King's

London Major Trauma System

King's College Hospital NHS
NHS Foundation Trust

Recognising the importance of frailty-identifying patients on admission to the Emergency Department

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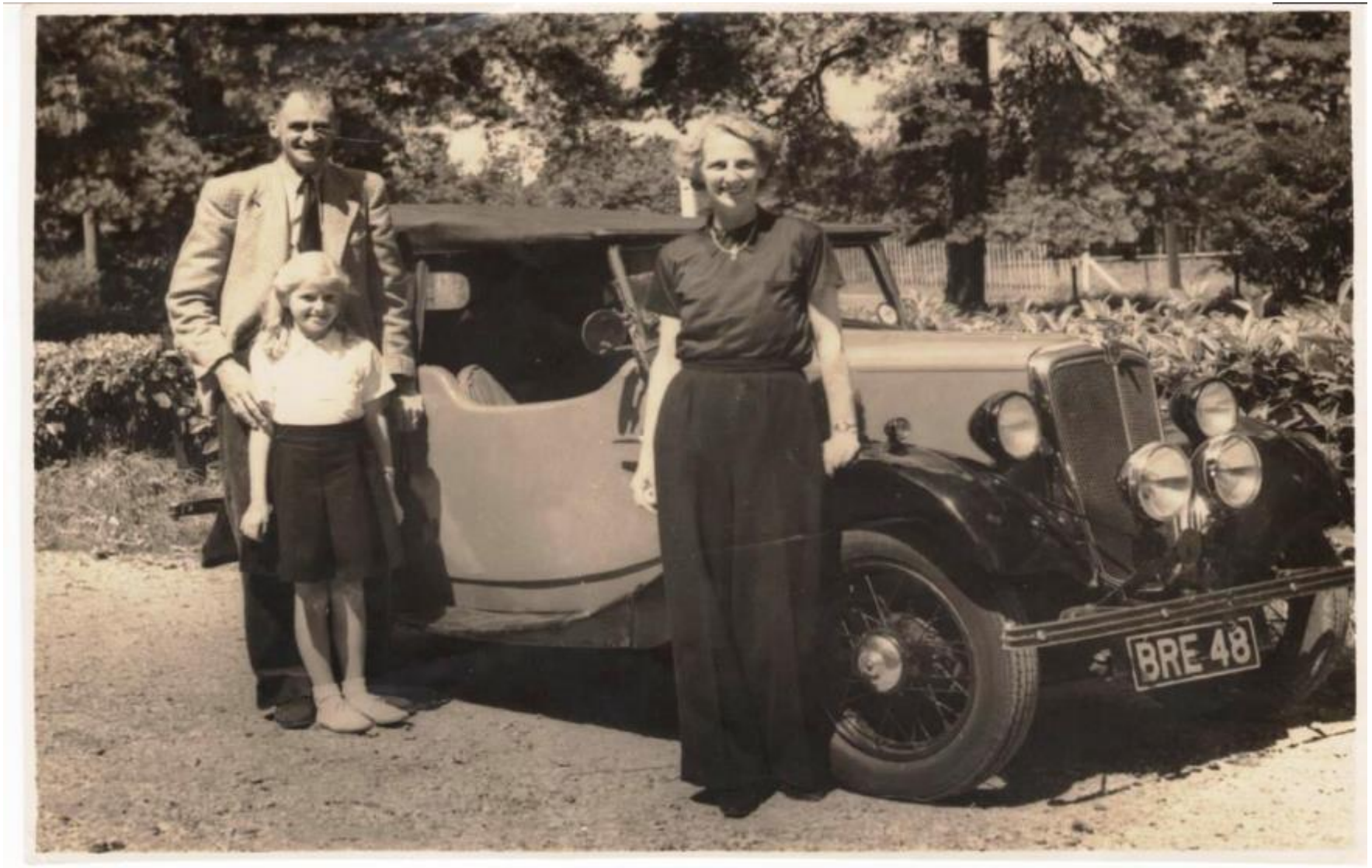

BRE 48

Loveliest of trees, the cherry now

Loveliest of trees, the cherry now
Is hung with bloom along the bough,
And stands about the woodland ride
Wearing white for Eastertide.

Now, of my threescore years and ten,
Twenty will not come again,
And take from seventy springs a score,
It only leaves me fifty more.

