1]. The Older Persons Assessment & Liaison Service (OPAL) will establish themselves in ED and systematically assess and treat patients with moderate to severe frailty using a comprehensive geriatric assessment (CGA).

This proposal aligns with a key objectives for the trust and NHS England: Frailty provision in ED. The NHS long term plan states that all hospitals with a type 1 ED will provide an Acute Frailty service for at least 70 hours a week, with the aim to complete a clinical frailty score within 30 minutes for patients over 65.

Emergency departments are increasingly seeing more older adults living with frailty. Between 5% and 10% of all those attending EDs and 30% of acute medical units are older adults living with frailty. ·

Aim

Mission statement:
*"To implement an **equitable service** in the Emergency Department which provides **better outcomes** for patients living with frailty (>CFS 5) and encourages an **integrated and collaborative** relationship with **all South-West London partners** involved within the system."*

The OPAL team aim to provide a service to the Emergency Department in addition to the Acute Medical Unit. The OPAL team will provide two frailty practitioners, a support worker, a senior doctor in acute geriatric medicine and a consultant Geriatrician, allowing for a 37.5 hour service over 5 days (Mon-Fri). The long- term aim is to provide a 70- hour service over 7 days, aiming to match peak patient arrival times and meet NHSe national guidance for frailty emergency care.

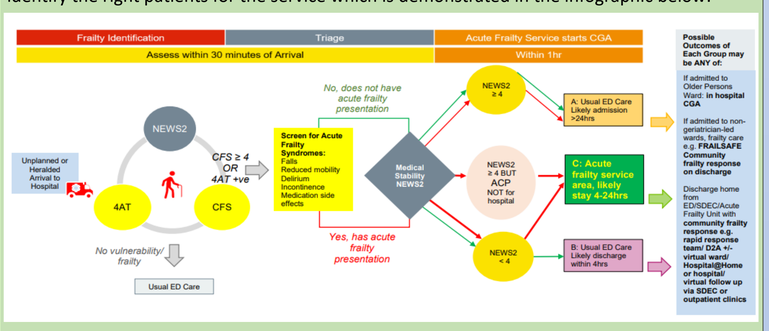
Methods

A Plan, Do, Study, Act approach to improvement was adopted for this project, data has been continuously collected over the period of a year. A working group consisting of key acute and community stakeholders was created and Key Performance Indicators were established. These have been reviewed and edited alongside the implementation of the new service.

No.	KPI and Metrics	
1)	KPI: % Of patients aged >65 have a CFS recorded	
1.i	All Older adults (65+) should be assessed for frailty within 30 minutes of arrival[1].	Time between admission and completed CFS
2)	KPI: % of unplanned care patients, aged >65 with a CFS of 5 or above discharged the same day.	
2.i	Reduced overall LOS for patients seen by OPAL and discharged	LOS (Days/ hours), admission to discharge.
2.ii	Reduce ED LOS for patients with frailty.	LOS (hours) for frailty cohort on ED
3)	KPI: Total occupied bed days for patients over 65 with a CFS of 5 or above.	
3.i	Reduced overall LOS for patients seen by OPAL and admitted to a ward.	LOS (Days/ hours) OPAL patients are admitted for.
3.ii	Reduce the % of patients over the age of 65 with a CFS of5 or above being admitted to a medical ward.	% of patients with a CFS of 5 admitted on to a medical ward
4)	KPI: Number of patients with a 7 day re-attendance/ re-admission seen by OPAL.	
5)	KPI: % OF Older adults (65+) with a Clinical frailty score >5 (CFS) will have a CGA initiated the same day (within 24 hours)	
	Other metrics	
3	An MDT capable of assessing and managing geriatric syndromes should be available 70 hours a week (Aiming to match clinical need where possible)[1]	Rostering/ Job plan
4	Improved patient/ carer experience/ partner experience	FFT & Qualitative measures
5	Increased referral activity to community services from opal (H@H, rapid response, social services).	Referral quantity

Interventions

The team aligned their practice with the National Acute Frailty guidance from NHSe and utilised the PAN London: unplanned hospital care acute frailty service guidance to help identify the right patients for the service which is demonstrated in the infographic below.



