NHS

# Six Steps to Better Care for Older People in Acute Hospitals

Guidance for managing the GIRFT Overall Frailty pathway – Geriatric Medicine

July 2023

GIRFT is part of an aligned set of programmes within NHS England

# Introduction

In conjunction with the British Geriatrics Society (BGS), Getting It Right First Time (GIRFT) have produced this guidance to accompany the GIRFT Hospital Acute Care Frailty Pathway, setting out six steps acute hospitals should take to improve care for older people living with frailty. Implementation of these steps will support hospital-wide structures to improve care and reduce hospital acquired dependency for those living with frailty. However, these structures are just the start of a process, so it is important that the quality and effectiveness of these interventions are monitored and link to wider community-based services for older persons.

The six steps include:

1. **Assess for frailty**: Systematically identify frailty in all settings using the Clinical Frailty Scale.
2. **Prevent complications**: Prevent, identify and effectively manage delirium and reduce hospital-acquired deconditioning.
3. **Home First**: Start discharge planning for older people with frailty and/or dementia as soon as possible after admission using a Home First principle.
4. **Surgical Liaison**: Provide evidence-based surgical specialty liaison that improves individual and service-level outcomes for older people.
5. **Rehabilitation**: Ensure there is effective recuperative rehabilitation for older people on all wards in hospital and linked community services.
6. **Primary and Community Care**: Develop effective primary and community care services that support older people to remain in or return to their usual residence.

**These interventions are best supported by the development of a local comprehensive strategy for supporting care for people living with frailty – see NHS Rightcare Frailty Toolkit.**

# 1. Assess for frailty

Systematically identify frailty in all settings using the Clinical Frailty Scale, and ensuring there is effective assessment including Comprehensive Geriatric Assessment (CGA) for those with Clinical Frailty Score* (CFS) of 6 or more. People aged > 65 years should have a CFS completed at point of referral including emergency referral, at outpatient clinic and/or on arrival at hospital for emergency or planned care:

a. People aged > 65 years, with a CFS ≥6 should be flagged on hospital systems to allow identification, tracking and triage for comprehensive multi-disciplinary assessment.
b. People aged > 65 years scoring CFS ≥6 with a frailty flag should have a CGA, as soon as possible after admission, by a team with specialist expertise in the management of frailty. This team should be multi-disciplinary with access to nursing, therapy, geriatrician, pharmacy and social care/discharge planning expertise (which may be delivered by trans-disciplinary teams). This approach has been shown to reduce length of stay and hospital readmissions.
c. Older people with a ‘frailty flag’ but who are medically stable can be discharged, with a referral for CGA delivered by a community-based team.

*CFS is assessed on a patient’s function 2 weeks before admission.

# 2. Prevent complications

Prevent, identify and effectively manage delirium and reduce hospital-acquired deconditioning:

a. Patients aged over 65 years with CFS ≥6 and/or confusion should undergo a 4-AT test on admission, to identify and enable an early response to delirium.

b. Delirium: All hospitals should have a delirium mitigation and management policy in place which should include:

    i. A delirium “flag” on hospital systems for patients who have a 4-AT result suggestive of delirium.

    ii. Minimising hospital moves for people who have delirium, or who are at high risk of delirium.

    iii. A delirium care pathway which focusses on evidence-based approaches to prevention of and management of delirium, including access to hearing and visual aids, attention to nutrition and hydration, avoidance of sedation where possible, a focus on early removal of urinary catheters and intravenous access devices (cannulae) when no longer needed. See BGS Delirium Hub.

c. Falls: Older people scoring CFS ≥6 and/or experiencing delirium and/or dementia may not be able to mobilise safely in hospitals. Specific strategies should be in place to ensure such patients are supported, throughout their admission, to:

    i. Mobilise to the toilet.

    ii. Sit out of bed during the daytime.

    iii. Move freely around ward settings, where safe to do so, without barriers or tethers.

d. Deconditioning/Reconditioning: Older people at risk of hospital-acquired deconditioning should undergo CGA assessment, have access to appropriate walking aids and have rehabilitation goals and plans established. There should be appropriate equipment to allow sitting out of bed in all wards where frail patients are managed. Personalised care using the principles of “End PJ Paralysis” campaign should be encouraged.

    i. Older people at risk of hospital-acquired deconditioning should have a nutritional assessment as part of CGA and be supported with red tray schemes, by hospital volunteers assisting at-risk patients at mealtimes. A hydration policy, which may include intentional rounding, should be in place.

e. Carers: The importance of family carers in maintaining orientation, nutrition, hydration and mobility in older people with frailty should be recognised with inclusive visiting policies which enable visiting through the day. Facilities should be made available, where possible, for family members to stay with patients living with dementia, in keeping with the recommendations of John’s Campaign.

