Transforming emergency services for frail older people in hospital

Deborah Thompson and colleagues discuss how managers can improve outcomes for this patient group

Correspondence
deborah@nhselect.org.uk

Deborah Thompson is programme director of the Acute Frailty Network, London

Mandy Rumley-Buss is an associate of the Acute Frailty Network, London

Simon Conroy is clinical lead at the Acute Frailty Network, consultant geriatrician at University Hospitals of Leicester NHS Trust and an honorary senior lecturer at the University of Leicester

Date of submission
March 12 2015

Date of acceptance
March 12 2015

Author guidelines
Journals.rcni.com/r/nm-author-guidelines

Abstract

Managers of emergency care, acute medicine and geriatric medicine care had a difficult few months over winter managing rising demand for emergency care, and the likelihood is that we will face similar demands in future winters unless we improve services and release capacity. The complexity of this demand is also changing with more frail older people presenting for emergency care. With this in mind, there is an urgent need to improve and streamline emergency services to meet the needs of this patient group. This article focuses on the principles that managers can employ to improve frailty services and the processes that can be adopted to develop effective frailty services in hospitals that deliver better outcomes for patients.

Keywords
Acute care, comprehensive geriatric assessment, emergency care, frailty, older people, urgent care

Introduction

Frailty is defined by Clegg *et al* (2013) as 'a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty'.

Frailty is a distinctive late-life health state in which apparently minor-stressor events are associated with adverse health outcomes. There is no internationally recognised tool to identify frailty but several indices are being tested. Until a validated tool is published, teams should agree simple criteria to identify patients with frailty, such as:

- Age 85 years or more.
- Age 65 years or more with one or more of the following presenting features: cognitive impairment, namely delirium or dementia; being a resident in a nursing or residential care home; having a fragility fracture; having Parkinson's disease; experiencing recurrent falls.

Frail older people present a challenge to emergency care services as processes are often designed around disease or clinical pathways, and frailty does not conform easily to either. Patients often present with non-specific problems and this can lead to delays in care management plans and an over-emphasis on investigations.

Most older adults have ageing processes that can disrupt renal or liver function without evidence of decline and are functional up until the point of admission. Patients can then, because of their age, be referred to services traditionally focused on older people without enough thought to the purpose of admission. This can then lead to longer lengths of stay and place strain on systems due to the higher numbers of older patients for whom staff need to care. The solution may be to avoid admission in the first place or search proactively for ways of managing people with frailty outside hospitals.

Whole-system approaches are required to modify urgent care use, in particular systems that align primary and secondary care (Ham *et al* 2011), without which older people, including those with frailty, will continue to be major users of acute hospital care. Improving the acute care response for frail older people may avoid, or reduce the effect of, potential adverse outcomes.

Improving this response includes the use of comprehensive geriatric assessment (CGA), which is considered best practice and is reflected in national guidance such as the Silver Book and the acute care toolkit produced by the Royal College of Physicians (RCP) (Banerjee *et al* 2012, RCP 2012).

The key to improving frailty services is designing a system in which CGA, which emphasises problem solving, team working and a patient-centred approach, is used as soon as patients enter a healthcare system, for example when they attend an emergency department.

There is reasonable evidence that CGA works in acute, post-emergency, care and is effective in streaming patients correctly to acute care for the elderly (ACE) units (Ellis *et al* 2011). Core principles underpinning the development of ACE units include:

- A dedicated environment that is modified to enhance patient safety, for example through greater patient visibility, better lighting, safer flooring and clearer orientation cues, and better team working and more consistent staffing that can help build better working relationships.
- Patient-centred care, so that individualised care takes account of competing comorbidities, polypharmacy and priorities, as opposed to standard, protocol-driven care.
- Preservation of activities of daily living through early, assertive, multidisciplinary rehabilitation.
- Early discharge planning, because early supported discharge saves lives (Shepperd *et al* 2009).
- Reducing iatrogenesis directly, for example by reducing the use of urinary catheterisation and unnecessary antibiotics, and the incidence of inpatient falls, and indirectly, for example by taking opportunities to review prescriptions, identifying hidden cognitive impairment and planning ahead.

It is unlikely that every hospital can establish ACE units and some will need to adapt to their local environments, staffing and professional relationships if they are to adopt these principles.

Frailty network

The Acute Frailty Network (AFN) is a 12-month national improvement programme to help hospitals develop emergency services for frail older people. It has been commissioned by NHS England to work with ten pilot sites across the country to improve the urgent care of frail older people in the first 72 hours of hospital attendance (Box 1). Part of the programme is to develop tools and techniques that can be adopted by the sider NHS.

Box 1 Acute Frailty Network pilot sites

- Cambridge University Hospitals NHS Foundation Trust (FT)
- Derbyshire Community Health Services NHS FT
- Gloucestershire Hospitals NHS Trust
- Imperial College Healthcare NHS Trust, London
- James Cook University Hospital, part of South Tees Hospitals NHS FT
- Kettering General Hospital NHS FT, Northamptonshire
- Poole Hospital NHS FT, Dorset
- Royal Berkshire NHS FT
- University Hospitals of North Midlands NHS Trust, Stoke-on-Trent
- York Teaching Hospital NHS FT

Outcomes predicted from this work are:

- The proportion of the ten health and social care communities who have tested and implemented new models of urgent care for frail older people can showcase their work to the wider NHS.
- A repository of best practice and case studies from the pilot sites, describing their work and lessons learned to support spread across the NHS, will be established.
- A bundle of tools and methodologies to support the implementation of AFN locally will be developed.
- A set of national guidance on how to implement better models of care that reduce hospital admissions and improve experience and outcomes for older people.

Findings will be published early 2016. To find out more about the AFN or to become involved, go to www.acutefrailtynetwork.org.uk

References

Banerjee J, Conroy S, O'Leary V *et al* (2012) *Quality Care for Older People with Urgent and Emergency Care Needs.* tinyurl.com/cebaqz3 (Last accessed: May 7 2015.)

Clegg A, Young J, Iliffe S *et al* (2013) Frailty in elderly people. *Lancet.* 381, 868, 752-762.

Ellis G, Whitehead M, O'Neill D *et al* (2011) Comprehensive geriatric assessment for older adults admitted to hospital. *Cochrane Database of Systematic Reviews.* doi:10.1002/14651858.CD006211.pub2.

Ham C, Curry N (2011) *Integrated Care.* King's Fund, London.

Royal College of Physicians (2012) *Acute Medical Care for Frail Older People.* Royal College of Physicians, London.

Shepperd S, Doll H, Broad J *et al* (2009) Early discharge hospital at home. *Cochrane Database of Systematic Reviews.* doi:10.1002/14651858.CD000356.pub3.

Conflict of interest
None declared