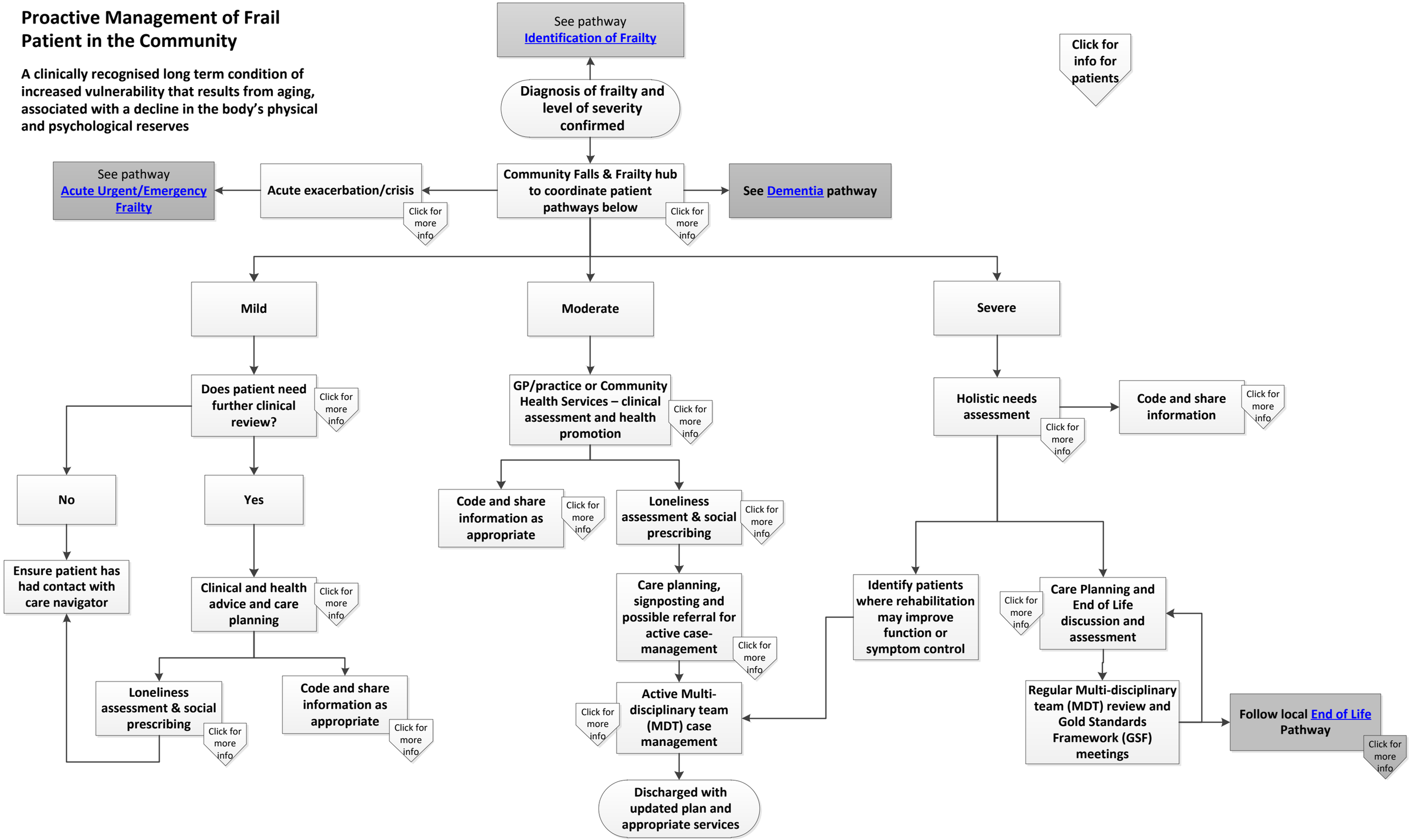
Proactive Management of Frail Patient in the Community

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



Back to pathway

Community Falls & Frailty hub to coordinate patient pathways below

NB: this pathway is primarily aimed at the proactive planned management of the frail patient, but please note:

- Refer to specialist services as required/appropriate (e.g. dementia, IAPT if screening positive for anxiety and depression, etc.)
- Patients with an acute exacerbation/crisis should be managed in accordance with the *Acute Urgent/Emergency Frailty Pathway*

Overview Function of the Hub

The Falls and Frailty Hub will be responsible for clinically triaging referrals of patients to deliver the most appropriate community response as outlined by the falls and frailty STP pathways.

The Hub will be responsible for coordination of the patient's care as appropriate and in accordance with the STP pathways (until such time as the patient has undertaken all appropriate/required assessments and has been successfully referred into a service or discharged). This may include an element of signposting.

