University Hospitals Coventry and Warwickshire NHS Trust

ACUTE FRAILTY UNIT

Dr Katie Thin

Consultant Geriatrician


This Ward Operates a
Protected Mealtimes
Service
Please avoid entering the ward or
visiting during mealtimes
ACUTE FRAILTY UNIT
WARD 21 MEDICINE
PLEASE
USE OTHER
DOOR

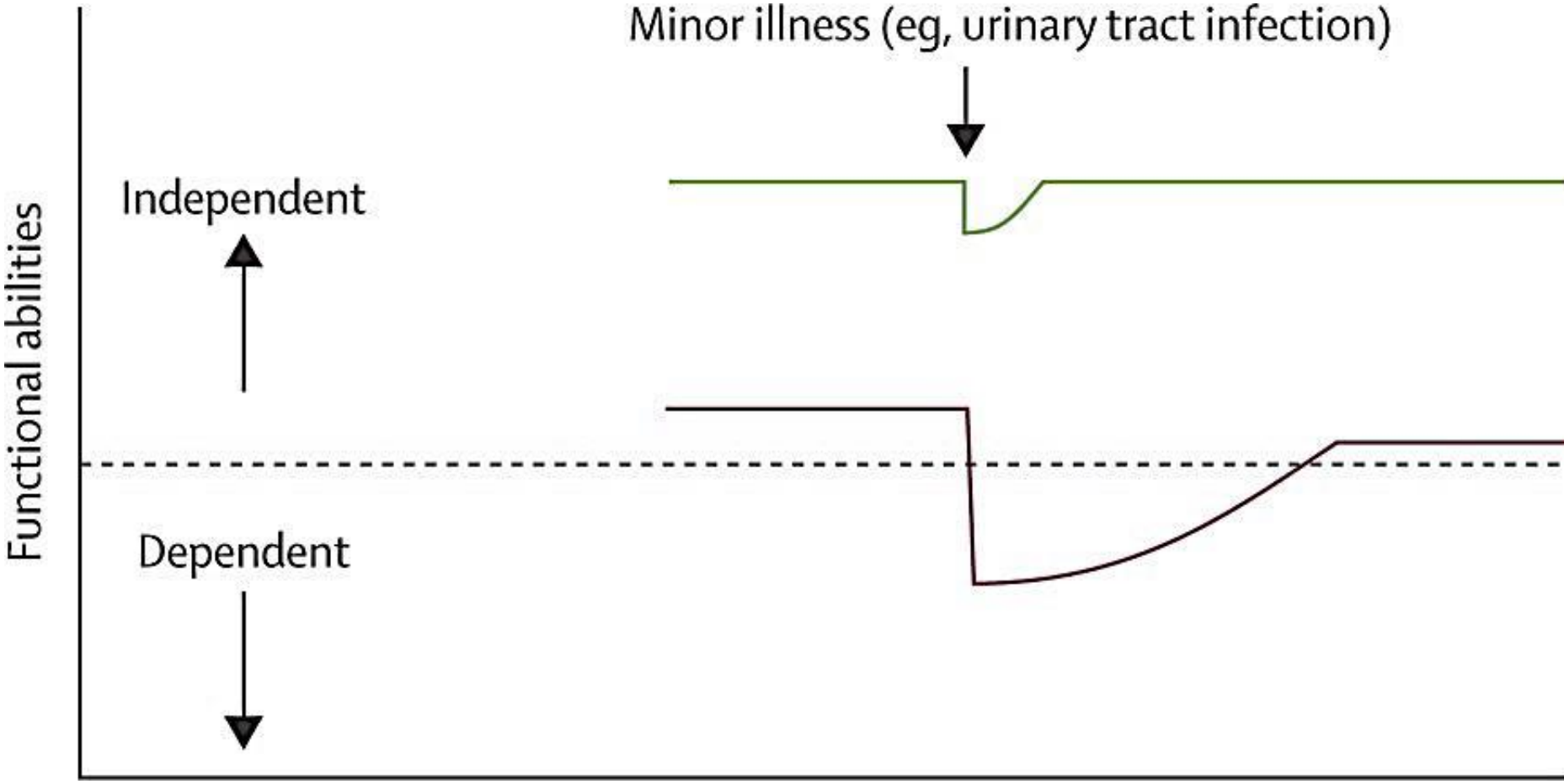
