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The Frailty Journey

Emergency Department
Royal Berkshire Hospital
2015-2018

16th March 2018 Dr Ruth Weldon, Anna Puddy

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Frail Elderly Revolution

- Over the next 20 years the number of people 85+ is set to  by 2/3
- 20 % ED attendances 65+ years = CORE BUSINESS
- Prof Oliver describes ageing and frailty as a GAME CHANGER
- 4 hour target skews decision making in this complex group



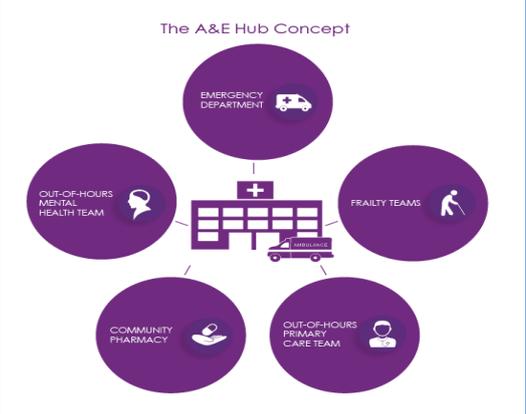


**The Royal College of
Emergency Medicine**

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Frailty is the no. 2 research priority in EM

The A&E Hub Concept



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Aim "To provide the best healthcare in the UK for our patients in our community"



- ❑ **POPULATION:** 500,000 patients in Berkshire, South Oxfordshire.
- ❑ **CHALLENGES:** Older patients attending ED ↑ 25% in 4 years
ED lack of flow, trolley waits, busy staff
No priority for frail patients, no time to care
Vacancies in Interface Geriatrics

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ED

Obs	Paeds
Majors	Minors
Resus	Stat

Main Hospital

1. ECPOD 8-8
2. Interface Geri
3. Physio
4. OT AMU/ED

Low risk Obs Bay was High Risk

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**Assessing for Cognitive Impairment
in Older People
Clinical Audit 2014-15**

Standard
1. All patients over the age of 75 are assessed for cognitive impairment in the ED .
2. Assessments are done using a structured tool.
3. The findings are provided to the inpatient teams.
4. The findings are provided to the patient's GP.
5. Information is given to the patient's carers.
6. All patients over the age of 75 have at least one Early Warning Score assessment.

RCEM Standards

Legend: ● National, ● Your ED



**Acute Frailty
Network**

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- NHS Elect 2015
- The purpose of the Acute Frailty Network is to optimise acute care of frail older people in England, but no one model will fit all systems, although the guiding principles can be derived from the existing evidence base, and locally adapted
- Professor Simon Conroy, Dr Jay Banerjee, Leicester
- 10 pilot sites
- 12 month collaborative improvement programme
- Regular national workshops, masterclasses & webinars
- Local working group ED, Interface Geriatrician, OT, Physio, Manager
- Site visit and peer review

