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CONFERENCE ABSTRACT

Timely identification of frailty & comprehensive multidisciplinary assessment on a newly established specialist geriatric ward

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Introduction: Beaumont Hospital catchment area has a 20% higher proportion of over 65's and over 85's than the national average. Between 2011 and 2026 it is predicted that there will be 44% increase in the population of North Dublin over 65 years of age 1. Older people are admitted to hospital more frequently, have longer length of stay and occupy more bed days in acute hospitals than any other patient group. Many older people are frail and present to hospital with acute or sub-acute illnesses often accompanied by functional and/or cognitive deteriorations. Furthermore, once hospitalised frail older people are at huge risk of further hospital based deconditioning due to reduction in habitual activity and sleep deprivation.

Once identified, the gold standard for the acute management of frailty in older people is early multidisciplinary team (MDT) assessment and delivery of high quality care with an emphasis on reduction in unnecessary delays and proactive case-management.Extensive research has shown that frail older patients who receive timely access to coordinated care under specialist geriatric teams (SGT) on a specialist geriatric ward (SGW), in the form of comprehensive geriatric assessment, have an increased likelihood of returning home, as well as reduced mortality rate following acute hospital admission 2.

Aim and practice change implemented: This change management project was completed in conjunction with the SGT on a newly established SGW (Hardwicke ward). It was carried out as part of a larger ward redevelopment project. This particular project took place over a 4 week period in April/May 2016.

The following key stakeholders were involved; patients, MDT, Clinical Nurse Managers, Geriatricians, Project Sponsor (Physiotherapy Manager). This project utilised quality improvement (QI) methodology incorporating; process mapping, development of a driver diagram, data collection and implementing multiple plan-do-study-act cycles to rapidly test changes (IHI, 2016). The following project aim was established:

To standardise a process to identify 100% of frail patients over 75 years of age who are admitted to Hardwicke ward under the care of a Geriatrician and ensure referral to all relevant multidisciplinary team members within 24 hours of admission by May 13th 2016.

Highlights: (innovation, impact and outcomes) A number of standardised processes have now been successfully implemented on Hardwicke ward for frailty triage, prompt referral to MDT and completion of common MDT assessment documentation. These standardised processes have led to 100% of new patients over 75 years of age being screened for frailty and all relevant MDT referrals being sent via a standardised method (electronic referral) within 24 hours of admission to the ward. This has increased from a baseline of 40% at initial data collection on week one.

The result is a more efficient, standardised, co-ordinated and patient-focused process which has led to a reduction in unnecessary wait times and thus a reduction in the risk of hospital-associated de-conditioning in frail older people. The use of QI methodology and interdisciplinary working were key factors in the success of this project. A clear line of sight with the National Clinical Programme for Older People 3 was also crucial to its success.

Sustainability and trasferability:

Future areas for further development are focused on the following;

Stabilise and embed the current standardised processes into practice on Hardwicke ward (incorporating succession planning and ongoing training for Junior rotational staff)

Further streamline the processes to reduce inefficiencies utilising QI methodology

Spread the learning to other acute wards & MDTs initially focusing on a 2nd SGW

Keywords: frailty; comprehensive geriatric assessment
