Benefits

• Improved communication and referral processes between department and support their management and care.
• Enabling a better predication of resources into the future
• Allowing monitoring of service demand and tracking of healthcare requirements
• Integrated health care delivery across the sector
• High quality care provision across the services
• Consumers will be supported to stay healthy, well and independent
• Integrated health care delivery across the sector
• Allowing monitoring of service demand and tracking of healthcare requirements based on level of frailty
• Enabling a better predication of resources into the future
• Improved communication and referral processes between department and services.

Questions to consider

1. Very fit
2. Well
3. Managed well
4. Vulnerable
5. Mildly frail
6. Moderately frail
7. Severely frail
8. Very severely frail
9. Terminally ill

Implementation steps

• Consultation with key stakeholders and executive leadership to drive project at site level
• Clinical Governance to develop a plan to roll out across sites
• Identification of key measures
• Risk mitigation
• Change management and education to engage with employees
• Communication strategies.

Project description

To implement the Rockwood Frailty Scale across all Calvary services to streamline the transition of frail older person and support their management and care. This will:
- Enable the frail older person to remain independent in their home
- Environment for longer
- Assist with hospital avoidance and emergency access
- Support reduced length of stay in the acute health sector
- Provide a common assessment language across the sectors
- To enable health care data to be utilised to better understand planned and unplanned transition between health services
- Provide better support for frail older person in residential facilities who usually present as severely frail.
- People 65 years of age and over and Aboriginal and Torres Strait Islander persons aged 50 years and over will be included in this project.
- Metro North Hospital and Health Service Qld showed that consumers with frailty in the community were high users of the emergency department and when admitted had longer lengths of stays. This was having a negative flow in the ED, and increased bed occupancy causing a decreased bed capacity which lead to consumers having poor outcomes and experience of their hospital stay.

Strategic Priorities

A focus on quality and safety
Use of frailty score across all Calvary services will enable better assessment and screening for elderly consumers enabling delivery of safe, high quality person centred care.
Consumers will receive structured, collaborative care across Calvary’s scope of care because all areas will be assessing and communicating using the same language and tool.

Partnering and planning for the present and the future
Increasing numbers of consumers entering the 65+ age group means there will be increasing pressure placed on healthcare resources into the future. Focus on keeping high users of the health care system more independent and better conditioned to support quicker recovery timeframes and shorter lengths of stay.
Efficiencies will be gained by targeted and planned care provision for consumers. Lower socio-economic, ATSI and CALD groups will benefit from targeted wellness education and care.

Future plans

Streamlining Care for the Frail Older Person

It is envisioned that the Rockwood Frailty Score will be implemented across all Calvary services by the end of 2020.

Participants

Bronwyn Johnston
Manager Clinical Services, Calvary Aged and Community Care Services

Proposed outcomes

Developing pathways that can be tailored to suit each individual consumers’ specific requirements, based on frailty score rather than diagnosis, would provide a more supported and person-centred approach to meeting their healthcare needs and ensuring safe high quality provision of care.

Using the visual, easy to complete assessment tool, a Calvary practitioner will investigate how to best respond to the issues of a frail older person within their services. Teams will be able to develop quality improvement initiatives to focus on ways to streamline transition between departments, multidisciplinary pathways of care within departments, early discharge planning that incorporates community and primary health care services.

Data collected across the continuum of care, collected from monitoring the Frail Older Person project.

Risks

• Lack of engagement of departments in this project
• Poor consumer engagement with the concept of aging well, to be independent at home
• Impact on occupied bed days.