



# Frailty

Alex Sharp & Katy Richards  
Clinical Leads- SWASFT



20% of  
England

4,000  
staff

Around  
1million  
999 calls  
per year

65%  
increase in  
demand  
over 10  
years

22,000  
incidents  
attended by  
volunteers  
each year

23million  
tourists per  
year

About SWAST

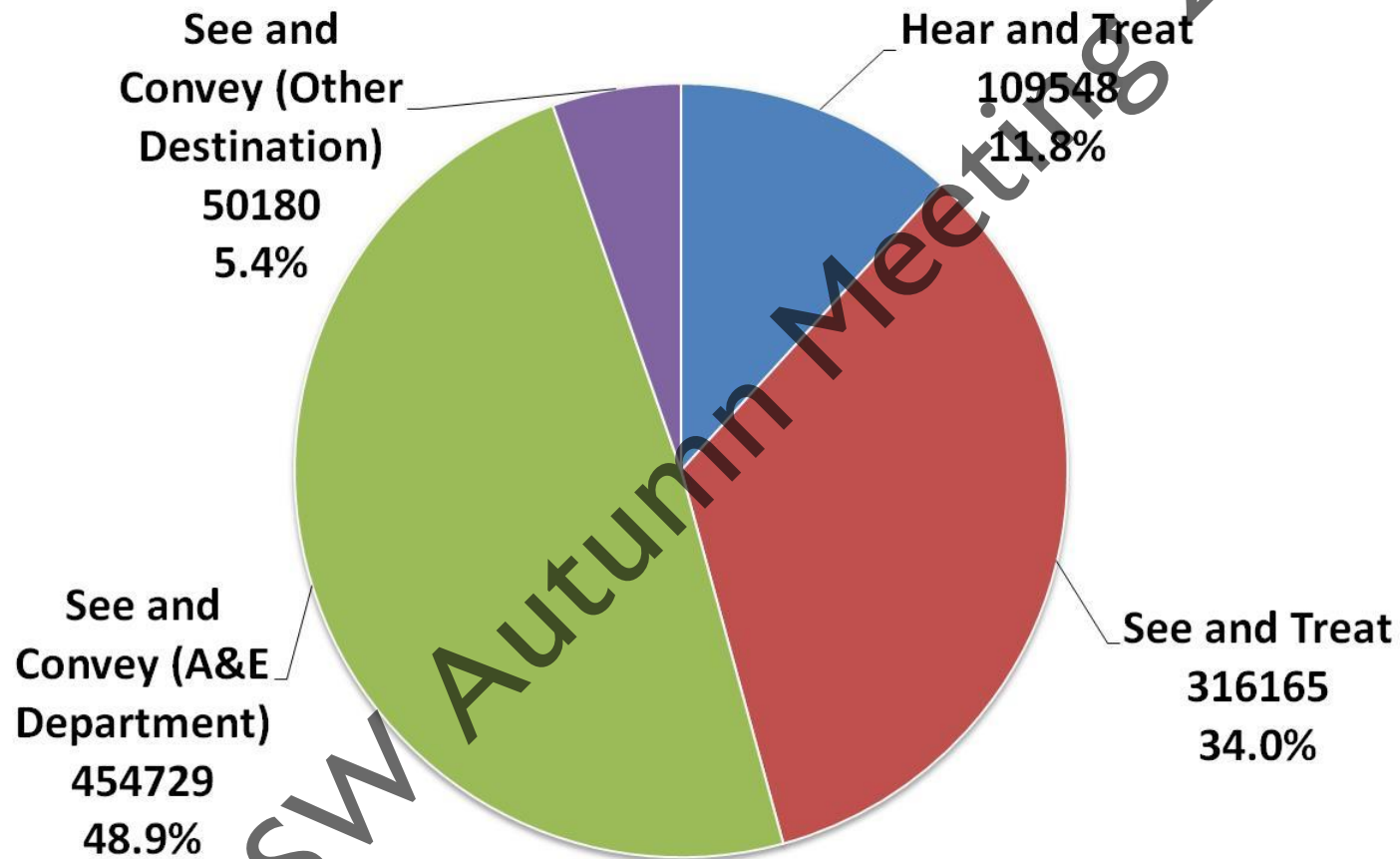
- Urgent and Emergency care within 4 hours
- Incidents from Health Care Professionals, members of the public and 111
- Interhospital transfers with urgent requirement for *upgrade* in care



- Routine, or planned Interhospital journeys
- Admissions to nursing or residential homes
- Transportation to out-patient appointments or discharges from Acute Trusts.

