

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

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Background

Comprehensive Geriatric Assessment (CGA) improves outcomes for frail older adults in acute hospitals¹.

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

Patients aged 75 and above admitted into the Emergency Department at the QEUH 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.



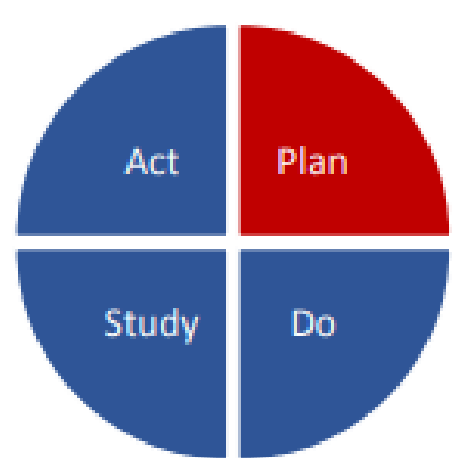
Royal College of Physicians & Society of Acute Medicine 2020 guidance on acute care for older people living with frailty.

Recommendation: ensure a system is in place to identify older people with frailty as they attend hospital².

Aim

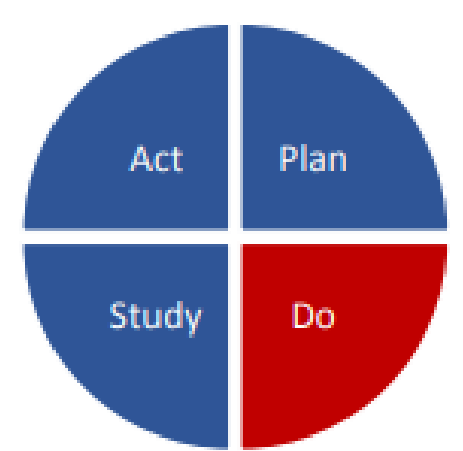
To use quality improvement methodology to increase the number of completed frailty icons for patients aged 75 and above before discharge from the ED.

Method



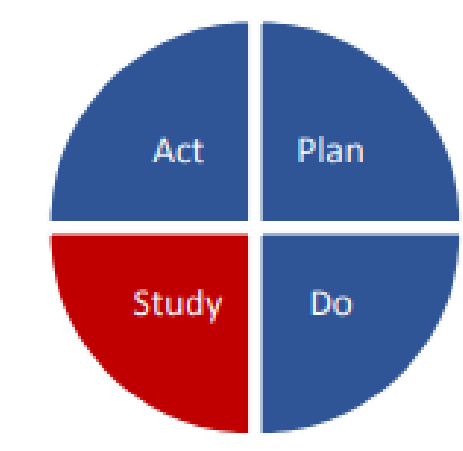
PLAN

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



DO

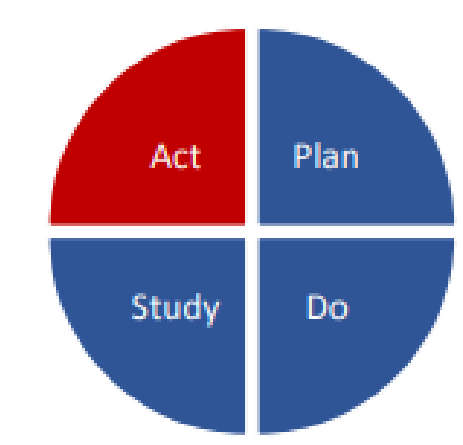
- ED medic and nurse ran frailty awareness tests together
- Baseline 28% completion of frailty icons pre-discharge
- Initial barrier to change as perceived “not ED work”



STUDY

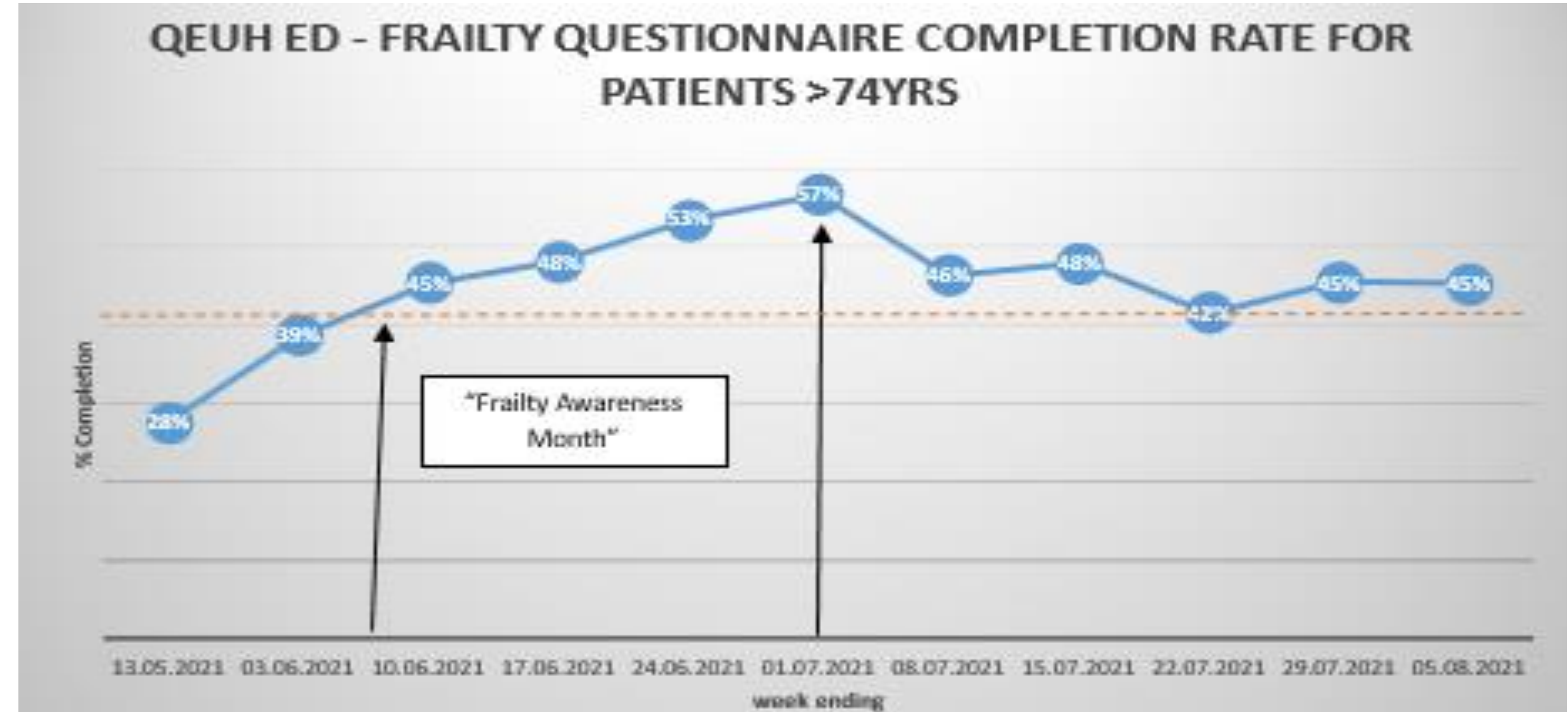
(see results section for run chart)

- 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



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.**

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 home³.**

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.

Future Direction

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

References:

1. 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 \(ihub.scot\)](https://www.improvingacutecareforpeoplelivingwithfrailty.org.uk/).
2. 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](https://www.rcplondon.ac.uk/resources/toolkits/acute-care-toolkit-3)
3. 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

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