**Essential Care for Frail Older Patients**

Ensure coordinated, reliable and safe care for frail older patients as they enter the hospital.

**Domain**

Patient Care Processes:
Clinical processes that ensure delivery of high-quality care to individual patients

**Aims**

- **Effective:** An evidence-based practice that produces better outcomes than its alternative
- **Safe:** Delivery of care in a manner that minimizes any risk of harm to a patient
- **Equitable:** Care delivered fairly, with consideration to need, and with no other discriminating factors

**Process Attributes**

- **Cost to Implement**
  - The monetary resources required to implement this process
  - **Minimal:** Just the cost of the improvement effort itself

- **Time to Implement**
  - The amount of time, from months to years, it will take on average to establish this process
  - **Fewer than 12 months**

- **Difficulty to Implement**
  - The challenges of implementing this process
  - **Moderately Challenging:** Either involves multiple units or disciplines OR requires a substantial shift in culture and/or operations, but not both of these

- **Level of Evidence**
  - The degree to which the actions in this process are supported by research and experience; based on the Cochrane scale
  - **Some Evidence:** Level III — Studies published with some control included
Elements

- Implement standard processes to assess frail older patients on admission to the hospital

- Considering the following and putting in place appropriate screening and interventions where necessary for a comprehensive approach to minimizing risk for older patients:
  - Delirium (*see Acute Delirium Prevention and Treatment)
  - Polypharmacy-multiple medications
  - Elderly on more than 5 meds are at increased risk for harm
  - Falls and Immobility (*see Falls Prevention)
  - Consider visual and auditory impairment as contributor to delirium, falls, etc.
  - Functional status and functional impairment
  - Nutritional Status (*see Nutrition Care Services)
  - Pressure Ulcer Prevention and Management (*see Pressure Ulcer Prevention)
  - VTE Prophylaxis (*see Venous Thromboembolus (VTE) Prevention & Treatment)
  - Advance care planning (*see Advance Care Planning and Palliative Care)
  - Case management, social work- family support, -plan discharge started on admission
  - Dysphagia screening

(* Indicates an Improvement Map process for patients of all ages is devoted to this item.) There is a robust geriatric literature on this subject, including many tools.

- Consider asking, “What is the greatest hazard that this patient faces?” and establish a prevention and treatment program to address the hazard upon each admission

Outcomes

- Mortality (HSMR): Decreased mortality (hospital standardized mortality ratio, or HSMR)
- Harm: Decreased harm to patient (e.g., Harms per 100 patient days, as measured by the IHI Global Trigger Tool)
- Cost of Care: Decreased cost per inpatient case
- Readmissions within 30 Days: Decreased readmissions within 30 days
- Reliability: Increased delivery of evidence-based care 100% of the time

Service Lines and Critical Functions

- Emergency Department
- Hospital Medicine, Adult
- Intensive Care
- Nursing
- Surgical

Key Measures

- Percent of patients who receive evidence-based care to prevent falls, pressure ulcers, and delirium, and to manage their medication

- Reduced harm to older patients as measured by the Global Trigger Tool

Reasons and Implications

Importance for Patients and Families
Older patients are often admitted to hospitals as emergencies; they stay in the hospital longer; are more at risk for safety problems; and have more complications than younger patients. Starting reliable care for older patients in the first hours of hospital admission can reduce these harm to these patients and help to ensure safe passage and better care for them.
Requirement, Standards, Policies, and Guidelines

- **Centers for Medicare & Medicaid Services (CMS)**
  Never Events:
  - pressure ulcer stages III and IV;
  - falls and trauma;
  - vascular-catheter associated infection;
  - catheter-associated urinary tract infection;

- **National Priorities Partnership (NPP)**
  - Safety
  - Palliative and End-of-Life Care

- **National Quality Forum (NQF)**
  Serious Reportable Events: Care Management
  - 4A: Patient death or serious injury associated with a medication error (e.g. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
  - 4E: Patient death or serious disability associated with a fall while being cared for in a healthcare facility
  - 4F: Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility

- **The Joint Commission (TJC)**
  2012 National Patient Safety Goals:
  - Goal 7 – Reduce the risk of health care–associated infections.
  - Goal 8 – Accurately and completely reconcile medications across the continuum
  - Goal 9 – Reduce the risk of patient harm resulting from falls.
  - Goal 14 – Prevent health care–associated pressure ulcers (decubitus ulcers).

Financial Implications

- Expense Reduction can occur due to fewer harms, less waste in the system through implementation of standard processes, and shorter length of stay.
- Revenue Reduction can occur due shorter length of stay.

Prerequisites

Engaged clinical leadership and a culture sensitive to the needs of frail older patients.

Resources

Additional Resources

- **The American Geriatrics Society**
- **US Department of Health and Human Services** Partnership for Patients
- **American Dietetic Association (ADA)**
  Evidence Analysis Library - Nutrition Screening
- **The Hospital Elder Life Program (HELP)**
- **Society of Hospital Medicine: Core Competencies**
  Care of the Elderly Patient (chapter 3.1)

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