Aim

- **What is Frailty?**
- **How does that fit in with hospital medicine?**

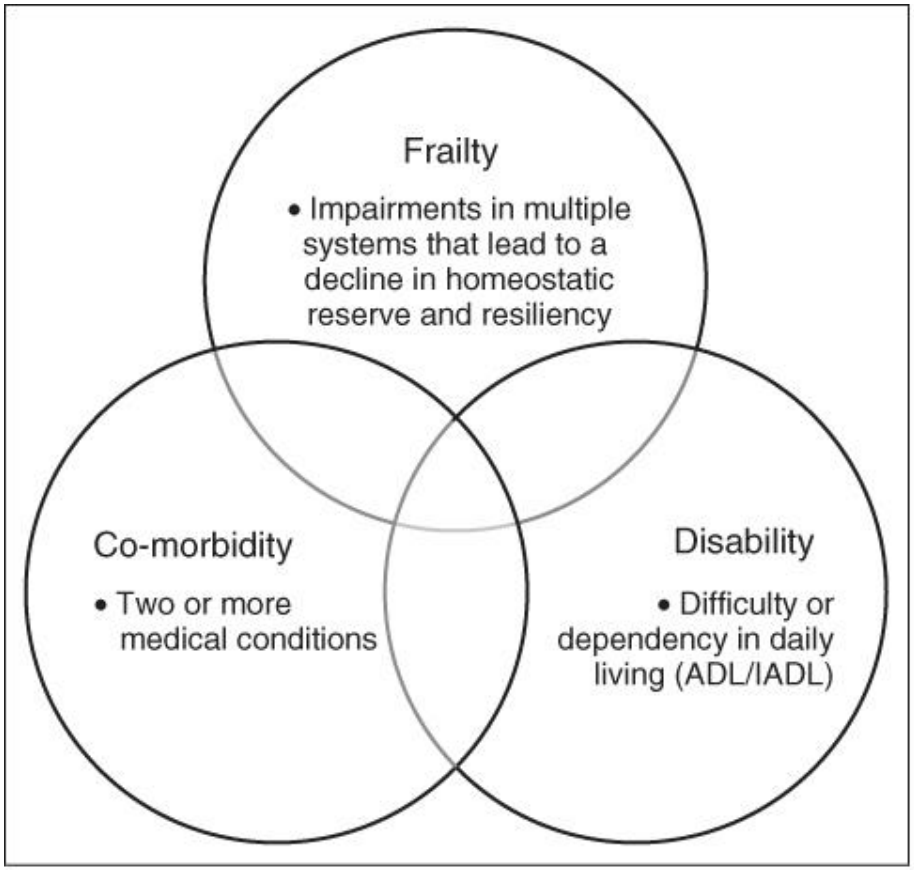
Frailty – a definition

- a distinctive health state
- related to ageing process
- Multiple body systems gradually lose their built-in reserve[poor functional reserve]