And since to look at things in bloom
Fifty springs are little room,
About the woodlands I will go
To see the cherry hung with snow.

from *A Shropshire Lad* (1896)

- By 2040 1 in 4 in the UK will be aged 65 or over
- Rising numbers of trauma
- Low level falls leading cause of severe injury

1000 days…

- **10 days in hospital (acute, sub acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80**

- **48% of people over 85 die within one year of hospital admission**

  Imminence of death among hospital inpatients: Prevalent cohort study

Purpose

Early identification of frailty allows early delivery of evidence based Comprehensive Geriatric Assessment (CGA).

What is frailty?

- Decreased reserves
- Diminished resistance to stressors
- “a medical syndrome with multiple causes characterized by diminished strength, endurance, and reduced physiological capacity that increases an individual’s vulnerability for developing increased dependency and/or death”

Define frailty…..

- Weakness
- Fatigue
- Weight loss
- Low physical activity
- Poor balance
- Slow gait speed
- Visual impairment
- Cognitive impairment

Why is frailty important

- Increasing elderly population
- Increasing admissions year or year
- Long length of stay
- Re-attendances common
- It is in our interests to get it right the first time to free up hospital beds and prevent re-attendance

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

Role of ED in frailty

Comprehensive Geriatric Assessment

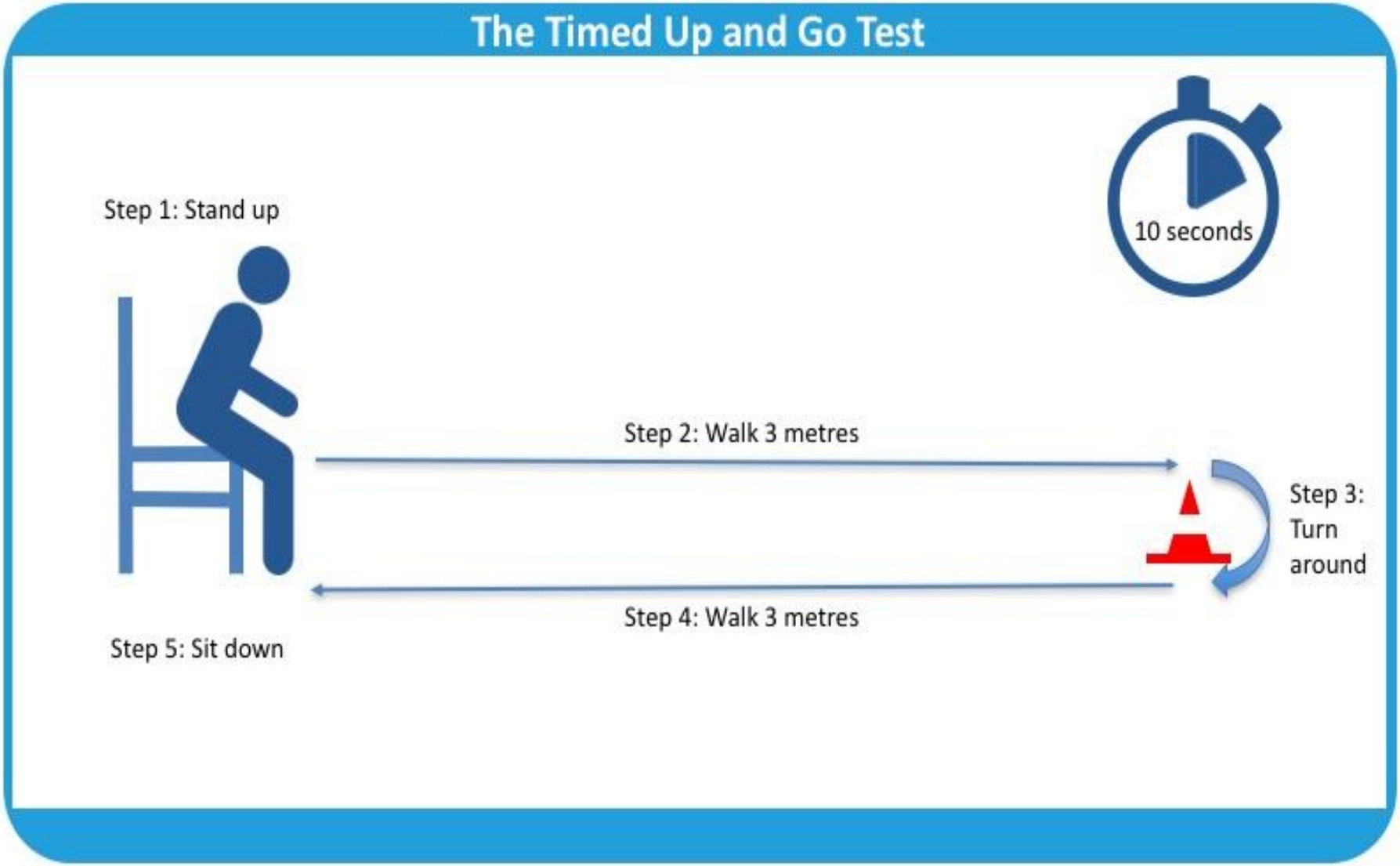
- A process of good, holistic care delivered within a geriatric medicine focused multi-disciplinary team, which goes above and beyond simply managing the acute problem that the person has presented with.

