Worcestershire Acute Hospitals NHS Trust

Emergency Medicine Standard Operating Procedures

Frail Elderly Pathway – Standard Operating Procedure

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Approved by	
Date of Approval	
Date of next review This is the most current document and is to be used until a revised version is available	

Aim and scope of Standard Operating Procedure

Target Staff Categories

1. Introduction

A demographic shift has resulted in a rapid increase in the number of frail older people who are now the most frequent users of acute hospital services. As a result, Geriatric medicine has become the largest medical speciality in England concerned with the clinical, preventative, remedial and social aspects of illness in old age. Frailty syndromes can mask serious underlying illness; therefore the response to frailty crisis should reflect the potential underlying illness rather than the symptom itself. Clinically, older people who are frail have poor functional reserve, so that even a relatively minor illness can present with sudden catastrophic functional decline – resulting in falls, reduced mobility or delirium. The presentation of older people with frailty in the Emergency Department is often complex and requires input from a team with specialised skills. The Frail Elderly Pathway has been developed following recommendations outlined in *Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders* (NHS England 2014). This document states that recent research has demonstrated better outcomes from frailty units at the front end of the hospital. These require a dedicated, well-led, multi-disciplinary specialist team.

2. Scope of this document

This document outlines the anticipated working practices of the Frail Elderly Pathway Team and guidance criteria for referral to the Frailly Assessment Unit at the Alexandra Hospital and onward admission when required to Ward 12 (ward), and Ward 14 (step-down) and when necessary only, repatriation criteria for Avon 4 and Evergreen on the Worcestershire Royal Hospital site for patients from south of the county. This document also contains details on the 'hot clinics' that will be accessible on both the WRH and Alex sites. The pathway aims to provide adequate access to specialist input, minimise harms and ward moves, and admission avoidance for people who would benefit from receiving care or treatment close to home.

The frail elderly model at the Alexandra Hospital embeds the following Trust strategic goals:

1. Deliver safe, high quality, compassionate patient care
2. Design healthcare around the needs of our patients with our system partners
3. Ensure the Trust is financially viable and makes the best use of resources for our patients

3. Statement of function

The Frailty Assessment Unit is a dedicated unit offering direct access to specialists providing Comprehensive Geriatric Assessment direct from emergency and community portals (WMAS and GP's). The overall aim of the Frail Elderly Pathway is to provide early prompt frailty assessment, thus facilitating evidence based interventions and comprehensive

geriatric assessment as soon as possible for frail elderly patients. Geriatrician led, the service functions with support of the wider multi-disciplinary team including ward based nurses, nurse practitioner, pharmacist frailty practitioners, physiotherapists, occupational therapists, speech and language therapist and dieticians. The fundamental aim of the service is to prevent admission to an acute hospital bed when an appropriate alternative is available to prevent patient decompensation that occurs when a frail patient is admitted to hospital. The services also supports, advanced care planning and medicines rationalisation, therapy and person-centred compassionate care, especially for those with dementia, delirium and multi-morbidity. The pathway will provide adequate access to specialist input, minimise harms and ward moves, and admission avoidance for people who would benefit from receiving care or treatment closer to home. The Frail Elderly Pathway Team is not responsible for caring for patients being managed outside of the Frailty Assessment Unit, Ward 12, Avon 4 or Ward 14. Patients who require a comprehensive frailty assessment, and who meet the frailty criteria should be only the only patients cared for in a frailty bed.

4. Objectives and benefits

- Early identification of frail patients, who require specialist Geriatric intervention. Optimism of their care in liaison with all members of the multi-disciplinary team.
- Comprehensive Geriatric Assessment (CGA), which involves a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health.
- Home first principle.
- Increase the number of patients returning to their usual place of residence.
- Decrease unplanned admission by enabling rapid access to specialist advice from hospital clinicians and the use of 'chair based' ambulatory care clinics.
- Admission to specialist acute and sub-acute frailty wards.
- Reduced length of hospital stay.
- Early identification of delirium.
- Provision of person-centred care.
- Reduced numbers of frail elderly with long assessments time in the ED departments
- Positive effect on the national 4 hour emergency department access standard.
- Improved satisfaction and outcomes for frail older people in urgent care.
- Improved satisfaction and delivery of care by staff.
- Reduced patient transfers around the healthcare system.

5 Responsibility and Duties

All staff involved with the care of frail elderly adults are responsible for ensuring this pathway is followed. This includes West Midlands Ambulance Service (WMAS) who will be responsible for conveying patients to the Frailty Assessment Unit.When the Frail Elderly Pathway is required, focus will be made on timely comprehensive geriatric assessment, intervention, treatment and discharge planning. This includes operational management support to optimise capacity and patient flow.

