Trapped in care: recognising and responding to frailty as a cause of delayed transfers of care.

Helen Walthall
Oxford Brookes University, and Oxford Institute of Nursing, Midwifery & Allied Health Research (OxINMAHR), Oxford, UK.

Brian Dolan
University of Salford, Manchester, and Oxford Institute of Nursing, Midwifery & Allied Health Research (OxINMAHR), Oxford, UK.

Debra Jackson
University of Technology, Sydney (UTS). Australia.

'Bedblocking' is a term many of us are familiar with. It refers to patients remaining in a hospital bed when they are medically fit to leave because they have nowhere to go or no social support to help them. Media reports refer to large numbers of patients being 'trapped' in hospital when they do not need to be there, and compromising that service's ability to provide care to other patients (https://www.theguardian.com/society/2015/jan/07/-sp-bedblockers-worsening-nhs-hospitals-crisis). As a result the media often refer to older people in this scenario as 'bed-blockers'.

A preferred, and less perjorative term to 'bedblockers' is 'delayed transfers of care' (DTOC) (Kings Fund 2018). In the UK alone, there were over 2.3 million episodes of DTOC in 2016/17 costing the NHS £173 million (Bate 2017). Health systems are undoubtedly stressed by patients who remain in hospital because of DTOC. However, not only do needless days and nights spent in hospital stress health systems, they are also undesirable from patient experience and safety perspective. Currently, 85% of patients who experience a DTOC are 65 years of age and over (National Audit Office, 2016).

The exponential growth of the ageing population and trend of an ever increasing life expectancy cannot be ignored. This will result in a higher number of older people living longer and living with frailty. Frailty however, is not an illness, but a syndrome that combines ageing and effects of a range of long-term conditions, resulting in various outcomes including loss of physical fitness and reserves as well as loss of cognition and ability to undertake activities of daily living. It is not fully understood how frailty develops, however Chen et al (2014) have highlighted physiological processes that are involved in frailty including chronic inflammation, activation of the immune system and 'wearing out' of both the musculoskeletal and endocrine systems. So-called 'frailty syndrome' involves five conditions that are often associated with frailty which includes; delirium, falls, immobility, incontinence and medication side effects (BGS, 2018).

In the context of an aging population with multiple co-morbidities frailty is an increasing concern, with frail older people presenting to hospitals with acute problems, and remaining in hospital wards where their frailty worsens. When the acute episode passes, they are unable to leave due to the worsening of the frailty syndrome. Hence, they become a DTOC patient, because we are unable to offer them a safe environment to return to without further support. The acute admission has thus worsened the problem, leading to functional decline. Noting the impact of hospital admission, 12% of people 70 years+ experience reduced ability to perform activities of daily living between hospital admission and discharge (Pinkney et al, 2016) and will lose 5% muscle strength each day spent in bed (National Audit Office, 2016). Similarly, Kortebein et al (2008) found that 10 days of bed rest in healthy older people leads to loss of strength and power in the lower extremities and reduction in physical activity, yet has no effect on physical performance. Thus, for older people admitted to hospital with a medical condition the impact on physical performance may be affected. The length of stay in hospital therefore has an effect on the older person's physical performance as the longer the hospital stay, the longer the potential to remain in bed. Immobility worsens the frailty syndrome, thus the person becomes labelled as DTOC due to a reduction in physical activity and the worse the health outcomes will be for older people.

Every day of unnecessary hospitalisation is unfair on our patients. In the UK we have recently had a campaign called 'Last 1000 Days' to raise awareness of the importance of time to patients, and how disrespectful and unfair it is to waste patients time. This campaign highlighted that many people in our care are in the last 1000 days of their lives, and making 'time the most important currency in health care' (http://www.last1000days.com/).

To combat this problem of DTOC, NICE (2016) and Age UK (2017) have highlighted the need for early discharge planning and for the involvement of all relevant parties within this planning, not just the nursing team (Mabire et al, 2017). There is guidance on the need for discharge assessment and for a clear plan aiming for discharge to occur on the expected date. However, older people have reported they do not always feel ready for hospital discharge. Slatyer et al (2013) in their study exploring why older people re-presented to emergency departments within 30 days of discharge, found older people felt ill-prepared for discharge, had limited knowledge of their disease trajectory and felt the only option open to them was to return to hospital. A systematic review by Blakey et al (2018) explored older people's experiences of readmission to hospital. They found older people illustrated two main causes for readmission; firstly during their time in hospital they felt powerless, disregarded and not ready for discharge from the hospital, and secondly they described uncertainty following discharge. This involved the older person having feelings of difficulty adapting to the new 'me', feeling hospital was the only place they felt safe and feeling the community-based services were not adequate to support them at home.

One vehicle to aid with patient mobilisation, reduce the risks of deconditioning and enhance patient dignity is #EndPJparalysis a new and increasingly global social movement created by one of the authors in November 2016 (https://www.england.nhs.uk/2018/03/70-days-to-end-pyjama-paralysis/) and which at the time of writing (March 2018) had >180 million impressions on Twitter. In essence, #EndPJparalysis encourages patients to get out of their hospital gowns or PJs (pyjamas) and get up, dressed and moving. It has been endorsed by senior nurses (https://www.england.nhs.uk/blog/valuing-patients-time/).

