# GeriPall Project—Bringing the best of Geriatric Medicine and Palliative Care together for patients with severe frailty, dementia and/or neurodegenerative conditions approaching end of life across the interface between acute hospital and community.

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- Listen to “What Matters Most” to the individual however it is expressed.
- A gap persists for people with advancing frailty, dementia, neurodegenerative conditions whose end-of-life needs are NOT recognized NOR appropriately met but nonetheless have no acute specialist palliative needs. End of life is harder to recognize with slowly deteriorating trajectory. Challenge indiscriminate use of single condition protocols as underlying frailty becomes increasingly irreversible at this stage.
- Identification: CFS 7 – 9 registered with a local GP on acute frailty unit, other medical and surgical wards. From community referred to Rapid Response Team experiencing frailty crisis. Exclude if EOLC needs require hospital or hospice level input.
- GeriPall interventions: “Tender conversations” mainly listening. Review history from all sources. Explain including uncertainties of outcomes to patient and family. Whatever else is needed—accurate and appropriate Fast Track completion, Urgent (Advance) Care Plan both online and paper copies
- Extensive medication review particularly deprescribing of items no longer of net benefit. Prescribe as required for symptom management.
- Harness existing pathways including ward discharge coordinators, D2A, community therapy, 2 hour urgent care MDT response
- In community: advise patient’s own GP and selectively use Palliative Care Coordination Hub, specialist palliative care, Care Home Support Team, district nursing, SALT, social care… (voluntary sector)
- Post discharge, Consistent phone follow up as soon as possible and sometimes visited. Ability to prescribe, review situation. Away from the large institution it is easier for death to become a social phenomenon as much as a medical one.
- Survey post-bereavement. Very limited due to admin staff shortage but individual feedback from relatives positive. One Datix from discharge team fully investigated for learning purposes.
- Outcome measures. 72 patients in 4 months, mostly from acute hospital. 19 RIP to end of March 2022. Average no of days for 10 sample patients: in index admission prior to GeriPall intervention =17.3, after GeriPall =3.1, previous 12 months in hospital =11, Days out of hospital under GeriPall=40
- Funded by winter pressures money 2021-22 and being sought for this winter.
- Shortlisted for HSJ Patient Safety Awards Care of the Older Person
- Hopes for future: funding, multidisciplinary staffing, systematic patient identification and referral. Data collection, MDT review post discharge and development and learning opportunities.