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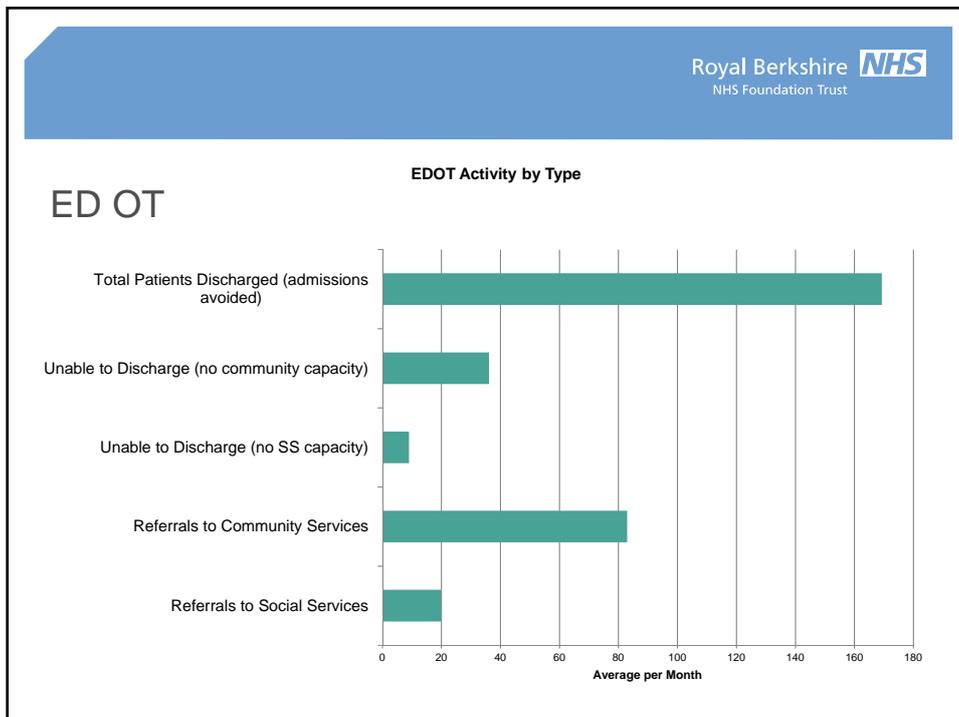
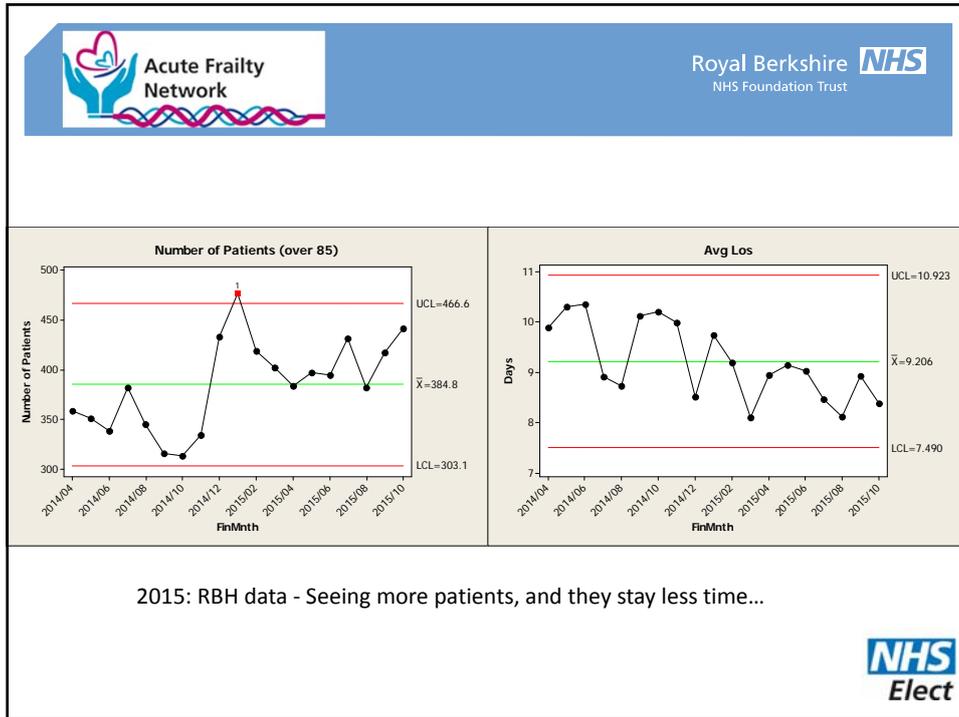


**Acute Frailty
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What does good look like in frailty care?

1. **Early identification of people with frailty**
2. **Comprehensive Geriatric Assessment (CGA) within the first hour**
3. **Rapid response system for frail older people**
4. **Clinical professional standards to reduce variation**
5. **Measurement mind-set**
6. **Strengthen links with services inside and outside hospital**
7. **Education and training for key staff**
8. **Identify clinical change champions**
9. **Patient and public involvement**
10. **Identify an executive sponsor and underpin with a robust project**



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Clinics for the Older Person

