Targeting Frailty

Presenters: Lesa Fox BScN, RN, CCRN, EN(C) Helen Armstrong Dip HE, RN

Address: Emergency department, CCDHB, Riddiford street, Newtown, Wellington, 6021

Phone: mob 0274979228 land 04 3855005

Email: helen.armstrong@ccdhb.org.nz lesa.fox@ccdhb.org.nz

BACKGROUND

The ageing population is accelerating worldwide. Based on the 2013 Census the average life expectancy in New Zealand is 80 to 85 years with 14% being over 65 (Statistics New Zealand, 2013). Average hospital stay for those aged 75 to 84 is estimated at 3 days and increases to 6 days for those over 85 (Sturgess, 2013). That is an estimated cost of $4500 to $9000 for one admission. (Based on statistics provided by the CCDHB finance dept)

The diverse nature and complex medical issues of the ageing population creates multiple challenges in patient care. A focal shift is needed to include the integration of care around the needs of people and population (Sturgess, 2013). Older patients admitted to the ED should be screened for risk of adverse outcomes. In patients at high risk of adverse outcomes, the CGA should be administered with brief tools validated in the ED. This two-step intervention has been shown to decrease the rate of functional decline, readmission, and institutionalization (Christophe E, et al) (2010) Multidisciplinary teams are needed to address the physiological, functional, and psychological changes that accompany frailty and illness (Clegg et al., 2013).

ABSTRACT

On of July 28th, 2014 Wellington Emergency Department initiated a frailty screening tool. Staff Nurses, ACNM, PFC, Registrars or SMOs can initiate this tool on anyone over the age of 75. This quick screening allows for the early identification of frail elderly patients.

Those patients identified as frail (score of 2 or more) are then referred to the multidisciplinary CaREFul Team (Caring for the Risk Elderly patient who is Frail) The CaREFul team then undertake a comprehensive geriatric assessment (CGA)

The CaREFul team work in collaboration with one another and ED to create care plans for those being admitted and discharged home.

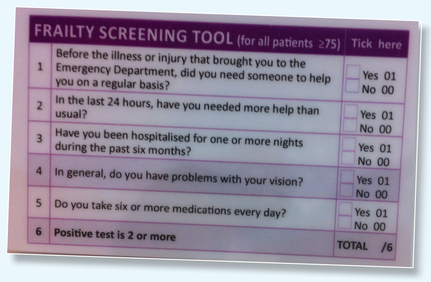
Although there are some limitations; by screening for frailty early and subsequently performing CGA in the emergency department, it is intended that patient safety will increase and independence both short and long term will be promoted and as a consequence, over all length of hospital stay will be reduced.

WHAT IS FRAILTY?

Frailty is a state of vulnerability and poor resolution after a stressor event that is often associated with a gradual decline in health status (Clegg, Young, Iliffe, Rikkert, & Rockwood, 2013). Frailty is multi-factorial and includes physiological, genetic, environmental, and nutritional components. As a result, minor illness can lead to major decline in health status (Fig 2). It is estimated that 25- 50% of people over 85 are frail (Clegg et al., 2013).

THE CAREFUL TEAM

Patients are referred to the CaREFul (Caring of the at risk patient who is frail) team by ED nursing staff using a **frailty screening tool** to flag at risk frail elderly patients. The team have been based in ED since July 2014 and will complete a 6 month trial of the service in January 2015. The team comprise of 2 geriatricians, 1 x pharmacist,1 x physiotherapist and 1 x nurse specialist and will complete a 6 month trial of the service in January 2015.



FRAILTY SCREENING TOOL (for all patients ≥75)		Tick here
1	Before the illness or injury that brought you to the Emergency Department, did you need someone to help you on a regular basis?	Yes 01 No 00
2	In the last 24 hours, have you needed more help than usual?	Yes 01 No 00
3	Have you been hospitalised for one or more nights during the past six months?	Yes 01 No 00
4	In general, do you have problems with your vision?	Yes 01 No 00
5	Do you take six or more medications every day?	Yes 01 No 00
6	Positive test is 2 or more	TOTAL /6

The CaREFul team enable and support discharges and prevent unnecessary hospitalisations for the frail elderly by performing comprehensive geriatric assessments (CGA) and ensuring the coordination of any follow up treatment provided by in-home community services. They also offer geriatrician and speciality allied health support to in-patient teams.

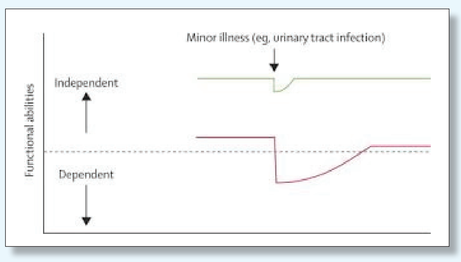


Fig 2. *Vulnerability of frail elderly to sudden change in health status after a minor illness. (Clegg et al., 2013)*

COMPREHENSIVE GERIATRIC ASSESSMENT

A Comprehensive Geriatric Assessment (CGA) is a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological and functional capabilities of a frail elderly person in order to develop a co-ordinated and integrated plan for treatment and long-term follow up. (Ellis at al) (2011)

It has shown to increase quality of life, decrease residential care admissions, decrease rates of death and deterioration at 12 months post illness, and improve care not only within the emergency department but throughout hospital stay (Ellis, Whitehead, Robinson, O'Neill, & Langhorne, 2011).