What we do



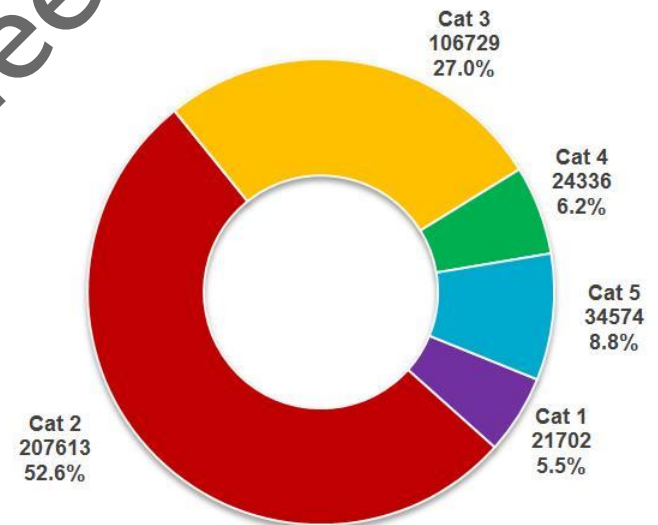


Conveyance

Category		
<b>Category 1</b> Average ≤7 minutes 90th centile ≤15 minutes	Time critical life-threatening event needing immediate intervention and/or resuscitation EG: cardiac/respiratory arrest, airway obstruction, ineffective breathing, unconscious with abnormal or noisy breathing, hanging. Mortality rates high where a difference of one minute in response time is likely to affect outcome and there is evidence to support the fastest response	
<b>Category 2</b> Average ≤18 minutes 90th centile ≤40 minutes	EG: Probable MI, stroke, major burns sepsis, serious injury,	Potentially serious conditions that may require rapid assessment, urgent on-scene intervention and/or urgent transport.  Mortality rates are lower; a difference of an extra 15 minutes response time is likely to affect outcome and there is evidence to support early dispatch.
<b>Category 3</b> Average ≤60 minutes 90th centile ≤120 minutes	EG: Hyperglycaemia, isolated limb fractures, non-major burns, abdominal pain	Urgent problem (not immediately life-threatening) that needs treatment to relieve suffering (e.g. pain control) and transport or assessment and management at scene with referral where needed within a clinically appropriate timeframe. Mortality rates are very low or zero; a difference of one hour or more might affect outcome and there is evidence to support alternative pathways of care.
<b>Category 4</b> Average - being monitored 90th centile ≤180 minutes	999 calls that may require a face to face ambulance clinician assessment	Problems that are not urgent but need assessment (face to face or telephone) and possibly transport within a clinically appropriate timeframe
<b>Category 5</b> EOC Clinician Hear & Treat 90th centile ≤180 minutes	EG: Home management advice or referral	Calls which do not require an ambulance response but do require onward referral or attendance of non-ambulance provider in line with locally agreed plans or dispositions, or can be closed with advice (Hear & Treat)