# 3. Home first

Start discharge planning for older people with frailty and/or dementia as soon as possible after admission using a Home First principle. For elective admissions, discharge planning should commence at the time of the decision to admit (e.g. preoperative assessment). This can be supported by:

a. Dedicated specialist multi-disciplinary teams for older people living with frailty in Emergency Departments and Acute Medical Units.
b. Establishing a planned date of discharge as soon as possible after admission to hospital.
c. Ensuring dedicated discharge co-ordinator support in all clinical areas.
d. Daily (seven days per week in acute/five days per week in specialty ward) multi-disciplinary board rounds in all clinical areas where care is provided for older people living with frailty. The focus of these meetings should be on pro-active discharge planning that is goal-focused, criteria-led and considers personal, social and environmental facilitators, and barriers to discharge.
e. Establishing delirium discharge pathways, so that older people with treatment plans in place for delirium can be discharged home safely.
f. Discharge 2 Assess (D2A) pathways that are supported by timely access to community intermediate care, rehabilitation and reablement support to enable older people to regain independence and reduce risk of readmission.
g. Pharmacist review of medicines prior to discharge to reduce risk of harm, optimise concordance and reduce inappropriate polypharmacy.
h. Provision of accessible information and advice to patients on managing their conditions and signposting carers to support for wellbeing.
i. Immediate discharge summary with sufficient information to enable the primary care team to undertake post-discharge medicine reconciliation and follow up.

# 4. Surgical Liaison

Provide evidence-based surgical specialty liaison models that improve individual and service level outcomes for older people, including:

a. Orthogeriatrics service for older patients with hip fracture and for older people with fractures and CFS ≥6 including, but not limited to, pelvic or rib fractures.
b. Geriatric medicine assessment for older patients undergoing emergency laparotomy, according to the National Emergency Laparotomy Audit (NELA) criteria.
c. Referral of older people with CFS ≥6 attending for elective surgery to specialist Peri-operative medicine for Older People undergoing Surgery (POPS) services. See CPOC/BGS guidelines.

# 5. Rehabilitation

Ensure there is effective recuperative rehabilitation for older people on all (including outlying) wards in hospital and linked community services:

a. All older people in hospital should be offered support to regain their pre-illness level of functional ability.

b. Delirium and dementia should not be used as a rationale for having "no rehabilitation potential" – about two-thirds of people with delirium will improve to the point where they can subsequently participate in rehab.

c. Older people with rehabilitation goals should commence rehabilitation in the hospital ward as soon as possible. Rehabilitation should not be delayed until transfer to the community as this may increase deconditioning and reduce likelihood of recovery.

d. Consistent with a Home First approach, when possible, rehabilitation should take place in the person's own home. Older people with rehabilitation goals should only be transferred to community settings where rehabilitation capacity is in place.

e. People living with frailty who have stayed in hospital for seven days or more, should be reviewed by a multi-disciplinary team on a weekly basis and have a more detailed clinical review when they have stayed in hospital for 21 days (see GIRFT Hospital Acute Care Frailty Pathway).

# 6. Primary and Community Care

Develop effective primary and community care services that support older people to remain in, or return to their usual residence including those who are approaching end of life:

a. Establish urgent community response services that are well-integrated with community intermediate care, reablement and rehabilitation services, virtual wards/hospital at home including those provided in community hospitals and step-down beds.

b. These services which should include access to specialist phone advice should be co-ordinated with the local ambulance service to provide alternatives to conveyancing to hospital as an emergency.

c. Provide enhanced health in care homes services which should include a focus on minimisation of avoidable harm by reduction in inappropriate polypharmacy, and a focus on person-centred approaches to advance care planning.

d. Deliver Virtual Ward/Hospital at Home services, which have outcomes equivalent to hospital admission where patients are triaged to take account of family support and safety of continued management at home. They should be adequately staffed with the right expertise and well-integrated with other urgent community response and intermediate care services.

e. Provide ambulatory care models that offer rapid CGA through SDEC, hot clinics or one-stop day hospital, or community MDT assessments.

f. Embed proactive anticipatory care for older people with escalating levels of frailty identified in primary care, supported by sufficient PCN capacity to undertake holistic MDT assessment, personalised care planning and tailored interventions.

g. Ensure effective falls prevention and response services, including shared pathways with ambulance services for non-conveyance of un-injured patients following a fall.
h. Provide co-ordinated and compassionate palliative and end of life care services that include hospice inpatient and day care, hospital liaison, community specialist advice, and district nursing support.
i. Understand the causes of unplanned readmission and frequent hospital admissions for frail older adults and develop interventions to reduce the rate and improve quality of care.

**Each of the above requires careful and creative use of available workforce. Expertise in managing frailty is often thinly spread across multiple services. Trusts and ICSs should consider whether that expertise is being utilised in the most effective way and ensure staff with the required expertise are deployed where they can add most value. In the short term, while more sustainable workforce strategies are developed, Trusts and ICSs should consider reprofiling services/workforce roles to increase the capacity and consistency of frailty-attuned services across the system.**

# Contributors

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**About GIRFT and the GIRFT Academy**
Getting It Right First Time ('**GIRFT**') is an NHS programme designed to improve the quality of care within the NHS by reducing unwarranted variation. By tackling variation in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

The GIRFT Academy has been established to provide easily accessible materials to support best practice delivery across specialties and adoption of innovations in care.

Importantly, GIRFT Academy is led by frontline clinicians who are expert in the areas they are working on. This means advice is developed by teams with a deep understanding of their discipline.

**GIRFT Academy has also published other pathways and case studies which are available via FutureNHS. These are available at:** Getting It Right First Time - FutureNHS Collaboration Platform

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