"Fit for frailty" – British Geriatric Society 2014

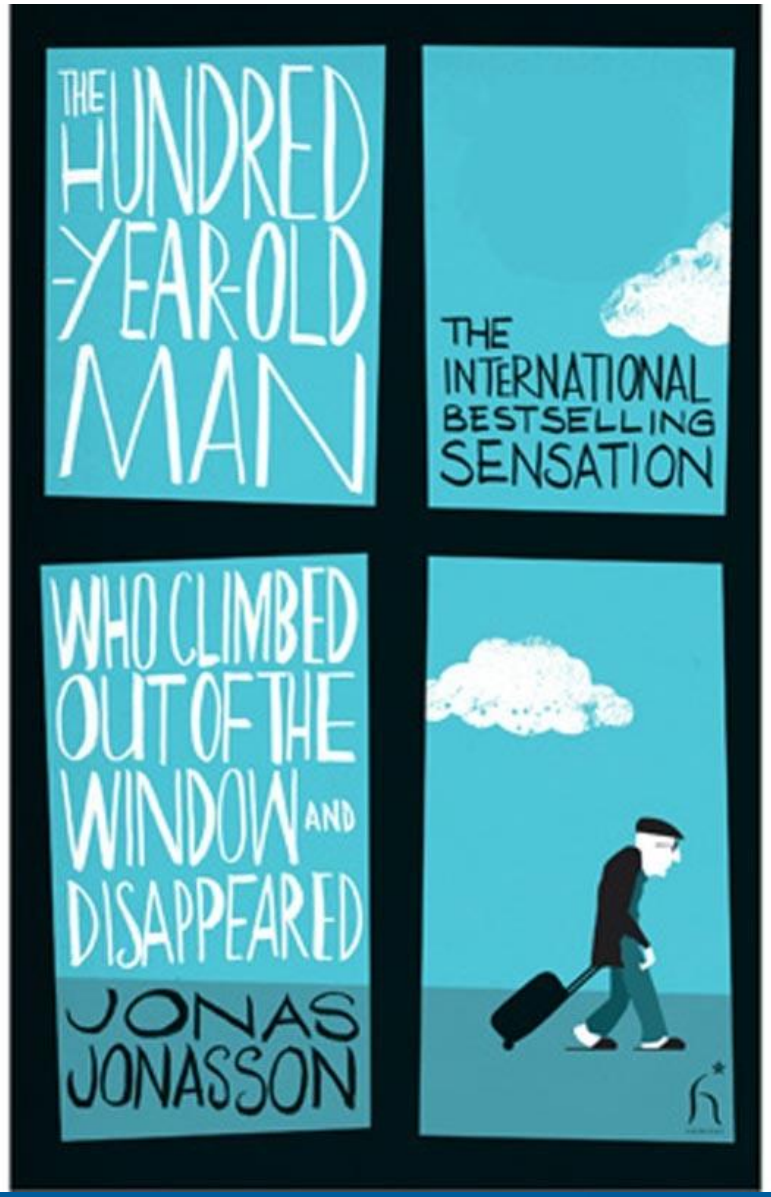

Minor illness (eg, urinary tract infection)
Independent
Functional abilities
Dependent

Overlap


Frailty
• Impairments in multiple systems that lead to a decline in homeostatic reserve and resiliency
Co-morbidity
• Two or more medical conditions
Disability
• Difficulty or dependency in daily living (ADL/IADL)

- Frailty is a long-term condition associated with ageing (not inevitable!!)
- Frailty is not static, it can be improved (or worsened)

Older Marathon Runners



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Why is it important to be aware of frailty

- Poor physiological reserve
- Risk of adverse outcome after apparently minor event eg infection/new medication
- Dramatic change in their physical and mental well being
- Poor outcome after operation

Why do we need to identify frailty

- Intervention to improve outcome

  [minor stress = adverse outcome]
- To avoid unnecessary harm

http://www.bgs.org.uk/index.php/fit-for-frailty

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To identify frailty

- **PRISMA 7 Questionnaire** - A score of > 3 is considered to identify frailty.
- **Walking speed (gait speed)** -
- **Timed up and go test** -
- **Self-Reported Health** -
- **GP assessment** -
- **Multiple medications (polypharmacy)** -
- **The Groningen Frailty Indicator questionnaire** - which is a 15 item frailty questionnaire

Screening for frailty on a population

- Expensive
- No evidence of improved outcome
- Tools; low specificity

- *Are we fit for frailty???*

When to look for frailty

- Routine OPD appt [med, surgical, memory]
- Primary care review for older people
- Social service assessment for care and support
- Review by community care team/home carers in community
- Ambulance crew called out
- [planning for any intervention,new medication/operation] without recognising frailty may result in significant harm