Other system partner responsibilities reside with:

- General Practitioners - to support identification of appropriate patients and provide information that will support patient assessment and management.
- The Worcestershire Health and Care Trust – who will primarily be responsible for supporting admission avoidance where appropriate, in- reach to facilitate patient discharge, community hospital capacity for patients who require non acute care
- Patient Flow Centre - for supporting patient discharge proactive in reach through an in-reach
- Worcestershire County Council – for supporting admission avoidance and timely patient discharge, this includes pathway 1 in reach
- WMAS – for supporting timely patient transport designed to support patient discharge home or transfer to the WRH site and as mentioned above conveying appropriate patients to the Frailty Unit 24 hours a day throughout the duration of the pilot.

All system partners where applicable are expected to deliver the same response times to the Frailty
Units as per all other assessments i.e. respond within an hour of referral.

6 Location

The Frailty Assessment Unit at the Alexandra Hospital has 8 spaces for recliner chairs/trollies and is located on the ground floor of the Alexandra Hospital Site. There is also access to 2 treatment / consultation rooms. Ward 12 has 26 beds unit which will be used for patients who require a short / medium term stay to allow for a treatment plan and intervention. Ward 14 has 19 beds which will be used for patients who no longer require acute intervention, and are awaiting discharge pathways that are not immediately available. The average expected length of stay is not expected to exceed 7 days.

7 Patient group

7.1 Frailty Assessment Unit Inclusion Criteria

The Frailty Assessment Unit will accept patients as detailed in the criteria below in accordance with the Bournemouth criteria:-

Group 1: Patients over 90 years of age
Group 2: Patients aged 75 and over, with 2 or more of the following geriatric giants:-

- IMMOBILITY - (movement disorders, Parkinson's Disease, new or worsening)
- INCONTINENCE - (new or worsening)
- INSTABILITY (including falls and frailty)
- INTELLECTUAL IMPAIRMENT (dementia and delirium, excluding learning disabilities)
- IATROGENESIS (polypharmacy – on 5 or more medications)

Group 3: Patients aged 65 or over, from a Nursing Home, Residential Home or Community Hospital

7.2 Frailty Assessment Unit Exclusion Criteria

The following patient exclusion applies. Patients with any of the following criteria should be directed to the WRH. This remains the same as prior to the implementation of the Frailty Assessment Unit.

- Patients (fitting into any of the above groups) with single organ pathology best managed by a specialist e.g. (not limited to):-
  - CURB 3 pneumonia
  - Primary Cardiac Issues
  - Upper GI bleeds
  - Acute Surgical Diagnosis
  - Trauma with a Suspected fracture including NOF Fracture
  - Acute Chest pain/suspected MI
  - Unstable Blood glucose <3 or > 28 including DKA
  - Acute abdominal pain with collapse
  - Suspected or new CVA/TIA

- Head injury/trauma, unconscious, GCS <9
- Collapsed patient requiring resuscitation

7.3. Access to the Frailty Assessment Unit

As highlighted in 7.1 and 7.2 the inclusion and exclusion criteria (as per the Bournemouth tool) must be used to determine entry to the frailty pathway. The contacts are as follows:

- In hours please ring: 01527 512100, where the frailty / AEC triage nurse will complete the triage paperwork and navigate the patient and advise the referrer.
- Out of Hours (OOH):
  - 01527 512030 Out of Hours (OOH)
  - If the patient does not meet the Bournemouth frailty criteria, then they should be referred through the normal / current OOH pathway for GP referrals
  - If the frailty patient requires a hospital admission outside of frailty unit opening times the patient will be admitted to either MAU or ward 12 and reviewed by the frailty team on the next working day

The triage nurses will use an triage assessment tool (as per appendix 2) and the GP and WMAS will be directed to one of the options below.

AEC	**MAU**	**Emergency Department**	**Frailty Assessment Unit**
Alexandra Hospital	Alexandra Hospital	Alexandra Hospital	Alexandra Hospital (all county patients who meet the frailty criteria) including frailty hot clinics when appropriate
Worcestershire Royal Hospital	Worcestershire Royal Hospital	Worcestershire Royal Hospital	

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When a frailty patient is identified WMAS will convey the patient directly to the frailty assessment unit between 9am and 5pm Monday to Friday (Excluding bank holidays) Out of these hours the patient will be conveyed to the Emergency Department at the Alexandra Hospital. Ambulatory Care staff will proactively 'pull' appropriate patients to Ambulatory Emergency Care during hours of operation.