## All incidents April- August '19

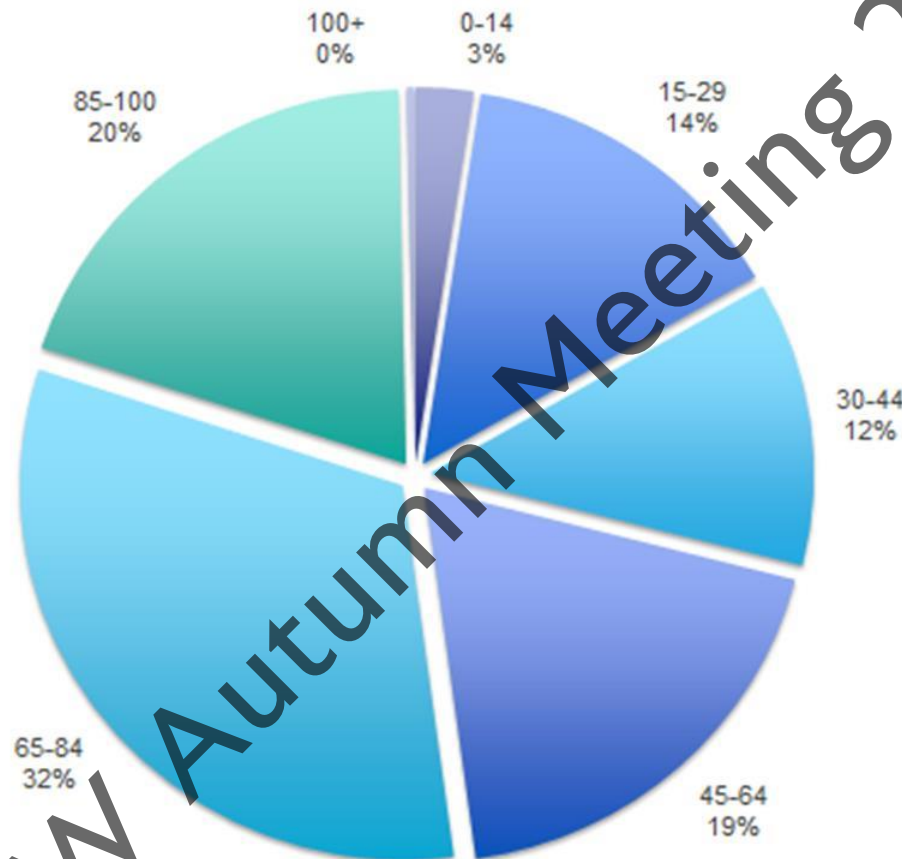




## Example interventions offered at each level of frailty



Engagement



SWASFT Activity by age



## Clinical Frailty Scale\*



**1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



**2 Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



**3 Managing Well** – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



**4 Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.



**5 Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



**6 Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



**7 Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



**8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



**9. Terminally Ill** - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

### Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

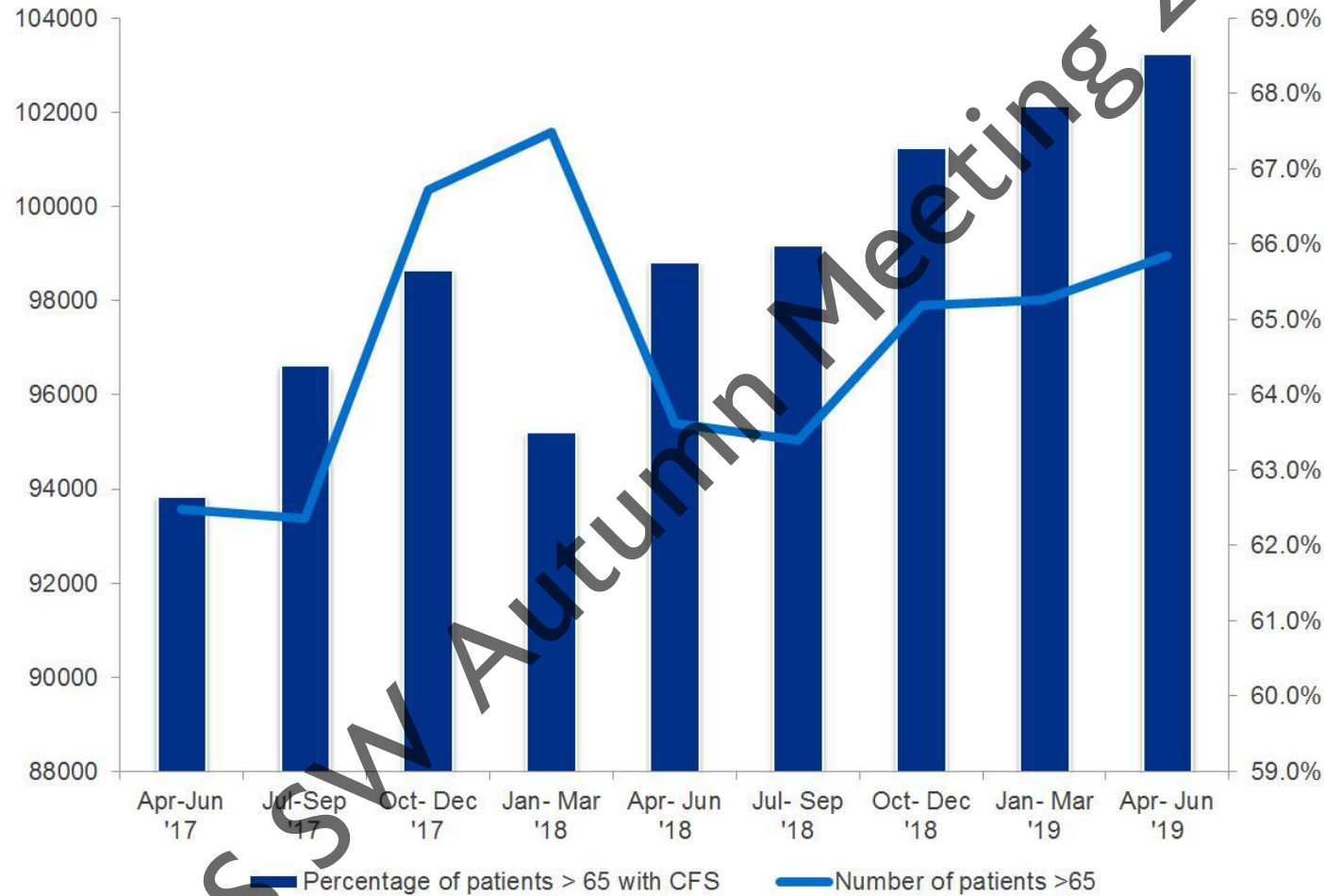
In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