The Hub will also serve as an information portal where falls and/or risk assessments completed in the community (by non-clinical staff e.g. third/voluntary sector) will be collected and added to a person's care/clinical record to avoid duplication of tests and to identify people who will potentially become high risk in the future.

Further information regarding the Hub is outlined in a separate document.

Back to pathway

Acute Exacerbation/Crisis

Immediate risks/acutely unwell:

- Manage any immediate risks within your capability and competence.
- Escalate any concerns.

Once the patient is out of immediate danger, resume pathway as appropriate.

Back to pathway

Does patient need further clinical review?

NB: Patient will have already seen a clinician to confirm mild frailty

Consider:

- Are there any aspects of clinical review that have not yet been completed? i.e. the items described in the box entitled 'Clinical and health advice and care planning'
- If yes, patient will need further clinical review
- If no, ensure patient has had a loneliness assessment, has received an STP resource pack and has had contact with a care navigator, if appropriate

Back to pathway

Clinical and health advice and care planning

The following actions can be completed by the GP and also by other healthcare professionals involved in the patients care:

Clinical and health advice – mild/moderate frailty

- Give STP Ageing Well resource pack
- Postural hypotension assessment
- Assess for risk of falls
- Polypharmacy review – use STOPP START methodology (ideally in clinical system)
- Mild cognitive impairment/ dementia screening/ anxiety and depression screening (if appropriate NB: discussion about loneliness might be more appropriate) – if positive outcome, refer to appropriate services/ the hub so this can be managed
- Review long term conditions as appropriate
- Signpost to and recommend sight and hearing checks
- Exercise self-management and advice e.g. signpost to NHS livewell - exercise for older adults: https://www.nhs.uk/Livewell/fitness/Pages/physical-activity-guidelines-for-older-adults.aspx
- Offer health promotion advice e.g. vaccinations, healthy eating, stop smoking, etc.
- Identify informal carers and record on clinical record and patient held care plan – consider carers assessment and referral as appropriate

Begin Discussions about Care Planning, Social Signposting, and Self-management

- Discuss individuals interests and priorities
- Use STP care plan documentation – start / maintain / update as appropriate
- Agree self-management goals and actions with patient if appropriate

Legal (NB. Information in STP Ageing Well resource pack)

- Power of attorney

  https://www.gov.uk/power-of-attorney

- Will writing

  https://www.gov.uk/make-will

- Advanced decision to refuse treatment:

  http://www.nhs.uk/Planners/end-of-life-care/Pages/advance-decision-to-refuse-treatment.aspx

Local Support

- Links to be added at place or neighbourhood level

Back to pathway

Code and share information as appropriate

- Ensure electronic frailty index (eFI) is complete
- Ensure diagnosis is recorded with 'Read Codes'
  - **CTV3** X76Ao: Frailty
  - XabdY: Mild Frailty
  - **Read** V22Jd: Frailty
  - 2Jd0: Mild Frailty
  - **SNOMED CT concepts for frailty** All linked to the concept 248279007: Frailty (finding)
  - 925791000000100: Mild frailty (finding)
- Discuss sharing of information – including gaining consent for/ opt into Summary Care Record (SCR)
- If appropriate record care planning conversation

Back to pathway

Loneliness assessment

A number of tools are available. The UCLA scale is described below. Staff may require training and support to ask negatively worded questions sensitively.

This scale comprises 3 questions that measure three dimensions of loneliness:
relational connectedness, social connectedness and self-perceived isolation. The questions are:

1. How often do you feel that you lack companionship?
2. How often do you feel left out?
3. How often do you feel isolated from others?

The scale generally uses three response categories: **Hardly ever / Some of the time / Often**

Using this scale: how to score and interpret your results

In order to score somebody's answers, their responses should be coded as follows:

Response score for each question

Hardly ever = 1
Some of the time = 2
Often = 3

The scores for each individual question can be added together to give you a possible range of scores from 3 to 9.
People who score 3 – 5 are usually classed as "not lonely"
People with the score 6 – 9 are usually classed as "lonely"

Care navigators to follow-up with individuals with loneliness within 6-12 months (check if any interventions have made a difference)

NB: If a person is at risk of/suffering from depression and/or anxiety, refer to appropriate services/ the hub so this can be managed.