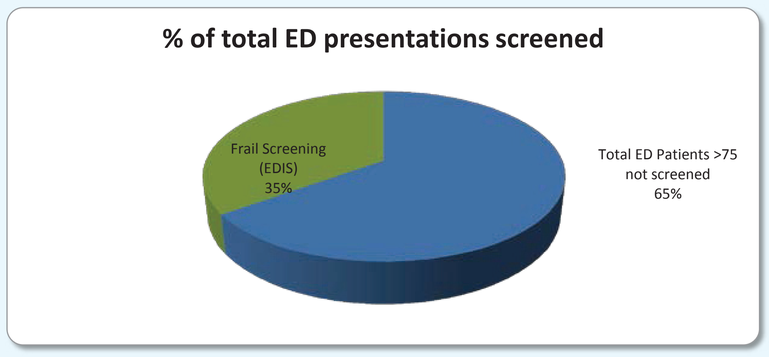
LIMITATIONS

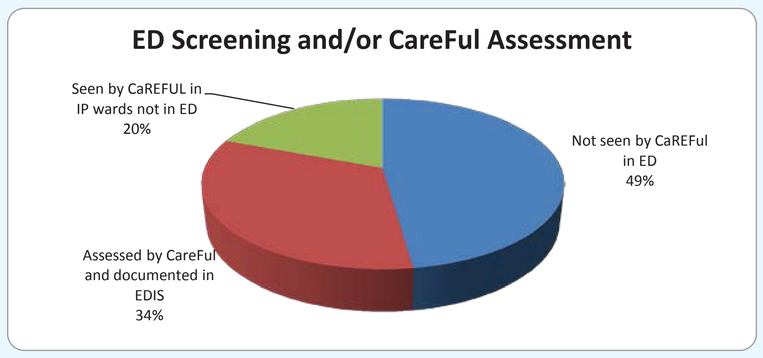
- Variation in research outcomes and recommendations e.g. differing targeted age groups
- Time of attendance v's CaREFul team working hours (Monday – Friday 10:00- 18:00)
- Patient non-compliance
- Lack of geriatric services at WRH (centred at Kenepuru)
- Patient age – difficult to get funding for < 65s regardless of frailty.
- Poor ED RN screening compliance (only 26% of > 75 yrs screened) Due to time constraints – unable to prioritise, lack of interest

DATA

Between August 1st and October 1st Wellington ED saw 1482 people over 75 years of age. Of those 495 were screened by ED and a total of 509 were assessed by the CaREFul team.

- Average age of those screened was 84.3 years
- 323 (22%) had frailty screening, but no CaREFul team referral was needed (score <2).
- 102 (20%) were screened, assessed, and discharged home from ED.
- 147 (29%) were assessed and admitted to hospital for medical issues.
- 62 (12%) were screened and admitted to SSU.





REFERENCES

Christophe E, 2010 Comprehensive geriatric assessment in the emergency department. Journal of the American Geriatrics Society Volume 58 issue 10

Clegg, A., Young, J., Iliffe, S., Rikkert, M. O., & Rockwood, K. (2013). Frailty in elderly people. The Lancet, 381(9868), 752-762. doi: http://dx.doi.org/10.1016/S0140-6736(12)62167-9

Ellis, G., Whitehead, M. A., Robinson, D., O'Neill, D., & Langhorne, P. (2011). Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of randomised controlled trials (Vol. 343).

Statistics New Zealand. (2013). New Zealand Period Life Tables. Retrieved September 17, 2014, from http://www.stats.govt.nz/browse_for_stats/health/life_expectancy/nz-period-life-tables-info-releases.aspx

Morely J E (2011) Frailty: diagnosis and management Journal of nutrition, health and aging, volume 15, no. 8

Rockwood K, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, Mitnitski A: A global clinical measure of fitness and frailty in elderly people. Canadian Medical Association Journal 2005, 173:489-495

Sturgess, I. (2013). Successful population ageing- The challenge for acute care. Paper presented at the New Zealand Integrated Acute Care Conference, Christchurch.

FACT FILE:

- Aging population in accelerating worldwide
- Avge hospital stay for 75-84 yr olds est. 3 days
- Multifactorial issues needs a multidisciplinary approach
- In NZ 14% of population is > 65 years
- The CaREFul team have engaged well with community providers to increase the package of care provided to patients after an acute event such as a fall at home.

Capital & Coast District Health Board
Ūpoko ki te uru hauora