Multiple PDSA cycles were completed:

PDSA cycle 1 April 23: 2 new practitioners and clinical fellow start and are based in ED

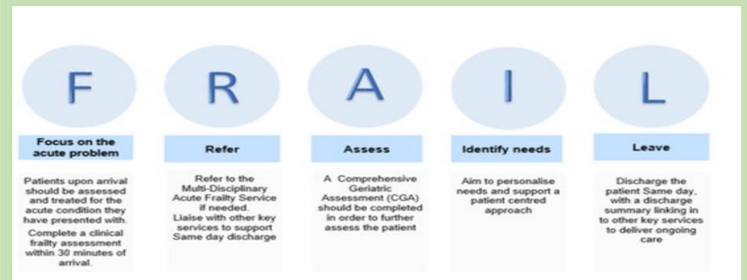
PDSA cycle 2 April 23: Trust committed to CFS CQUIN – communications and education delivered to ED staff

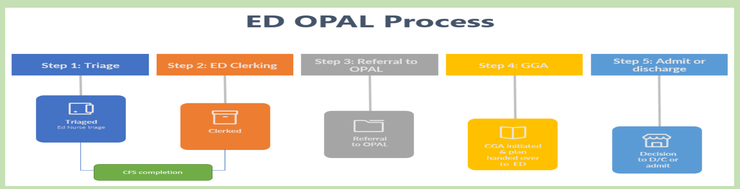
PDSA Cycle 3 July 23: ED OPAL poster produced and circulated to ED staff

PDSA cycle 4 Aug 23: Geriatric registrar joined OPAL team

PDSA cycle 5 Oct 23: Increased Consultant Geriatrician support

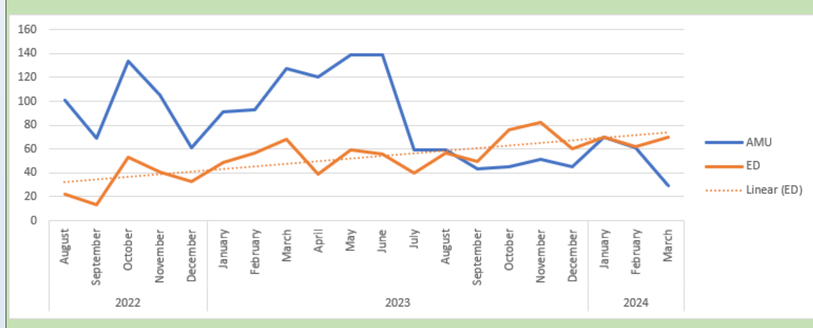
PDSA cycle 6 Nov 23: 2 computer workspaces dedicated for OPAL in Emergency department





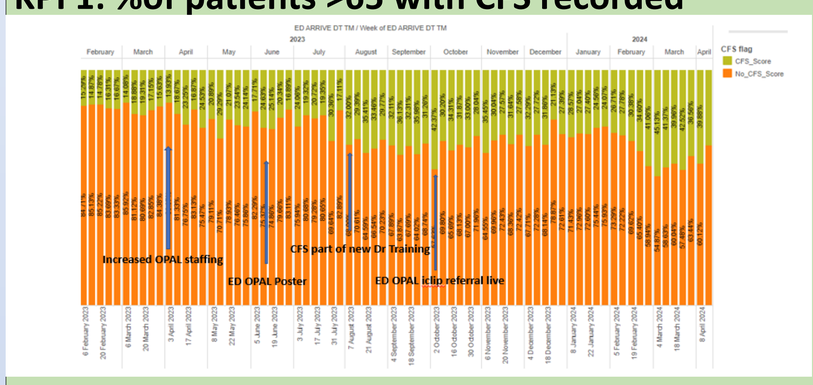
Results

Activity



Increase in OPAL activity in ED resulted in a decrease in activity on the acute medical unit

KPI 1: %of patients >65 with CFS recorded

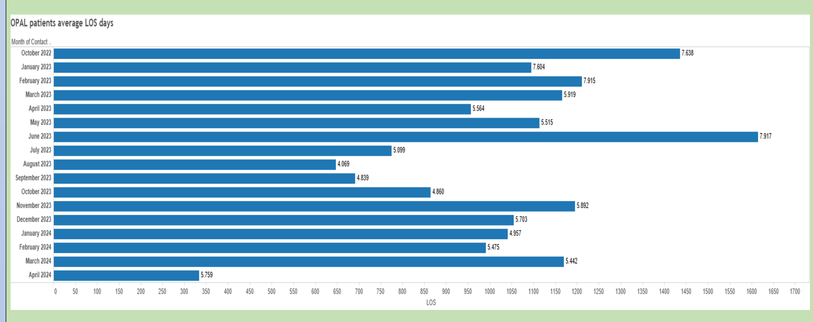


Frailty scoring increased from an average of 15% to 35% over the first year. This has been sustained with over 40% of over 65s receiving a frailty score in the Emergency Department.