Frailty syndromes ("Geriatric Giants")raise suspicion that individual concerned has frailty

- Falls
- Immobility
- Delirium
- Incontinence
- Susceptibility to medication side-effects

Intervention 1

- Comprehensive, holistic review
  - Medical needs
  - Functional needs
  - Psychological needs
  - Social needs

e.g. Comprehensive Geriatric Assessment (CGA)

Evidence around CGA

- increases a patient's likelihood of being alive and in their own home at up to 12 months [CGA for older person admitted as emergency]. Cochrane review
- CGA followed by home care or by a hospital based multidisciplinary outreach team demonstrated a lower rate of readmissions during the first 30 days

Intervention 2

- Consider & address reversible conditions
- Consider specialist input (e.g. geriatrician, old-age psychiatrist)
- Consider other MDT input
  (e.g. community matron)
- Medication reviews
- Personalised care planning
  (and share it –with who?)

Advance Care Planning

- Planning of care towards the end of life
- Patient's wishes:
  - Preferred place of death
  - Emergency medications at home
  - Resuscitation status
- Record patient consent (if capacity)
- Record the patient's understanding of diagnosis / issues
- Next of kin & carer details

Integrated Frailty service IFS

- aims to offer early and holistic assessment for frail/older patients within ED, Acute Medicine and the Acute Frailty Unit (AFU).
- colleagues from primary care, community and voluntary sector

- The IFS offers an acute assessment service whereby frail/older patients receive direct specialist input from the onset of their care.

- stream patients from ED and Acute Medicine to the AFU

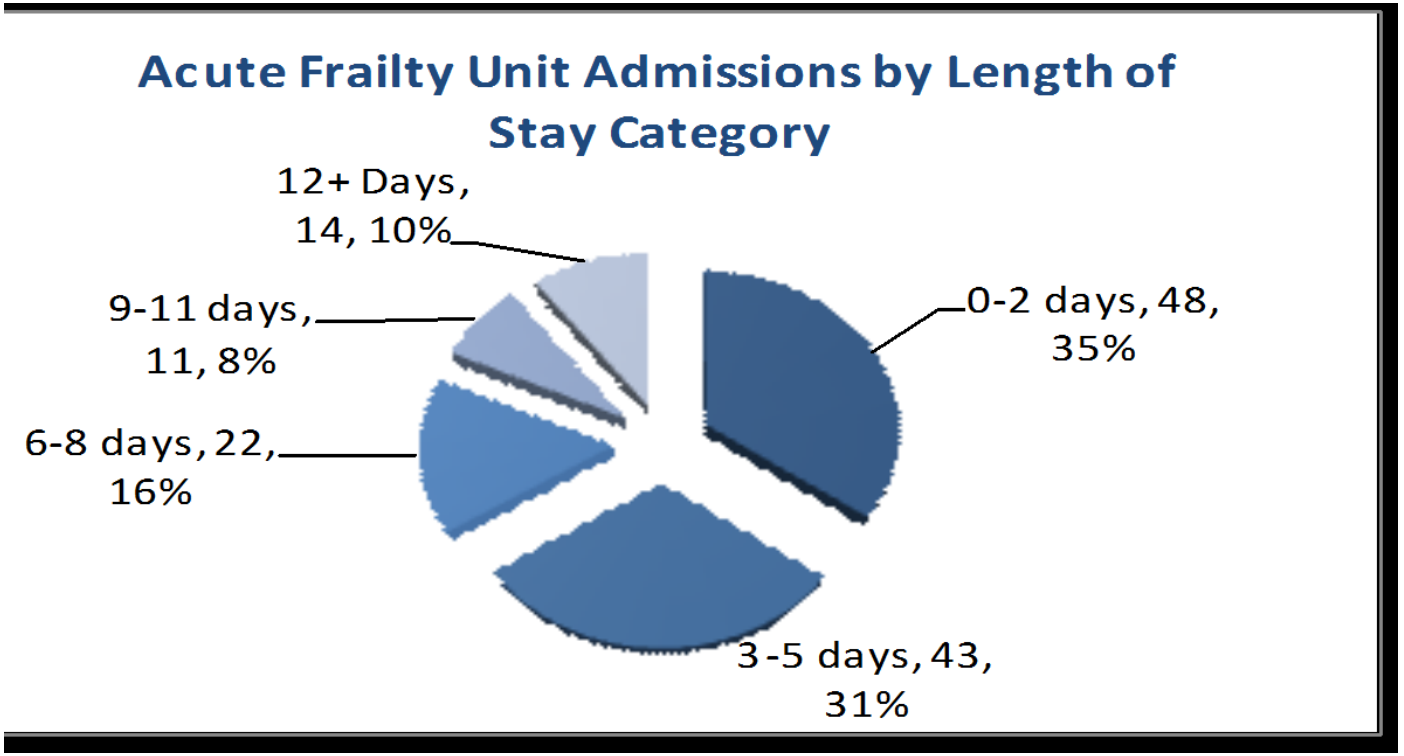
- AFU; part of IFS
- Frail elderly, can not be discharged from ED = admission to AFU
- Jan 2017
- 12 bedded unit short stay Geriatric assessment unit [wd 21]

