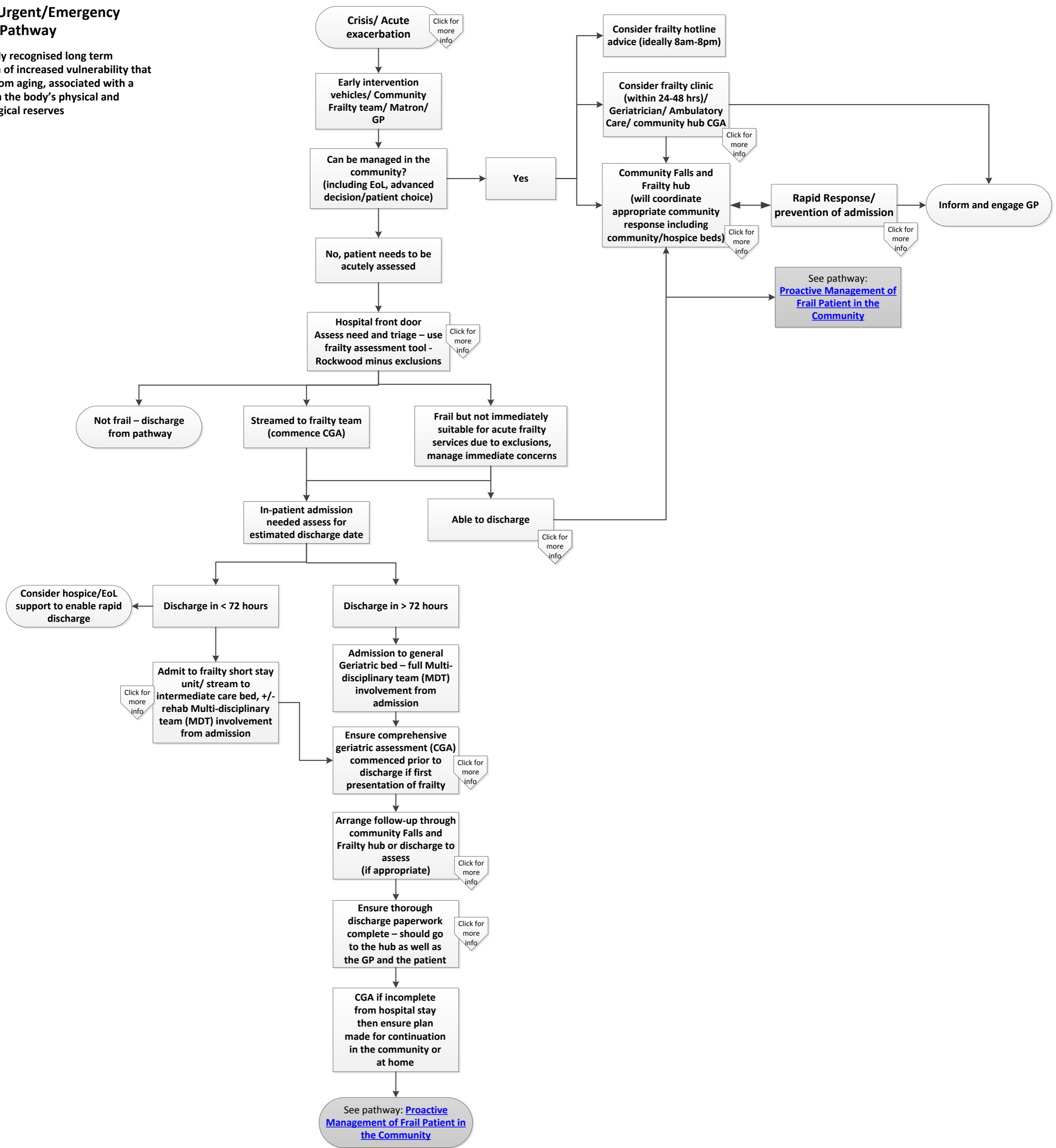


Acute Urgent/Emergency Frailty Pathway

A clinically recognised long term condition of increased vulnerability that results from aging, associated with a decline in the body's physical and psychological reserves



Crisis/ Acute exacerbation

Follow any care plans in place

Avoid hospital admission where possible and step up care if required

- i) Community frailty response team
- ii) Ambulatory care / Emergency department stabilisation
- iii) Assess for and treat exacerbating condition(s) (I.V abx for pneumonia, UTI, cellulitis etc. – escalation of care where necessary. Fluid resuscitation for dehydration, I.V diuretics for heart failure – consider Cardiology review. Review co-morbidities and request specialist review if poorly managed e.g. COPD exacerbation and respiratory review)
- iv) Discuss ceilings of treatment
- v) (Early) Supported discharge – ensure community services are available to continue care
- vi) Discuss patient with relevant hospital team including frailty if necessary



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pathway

Full CGA must be completed for all moderate and severe frail initiated either in acute trust or community setting. Partially completed assessments should be completed in patients' discharge destination

CGA should ideally be completed electronically on a shared clinical system

Assessments must be built upon using the trusted assessor model in the community or the acute rather than started again which would be an inefficient use of resources for staff and patients

Access with consent community health/GP/social care/voluntary care and third sector/mental health records/secondary care if appropriate to build a full picture of the patients' normal level of functioning and previous input

Rapid Response/ prevention of admission

This could be undertaken by

- Community health staff (admission prevention, EIV (Early Intervention Vehicle)/ECP)
- Social care staff (step-up specialist care at home, housing solution, increase in existing care package)
- Access to step-up intermediate care beds – must be within 48 hours of identifying need for intermediate care so that patient can gain best outcome
- Access to respite care

