A person centred approach to Frailty @ Front Door: Service Redesign

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INTEGRATED ASSESSMENT TEAM LEAD
Victoria Hospital - Kirkcaldy
Aims
To deliver the highest quality healthcare services to the people of Scotland

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting
Challenges

• Older people who are discharged under traditional arrangements often have sub-optimal outcomes

• Acute hospital admission may not be the best pathway for managing the older person with frailty

• Frailty therefore identified within NHS Fife as high volume patient flow priority
Innovative Ways Of Working

Old Model
- 5/7 day service 8am-4.30pm
- PT, OT, SNs
- AU1 & ED only
- Minimal shared competencies

New Model
- 7 day service 7am-7.30pm
- PT, OT, SN, Frailty NPs and Assistant Frailty Practitioners (Band 4s)
- Supported by Geriatrician and Nurse Consultant
- AU1, AU2, ED
- Shared team competencies
Vision

To improve patient experience by promoting independence in patients presenting with frailty to all front door areas at the Victoria Hospital Kirkcaldy by providing alternative pathways rather than acute care and supporting patients as close to home as possible, using a patient centred approach. The team promptly recognises deterioration of the older adult and ensures that appropriate pathways are identified for patients who require acute hospital care.
**FRAILTY SCREENING TOOL**

Would this person benefit from Comprehensive Geriatric Assessment? If answered “Yes” to any of the following questions please refer to the Integrated Assessment Team

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
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<td>1. Has the patient been admitted from a nursing or residential home?</td>
<td>☐ YES ☐ NO</td>
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<td>2. Does the patient have NEW functional decline?</td>
<td>☐ YES ☐ NO</td>
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<td>3. Dementia diagnosis or are there any concerns about memory/cognition?</td>
<td>☐ YES ☐ NO</td>
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<td>4. Is the patient acutely confused, more confused than usual or more sleepy/drowsy than usual?</td>
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<td>5. Has the patient fallen in the past 3 months or is a fall the reason for admission?</td>
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<td>6. Does the patient attempt to walk alone although unsteady or unsafe?</td>
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<td>7. Does the patient or their relatives have fear or anxiety re falling?</td>
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If YES to Question 3, 4 or 5: Complete 4AT below. THINK DELIRIUM
Initiate FALLS PATHWAY if FALLS and COGNITIVE questions positive

**4AT** RAPID ASSESSMENT TEST FOR DELIRIUM

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FALLS PATHWAY initiated | ☐ YES ☐ NO
Integrated Assessment Team

- Consultant Nurse Older people
- Team Lead Physiotherapist
- Frailty ANPs
- Specialist Static Physiotherapists
- Specialist Static Occupational Therapists
- Rotational Band 5 Therapists
- Staff nurses specialising in Frailty
- Assistant Frailty Practitioners
12.5 hour cover
7 days a week
365 days a year
Frailty Huddle

- Geriatrician
- AU1 Floor Coordinator
- Physio
- IAT Team Lead
- Frailty NP
- D/C Hub
- MOE SCN
- Service Manager
- AFP
- OP Nurse Consultant
- Consultant
IAT: Front door Frailty Team

- Starts at Front Door ED, Medical & Surgical assessment
- CGA + decision-making + Plan + ACTION
- Facilitating discharge direct from ED, AU1, AU2
- Liaising with H@H, Care Homes, GPs and community services including intermediate care & community hospitals
- Advance care planning, Assess to EOL care
Frailty @ Front Door Pathway

- Frailty Screening at point of access to Acute Care
  - AU1
  - ED
  - AU2

- Triaged by IAT
  - 7.00am
  - Telephone calls referrals throughout 12 hour period.

- Frailty Huddle @ 11.00hrs & 14.30hrs
  - Real-time MDT/Case Conference with access to:
    - Geriatrician of the day (GOD)
    - Older Peoples Nurse Consultant
    - Proactive Pharmacy Team
    - Discharge Hub
    - MOE liaison

- Patients Needs can be supported in alternative to acute care
  - H@H
  - ICASS
  - Supported discharge service
  - Discharge to Assess
  - Community Beds

- Patient Needs Acute Hospital Care
  - Admit MOE
  - Or Specialist Bed
Frailty Assessment - CGA

Mrs P's Story

1. GP Assess
   Trolley 2: M/F 1 Delirium 2. Falls.
   Day 1 @ 18:30

2. IAT Response Time 30 mins
   Day 1 @ 19:00.

3. CCA/Frailty Assessment

4. Outcomes
   - Bloods
   - Sepsis
   - GAT 4
   - MOCA 19/30
   - Mob EA

5. Frailty Huddle
   - Family
   - Bloods
   - Kitchen
   - Refusal
   - Mob EA
   Day 2 @ 11:00 am.

6. Discharge to Assess
   Short-term discharge

7. Home with Support
   Day 2 @ 13:00

8. Day 2 @ 12:00
“I felt safe and understood”

“Made me feel at ease”

“Very friendly”

“I arrived in a state of panic but soon felt calm”

“I feel positive about my future as everything has been better explained to me and I’m going home with ongoing treatment from hospital at home”

“What matters to you?  
Ask what matters.. Listen to what matters.. Do what matters..”

“Staff were very helpful and kind which makes it more hopeful for the future for us golden oldies”
Number of patients over 65 staying under 24 hours

Victoria Hospital

April 15 - Frailty huddle introduced

8% increase

Count

Number of patients over 65 staying over 48 hours

Victoria Hospital

April 15 - Frailty huddle introduced

Count

0 20 40 60 80 100 120 140

Avg hospital length of stay for all patients discharged from MOE

19% reduction