Around the Clock: The Development of an Out-of-Hours Frailty Service to the Emergency Department

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Aims

With an increase in the prevalence of frailty, benefits of Comprehensive Geriatric Assessment (CGA) is well known (Clegg, 2013). Patients with frailty syndromes should have access to CGA regardless of attendance time in the Emergency Department (ED).

Following retrospective case note review it was apparent that some patients, who had attended A&E/ED out with the working hours of the front door frailty team (Integrated Assessment Team) at NHS Fife, would benefit from secondary prevention measures allowing them to remain in their own home or as close to home as possible (Scottish Government 2011). Therefore our aim was:

“To identify and improve outcomes for the older people attending the Emergency Department Out of Hours (OOHs) who are screened frailty positive due to falls, functional or cognitive decline who would benefit from comprehensive geriatric assessment. These patients were deemed safe to leave the department, but secondary prevention measures would be beneficially addressed in a community setting.”

Method

An updated OOHs frailty referral form was developed which included consent from patient or Next of Kin/Power of Attorney for onward referral. Using the electronic frailty screening tool, the ED medical and nursing team would identify any patients that had a positive screen during the out-of-hours period from 7.30pm to 7am. For each of these patients a referral form was completed and triaged by the Integrated Assessment Team (IAT) next working day. IAT is a multi-professional team supported by a Geriatrician working across the front door areas of NHS Fife supporting and managing early identification of patients with frailty syndromes and rapid comprehensive assessment. IAT will review the patient’s electronic records on the Clinical Portal to determine if they have had any previous interaction with relevant services, e.g. inpatient Medicine of the Elderly (MOE); Hospital at Home; Day Hospital or MOE clinic. Where appropriate the patient or caregiver will be contacted if further information is required. Following this the patient can be referred electronically to the following pathways as needed:

1. Hospital at Home
2. Day Hospital
3. Community Rehabilitation
4. Medicine for the Elderly Clinic (including rapid access)

Results/Outcomes

The introduction of the enhanced OOHs pathway has led to a multitude of onward referral options for patients allowing pro-active management of frailty out with core business hours. This has led to secondary prevention measures being implemented, mainly in review of medications and amendments to medications to minimize falls risk and the addition of bone protection where appropriate. Following retrospective review of patients screened in OOHs period, 80% of those referred to clinic or day hospital had interventions which included medication amendments or further investigations.

Conclusion

This process has ensured that regardless of the time of presentation to ED patients screened positive for frailty syndromes will have access to CGA in community.

This service development has been well received by the ED team as they are now able to ensure patients who are frailty screen positive who are safe to be discharged from the ED OOH will still benefit from review of their case by the team leading to appropriate onward referral for specialist assessment where required.