Background

Attendances at Emergency Departments are increasing with the greatest increase seen in those over 75. Over 65’s accounted for 586,037 of the 12.2 million first attendances in EDs in 2008/9, and 62% were admitted to hospital. Those aged 85 and over are nearly 10 times more likely to have an emergency admission than those aged 20-40. (1)

If admitted, their readmission rate is high and admission is often associated with physical deconditioning. Community interventions have had limited impact on preventing admissions and thus the acute care interface remains a key point where older people with crises are assessed. The clinical assessment of frail older people is challenging due to non-specific presentation with frailty syndromes, which can obstruct immediate diagonalisation. This compound is the 4 hour target.

There is growing evidence to support the role of frailty focused senior multidisciplinary team working at the acute care interface to support ED departments and to improve quality of care for older frail adults. It is uncertain as the optimal service model to deliver this. We report on our experience of setting up and running an acute frailty unit within the confines of the ED acute care setting at Guys and St Thomas Hospital.

Avocado’s Background

Method

Patients were referred by ED doctors or directors from the rapid assessment team (i.e., directly from ambulance arrival) to the unit. Admissions were identified by ED staff (medical and nursing) and briefly discussed with the consultant geriatrician. The unit operated 08.00 – 20.00 with last referral at 18.00. ED physicians could place patients overnight on the unit and would automatically come under the care of the frailty team the following day. During the project the unit was operated for the same time on a few weekend days. Patients underwent CCGA with a care management plan initiated within 2 hours (14 hours if admitted overnight). Those who could be safely discharged following assessment / same day intervention were identified quickly and the team’s focus was on facilitating rapid discharge. Those that required admission underwent comprehensive MDT assessment with a robust treatment plan and estimated discharge date prior to being moved to the OPU or specialist inpatient ward. If the unit was full, the Geriatrician would flex out to provide support in major. Funding was provided for 28 patient F2 and extensive support from the emergency and hospital admission team.

The MDT project was initiated after discussions with consultant geriatrician, facilitated by the team’s intention to learn from previous experience of emergency and hospital admissions. Feedback on staff introducing and implementing the model was positive and suggested the model was replicable.

Outcomes

Readmissions from the units discharges were the same as those from the OPU, indicating that more rapid decision making and discharge does not pose a higher readmission risk, provided the MDT input is comprehensive. (see table)

Case study

92 year old male presented to A&E 6 times in 1 week with un witnessed fall at home. Consents with ambulance to go to A&E but once there becomes combative and reluctant to stay.

Medical history: Dementia, Parkinson’s Disease, Diabetes.

Social history: Living in ex sheltered accommodation with carers visiting 4 times daily.

Patient Experience

Outcomes

Readmission from OPU and ED

BED USAGE & COST EFFECTIVENESS

Hospital bed use over by 75% reduced by 12 beds (as in graph 2 – right), despite an 8% increase in the number of older people presenting to the ED. The cash released benefit over a full year is estimated at £1,24 million vs costs of a 7 day Frailty service of £1.1 million, thus the Frailty model appears to be 10% more cost effective. Finally referring a patient to the Frailty Pathway improved ED capacity in the order of 110 minutes per patient

Admission Avoidance

There were 702 patient episodes with 5 patients having at least 5 episodes each. The mean age of the patients was 84.0; range: 53.8-104.4; with 58.1% being female. Of those 81.6% were discharged within 24 hours and of those 79% were discharged on the day of presentation. Without a control group it is difficult to be sure how many of these would have been discharged prior to the set up of the unit. The conversion rate however provides some indication as to whether this was the case.

Conversion Rate

During the time of the project the attendance rate was marginally up from the previous quarter and in comparison to the same period the previous year. Despite this the conversion rate from ED attendance to hospital admission beyond the ED floor space reduced by 8% (20 relative reduction) compared to the prior quarter and by 3% (9 relative reduction) compared with the equivalent time period for the previous year.

Aim

An “8-bedded” (6 beds and 2 rotator chairs) acute frailty unit was set up within the ED floor space in what had previously been a surgical assessment unit at St Thomas Hospital. The aims of the unit were to:

1) provide timely multidisciplinary comprehensive geriatric assessment (CGA) and intervention by senior decision makers for older frail people presenting to the ED in accordance with the “Silver book”.

2) facilitate a safe and rapid discharge to reduce the conversion rate from ED attendance to hospital admission for such patients

3) link with community teams to ensure appropriate care and non-acute medical intervention was provided to older people in their own homes

4) for those that require admission, establish a clear care plan early and facilitate transfer directly to the Older Persons Unit (OPU) rather than to the acute admissions ward (AAW). Pre-project data suggested that of around 80% of those aged 75+ admitted to the AAW were being moved during their inpatient episode to the OPU

5) assess appropriate patients (medically stable and “looked frail”) presenting with frailty syndromes rapidly in the unit by “pulling” patients from majors or taking them directly from the ambulance on arrival and thus freeing up ED capacity.

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Input provided:

- Assessed each time by whole MDT.
- Known high risk of falls with maximum community assistance.
- Patient discharged with additional from GSTT home team but still kept returning to hospital.
- Eventually agreed to placement and placed in emergency respite to await formal assessment.

Benefits of frailty unit

- 85% to 90% of frailty team. Alternative would be patient seen by different medical take on each admission and likely Older Person’s ward admission, lengthy inpatient stays with the need for scheduled MDM / discharge planning meetings.
- Since patient was technically “admitted” to hospital Social Services could access emergency placement, thereby preventing a long stay.