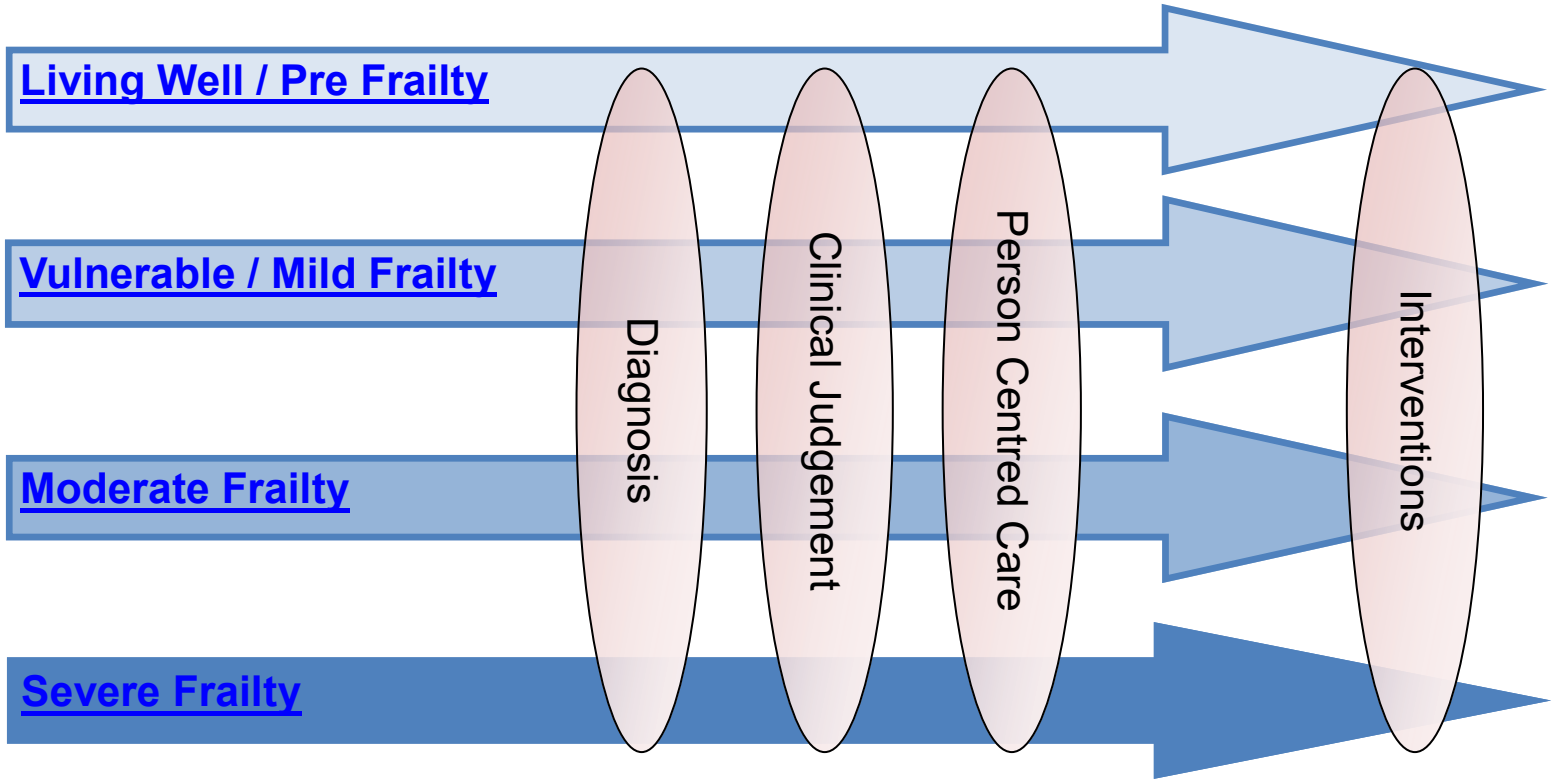
B&NES Community Frailty Pathway



To be considered yearly, or if a change in health state e.g. hospital admission, acute illness, move to care home, bereavement

Person Centred Care Plan / Comprehensive Geriatric Assessment (CGA)*

MDT Review/ Discussion / Long Term Conditions reviewed and managed appropriate to level of frailty (e.g. Diabetes/Hypertension)
Urgent Care Plan in place for illness, decline or care breakdown / Medication Optimisation (STOPP/ START or other tool)
Self Care / Means for Resilience Encouraged
Health Records and Summary Care Record with additional information (SCR AI) opened and shared (with consent or in best interests) eDSM
Education and Supportive Advice

* In development

Living Well / Pre Frailty

Potential Tools for Diagnosis (+ Clinical Judgement):

Rockwood (1-3)

May be over 65yrs, but not exclusively.

Clinical Judgement may include:

Illness and disease under control

Managing well

Living at home

May or may not engage in exercise

Consider for Person Centred Care Plan:

Self-care and self-management advice.

Maintaining physical and mental health.

Personal goals

Friends, family and loved ones involvement.

Bills, pensions, finances including fuel poverty

and unclaimed benefits.

Personal care and living arrangements and transport.

Medication management and teaching.

Self-reporting concerns.