Pathway

- PRIMA 7 questionnaire,
- NEW less than 4
- Could get benefit from CGA
- Frailty syndrome
- Direct admission from ED to AFU

- Clinical team;2 consultants; Dr Ong and Dr Thin, StR, junior drs, presence of senior decision maker every day
- Nursing team ,therapy team ,discharge team
- MDT team. Age UK, community matron support
- Board round on wd and daily MDT at frailty HUB
- CGA ,rapid and safe discharge plan, FU at day 7 and day 30
-

Length of Stay ;Jan 17 to March 17; 138 patients



- **66%**, have been inpatients a maximum of **5 days or less** compared to only 27% of patients on Ward 20 and 32% of patients on Ward 40 staying 5 days or less.
- this trend for **short stay patients** on the AFU will continue to rise with long stay patients decreasing.

Re admitted within 30 days

- Feb ;45 discharges;17 readmission.37%
- Mar;21 discharges ;6 readmission. 28%
- Apr; 29 discharges ;4 readmisison.13%

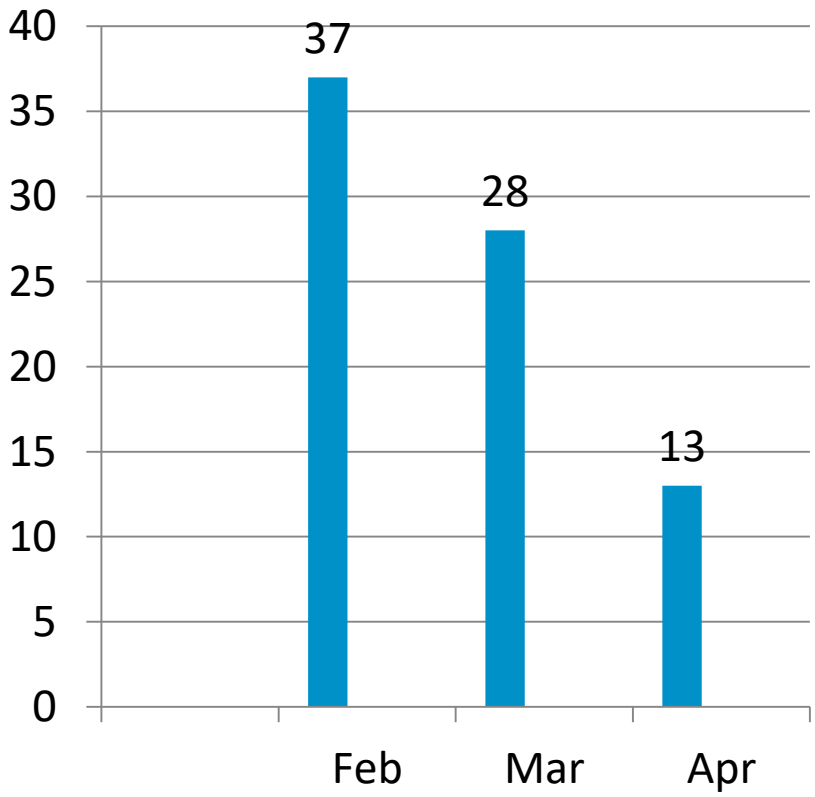
- Feb= combined 21 medicine and AFU ;AFU code in CRRS started in March.