Comprehensive Geriatric Assessment (CGA)

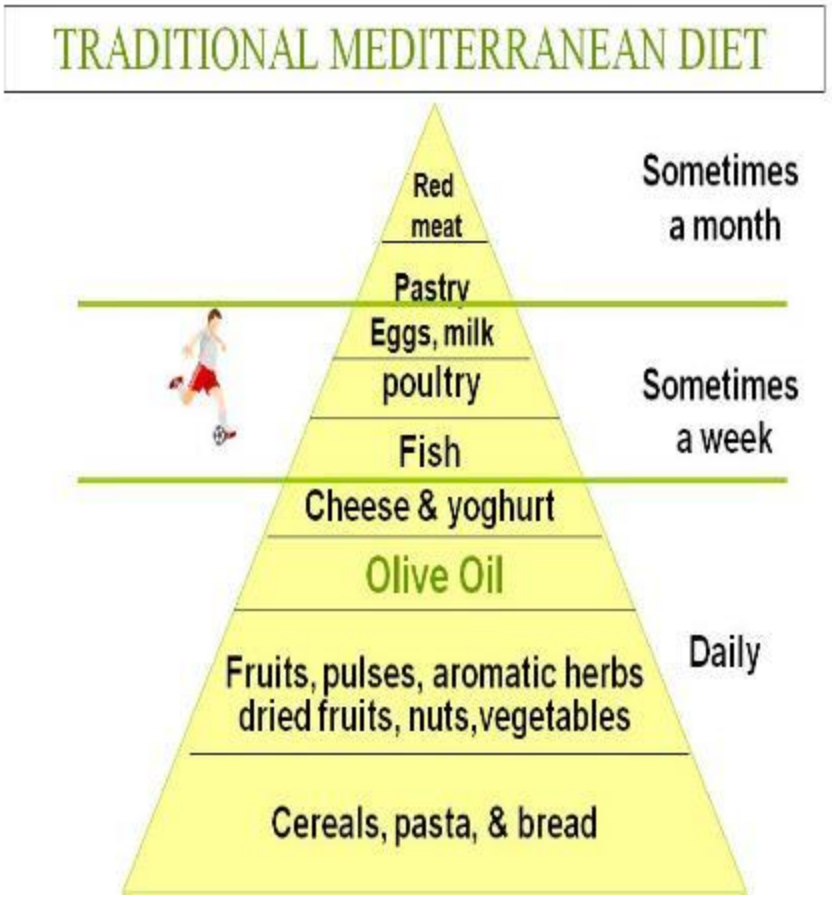
- Comprises multiple domains of assessment including
  - Physical Symptoms: Pain, continence, Sensory impairment, Musculoskeletal problems, nutritional and skin assessment
  - Mental Health symptoms: Mood, cognitive impairment
  - Functional abilities and living environment
  - Social support networks

Mobility

The Timed Up and Go Test



Medication and Nutrition



Mood Delirium and Dementia

TABLE 4.

Distinguishing Features of Dementia Versus Delirium

Feature	Delirium	Dementia
Onset	Abrupt or subacute	Insidious
Course	Fluctuates	Progressive
Duration	Days to weeks	Permanent
Attention	Impaired	Impaired in late stages
Consciousness	Fluctuates/impaired	Alert/stable (can be impaired in dementia with Lewy bodies and terminal stages)
Reversibility	Usually	Often irreversible
Behavior	Agitated or withdrawn (change from premorbid state)	Impaired in late stages; can be apathetic to agitated depending on dementia
Orientation	Impaired but can fluctuate	Impaired in late stages
Memory	Impaired (change from premorbid state) mainly due to inattentiveness	Impaired, progressive
Perception	Visual hallucinations predominate	Auditory or visual hallucinations (depending on dementia process)
Speech	Incoherent	Word-finding difficulty
Thought	Disorganized	Impoverished
Sleep	Sleep/wake reversed or disturbed hour to hour	Fragmented sleep