7.4. Hot Clinics

If a **frailty hot clinics is deemed appropriate these are available as below**
The hot clinics are available daily, Monday to Friday (with the exception of bank holidays) on the following sites:

- Worcester Site: Tuesday and Wednesday AM
- Alex site: Monday PM, Thursday and Friday AM

The clinics can be booked by A&E (Alex or WRH), Pharmacist frailty practitioners, AEC (Alex or WRH), FAU or MAU at the Alex. The clinics are in Oasis and are badged under 'Consultant Geriatrician' and as 'Frailty assessment clinic'. The aim of these clinics is both for follow up and to mitigate risk of discharge. Any issue with clinic availability or access should be escalated to the FAU.

Whilst the frailty pathway is the Alexandra Hospital is 24/7 the core hours are Monday – Friday (except bank holidays) between the hours of 9am and 5pm. The last patients will be accepted at 4pm. Outside the core hours referrals will be made prior to the patient being conveyed to hospital via the OOH number and the patient will be sent in via the Alexandra Hospital ED department

Multidisciplinary Team Approach

The Frail Elderly Pathway team will use a multi-disciplinary approach to enable the holistic care of patients and to enable early safe discharge whenever possible. This will incorporate the skills of the following services:

8.1 Medical cover

Frailty Assessment Unit:-

1.5 x WTE Consultant Geriatricians
1 x WTE SpR
1 x WTE Frailty Practitioner (Pharmacist)
1 x WTE SHO

Ward 12:-

3 x WTE Consultants Geriatrician
3 x WTE SpR
3 x WTE SHO

Ward 14:-

1 x WTE SHO
1 x Nurse Practitioner

Job plans have been confirmed and the above medical team will cover all the areas included in the pathway 5 days a week.

Weekends and bank holidays will be covered by medical on-call rota

8.2 Nursing team

Matron
Ward Manager Frailty Assessment Unit
Ward Manager Ward 12
Ward Manager Ward 14
Senior Staff Nurses, Staff Nurses, Associate Practitioners, Registered Mental Health Nurses, Registered Learning Disability Nurses and Healthcare Assistants all dedicated and experienced in caring for frail patients.

8.3 Other professionals

Frailty pharmacy practitioner
Physiotherapists
Occupational Therapists
Speech and Language therapy
Dietetics
Phlebotomy
Patient Flow Centre
Discharge Liaison Nurses
Social Services
Dementia Specialist Nurses
Mental Health Nurses
Palliative Care Specialist Nurses

8.4 Interdepartmental relationships / specialist and support services

Medical Assessment Unit
Emergency Department
Radiology

Pathology
Clinical Investigations
Physiotherapy and Occupational Therapy via bleep
Clinical Specialist Teams including Oncology and Palliative Care
Dementia Team
Mental Health Liaison Nurse
Discharge Liaison Team
Rapid Response Team including Social Worker
Alcohol liaison via bleep
Patient Flow Centre
Health & Care NHS Trust In-reach Nurses
Operational Management
Worcestershire Association of Carers
Bed Management team
WMAS

9. The Multi-Disciplinary Team Patient Assessment (CGA)

The gold standard for the management of frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA). It involves a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health and has been demonstrated to be associated with improved outcomes in a variety of settings.

CGA is a clinical management strategy which will give a framework for the delivery of interventions which address relevant and appropriate issues for an individual patient. After CGA it will be possible to use the Rockwood Clinical Frailty index to demonstrate the level of frailty of the individual. However, it is not a rapid process. The initial assessment and care planning for a full CGA is likely to take at least 1.5 hours of professional time, plus the necessary time for care plan negotiation and documentation (likely total of 2.5 hours, plus there is a need for ongoing review). Therefore it is simply not feasible for everyone with frailty (from mild up to severe life limiting frailty) to undergo a full multidisciplinary review with geriatrician involvement. The team at the Alexandra Hospital includes medical, nursing, pharmacy, Occupational Therapy, Physiotherapy, Dietetics, Speech and language therapy, and social work.

There will be multidisciplinary input in all areas of the frailty pathway, assessing the individuals mobility, activities of daily living, any swallow or nutritional issues, polypharmacy, and also any potential social care needs.