\* 1. Canadian Study on Health & Aging, Revised 2008.  
 2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

© 2007-2009, Version 1.2. All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada. Permission granted







ortivus

10:29

Guidelines <<

General

Frailty Nausea & Vomiting Skin

**Rockwood Frailty Scale**

<p><b>Very Fit:</b> People who are robust, active, energetic, motivated. These people commonly exercise, they are among the fittest for their age.</p> <p><b>Managing Well:</b> People whose medical problems are well controlled, but are not regularly active beyond routine walking.</p> <p><b>Mildly Frail:</b> These people often have more evident slowing and need help in high order activities of daily living. Typically mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.</p> <p><b>Severely Frail:</b> People who are completely dependant on personal care, from whatever cause physical or cognitive. Even so, they seem stable and not at high risk of dying.</p> <p><b>Terminally Ill:</b> People approaching end of life, this category applies to people with a life expectancy of under six months.</p>	<p><b>Well:</b> People who have no active disease but are less fit than category one. Often, they exercise or are very active occasionally.</p> <p><b>Vulnerable:</b> While not dependant on others for daily help, often symptomatic limitations.</p> <p><b>Moderately Frail:</b> People who need help with all outside activities and with shopping house. Inside they often have problems with stairs and need help with bathing and dressing.</p> <p><b>Very Severely Frail:</b> People who are completely dependant, approaching end of life.</p>
---	--

1 Very Fit	2 Well	3 Managing Well	4 Vulnerable	5 Mildly Frail
6 Moderately Frail	7 Severely Frail	8 Very Severely Frail	9 Terminally Ill	

**Mobility Assessment**  
 The person may wear their usual footwear and is use any assistive device they normally use.

1. Have the person sit in the chair with their back to the chair and their arms resting on the arm rests
2. Ask the person to stand up from a standard chair and walk a distance of 10 ft. (3m).
3. Have the person turn around, walk back to the chair and sit down again.

Timing begins when the person starts to rise from the chair and ends when he or she returns to the chair and sits down.

The person should be given 1 practice trial and then 3 actual trials. The times from the three actual trials are averaged.