Adapted from Philbrick et al.[7]

Continence

- Incontinence isn't normal
  - If not addressed will lead to pressure ulcers
- Do not – however – catheterise lightly
- UTIs massively over-treated – well and asymptomatic – do not treat positive dipstick

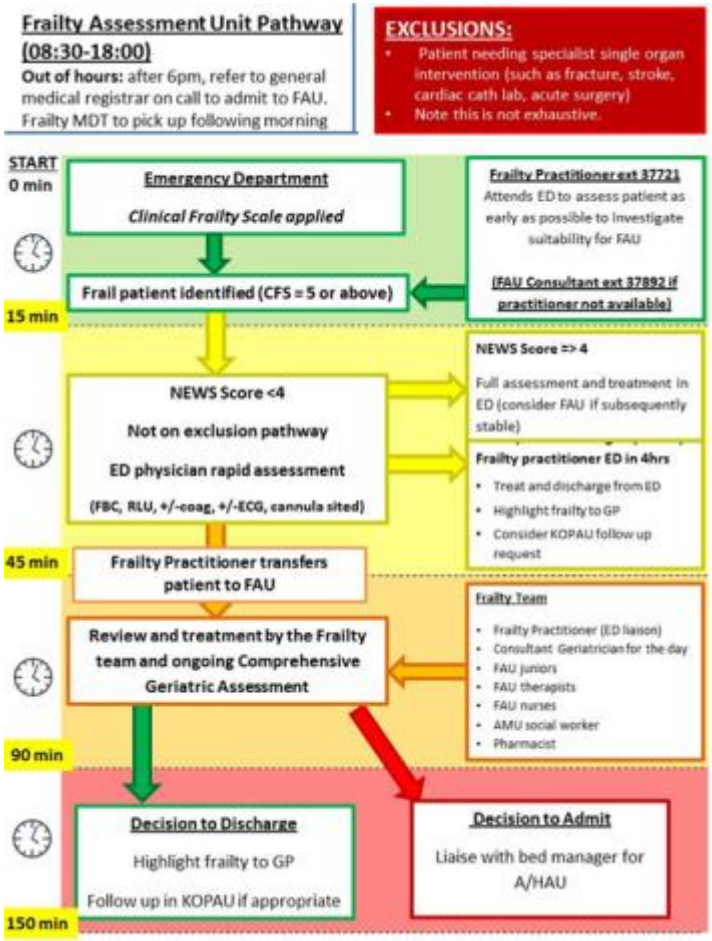
End Of Life Care

- Think about EOLC planning
- Opportunity to talk about resus status
- PEACE document if in a care/ nursing home

