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Comprehensive Geriatric Assessment (CGA) from secondary to primary care

an inter-professional approach and locality based partnership

Lucy Lewis
Older Persons' Practitioner
Medicine for Older People

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Overview

- Health Education Wessex Living with Frailty Fellowship 2015
- Service Improvement project aims and objectives
- Results at 1 year
- Future direction at UHS/Solent

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HEW Living with Frailty Fellowship 2015

- Development of clinical leaders to work with vulnerable older adults and those living with frailty
- Highly motivated nurses and AHPs passionate about leading and advancing integrated practice development

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Course Components

- Participant-led facilitated by Consultant Nurse Dr Gwyn Grout & Health Dean Dr Fleur Kitsell
- Expert speakers
- Journal club
- Action learning
- Individual service improvement project

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Service Improvement Project

- Work Based
- Developing Q.I skills
- Developing leadership behaviours
- Learn how to conduct CGA

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Aims and objectives: *Plan, Do, Study, Act*

- Develop and implement an inter-professional approach to Comprehensive Geriatric Assessment in the acute hospital setting
- Develop stronger links with community partners
- Improve patient care and experience
- Impact on length of stay
- Avoid inappropriate acute readmissions

CGA Pilot

- 7 patients from Cluster 1 (West City locality)
- CGA as in-patient
- Care plan shared with patient, relatives and community health team colleagues
- Follow up visit approx 4 weeks post discharge

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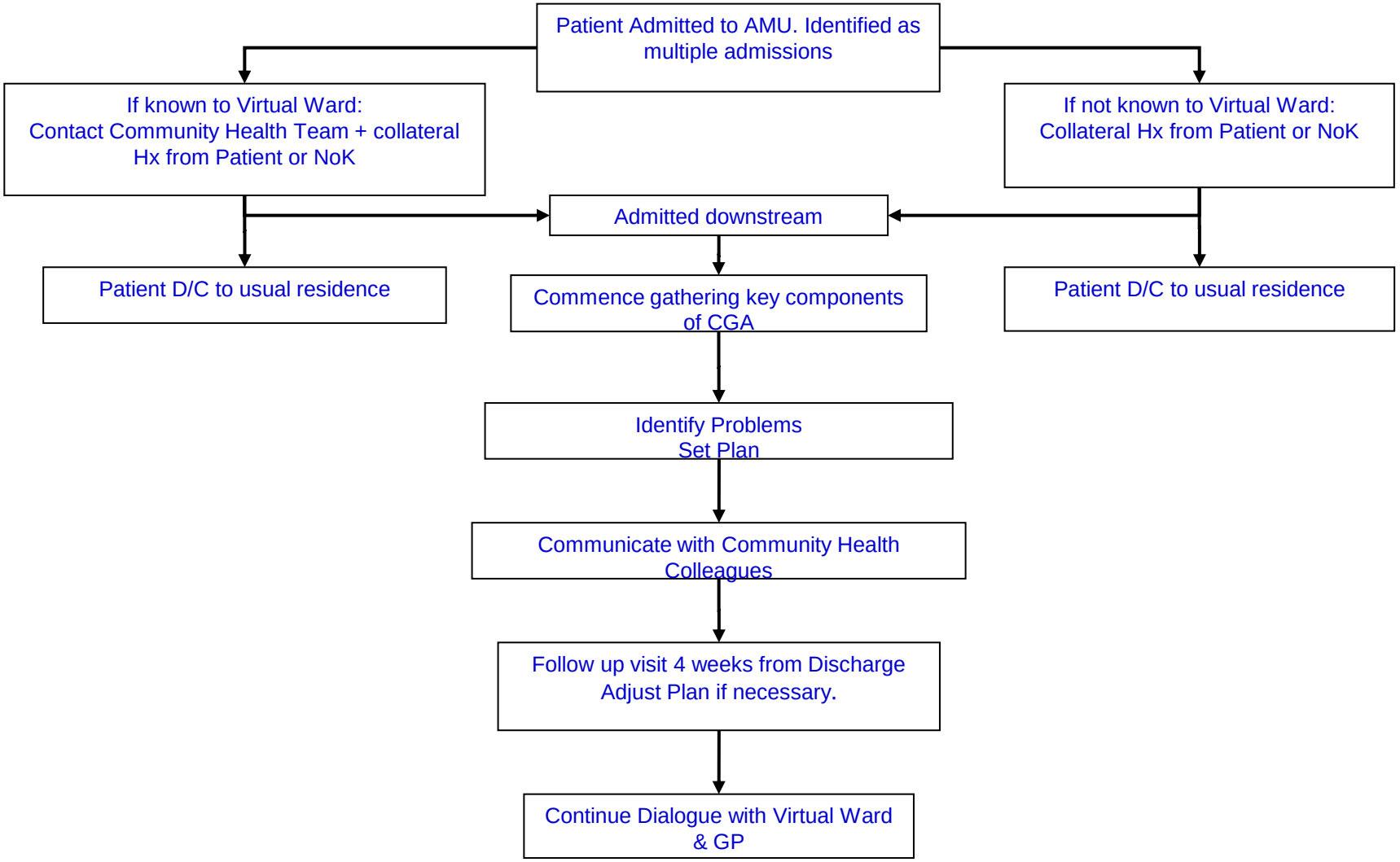