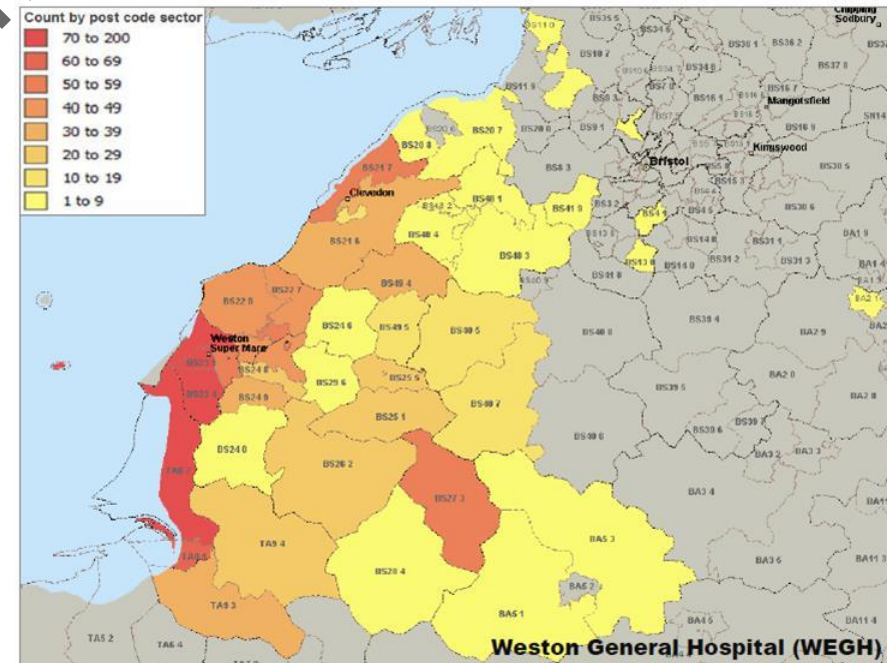
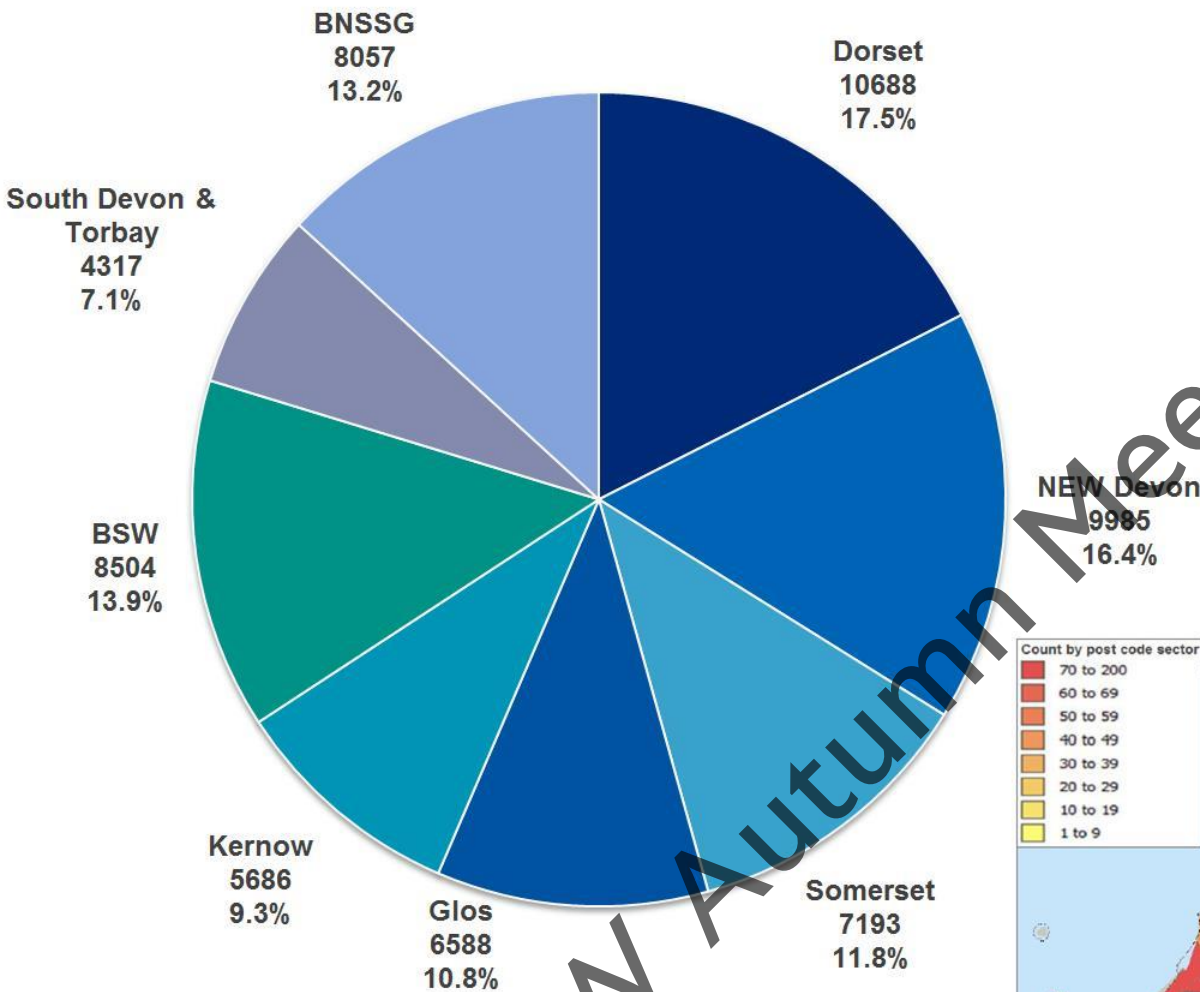
**Mobility Assessment**

<10 sec = Free/mobile

10-19 sec = Mostly independent

20-29 sec = Variable mobility

>30 sec = Impaired mobility



Data





## Sarcopenia

Sarcopenia is a syndrome characterised by progressive and general muscle mass and strength with a risk of adverse outcomes, including physical disability, poor quality of life, and death.