Frailty Working Group

Frailty Pathway

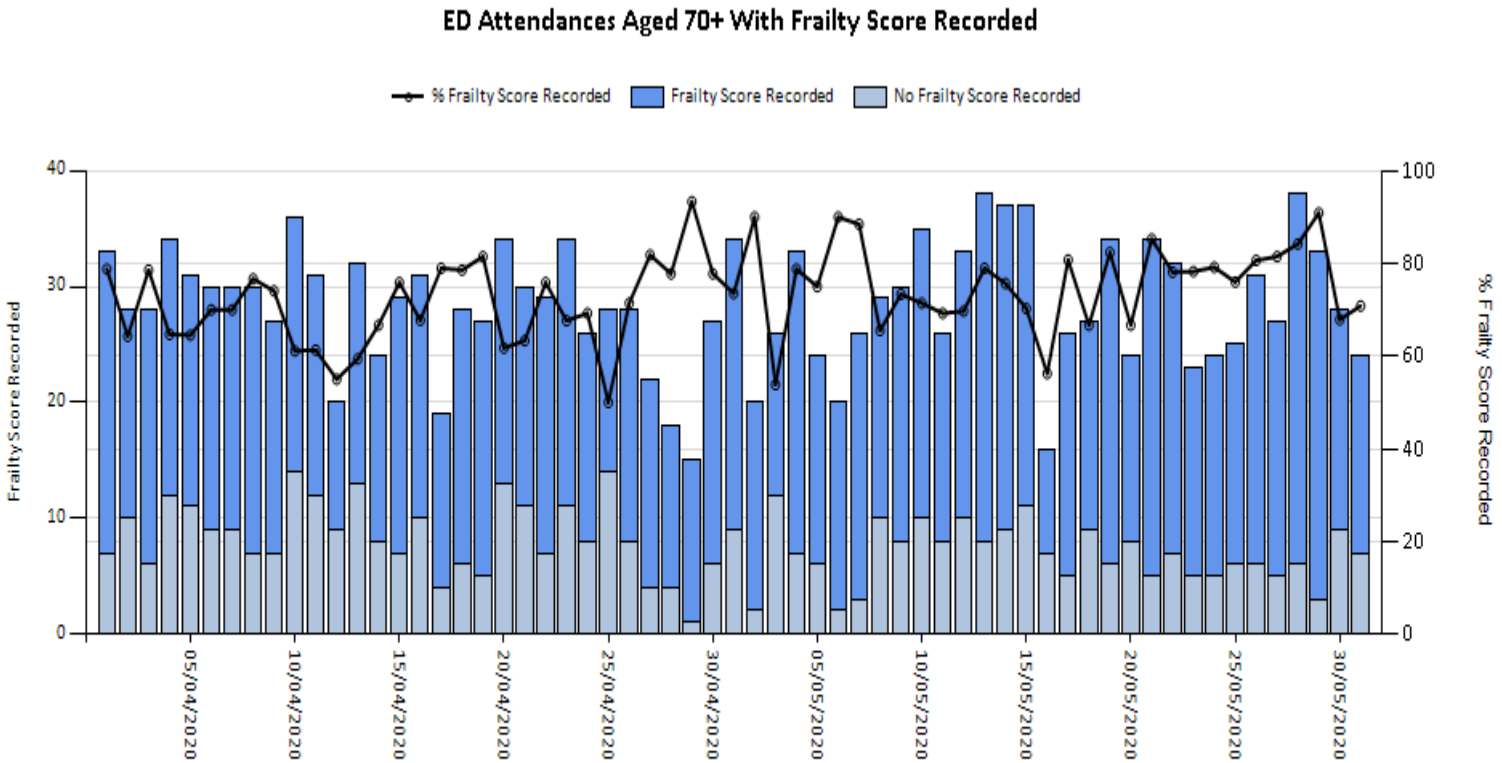
1. Frailty Score at triage
2. Nursing assessment
3. Identified as suitable for Frailty Unit
4. Rapid Assessment and Treatment by ED senior
5. Discussion with frailty practitioner
6. Move to frailty unit to be assessed by geriatric team
7. At night – usual pathway – full clerking – medics or CDU



Feedback

- To ED staff
- From Patients and carers
- From Staff

Frailty scores-progress report



Percentage Frailty Score Recorded for ED Attendances Aged 70+ (SPC Chart)

Older people using King's ED- findings from a story project

- In-depth interviews 2-3 weeks post-discharge with 16 people in total: 8 patients and 8 relatives/family members
- Patients included 5 women and 3 men between the ages of 75-97 years in different living situations including a care home, supported accommodation, living with/supported by family carers and living alone
- Presenting problems: falls (3 patients), blackout, hallucinations, breathing difficulty, reduced mobility /acute pain

Positive findings

- **Generally, patients and their families reported positive experiences of the care and treatment they received from LAS and at King's.**
- **Patients/relatives described King's Emergency department staff as friendly and caring.**
- **Patients and families cared for by the frailty team were particularly positive about the team's role and expertise, highlighting the difference this made to their experience.**
- **Discharge planning was positive: MDT perceived to be pulling together**

Volunteer support

'I was holding the hand of a patient with dementia. During this time she fell asleep. As I pulled my hand away, she stirred and said, " please hold my hand- I feel safe"

Susan, ED volunteer

Aim for home

- Best bed is own bed
- Deconditioning starts in ED
- Sit out if possible
- Try get patient home or to FAU to facilitate early discharge

“Last time mum was in hospital it was a long wait to be transferred to the ward, this time it was only two hours and she was transferred to the new specialist ward for older people”

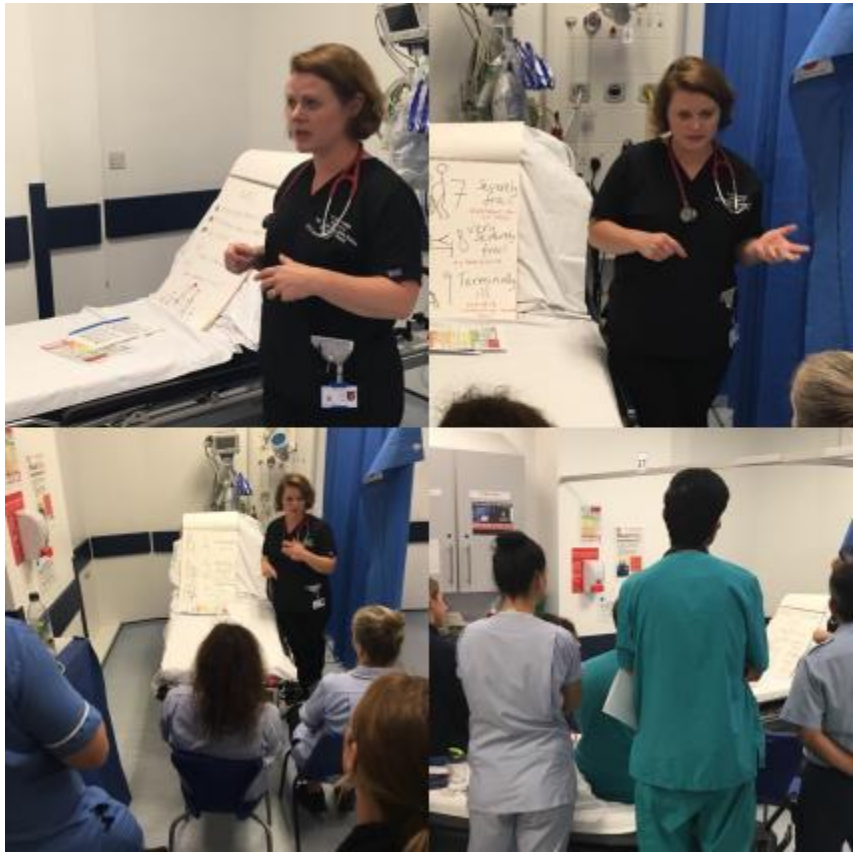
Need to do differently

- **Staff too busy to provide necessary information, including explanation of treatment and tests**
- **Did not always get food and drink that was requested**
- **Focus on social support and links with other health and social care services**

“ The doctor had asked if mum wanted a sandwich and a cup of tea as she arrived in A&E during lunch time. After some time it had not arrived so I didn’t want to to ask the doctor for the sandwich so I went to xx to get something for mum. If I was not there, I wondered if mum would have had anything to eat, as mum isn’t the type to complain”

How did you learn about the pathway?

- Formal teaching
- Teaching in clinical area
- Induction meeting
- Staff handover
- 1:1 meeting
- Read information



Frailty Champion Training

Training for King's Frailty Champions

Two and a half formal training days and competencies carried out and signed off in the work setting.
Training involves interactive sessions focusing not just on the subject of frailty but also on teaching, leadership and quality improvement skills.

Day 1
- Understanding frailty and Comprehensive Geriatric (CGA)
- Frailty bundle domains

Day 2
- Principles of leadership
- Teaching adults
- Quality improvement

Day 3 (half day)
- Deliver bitesize training session to the other champions
- Receive feedback

In 6 months
- Complete frailty competencies
- Deliver bitesize staff training
- Develop QIP ideas

Who are King's Frailty Champions?

- Frontline health care professionals working in urgent care
- Nurses and therapists
- Band 5-7

"Training to become a frailty champion has opened my eyes to an aspect of care where there is great scope for improvement in the ED"

"The course provided a comprehensive look at Frailty with high quality presenting and good use of interactivity."

Results to Date

Cohort 1= 15 frailty champions completed training from ED and urgent care on both KCH sites