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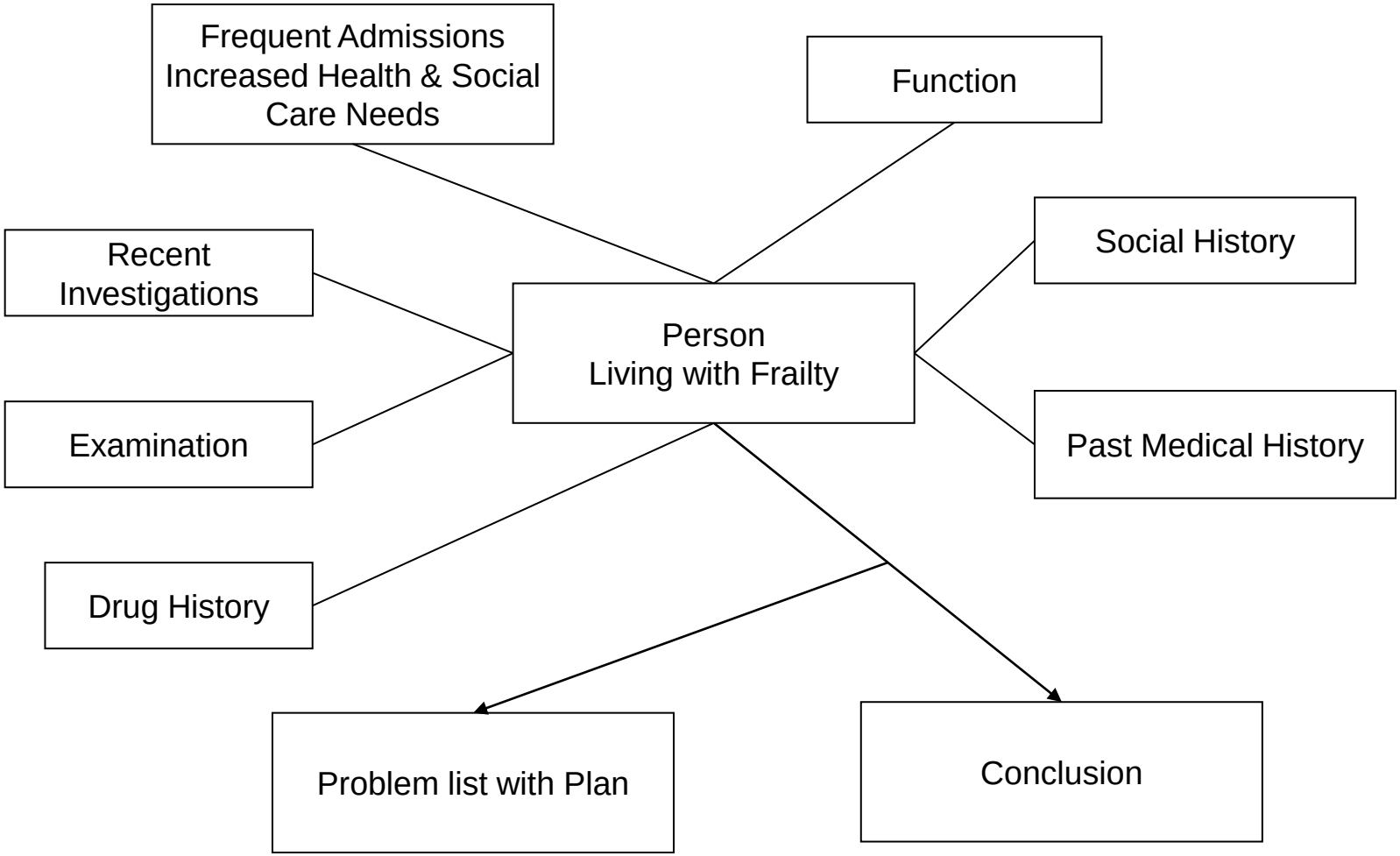

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Results at 6-9 months

Patient	Number of admissions pre CGA	LOS peri CGA	Readmission rate after CGA	Days out of hospital between readmissions	LOS during readmission
1	4	10	1	195	2
2	5	50	1	216	1
3	10	3	0	N/A	-
4	3	13	2	34, 156	33, 18
5	3	10	0	N/A	-
6	11	49	2	48, 3	1, 8
7	0	57	0	N/A	-

Results at 1 year

Patient	Number of Admissions pre CGA	LOS per CGA	Number of readmission after CGA	Days out of Hospital between readmissions	LOS during readmission
1	4	10	1	195	2
2	5	50	1	216	1
3	10	3	5	233, 56, 21, 11, 5	2, 10, 1, 3, Current inpatient
4	3	13	2	34, 156	33, 18
5	3	10	0	N/A	N/A
6	11	49	2	48, 3	1, 8
7	0	57	0	N/A	N/A

Improvements

- Focused inter-professional and holistic approach to care planning improved the experience of accessing health and social care from the perspective of an older person living with frailty in this study.
- Increased knowledge of individual patients, better communication and care planning between secondary and primary colleagues positively impacted on length of stay during readmission.
- Avoidance of inappropriate hospital admission with additional support at home can improve frailty markers and there is scope to develop this work further with a larger sample size.

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Workforce & Education Initiative to support the delivery of better care to frail patients across Wessex

- **Frailty practitioners** (Wessex CLAHRC)

- Recognition, assessment and planning of care for older persons living with frailty, presenting at front door but who are admitted down stream

- Community working to ensure care plans are enacted

Training and Education

- Develop system wide processes, without barriers, to manage older people living with frailty in Southampton
- Formal supervision process, supported by clinical directors and transformation team
- Specific focus on frailty, conducting and implementing CGA delivered to both hospital and community practitioners

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Acknowledgements

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