Social prescribing

- Signpost to voluntary/third sector for support (e.g. HILS, Age UK)
- Promote the concept of the patient volunteering (helps loneliness wellbeing, physical activity) – signpost/ help to find opportunities to volunteer
- Advice on keeping warm
- Home safety checks – if not done in the last year
- Technology innovations e.g. alarms
- Signpost to social opportunities (e.g. lunch clubs, local older people's groups, digital inclusion)
- Signpost to physical activities opportunities – consider exercise on prescription and falls prevention (see STP *Falls Risk Identification in the Community* pathway)
- Social needs assessment
- Signpost to Herts Help (Hertfordshire) or Living Well (west Essex)
  HertsHelp: https://www.hertshelp.net/hertshelp.aspx
  Contact us
  Phone: 0300 123 4044
  Email: info@hertshelp.net
  Skype: HertsHelp
  Text: hertshelp to 81025
  Minicom: 0300 456 2364
  Fax: 0300 456 2365
  BSL: https://www.signbsl.com/

  Living Well Essex: https://www.livingwellessex.org/
  Contact us
  Phone: 03457 430 430 or 01245 430 430
  Textphone: 0345 758 5592
  Email: contact@essex.gov.uk
  Opening hours are 8.30am-5pm Monday to Friday.

Legal (NB. Information in STP Ageing Well resource pack)

- Power of attorney

  https://www.gov.uk/power-of-attorney

  Other information about health and care services available: *Healthwatch Essex Information Service* on 0300 500 1895.
- Will writing

  https://www.gov.uk/make-will

Local Support

- Provide support at neighbourhood or place level

Back to pathway

Active case management

- Comprehensive geriatric assessment to be completed on template supplied. Ideally this should be conducted in the patient's home or usual place of residence (functional and environmental parts). To include:
  - Prevention, self-management and promotion of independence
  - Medical assessment
  - Mental health assessment (to include screening for anxiety and depression) – consider following *Dementia* pathway and refer to appropriate services/ the hub so this can be managed.
  - Functional assessment
  - Physical assessment
  - Environmental assessment
- Based on Multi-disciplinary team (MDT) assessment must include a specialist in elderly medicine (i.e. geriatrician, GP with Specialist Interest (GPwSI), or a nurse consultant), community nurses, mental health professional (including IAPT), learning disability professionals, allied health professionals, social care and voluntary/third sector as appropriate (to be determined by locality, should include prescriber)
- Further assessment in acute frailty service if specialist investigations required
- Outcome to develop management plan including patient self-management plan
- Active management for up to 6 weeks
- Onward referral to social care and voluntary/third sector services as appropriate
- Multi-disciplinary team (MDT) discharge discussion and plan if required. Should include care navigation and voluntary/third sector support
- Discuss individuals interests and priorities
- Start / maintain / update STP care plan as appropriate
- Agree self-management goals and actions with patient if appropriate

Back to pathway

Code and share information as appropriate

- Ensure electronic frailty index (eFI) is complete
- Ensure diagnosis is recorded with 'Read Codes'
    - **CTV3** X76Ao: Frailty
    - Xabdb: Moderate Frailty
    - **Read V2**2Jd: Frailty
    - 2Jd1: Moderate Frailty
    - **SNOMED CT concepts for frailty** All linked to the concept 248279007: Frailty (finding)
    - 925831000000107: Moderate frailty (finding)
- Discuss sharing of information – including gaining consent for/ opt into Summary Care Record (SCR)
- If appropriate record care planning conversation

Back to pathway

Begin discussions about Care planning conversation and social signposting with a view to active case-management

- The GP with practice team and/or community health services and/or domiciliary care or care home staff should identify if patient is suitable for case management including comprehensive geriatric assessment by community services via the falls and frailty hub. Possible priority cohorts include those who have had one unplanned admission this year or attendance at A&E or risk of admission to 24hr care. Localities may identify target cohorts.

The following actions can be completed by the GP and also by other health and social care professionals involved in the patients care:

- Discuss individuals interests and priorities/ assess capacity to make decisions
- Agree self-management goals and actions with patient if appropriate
- 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/ functional preferences in activities of daily living (ADL) (e.g. environmental hazards etc.)
- Give patient STP Ageing Well resource pack
- Consider Lasting Power of Attorney conversations (further information will be in the resource pack)
- Start DNACPR conversation and end of life conversations if not previously raised
- Consider referral to hospice for rehabilitation if available and considering patients' ability to travel (ambulances will not be available – if not able to travel in a car, will be referred to home-based rehab within the community teams).
- Consider following other pathways, depending on the person's co-morbidities

Back to pathway

Holistic needs assessment including loneliness

- More than one clinician may be required to complete this assessment (not necessarily at one time)
- Identify and refer to the professionals who are best placed to conduct holistic needs assessment and where is should be held (unless known to palliative care, this will usually be the district nurse, or health care professional that the patient is well-known to)
- The assessment should focus on the individual's interests and priorities
- Community staff undertaking assessment should use standardised template for assessment
- Palliative care staff undertaking assessment should use OACC (Outcomes Assessment and Complexity Collaborative). This includes three key measures (Phase of Illness (POI), Australia-modified Karnofsky Performance Status (AKPS), Palliative Care Outcome Scale (IPOS). This should be recorded into EPaCCS (Electronic Palliative Care Co-ordination Systems)