RACOP

- Rapid Access Clinic for the Older Person!
- Multi-disciplinary assessment, led by Dr Wearing to assess, treat and avoid admission
- 4 clinics a week, seen within 7 days or 48 hours if urgent
- Need to transfer with 1, may take up to 3 hours

Bleep 510 in hours
Fax 6704 Out of hours

FALLS CLINIC

- Consider in all falls presentations
- Weekly, led by Dr Pearson
- Nurse, Physio and OT review
- Not suitable if have cognitive impairment
- Review patients medications before referral

FAX referral to 6544

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Frailty Awareness

All patients 65 years and over

Is this patient at risk of frailty?

•85 years and over	Y / N
•65-84 years AND from a care home	Y / N
OR cognitive impairment	Y / N
OR Parkinson's Disease	Y / N
OR admitted after fall	Y / N

**If YES to any of the above, the patient is at risk of frailty, and would benefit from a CGA
Please record completion of CGA on all frail patients.**

Assessment	When?	By? (name & grade)
Cognition		
Mobility		
Function		
Continence		
Medication review		

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12 Days of Geriatric ED

- 12 ladies falling
- 11 bit confused
- 10 men collapsing
- 9 trolleys waiting
- 8 fractured hips
- 7 short of breaths
- 6 angry relatives
- 5 UTI's
- 4 found on floor
- 3 can't walk
- 2 broken wrists
- 1 Obs Bay that is full up

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Recognising Frailty in ED Audit 2015

- Audit of current practice based on silver book recommendations
- Documentation of basic aspects of CGA and frailty syndromes
- RESULTS: Poor documentation of all aspects of CGA and frailty
- CONCLUSIONS: Poor recognition of frailty in older patients
- ACTION PLAN: Standardising frailty identification
Continue education sessions about frailty

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2016 : Increasing national focus on frailty

Diploma in Geriatric Medicine

First Geriatric Emergency Medicine Conference, Leicester

Frailty at the Front Door, RCP

– TEAM ENGAGEMENT IN ED WAS A CHALLENGE

– ELDERLY CARE TEAM HAPPY WITH THEIR SERVICE in AMU

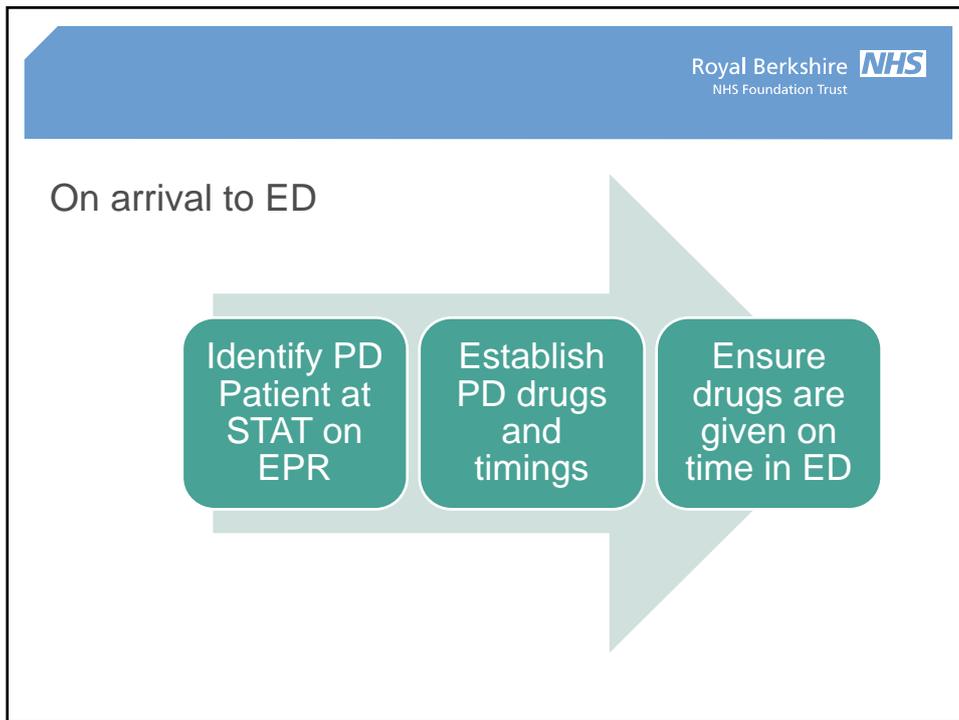
Where is the Front Door?

