social care institute for excellence

in collaboration with Integration and Better Care Fund

Better Care Fund resources

The role of the practice frailty nurse

Scheme

Who?

Care Closer to Home Network

North Cumbria, North East England and Hambleton Richmondshire and Whitby on behalf of Gateshead Primary Care Services

What

A practice nurse providing care for older people living with frailty.

Why?

The role of the frailty nurse supports the area's plan to reduce the number of frail older people who have:

- avoidable admissions to hospital
- delayed discharges from hospital.

The need for this has arisen because routine and unscheduled care has not changed in line with the needs of an ageing population. Therefore

- Many older people are admitted to hospital several times in their last year of life. Some of these admissions will be unavoidable, but in many cases hospital admittance could be avoided by providing alternative forms of urgent care
- Normal ageing brings lost muscle mass and even a short hospital stay can impact on this further. By avoiding long hospital stays people will experience less deterioration in their general health.
- Older people can live with several health conditions and a gradual decline may be missed until a crisis occurs – preventative work can help to avoid the person reaching a crisis.

When?

Building on the success of providing an enhanced service to care home residents, a one-year pilot was undertaken in July 2013 leading to substantive posts being introduced in 2015.

How?

The frailty nurse's role is fundamentally to case manage older people living with complex needs and frailty. Their responsibilities include:

- undertaking comprehensive assessment and care planning
- ordering and acting upon diagnostic tests
- making and receiving referrals
- making decisions about admitting and discharging from hospital and intermediate care units
- coordinating and chairing multidisciplinary team meetings
- building meaningful and caring relationships with the person and their family.

Skills and experience needed:

- significant experience in the care of older people
- highly skilled in comprehensive assessment, problem identification and care planning.

Challenges

While there weren't any challenges during the pilot or when introducing the posts substantively, thereafter it was noted that it may prove challenging to recruit a significant number of nurses 'ready to go' with the same skill set

until wider workforce development initiatives are undertaken.

It is also acknowledged that time was invested in ensuring wider community health and social care teams were made familiar with the nurses and their role.

Impact

Working closely with the North of England Commissioning Support Unit and in undertaking robust clinical audits it has been identified that:

Patients managed by practice frailty nurses are admitted to

hospital less and attend the EDs less than older people living with frailty registered with other practices. This is not because they are working with patients who have less long-term conditions, are from more affluent areas and are less likely to be housebound.

More information can be found at **Frailty nursing: Neither traditional practice nursing nor traditional community nursing** link 1 .

Case study

Jackie was referred to the practice frailty nurse by his GP who noted that, for the first time in more than 20 years, he hadn't attended his annual long-term condition review appointments. Jackie, who had recently been widowed, had been categorised as

extremely frail on the electronic frailty index (eFI), a software system used in primary care. For the first time in his 82 years he was living alone, a major life event for anyone, but particularly overwhelming for someone already living with frailty and complex needs. A comprehensive geriatric assessment was undertaken by the nurse and Jackie's needs were identified and a care plan drawn up. Referrals were made to other disciplines as appropriate and over the course of 30 months Jackie was 'case managed' by the practice frailty nurse and supported by the independent care sector for assistance with personal care. He was appropriately admitted to hospital on two occasions but had care crises managed on another six occasions by community health and care services.

Read more information about **Understanding the key components of a frailty 'care pathway'** link 2 .

View all practice examples link 3

link 1 | https://www.enhancedcare.org/frailtynurses

link 2 | http://frailtyicare.org.uk/frailty-i-care/frailty-pathway/

link 3 | https://www.scie.org.uk/integrated-care/better-care/practice-examples