Social isolation

Interventions to Consider:

Self Care-Guided Support e.g. BaNES Wellbeing options

Self-Assessment Tools

Code Diseases / Disabilities / Symptoms

Clubs and Activities (e.g Wellbeing College)

Voluntary Organisations (e.g St Johns, Alzheimer's Society, Age UK)

B&NES Council Support

Give advice on Using 111 Vs 999

Citizens Advice Bureau

Vaccinations (Flu / Shingles)

Smoking / Alcohol / Weight Interventions

Spiritual Care

Local Pharmacy

Active Ageing Service

Vision / Hearing / Dental reviews

Village connectors

GP Consultant Connect (Geriatrician)

Bold = Essential

Vulnerable / Mild Frailty

Potential Tools for Diagnosis (+ Clinical Judgement):

Rockwood (4-5)

PRISMA-7 >3 TUGT> 10s

Unintentional weight loss, sarcopenia, slow walking speed, self-reported exhaustion, low physical activity, weakness **(3 or more).** Fried**.**

If living with dementia, forgetting details of recent events but remembering events in general, repetition, social withdrawal.

Clinical Judgement may include:

Delayed or incomplete recovery from even a minor illness, stress, change in circumstance or bereavement.

Presence of frailty syndrome (i.e. Incontinence, Falls, Immobility, Delirium).

Needs help with shopping, finances or activities.

Multiple medications **(>4)**

Memory concerns.

Consider for Person Centred Care Plan:

Assess for Frailty Syndromes: Delirium, Falls, Incontinence, Immobility

Assess for possible outcomes of frailty such as skin breakdown, poor nutrition or hydration, pain or worsening cognition.

Seek Opportunities for Advance Care Planning

Health Priorities / Goals / Discussion

Treatment Escalation Plan

Monitor for Anxiety / Depression / Low Mood (DiADeM tool)

Falls - Have you fallen in the last 12 months? Yes? — consider action

Social Care Needs Review

Interventions to Consider:

GP/ Nurse Practitioner review

Code—Frailty Level and Interventions

Carer Identification and Support

Comprehensive Geriatric Assessment (CGA)*

Medication Review (STOPP/ START or other tool)

Long Term Conditions reviewed and managed well

Carers Centre referral for carers

Advice to Carers

Physiotherapy Advice / Interventions / Community Pharmacist review

Referral to Dietitian, / TVN / SaLT / Falls and Balance Clinic

Occupational Therapist Advice/ Interventions

Mental Health/ Psychological Therapies review/ RICE review

Practice Nurse Involvement

Home Assessment for clutter/ adaptations

Patient held records at home (Orange Folder/ Message in a Bottle)

Use of Information Technology (mobile phone/ telehealth/ telecare)

Lasting Power of Attorney

Planning Ahead/ Guidance Leaflet

* in development

Bold = Essential

Moderate Frailty

Potential Tools for Diagnosis (+ Clinical Judgement):

Rockwood (6)

If living with dementia, recent memory is very impaired although can remember past life well. Can do personal care with prompting.

Clinical Judgement may include all previous and:

Has progressive illness or disease.

Difficulty with outdoor activities, decreasing mobility.

Requires help with daily care such as washing and dressing.

History of recent unexpected admissions or out of hours calls.

Multiple health providers or multiple and regular health appointments.

Increasing concerns over physical health and / or cognition.

Poor concordance with medications, care plans.

Previous interventions from Mild Frailty

Consider for Person Centred Care Plan:

Advance Care Plan (ACP)

Early planning for potential deterioration in condition.

Urgent illness Care Plan in place.

Goals for place of residence if deteriorates.

Interventions to Consider:

Allocated person to assist with care management.

Baseline NEWS2 score and vital signs, height and weight.

Discussion in Practice MDT

Social Care review for plan for deterioration.

Intermediate Care Services / Reablement

Older Persons Specialist review

Community Matron review

District Nursing care

Alert to SWASFT ambulance/ RUH admissions in advance for known/ expected concerns.

Alert to RUH Frailty Flying Squad if admission imminent (via switch).

Home Response Service (Age UK)

Frailty Nurse Practitioner

Palliative Care Support and advice around frailty.

Safeguarding review

'This is Me' document

MCA Tool / DOLS

All previous interventions to be undertaken with increasing frailty

Bold = Essential

Severe Frailty

Potential Tools for Diagnosis (+ Clinical Judgement):

Rockwood (7-9; Terminally Ill)

SPICT Tool

'Surprise question' - Would you be surprised if this person were to die in the next 12 months?

If living with dementia, cannot complete personal care without help.

Consider for Person Centred Care Plan:

Review Advance Care Plan

Treatment Escalation Plan reviewed

Medication rationalisation / Joint pharmacist review

Funeral wishes

Will

Preferred place of death

DOLS/ Lasting Power of Attorney active or considered.

Clinical Judgement may include all previous and:

Progressing illness or disease or rapid physical and cognitive decline.

A range of long-term conditions/ multi-morbidities.

High risk of dying in hospital.

High risk of unplanned / unwanted admission to hospital

In a care home setting.

Highly dependent on personal care (2 carers, all care, 4x daily care).

Has requested to reduce or stop treatments.

Lacks capacity for even simple decision making.

Previous interventions from Mild Frailty and Moderate Frailty

Interventions to Consider:

End of Life wishes documented and shared

Supported Early Discharge from Hospital

Admission Avoidance

Family and carers aware of plans (with consent or best interests).

Discussed at Practice Palliative MDT

Red Bag Project (Care Home)*

Care Home Liaison Psychiatry service

Anticipatory Prescribing

Enhanced Care Home support

Care Home Pharmacist review

* in development

All previous interventions to be undertaken with increasing frailty

Bold = Essential