A CGA may include the assessment of:

- Physical Symptoms (which must include pain) and the underlying illnesses and diseases
- Mental Health Symptoms (including memory, mood and poor organisation) and the underlying illnesses and diseases

- Level of function in daily activity, both for personal care (washing, dressing, grooming continence and mobility) and for life functions (communication, cooking, shopping using the phone etc.)
- Social Support Networks currently available, both informal (family, friends and neighbours) and formal (social services carers, meals, day care). It needs to include the social dynamic between the individual and his/her family and carers (whilst trying to avoid too much judgement)
- Living Environment – state of housing, facilities and comfort. Ability and tendency to use technology. Availability and ability to use local transport
- Level of Participation and individual concerns, i.e. degree to which the person has active roles and things they have determined are of significance to them (possessions, people, activities, functions, memories). Will also include particular anxieties, for example fear of 'cancer' or 'dementia'. Knowledge of these will help frame the developing care and support plan
- The compensatory mechanisms and resourcefulness which the individual uses to respond to having frailty. Knowing this will allow the care and support plan to incorporate strategies to enhance this resilience

10. Pathways available following Frailty Assesment Unit assessment

No acute need – It is anticipated that a number of patients will be discharged directly from the unit. When it is determined by the MDT that no acute care is required

- but care and support are needed in the patient's own home a referral to the Patient Flow Centre – for pathway 1 should be made ASAP. The Patient Flow Centre will prioritise this referral and have a 1 hour response time
- but a community based bed is required a referral to the Patient Flow Centre – for pathway 2 should be made ASAP. The Patient Flow Centre will prioritise this referral and have a 1 hour response time
- but a patient arrives from a Care Home (Residential or Nursing) the frailty unit nurse should telephone the care home to let the care home know the patient has arrived if the patient is not accompanied by a carer. The Care Home should be advised that the patient is likely to be returning to the Care Home once the assessment is complete unless an acute medical need requiring acute hospital care is identified.

If the patients immediate discharge needs cannot be met, the patient will not be admitted to ward 12. They will be transferred to a step down bed, either on Ward 14, WRH Evergreen or Avon 4. In these circumstances system partners are expected to facilitate the patient's discharge within the next 24 hours.

Decision to admit to acute hospital – patient will be transferred initially to the Frailty Assessment Unit or directly to Ward 12 for acute treatment following CGA which will be decided by the Frailty Team.

Discharge should be possible within 24hrs/ seven days a week unless continued hospital treatment is required. The FAU should have the same access to resources as other

assessment units, facilitating admission prevention where able. The patients will be set an Expected Date Discharge, and discharge planning will be commenced on admission.

10.1. Ward 12 Admission Criteria (from the Frailty Assessment Unit)

Patients who require an acute treatment/plan of care, as documented by the Frailty Team.

INCLUSION CRITERIA

Patients who require in hospital intravenous (IV) antibiotic treatment. (i.e. those who are not suitable for IV antibiotics at home)
Patients who require intravenous fluids.
Patients who require acute assessment of their nutritional requirements including swallow assessment due to their acute frailty presentation.
Patients who require in hospital investigations and diagnostics that cannot be completed in FAU or A&E
Patients who require further acute hospital assessment

10.2. Ward 14 Admission Criteria (from the Frailty Assessment Unit or Ward 12)

Patients who are clinically stable or who no longer require an acute hospital bed, as documented by the Frailty Team to step down to sub-acute care.
Patients medically fit for discharge awaiting discharge home with support (Pathway 1).
Patients medically fit for discharge awaiting discharge to community hospitals (e.g. inpatient rehabilitation – Pathway 2).
Patients medically fit for discharge awaiting Discharge to Assess placements (Pathway 3).
Patients whose chosen place for end of life care is hospital (Stephen Bailey Suite if available).

10.3. Avon 4 Admission Criteria (from the Frailty Assessment Unit or Ward 12)

Patients from the south of the county only, who are:-

Clinically stable or no longer require an acute hospital bed, as documented by the Frailty Team to step down to sub-acute care.
Medically fit for discharge awaiting discharge home with support (Pathway 1).
Medically fit for discharge awaiting discharge to community hospitals (e.g. inpatient rehabilitation – Pathway 2).
Medically fit for discharge awaiting Discharge to Assess placements (Pathway 3).
All patients should have an EDD

10.4. Avon 4 Exclusion Criteria

Patients who have not completed their acute treatment plan.
Patients who have not had an Electronic Discharge Summary (EDS) completed.

10.5. WRH Evergreen Admission Criteria (from the Frailty Assessment Unit or Ward 12)

Patients from south of the county only who are:-

Medically fit for discharge awaiting discharge home with support (Pathway 1).
Medically fit for discharge awaiting discharge to community hospitals (e.g. inpatient rehabilitation – Pathway 2).
Medically fit for discharge awaiting a Discharge to Assess (DTA) placement (Pathway 3).