The term originates from the Greek term 'sarx' meaning muscle and 'penia' meaning loss.

of muscle loss and strength can be further defined as 'primary sarcopenia' (with no other cause evident, or 'secondary sarcopenia' (table 1).

of secondary sarcopenia<sup>2</sup>:

Can result from bed rest, sedentary lifestyle and gravity conditions

Associated with advanced organ failure (brain), inflammatory disease, malignancy

Results from inadequate dietary intake with malabsorption, gastrointestinal disorders that cause anorexia.

defined by the European Working Group on sarcopenia in older adults living in the community in long-term care institutions and 10% of studies did not show significant correlation

that patients with sarcopenia may experience age-related reduction of muscle mass. This is termed sarcopenia

strength is due to loss of weight, loss of muscle mass that leads to a reduction in muscle mass. This includes fat infiltration into the muscle and visceral fat increase with age

# MECHANICAL FALLER

## MONTHLY ISSUE 1

QR CODE

**TODAY ELSIE MEETS SOUTH WESTERN AMBULANCE SERVICE!**

INTRO PRICE £2.99

## Frailty

Increased vulnerability to stressor events resulting from a decline in physiological reserves, often, but not always, associated with ageing

### Documentation

A Backwood frailty score (found under the secondary survey tab) should be documented for all patients over the age of 65, or patients of any age presenting with a frailty syndrome:

1. Falls
2. Immobility
3. Delirium
4. Incontinence
5. Susceptibility to side effects of medication

**REMEMBER...** your documented frailty score should be based on the patient's 'norms'. Use two weeks prior to the patient's attendance and always include your frailty score during clinical handover.

### Referrals

Over 65% of older adults experience functional decline following hospitalisation.

Always consider community referrals wherever conveyance to the Emergency Departments is not essential.

Such referrals or signposting may focus on:

- Smoking and alcohol intake
- Nutrition
- Mobility/physical inactivity
- Social isolation
- Falls
- Polypharmacy
- Continence
- Low mood
- Cognitive impairment

**Remember to take a change of clothes, including appropriate foot wear, if conveying to hospital**  
**#ENDP/PARALYSIS**