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Feb 2017: Think PD in ED

- Highlight all PD patients on arrival
- PD patients must NEVER miss or delay their medication
- Do not give Dopamine Antagonists Haloperidol, Antipsychotics, Prochlorperazine or Metoclopramide (HARM)
- PD drugs available in ED Resus
- Awareness of PD Nurse, PD Guidelines and resources



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EDucate evening on PD and Frailty

We had improved PD care in ED which felt GOOD

“MY GRANNY” MEDICINE



Could we do better??

100% said YES

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CEO Transformation Funds: 2017

£1 million to improve services for our patients in a financially efficient way

- Successful bids demonstrate:
 - A team approach with energy and commitment
 - An innovative approach to changing the way that services are delivered for patients
 - A real cash releasing efficiency saving

Application process followed by Elevator pitches to the CEO Board

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Frailty Friendly Front Door

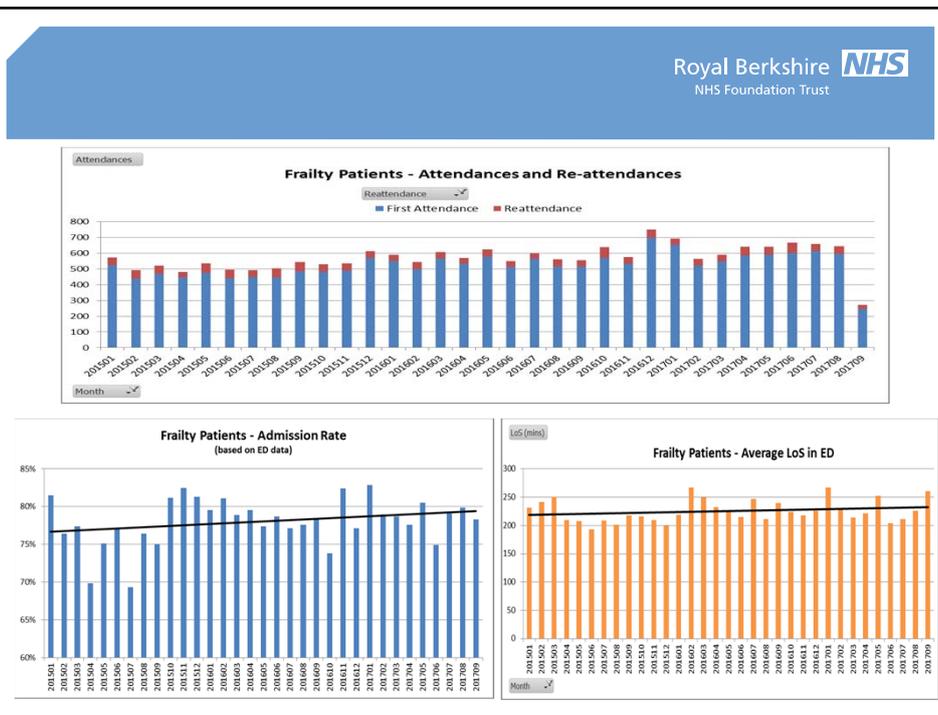
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The Big Idea: To identify patients at risk of frailty in ED, and for those not medically unwell, to be assessed by Frailty Practitioners to arrange timely discharge home or to alternative pathways

What should this achieve:

- Frailty Screening for over 65s in the ED
- Reduced average length of stay and conversion rates for frail patients in ED
- Comprehensive Geriatric Assessment at the front door
- 4AT Delirium assessments in all patients seen by frailty practitioners
- Improved awareness of Parkinson’s patients and their needs
- Improved communication with patients, relatives and carers
- Improved networking with alternative pathways: RACOP, RRAT, Falls clinic, RACU, EDOT