Nursing is in an ideal position to value patient time and lead the health care delivery team to assess, plan and implement strategies to ensure the frail older person is effectively prepared for hospital discharge and for life after discharge. This can lead to fewer patients feeling 'trapped' in their hospital beds when they have been medical deemed fit to leave, thus reducing the DTOC numbers for the health service. To do this, the main conditions attributed to the worsening of the frailty syndrome need to be addressed on admission to ensure the patient is confident and ready to be discharged to their preferred place, both medically and functionally.

How does nursing do this? Nursing cannot act alone in this scenario, but lead the way. For a frail older person, to be seen as fit to be discharged the whole multidisciplinary team need to engage and develop strategies to ensure this can happen. Ellis et al (2017) in their Cochrane review found comprehensive geriatric assessment (CGA) on admission to hospital was key to enabling the frail older person to be discharged to their preferred place but also to remain there one year post-discharge. The CGA involves clear multiprofessional working with the assessment of its 5 core capabilities; medical, psychological, social, environment and function and the execution of the defined interventions to support the assessment. However, within acute hospital settings, many areas are not using CGA as a key assessment tool for frail older people. In Ellis et al's review, the evidence demonstrated most areas that did implement CGA on admission do so through designated frailty teams or designated frailty wards and not as usual care.

Is this an opportunity for nursing to take the lead and to explore how this multi-professional tool can be implemented as usual care? Doing so could enable all frail older people to be assessed in the key areas for frailty to ensure not only support for their health needs on admission, but also to facilitate safe hospital discharge as soon as they are 'fit to leave'.

It is sobering to realise that it has been estimated that some 46% of patients over 85 years die within one year of admission (Clark et al 2014). In recognising and responding to frailty as a cause of DTOC, we can better support patients to return to their preferred place. Through comprehensive

assessment, robust interventions to prevent deconditioning, and multi-disciplinary teamwork, we can prevent needless harm, suffering and waiting because while our time is busy and important, our patients' time is sacred.

References:

Age UK (2017)Hospital Discharge Factsheet 37, Age UK, London

Bate A (2017) House of Commons briefing paper; Delayed transfers of care in the NHS, Number 7415; 20 June.

Blakey E, Jackson D, Walthall H, Aveyard H (2018) What is the experience of being readmitted to hospital for people 65 years and over? A review of the literature. *Contemporary Nurse*;**53**(6), 698-712

British Geriatric Society (2018) http://www.bgs.org.uk/recognise-frailty-syndrome/resources/campaigns/fit-for-frailty/frailty-frailty-syndromes. Accessed 13/03/18.

Chen X, Mao G, Leng SX (2014) Frailty Syndrome: an overview. *Clinical Interventions in Aging*;**9**:433-441.

Clark D, Armstrong M, Allan A, Graham F, Carnon A, Isles C. (2014) Imminence of death among hospital patients: Prevalent cohort study. *Palliative Medicine*, **28**(6), 474-479

Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O, Harwood RH, Conroy SP, Kircher T,Somme D, Saltvedt I, Wald H, O'Neill D, Robinson D, Shepperd S. (2017) Comprehensive geriatric assessment for older adults admitted to hospital (Review) *Cochrane Database of Systematic Reviews*; **Issue 9**. Art. No.: CD006211. Comprehensive.

Kings Fund (2018) https://www.kingsfund.org.uk/publications/delayed-transfers-care-quick-guide. Accessed 13/03/18

Korterbein P, Symons TB, Ferrando A, Paddon-Jones D, Ronsen O, Protas E, Conger S, Lombeida J, Wolfe R, Evans WJ. (2008) Functional impact of 10 days of bed rest in healthy older adults. *Journal of Gerontology*, **63a**(10), 1076-1081

Mabire C, Dwyer A, Garnier A, Pellet J (2017) Meta-analysis of the effectiveness of nursing discharge planning interventions for older inpatients discharged home. *Journal of Advanced Nursing*; 1-12; Doi: 10.1111.jan13475.

National Audit Office (2016) Discharging Older Patients from Hospital; Department of Health, London

National Institute for Health and Care Excellence (2016) Transition between inpatient hospital settings and community or care home settings for adults with social care needs. Quality standard, QS136.

Pinkney J, Rance S, Benger J, Brant H, Joel-Edgar S, Swancutt D, Westlake D, Pearson M, Thomas D, Holme I, Endacott R, Anderson R, Allen M, Purdy S, Campbell J, Sheaff R, Byng R. (2016). How can frontline expertise and new models of care best contribute to safely reducing avoidable acute admissions? A mixed methods study of four acute hospitals. *Health Services and Delivery Research* 2016;4(3). https://dx.doi.org/10.3310/hsdr04030

Slayter S, Toye C, Popsecu A, Young J, Matthews A, Hill A, Williamson DJ (2013) Early representation to hospital after discharge from an acute medical unit:perspectives of older patients, their family caregivers and health professionals. *Journal of Clinical Nursing*;**22**:445-455.