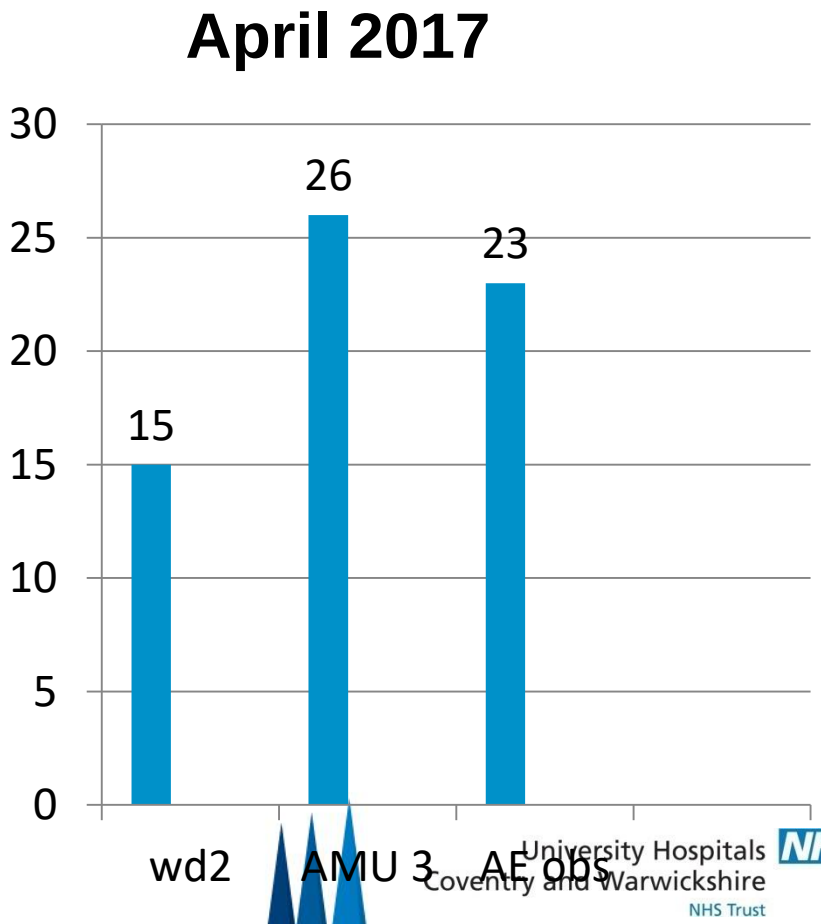
Re admission in percentage *source PPMO*