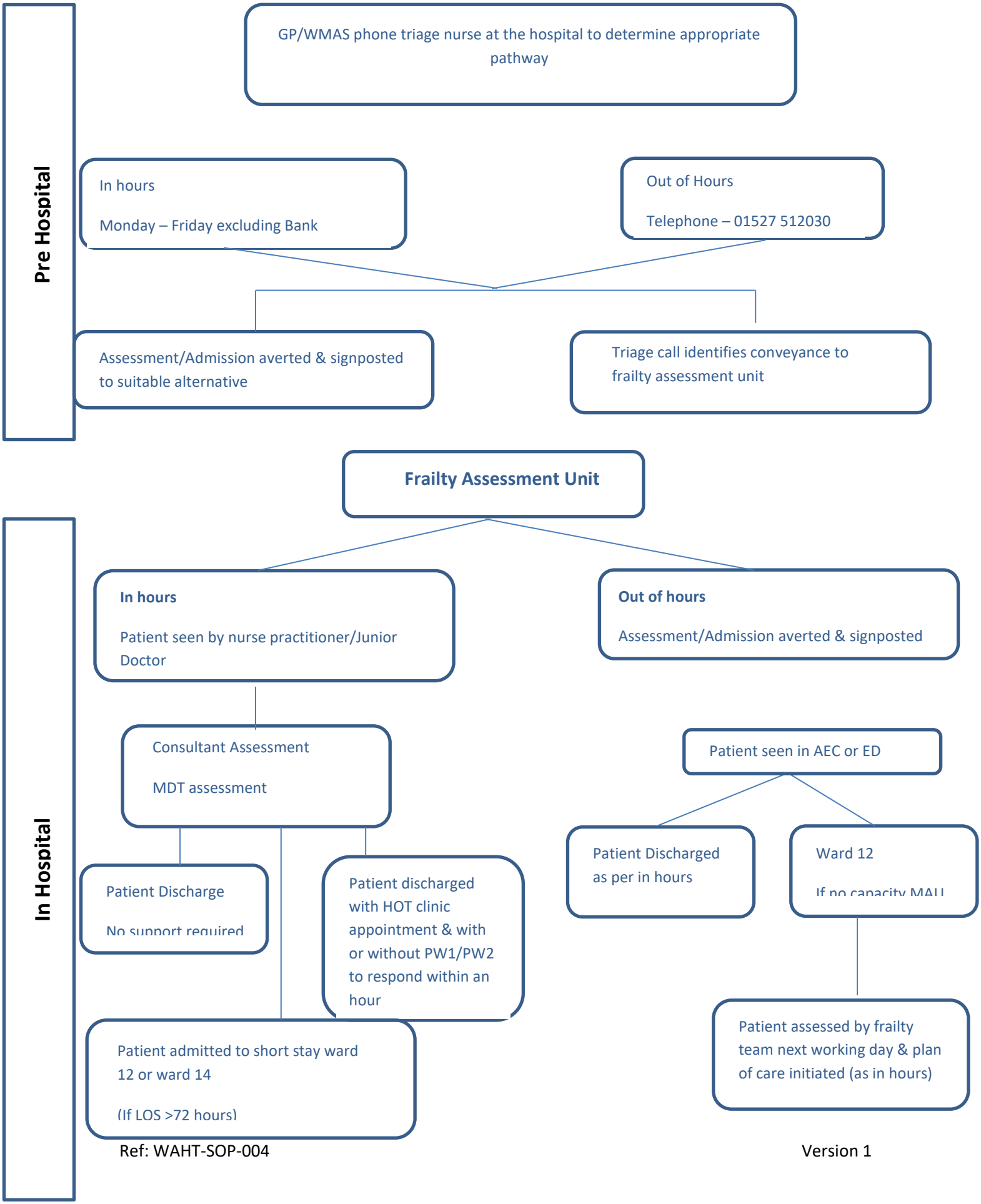
Whilst this document makes reference to patients being in certain places whilst awaiting supported discharge capacity via one of the Worcestershire discharge pathways it is the expectation that no patient waits any longer than the accepted referral to discharges standards agreed and that discharge planning commences on arrival to the hospital

10.6. WRH Evergreen Exclusion Criteria

Patients who are confused and wandering
Patients detained under Mental Health Act
Patients at risk of self-harm
Patients who are substance dependant or experiencing withdrawal symptoms
Those that require diagnostics prior to discharge
Patients who have not completed their acute treatment plan.
Patients who have not had an Electronic Discharge Summary (EDS) completed.

Appendix 1

Frail Elderly Pathway



Appendix 2 – Triage Assessment Tool