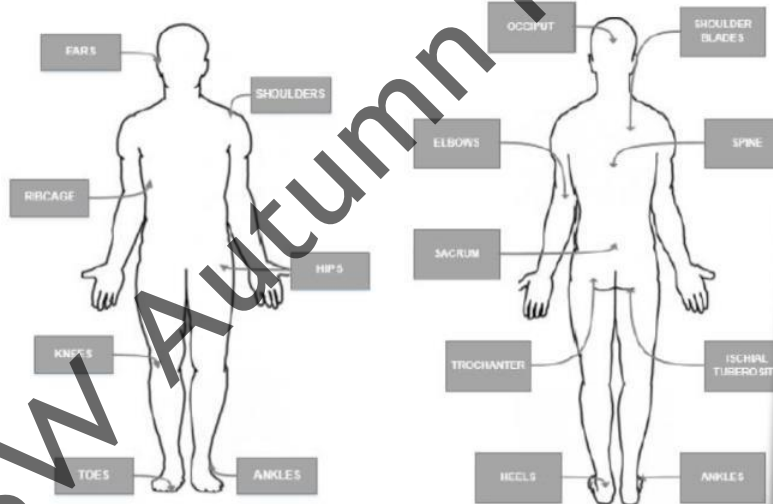


Education

## Appendix B. Falls assessment checklist

Falls history	<ul style="list-style-type: none"> <li>See section 5.</li> </ul>
Cardiovascular	<ul style="list-style-type: none"> <li>Consider cardiac arrhythmias, TLoC and postural hypotension (NB: postural hypotension may be affected by drugs, disease or age-related deterioration of autonomic nervous system)- see section 6.</li> </ul>
Neurological	<ul style="list-style-type: none"> <li>Consider delirium; refer to Confusion Assessment Method in SWAST CG29- Frailty</li> </ul>
Functional, mobility and gait assessments	<ul style="list-style-type: none"> <li>Record an informal assessment of mobility- see section 14</li> <li>Consider footwear, availability and appropriateness of mobility aids and orthotics</li> <li>Assess frailty and consider referral for Comprehensive Geriatric Assessment (SWAST CG29 - Frailty)</li> <li>Is the patient able to undertake basic Activities of Daily Living (ADLs):                     <ul style="list-style-type: none"> <li>Personal hygiene e.g. bathing and grooming</li> <li>Dressing.</li> <li>Eating</li> <li>Maintaining continence</li> <li>Transferring/Mobility</li> </ul> </li> </ul>
GI/GU	<ul style="list-style-type: none"> <li>Assess alcohol intake- see section 9.</li> <li>Consider nutritional intake and dehydration</li> <li>Assess urgency or frequency of micturition and any symptoms indicative of Urinary Tract Infection. Noct lighting, not using mobility aids</li> </ul>
Mental Health	<ul style="list-style-type: none"> <li>Depression</li> <li>Sleep disturbance</li> <li>Social isolation</li> <li>Fear of falling</li> </ul>
Sensory disturbance	<ul style="list-style-type: none"> <li>Ask if the patient noted loss of vision at night, if an eye test has been done or required.</li> <li>Ask if the patient has noticed changes in their hearing or if they are working adequately</li> </ul>
Musculoskeletal	<ul style="list-style-type: none"> <li>Undertake a C-Spine assessment (immobilisation) and assess</li> <li>Assess joints and muscle strength</li> <li>Consider low muscle mass</li> <li>Undertake a skin assessment (SWAST CG44 - Pressure Ulcers)</li> </ul>
Medication/ Drug History	<ul style="list-style-type: none"> <li>Consider prescribed and over-the-counter medications and prescriptions and if they are appropriate</li> <li>Date of last medication review</li> <li>Adherence to regime</li> <li>Ability to self-administer</li> </ul>

3.4. Figure 1. High risk areas for the development of a pressure ulcer.



SWAST CG29

### Frailty

**Clinical Publication Category**

**Guidance (Green) Deviation permissible; Apply clinical judgment.**

**Guideline Type:** Clinical Guidelines  
**Supplements / replaces:** None  
**Reference No:** CG29

1. Introduction
2. Frailty Assessment
3. Frailty Syndromes

3.1 The following symptoms, known as frailty syndromes, have been shown

Dashboard Guidelines Drugs Algorithms Page for Age





Services	Show	All Available	Rank By	Distance	Name
1					Emergency Department, Musgrove Park Hospital Taunton (1.46km or 0.9miles)
2					GP OOH Clinical Assessment, Somerset (4) (1.46km or 0.9miles)
3					GP OOH Clinical Assessment, Somerset (16.12km or 10.02miles)
4					GP OOH Clinical Assessment, Somerset (2) (31.49km or 19.57miles)
5					Community Based Service - Rapid Response Team - Somerset (32.53km or 20.22miles)
6					Emergency Department, Yeovil District Hospital, Yeovil (34.47km or 21.42miles)
7					GP OOH Clinical Assessment, Somerset (5) (34.47km or 21.42miles)
8					GP - Out of Hours Doctor Dorset - 3 (39.42km or 24.49miles)
9					OOH DN - District Nurse - Out of Hours Dorset (Bridport) (39.42km or 24.49miles)
10					SPoA - Intermediate Care Single Point of Access - Eastern Devon (42.80km or 26.59miles)

### Community Based Service - Rapid Response Team - Somerset

Patient signposted
Report an issue

Address: BA6 8JD  
Telephone: 01749 836700 SWASFT and GP only

Post code for return purposes only

Service Information

Professional Notes

Opening Hours

prevent unnecessary admissions to hospital.

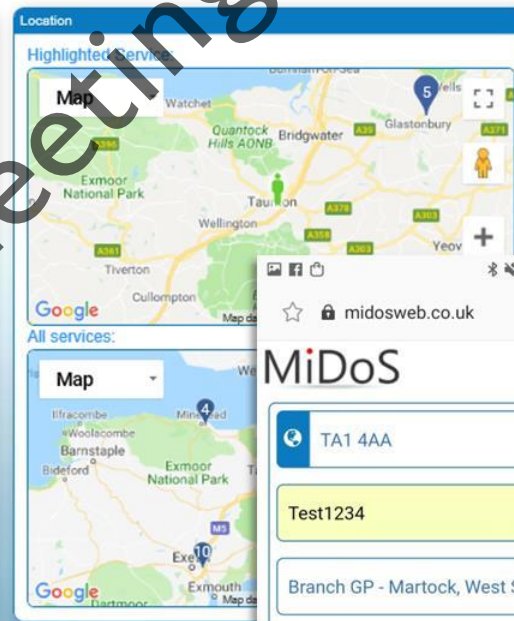
Service aims to reduce the number of inappropriate admissions to hospital for patients who may otherwise been able to remain at home.