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>340 patients a day,
60-80 patients at a time
24 trolley spaces
New career in corridor medicine

Every frail patient should get an emergency
response



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Right Patient, Right Place, Right Time

Think Frailty +65s If not acutely unwell Frailty Practitioner review Decision making Plan Action

↑ discharges to home or appropriate community pathway

↑ improved liaison with ECPOD, RACOP and community teams



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Paed ED Improvements in 10 years

- Paeds ED
- Paed Emergency Consultant
- Paediatric nurses
- Improved teamwork
- High quality patient care



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Frailty Friendly Front Door in ED



Frailty Practitioners in ED
Frailty Tool
ECPOD Liaison
Community links

↓ admissions
↓ length of stay
↑ staff morale

Patient centred care

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The Frailty Friendly Front Door has gone live!



Frailty Practitioners are now in the Emergency Department

Bleep 579

8am – 8pm, 7 days a week

The team will be carrying out parallel assessments alongside the Emergency Department doctors, to expedite prompt discharge home and/or referral to alternative pathways, for patients living with frailty.

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THINK FRAILTY ON ARRIVAL

IN ALL over 65s

Falls

Reduced mobility

Acute/chronic confusion

Is known Parkinson's

Lives in a Care Home

THINK 5 TO GET HOME FIRST

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What have we achieved?

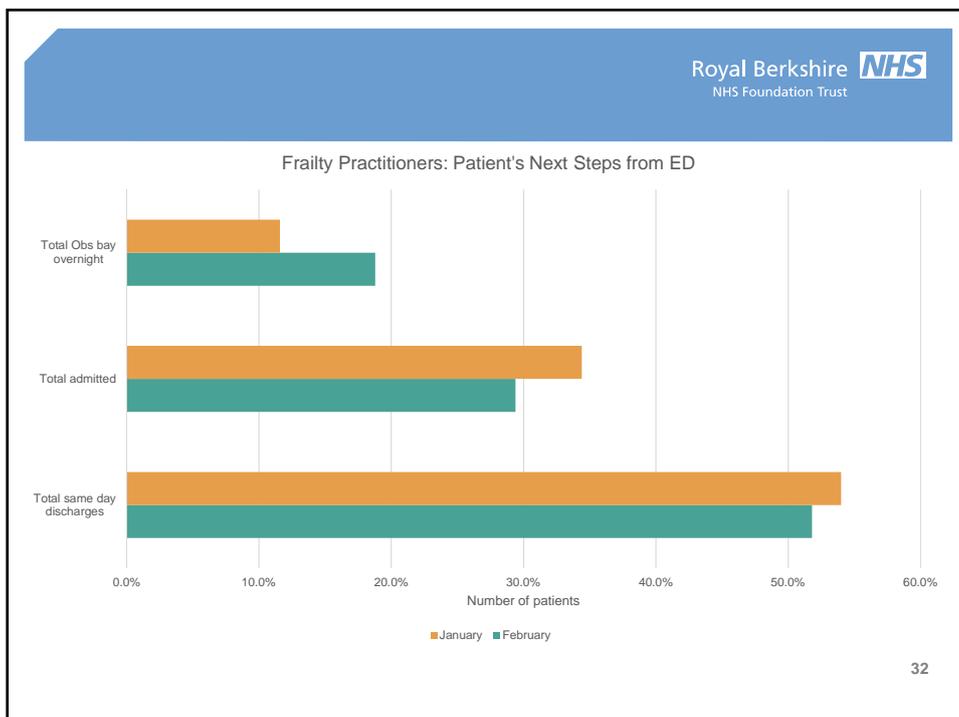
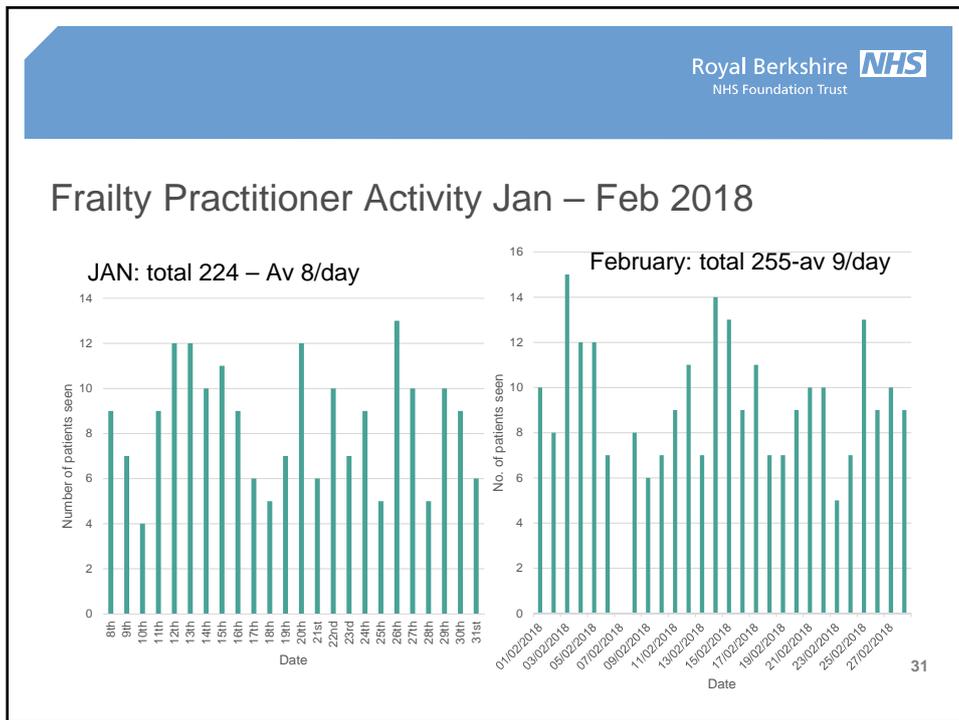
ED (USING FRAILTY FLAG from 14th Dec)	BEFORE	AFTER	VARIANCE
	14th Dec to 7th Jan	8th Jan to 8th March	
Attendances (ave day)	22.1	22	-0.1
Re-attendances (ave day - within 72 hours)	5	2.5	-2.6
Re-attendance Rate (within 72 hours)	22.8%	11.2%	-11.6%
Average Length of Stay in ED (mins)	272	237	-35