KPI 2: % of OPAL patients dc the same day

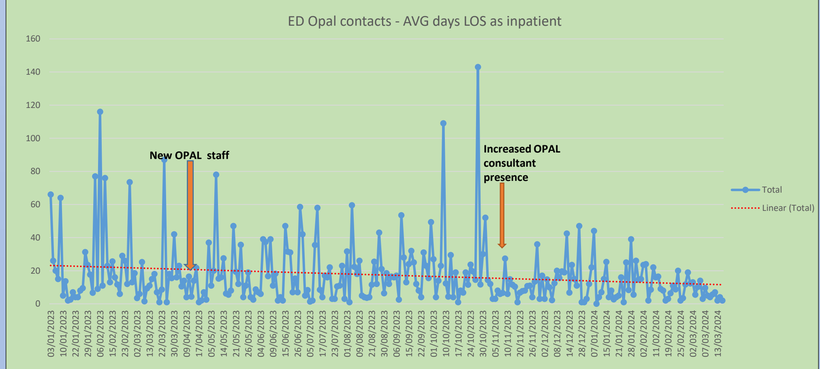
Month	Number of contacts	Number dc from ED (within 24 hrs)	Number on same day
Jan 2024	77	22	6
Feb 2024	89	23	5
March 2024	101	33	13
April 2024	96	48	25
May 2024	97	15	6
June 2024	101	23	7
July 2024	90	23	8
August 2024	96	22	5
September 2024	91	10	3

Between 25 and 35% of patients seen in ED are dc within 24 hours of arrival



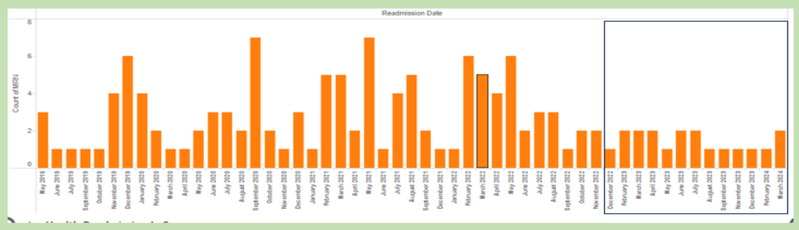
Length of stay for patients seen and discharge by OPAL reduced by 1.5 days

KPI 3: Reduction in overall LOS for OPAL patients



Length of stay for all patients seen by OPAL (admitted and not admitted) reduced by 10 days

KPI 4: Re-admissions



Re-admission rates remained stable

Conclusions

Having a Specialist Geriatric team imbedded in the Emergency Department resulted in:
Increase in Frailty scoring
Decreased time between attendance and Comprehensive Geriatric Assessment
Increase in Same day discharges for frail older adults
Decreased length of stay of frail older adults seen by the front door frailty team.

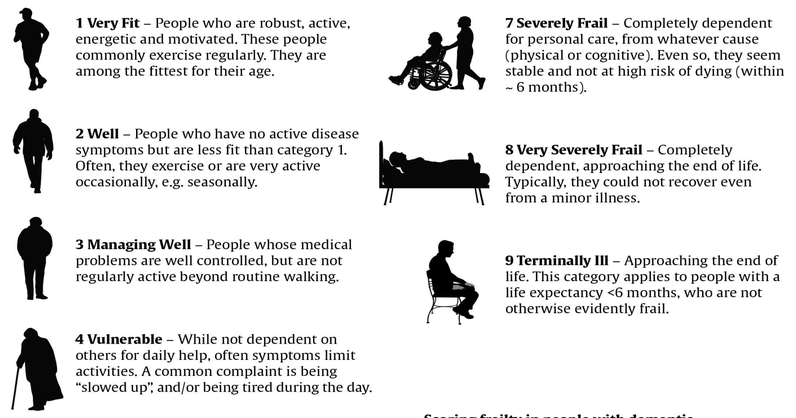
There were also a number of Indirect conclusions noted during the project period:
Increased utilisation of hospital at home
Reduced OPAL activity in AMU
Increased trust wide frailty scoring

Next steps

As there was no expected increase in re-admissions there is an argument that the team are not taking enough 'risk'. Therefore, the team are going to review the patients seen by the service that have a 1-2 day LOS and see if there was any opportunity to discharge them on the day of attendance and if not why not. This will help to shape future conversations around community and social care provision.

The team hope to pilot accepting direct referral from LAS and Comm services with the aim of working towards a frailty Same day emergency care model.

Clinical Frailty Scale



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – 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.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – 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.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People 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.

7 Severely Frail – 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).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty 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.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

References:

FRAIL strategy – NHSE 2024
London unplanned frailty care guidance
NHSE Long term plan

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust