

Frailty Service Improvement Flow

Project aim

To identify frailty patients and provide a comprehensive geriatric assessment (CGA) and intervention to older people (>75) at the right place & the right time avoiding unnecessary time spent in hospital by Aug 2020.

Timeline for delivery

From: Jan 2019 To: Aug 2020

Measures

- Number of patients >75 y.o. seen by Frailty team in FAU & ED and Harold 72 hrs beds
- Length of Stay reduction and number of COE outliers

Tests for change

1. Relocation of FAU closer to ED (earlier frailty ID and CGA)
2. Mandatory frailty score on ED Triage & discharge summary (>75yrs) ; use of visual Frailty criteria
3. System interoperability (access to primary care records)
4. Frailty MDT Huddle (FAU & ED patients)
5. Use of different types of Pharmacy prescriptions to decrease TTA delays.
6. Training for acute and community colleagues.
7. Extension of FAU hours Mon- Friday (8am-8pm)

Learning and next steps

Multidisciplinary work essential to achieve goals and run frailty service as planned.

- To create sustainable workforce.
- To align social care working hours.
- To optimise use of voluntary sectors



Project team

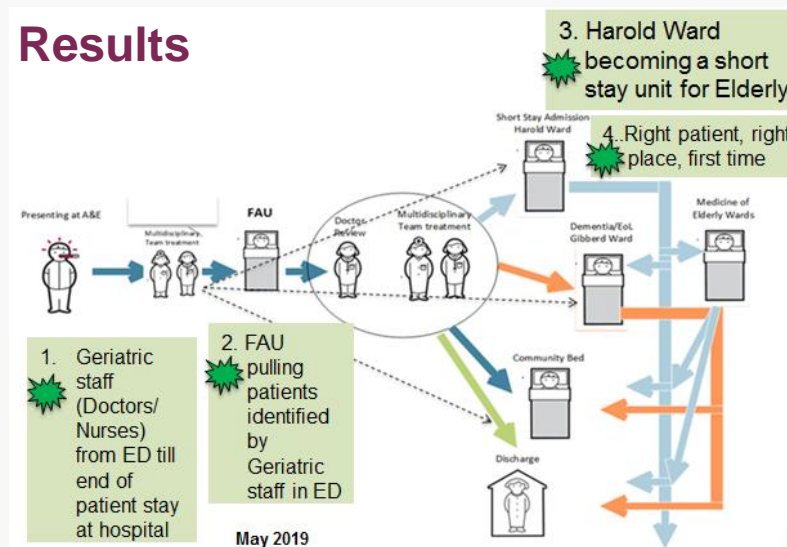
Front: (Left- Right)

Patricia Silva(Nurse); Theresa Estuya (Mental Health Liaison); Janice Bernardo (Frailty Lead Practitioner); Gaby Jenkinson (Frailty Nurse)

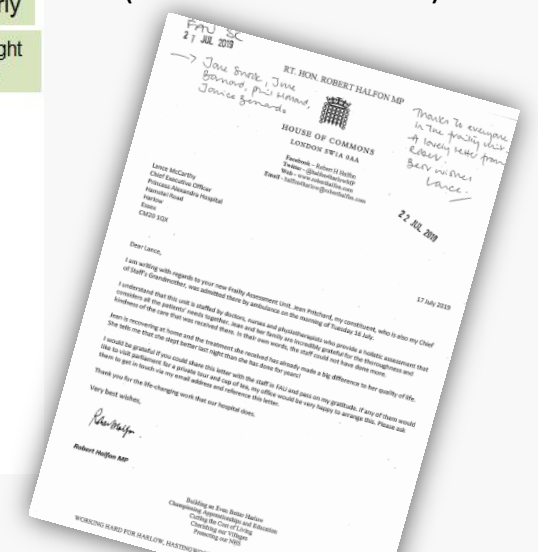
Back: Left-Right)

Dr Abdul Malik (Frailty Consultant); Lilian DelaLuna (OT); Perminder (Social Worker); Jenny Honour(PT); Tolu (Social Worker- Herts)

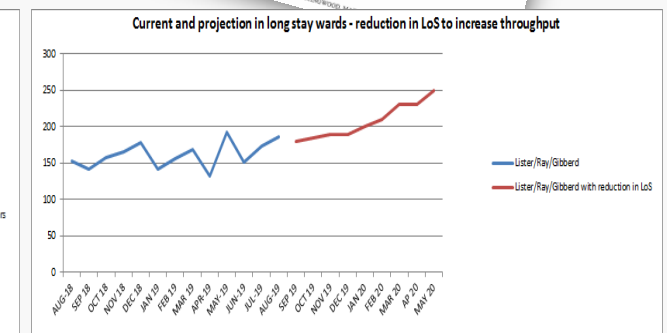
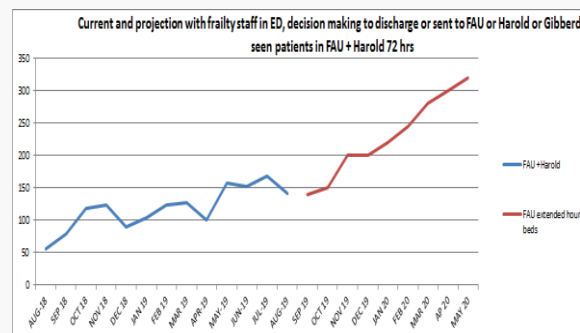
Results



Compliment letter from patient (House of Commons)



Number of patients



The blue line is actual activity achieved and the red line is projected/planned frailty activity