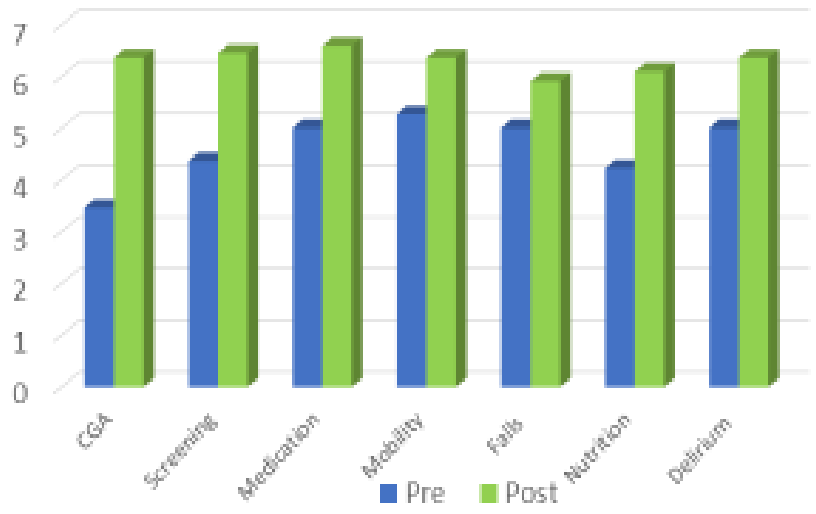
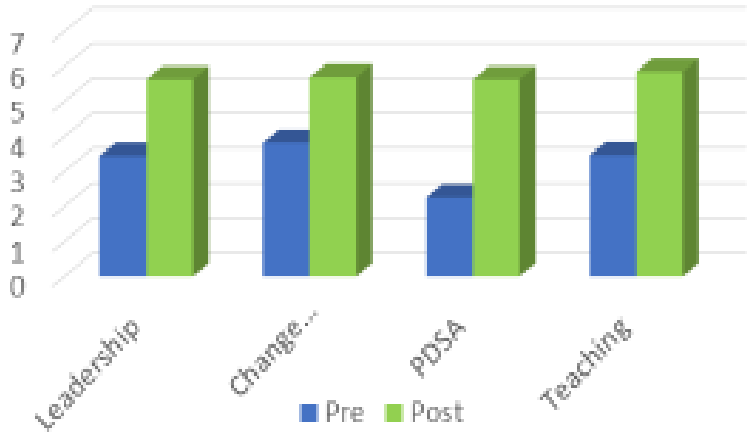


Figure 1. Mean understanding of different aspects of frailty care before and after the first training day (score 1-7, highest = best understanding)

References

Rockwood et al (2005). A global clinical measure of fitness and frailty in elderly people. CMAJ.173: 489-495.

Figure 2. Mean understanding of leadership and teaching before and after the second training day (score 1-7, highest = best understanding)



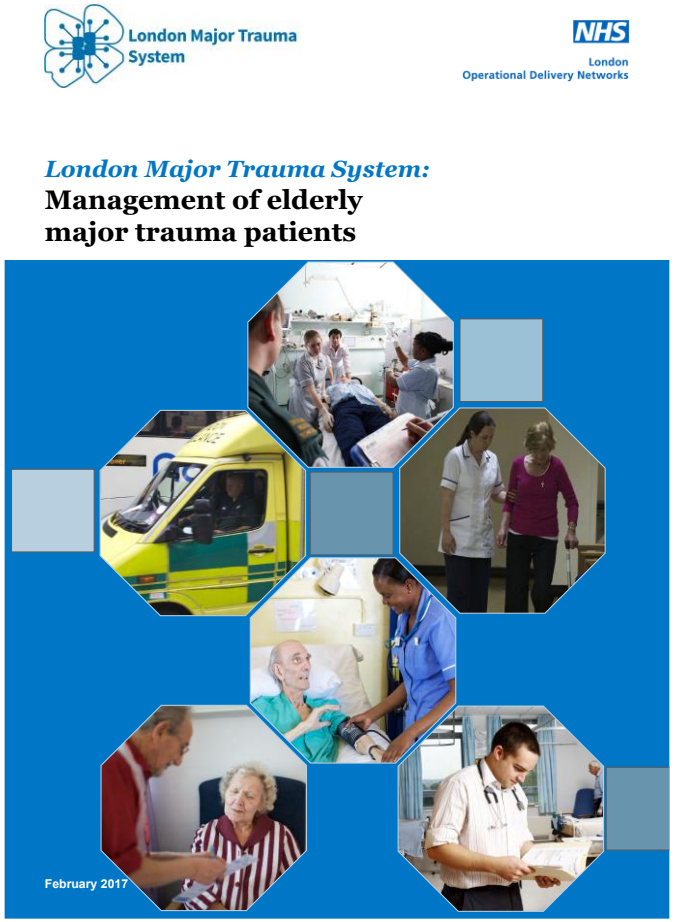
Next Steps

A recent audit highlighted 95% of Frail patients had some documented evidence of the frailty bundle. Future plans include:

- Delivery of further Frailty Champion training
- Improve the environment and available facilities in ED for the frail patient
- Specific user group engagement and feedback

Silver Trauma

- Improve recognition of injury
- Improve clinical management outcomes
- Improve patient and family experience