AFU

Feb;AFU+wd 21 med

Mar Apr.AFU





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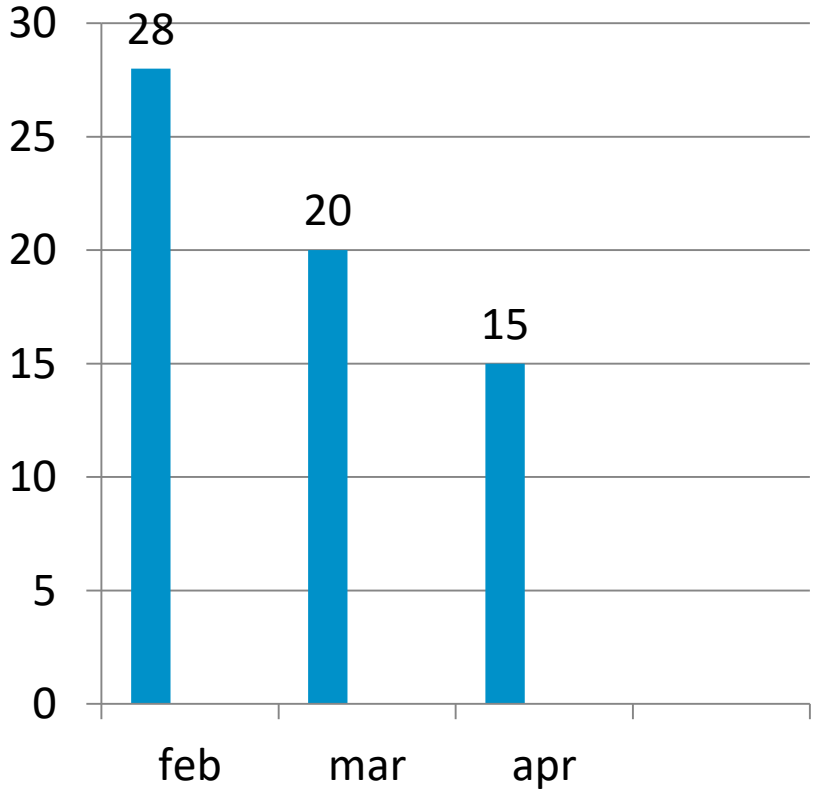
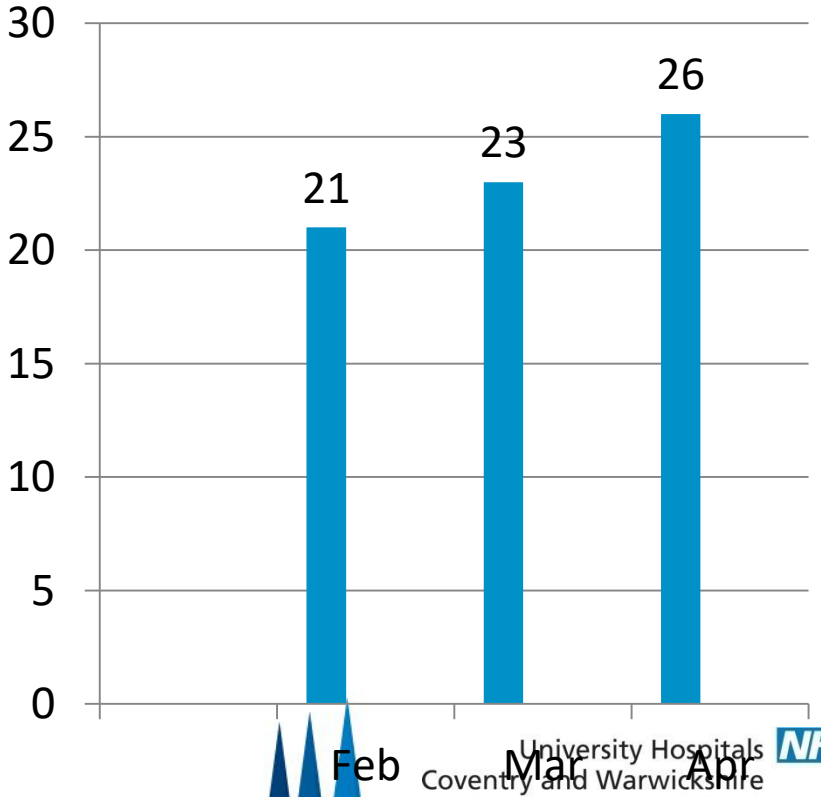
Wd 2 and 3- acute med short stay wd with some IFS support *source PPMO*