Assessment needs to include:

- Postural hypotension assessment
- Assess for risk of falls
- Mild cognitive impairment/ dementia screening (if appropriate)
- Screening for anxiety and depression – if positive outcome, refer to appropriate services/ the hub so this can be managed
- Conduct a multi-morbidity review
- Conduct polypharmacy review – use STOPP START methodology
- Signpost to and recommend sight and hearing checks (can be conducted in the home if necessary)
- Advise on health promotion, including the value of exercise (as appropriate). Signpost as appropriate
- Update STP patient held care plan
- Identify informal carers and record on clinical record and patient held care plan – conduct carers assessment and referral as appropriate
- Loneliness assessment see below:

  A number of tools are available. The UCLA scale is described below. Staff may require training and support to ask negatively worded questions sensitively.

  This scale comprises 3 questions that measure three dimensions of loneliness:
  relational connectedness, social connectedness and self-perceived isolation. The questions are:
  1. How often do you feel that you lack companionship?
  2. How often do you feel left out?
  3. How often do you feel isolated from others?
  The scale generally uses three response categories: **Hardly ever / Some of the time / Often**

  Using this scale: how to score and interpret your results
  In order to score somebody's answers, their responses should be coded as follows:
  Response score for each question
  Hardly ever = 1
  Some of the time = 2
  Often = 3

  The scores for each individual question can be added together to give you a possible range of scores from 3 to 9.
  People who score 3 – 5 are usually classed as "not lonely"
  People with the score 6 – 9 are usually classed as "lonely".

People who are classed as lonely consider referral to local services that are able to meet the needs of this patient cohort

Back to pathway

Code and share information

- Ensure electronic frailty index (eFI) is complete
- Ensure diagnosis is recorded with 'Read Codes'
    - **CTV3** X76Ao: Frailty
    - Xabdd: Severe Frailty
    - **Read** V22Jd: Frailty
    - 2Jd2.: Severe Frailty
    - **SNOMED CT concepts for frailty** All linked to the concept 248279007: Frailty (finding)
    - 925861000000102: Severe frailty (finding)
- Discuss sharing of information – including gaining consent for/ opt into Summary Care Record (SCR)

If appropriate record care planning conversation

Back to pathway

Care Planning and End of Life discussion and assessment

All severe frailty patients should be managed in the same way as patients identified to be in the last year of life. By definition the Gold Standards Framework (GSF) predictive tool means that people with severe frailty are likely to be in the last 12 months of life. Please note, some patients with severe frailty have the potential to move to moderate frailty with appropriate assessment and management. These patients should be considered for referral for Comprehensive Geriatric Assessment (CGA) and case management as per the moderate frailty pathway

NB: these steps could be completed over a number of consultations by a variety of health and social care staff

- Organise end of life discussion, considering who is best placed to have this discussion, when it should be held and where it should be held. Assess capacity to have discussion
- Make reasonable adjustments for people who qualify under the Care Act
- Enter patient into end of life register
- Use electronic palliative care co-ordination system registration (EPaCCS) – templates in SystmOne/EMIS
- Get consent to share records if not already done including out of hours, and ensure records shared
- Establish or update STP Care plan
- Consider DNACPR form if appropriate
- Discuss advanced decisions to refuse treatment
- Multi-disciplinary team (MDT) review and referral as appropriate
- Consider cognitive/ severe memory problems – advocacy to support decision making
- Consider equipment needs to support activities of daily living (ADL) at home or in care homes
- Review in practice Gold standards meetings
- Consider Lasting Power of Attorney conversations (further information will be in the resource pack)

Legal (NB. Information in STP Ageing Well resource pack)

- Power of attorney

  https://www.gov.uk/power-of-attorney

- Will writing

  https://www.gov.uk/make-will

Local Support

- Provide support at neighbourhood or place level

Back to pathway

Follow local End of Life Pathway

To include GSF prognostic indicators, just-in-case anticipatory medication and appropriate pathways

Back to pathway

Information for patients with learning disability and/or severe mental health issues

For people who have additional needs (e.g. deafness, learning disability or dementia) or in whom English is not their first language, reasonable adjustments should be made e.g. this may include having an interpreter or carer present. People with a learning disability and/or severe mental health issues should have holistic and multi-disciplinary care provided – they should not be denied access to treatment under this pathway and appropriate care planning should be undertaken.