Key management principles

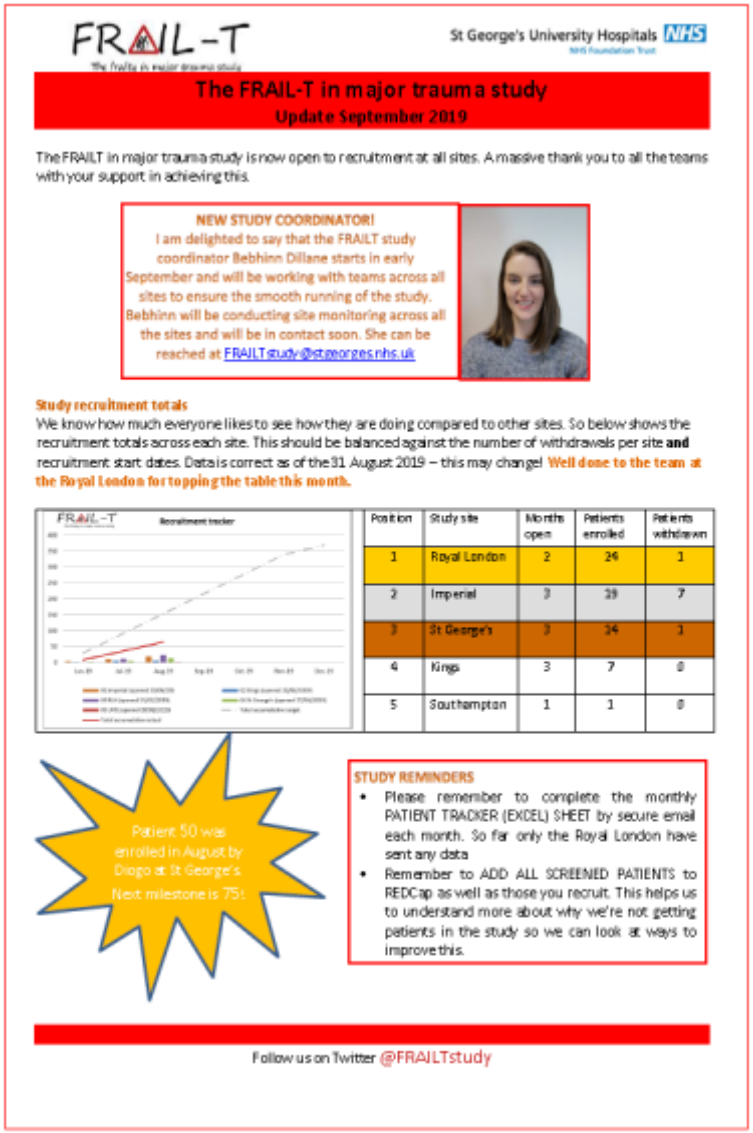
- Altered physiological presentation
- Anticoagulant reversal
- Assessment of pain
- Early collateral history

In the ED

- Training- specific for lower energy mechanisms
- Comorbidities
- Premorbid function
- Immediate reversal of anticoagulation
- Safeguards

FRAIL-T

- Primary aim
  - To determine the feasibility of nurse-led assessment of frailty in patients aged 65 or more admitted to Major Trauma Centres in the UK following traumatic injury



FRAIL-T

St George's University Hospitals NHS

The FRAIL-T in major trauma study
Update September 2019

The FRAILT in major trauma study is now open to recruitment at all sites. A massive thank you to all the teams with your support in achieving this.

NEW STUDY COORDINATOR!
I am delighted to say that the FRAILT study coordinator Bebhinn Dillane starts in early September and will be working with teams across all sites to ensure the smooth running of the study. Bebhinn will be conducting site monitoring across all the sites and will be in contact soon. She can be reached at FRAILTstudy@stgeorges.nhs.uk

Study recruitment totals
We know how much everyone likes to see how they are doing compared to other sites. So below shows the recruitment totals across each site. This should be balanced against the number of withdrawals per site **and** recruitment start dates. Data is correct as of the 31 August 2019 – this may change! **Well done to the team at the Royal London for topping the table this month.**

Position	Study site	Months open	Patients enrolled	Patients withdrawn
1	Royal London	2	24	1
2	Imperial	3	19	7
3	St George's	3	14	1
4	Kings	3	7	0
5	Southampton	1	1	0

Patient 50 was enrolled in August by Diogo at St George's. Next milestone is 75!

STUDY REMINDERS
- Please remember to complete the monthly PATIENT TRACKER (EXCEL) SHEET by secure email each month. So far only the Royal London have sent any data
- Remember to ADD ALL SCREENED PATIENTS to REDCap as well as those you recruit. This helps us to understand more about why we're not getting patients in the study so we can look at ways to improve this.

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Questions?

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