Over 65 readmission wd 2 in percentage



Over 65 readmission wd 3 in percentage



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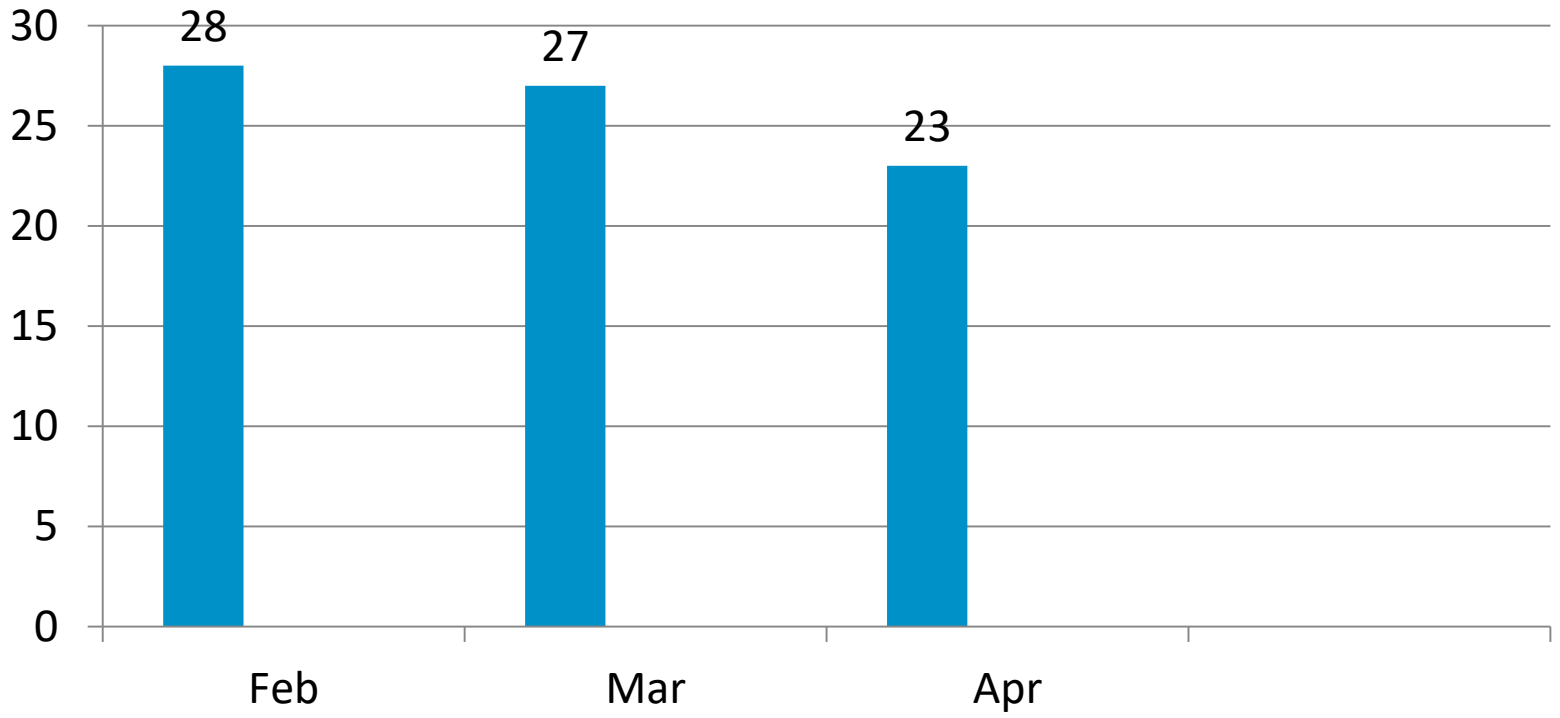
Over 65 re admission AE observation



What is next?

- Looking for discharge destination. Residential home admission vs living in own home
- Mortality
- CGA at ED?
- Training for ED dr e.g. HECTOR course *(Follow on Twitter: @HECTORcares)*

HEARTLAND ELDERLY CARE
TRAUMA AND ONGOING RECOVERY

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Thank you for your attention!