Full CGA must commence for all moderate and severe frail patients in Rapid Response and completed in patients' discharge destination

CGA should ideally be completed electronically on a shared clinical system

Assessments must be built upon using the trusted assessor model in the community or the acute rather than started again which would be an inefficient use of resources for staff and patients

- MDT assessment must include a specialist in elderly medicine (i.e. geriatrician, GPwSI (GPs with Special Interest), or a nurse consultant), community nurses, mental health professional, allied health professionals (including social care OTs), social care and voluntary/third sector as appropriate (to be determined by locality, should include prescriber)
- Ideally conducted in the patient's home
- Further assessment in acute frailty service if specialist investigations required
- Outcome to develop management plan including patient self-management plan or referral for active case management see Proactive Frailty pathway
- Onward referral to social care and voluntary/third sector services as appropriate
- MDT discharge discussion and plan if required
- Update STP Care plan
- Follow Falls pathway as appropriate

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pathway

Hospital front door

Access with consent community health/GP/social care/voluntary care and third sector/mental health records if appropriate to build a full picture of the patients' normal level of functioning and previous input

Assess need and triage – use frailty assessment tool - Rockwood minus exclusions

Assess using Rockwood tool for aged >75 or other reason to suspect frailty

Frailty syndromes

- Predisposition to / falls
- Immobility
- Delirium / acute confusional state or acute decline of dementia
- Change in continence
- Poly-pharmacy and/or high susceptibility to medication side effects

Exclusion criteria

- Likely ACS
- TIA / CVA
- MEWS / NEWS > 3
- Need for HDU/ ITU / CCU
- Need for renal dialysis
- Clear need for a specific specialty
- GCS < 13
- Acute abdomen
- Trauma and suspected fracture
- Fractured NOF
- Unstable blood glucose (<3 or >28)

Able to discharge

This could include:

- Community health staff (admission prevention, discharge home to assess, supported discharge)
- Social care staff (step-up specialist care at home, housing solution, increase in existing care package)
- Access to step-down intermediate care beds – must be within 48 hours of identifying need for intermediate care so that patient can gain best outcome
- Access to respite care
- Access to hospice if appropriate
- Discharge to assess or placement without prejudice

Begin or continue discussions about Care planning conversation and social signposting (to include end of life conversation where appropriate)

- Assess capacity to make decisions
- Use STP care plan documentation – start / maintain / update as appropriate
- Make reasonable adjustments for people who qualify under the Care Act
- Identify informal carers and record on clinical record and patient held care plan – consider carers assessment and referral as appropriate
- Signpost to community organisations relevant to patients' preferences including exercise opportunities
- Start or continue DNACPR conversation and end of life conversations if not previously raised. Discuss with patient and family if discharging with a **regional** DNACPR
- Consider following other pathways, depending on the person's co-morbidities
- Refer to electronic palliative care co-ordination system if appropriate (Electronic Palliative Care Co-ordination Systems)

Admit to frailty short stay unit/ stream to intermediate care bed, +/- rehab MDT involvement from admission

If admitted to bed, involve social and medical MDT from admission. Consider step-down care at first opportunity:

- End PJ paralysis
- Convert IV antibiotic to oral tablets when medically stable
- Encourage oral fluids
- Involve therapists early
- Involve social services, voluntary/third sector, official and unofficial carers for early discharge planning

If discharging from hospital/intermediate care bed consider need for:

- Community health staff (discharge home to assess, or see STP *Proactive Management of Frail Patient in the Community* pathway)
- Social care staff (step-up specialist care at home, housing solution, increase in existing care package)
- Utilise impartial assessor for care home placement if possible
- Access to hospice if appropriate

Begin or continue discussions about Care planning conversation and social signposting (to include end of life conversation where appropriate)

- Assess capacity to make decisions
- Use STP care plan documentation – start / maintain / update as appropriate
- Make reasonable adjustments for people who qualify under the Care Act
- Identify informal carers and record on clinical record and patient held care plan – consider carers assessment and referral as appropriate
- Signpost to community organisations relevant to patients' preferences including exercise opportunities
- Start or continue DNACPR conversation and end of life conversations if not previously raised. Discuss with patient and family if discharging with a **regional** DNACPR
- Consider following other pathways, depending on the person's co-morbidities
- Refer to electronic palliative care co-ordination system if appropriate (EPaCCS)



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pathway

Ensure comprehensive geriatric assessment commenced prior to discharge if first presentation of frailty

CGA should ideally be completed electronically on a shared clinical system

Assessments must be built upon using the trusted assessor model in the community or the acute rather than started again which would be an inefficient use of resources for staff and patients



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pathway

Arrange follow-up through community Falls and Frailty hub or discharge to assess (if appropriate)

- Book a follow- up at the community frailty clinic (within 2 weeks of discharge) as indicated
- Arrange community assessment as required (discharge to assess) or consider placement without prejudice
- Package of care if required including therapists
- Community Falls and Frailty hub to coordinate community response if patient at risk of re-admission or CGA not completed or appropriate follow-up needed

Ensure thorough discharge paperwork complete – should go to the hub as well as the GP and the patient

Should include:

- Rockwood score
- Summary of the admission and investigations
- CGA status and plan
- Up-to-date medication
- Up-dated care plan original with patient
- End of life conversation
- Any advanced decisions to refuse treatment
- DNACPR original with patient – East of England



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pathway

Community Falls and Frailty hub
(will coordinate appropriate community response including community/hospice beds)

- Consider holistic needs assessment including loneliness if not already completed
- Consider referral to community services, including nursing/ therapy/ enablement