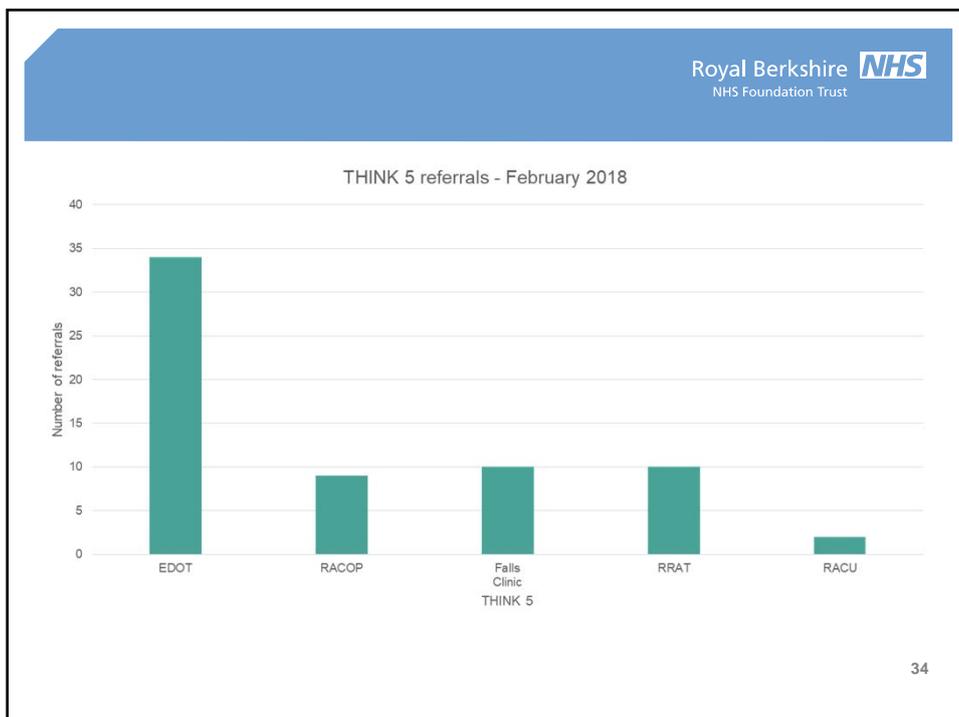
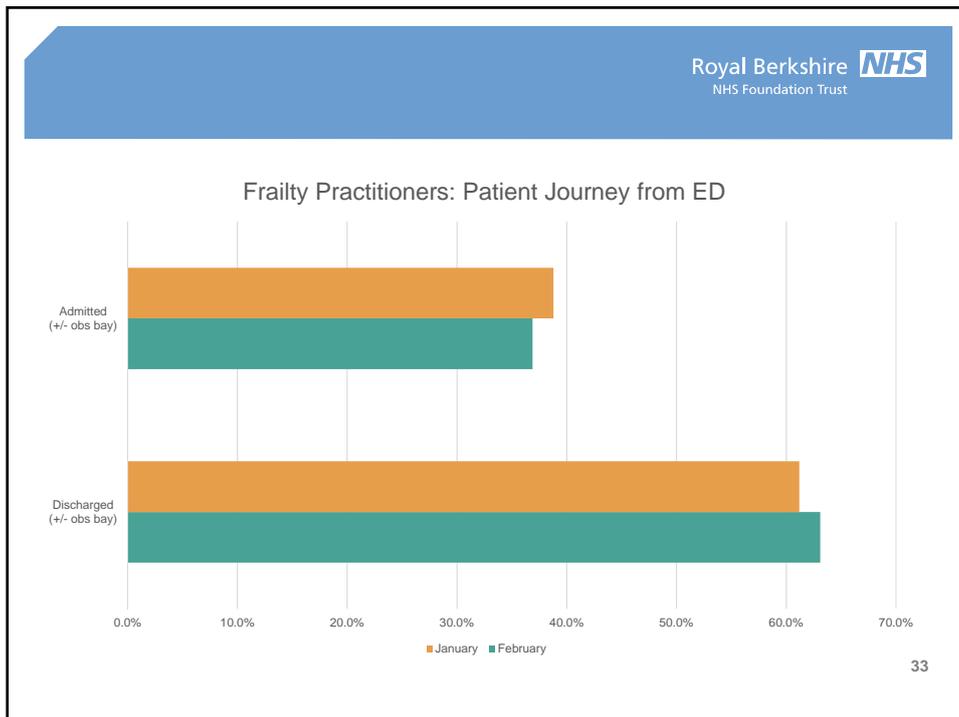
LoS Outliers 8 to 8 Exp

Frailty Patients - Average LoS in ED

ARRIVAL_DATE

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Quality Benefits

Improved patient-centred care during the busiest ever ED period

- Positive patient, carer and staff feedback
- Positive feedback from RRAT, RACOP Consultants, Elderly Care Clinical Governance, Falls Clinic, ED Team
- Establishing formal patient, carer and staff feedback daily



TOP TIPS

- Team engagement – persist, smile, repeat
- Specialty Team and community involvement – persist, smile, repeat
- Grab attention and educate at every opportunity
- Board rounds, Clinical Governance, Newsletters, Posters
- Reward good practice – awards, rosettes, Frailty Doctor of the day
- Make data collection and analysts your friends

Pitfalls

- Working with non-clinical teams Finance, Payroll, HR, EPR
- Be prepared for their different timescales to ED Doctors
- Develop new skills – write a business case, job descriptions
- Data collection, data collection, data collection
- Change can be hard for some colleagues – persist, smile, repeat
- Don't give up, make it better

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Questions?

