Frailty Network Event – 25 August
Frailty Pathways – Key themes

**Systems**
- Making use of available technology
- Links between systems
- Frailty tool → data in system
eF1 identified in community
- Sharing of any anticipatory care planning: Where is it stored and shared?
- Sensitivity if system, react or case seeking
- Virtual board rounds (if know to Primary Care)

**Early/preventive interventions**
- Intervene before fall – community assessment
- Falls – national active living – developing pathways to admission to hospital
- Life curve
- Proactive identification of frailty by community teams
- Community falls framework
- Missed opportunity to identify early

**Assessment**
- Shared assessment
- Cognitive assessment
- Home assessment → community CGA

**Education & Engagement of family**
- Awareness / early discussion around ACP for Mrs Andrews
- OT/PT assessment. When husband noticed decline
- Communication sharing between service involved and the family
- Opportunities to discuss carers ax/support for Arthur
- Introduction of frailty aware primary care teams
- Public awareness, GP awareness
- Training + education use of tool to access

**First Response**
- SAS falls pathway
- SAS assessment
- Criteria for SAS – could this have been picked up?
- First responders
- Enable SAS to return home
- 1 hour response after 1st responder
- Confidence or paramedics

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**GP involvement**
- Med stopped to prevent further falls
- Deterioration, GP – how do we assess this?
- E Frailty Index eF1
- Medication – recall for checks (BP)
- Medical review

**Community support options**
- Enhanced community support MDT
- Hospital @ home team
- Mental health service
- District nurse role
- ANP 1/c specialty + empowering district nursing teams
- 3rd sector support
- Enablement team
- Use of ANP support – could this have been managed at home?
- Community ECANS
- Community hospitals
- Intermediate care services

**Frailty Network Event – 25 August**

**Frailty Pathways – Key themes**

**TIME**

**Home**

**Front Door**
**Time**

**Front Door**

**Assessment**
- Rapid response service
- AHP – (Fife) 30 mins response time
- Sign posting to AMN → pick up OOH stuff
- Frailty team at the front door
- Assessment as early as possible
- Start pathway as soon as possible
- What caused the fall?
- Frailty screening
- Anticipatory Care Planning
- React triage all patient right place
- Triage for right place of care
- All arrivals AMU → acute frailty team
- AMU → Home
- Prompt diagnostics e.g. X-ray, bloods
- Engage carers and family
- Pre hospital frailty triggers
- Ensure familiar walking aid is with her

**Systems**
- Focus on 4 hour target
- Not in A+E
- Special frailty unit (off the clock!)
- GP refers directly to frailty service
- Joined up comms
- Access to S.W. system
- Single patient record
- Frailty score with GP
- Frailty score recorded
- Adequate senior decision making

**Communication**
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**Co-ordination of care**
- Frailty huddle
- 3rd sector input
- 3rd sector transport
- Transition home teams?
- Rapid access to community
- Discharge to assess
- Intermediate care
- Appropriate placement – better outcomes
- Relationships – bed management
- Community rehab
- Whole system approach, primary, secondary care
- Hospital @ home from ED
- 7 days service 12 hr p/d
- Specialty bed and prompt access if required

**Knowledge & Skills**
- Recognition skills, early CGA
- Competence + skills
- Develop advanced roles
- Confidence to discharge
- Diverse roles
- Keep home the focus
- Risk enablement
**Service Redesign**
- 24/7 provision / 7 day ward rounds
- AHP weekend working
- Staffing ration that reflects demand
- Estimated Date of Discharge
- Clearly defined pathway where assessment follows the person
- Multi agency involvement
  - Intermediate care
  - Red cross
  - Discharge to assess
  - Hospital at home
  - ECAN rehab provision
  - Frailty unit
  - Frailty team – early CGA
  - Specialist unit in reach
- Staffing ration that reflects demand
- Hospital doesn’t have to do it at all
- Every day should have a purpose for services
- Avoid / minimise hand off

**Discharge**
- Possible early discussion discharge / transport
- Transport home (own, hospital, taxi)
- Safe discharge time

**Communication**
- Follow up call or visit once home
- IT system to support assessment / communication
- Pick up the phone
- Engagement with HSCP
- Better huddles / Safety

**Education**
- Shared roles - ANP / AHP
- Advanced roles training / competency
- Empower staff to make decisions
- Dementia staff training HCSW
- MDT education
- ECAN / ACE nurse knowledge spread
- Learning from CAUTI

**MDT Assessments**
- Comprehensive Geriatric Assessment
- 4AT
- Frailty bundles
- Functional
- Medical
- Carer
- Single shared
- Risk management not risk adverse
- Medication – adverse side effects
- Access to walking aids
- Anticipatory Care Planning
- Simultaneous not Sequential review

**Patient centred-care**
- Get up, get dressed, get moving
- Decondition = HARM
- Pyjama paralysis
- Physical activity in hospital
- What matters to me?
- Rephrase care ‘what to do to get home’ rather than ‘what’s wrong’
- E.D.D.
- Criteria led discharge/daily dynamic discharge
- HIS have made delirium a medical emergency
- John’s campaign open visiting
- Close liaison with families
- Care involve families
- Delirium involve families in care
- Involvement with carers – support and education for carers
- Sanitary in bed

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TIME

Systems / communication
• Frailty outreach
• Frailty unit
• Intermediate care beds
• Ward architecture layout
• System failure
• Better equipment
• Responsive care package → starting now
• Medical record → avoid further problem
• Communication expectations e.g. If falls rise, tell frailty staff
• Estimated Date of Discharge

Multi-disciplinary teams / Services
• 7 day working
• Share skills with team physio and nurse
• AHP work with ward staff
• Role blurring of nurse / OT e.g. Physio
• Staff levels prevent assisting physical activity
• Contact with community support → rapid
• Re-ablement services
• Third sector
• Education and training

Patient-centred care
• Keep family involved
• Removal of own clothes
• Difficult to get family to bring own clothes
• Get up, get going
• Single rooms → social exclusion
• Not patient-centred
• Discussion with partner → support for carers
• Explain delirium
• Carer assessment
• Reduce moves
• Patient has to fit into category

Assessment
• Home assessment
• Access in home
• Care home community liaison after respite
• Still no assessment
• Intermediate care

Discharge planning
• Start planning discharge day
• Post discharge visits and follow up visit
• Discharge decision
• Discharge access and transitional care
• Physio / OT support re discharge
• Avoid patient storage

Anticipatory Care Planning
• Hospital input to ACP with tool re-election
• Anticipatory care plan → social service community rehab team
• ACP next time

HOME