Referrals are taken seven days a week 09:00-21:00

Referral process  
Referrals from GP and Ambulance crews only.

Referrals can be made Monday to Friday between 09:00-21:00

Exclusion Criteria  
Acute confusion of unknown cause (i.e. without a known diagnosis and where pattern of behaviour is unusual)  
Wound closure  
Presenting complaint of mental health crisis  
Dental problems



53% 10:16

midosweb.co.uk

## MiDoS

TA1 4AA

Test1234

Branch GP - Martock, West Street Surger

Hide Advanced Options

0-1 2-4 5-15 16+ 65+

Frail Elderly

Search

Back Forward Home Bookmarks Tabs



## DEVON

### NDDH

- MAU/SAU- only GP admissions

### Derriford

- AMU- only GP admissions
- Acute Assessment Unit- referrals accepted (not frailty specific)

### RD&E

- ? #NOF- call to ward coordinator to pre-alert
- AMU- direct access available
- Acute care of the Elderly team- direct access and advice available

### Torbay

- Ambulatory Unit- Direct access available (not frailty specific)
- JETT/ Rapid assessment and discharge service (therapies) direct referrals possible

## CORNWALL

### RCHT

- Non urgent acute frailty assessment unit (referrals available) Monday – Friday, 12:00 – 15:00
- AMU/SAU- GP admissions only
- 'Silver phone' advice line

## SOMERSET

### Musgrove Park

- No direct access pathways
- AMU/SAU- GP admissions only

### Yeovil District

- Frail Older Persons Assessment Unit- referrals/direct admissions accepted
- AEC available
- AMU/SAU- GP admissions only

## BNSSG

### Weston General

- GEMS team in ED- utilising SWASFT CFS
- Overnight #NOF pathway when ED closed
- MAU/SAU- GP Admissions only

### Southmead

- No direct access pathways - AMU/SAU- GP admissions only

### BRI

- No direct access pathways - AMU/SAU- GP admissions only

## GLOUCESTERSHIRE

### Cheltenham General & Gloucestershire Royal

- Frailty Assessment Service- accepts referrals
- ACU/ AMU Direct access available at Cheltenham overnight and GRH during the day

## BaNES, SWINDON, WILT SHIRE

### RUH

- RUH frailty flying squad advice/referral line in development
- AMU/SAU- GP admissions only

### GWH

- No direct access pathways - AMU/SAU- GP admissions only

## DORSET

### Poole

- Rapid Access Consultant Evaluation (RACE)- direct referrals available
- MAU/SAU- only GP admissions

### Bournemouth

- No direct access pathways - AMU/SAU- GP admissions only

### DCH

- No direct access pathways - AMU/SAU- GP admissions only



SWASFT attended patient following a fall and referred to the community frailty service via email prior to conveyance to ED.

The lady was admitted and remained in hospital for a week. On discharge she was seen by D2A for a few days. Geriatric team in ED stopped an inappropriate medication.

After discharge the frailty service visited the patient and completed a full CGA (90 minutes) and identified another 4 recommendations, one being need for urgent physiotherapy as her balance remains very poor, Roberg's test was positive in line with cerebrovascular changes identified in scan ordered by GEMS on admission.

Case study



? Potential missed opportunity for direct community frailty referral from D2A, ED Geriatric team or the GP following discharge

The Falls service also received a further referral from SWASFT which was no longer required

? Missed communication to GP; the ED Geriatric team stopped an inappropriate medication which still appeared active

Community frailty service unaware of the work already done- duplicated efforts

Challenges





## Summary Care Records

Your emergency care summary



### Wave 1

- Greater Manchester
- One London
- Thames Valley & Surrey
- Wessex
- Yorkshire & Humber

### Wave 2

- Great North Care Record
- Share 2 Care
- South West

### Wave 3\*

- Eastern
- West Midlands
- Remaining Areas that did not bid

Access to care plans



Back Atrial Fibrillation

SWAST CG06

### Atrial Fibrillation

**Clinical Publication Category**

**Guidance (Green) Deviation permissible; Apply clinical judgment.**

**Guideline Type:** Clinical Guidelines  
**Supplements / replaces:** None  
**Reference No:** CG06

1. Scope +

2. Background -

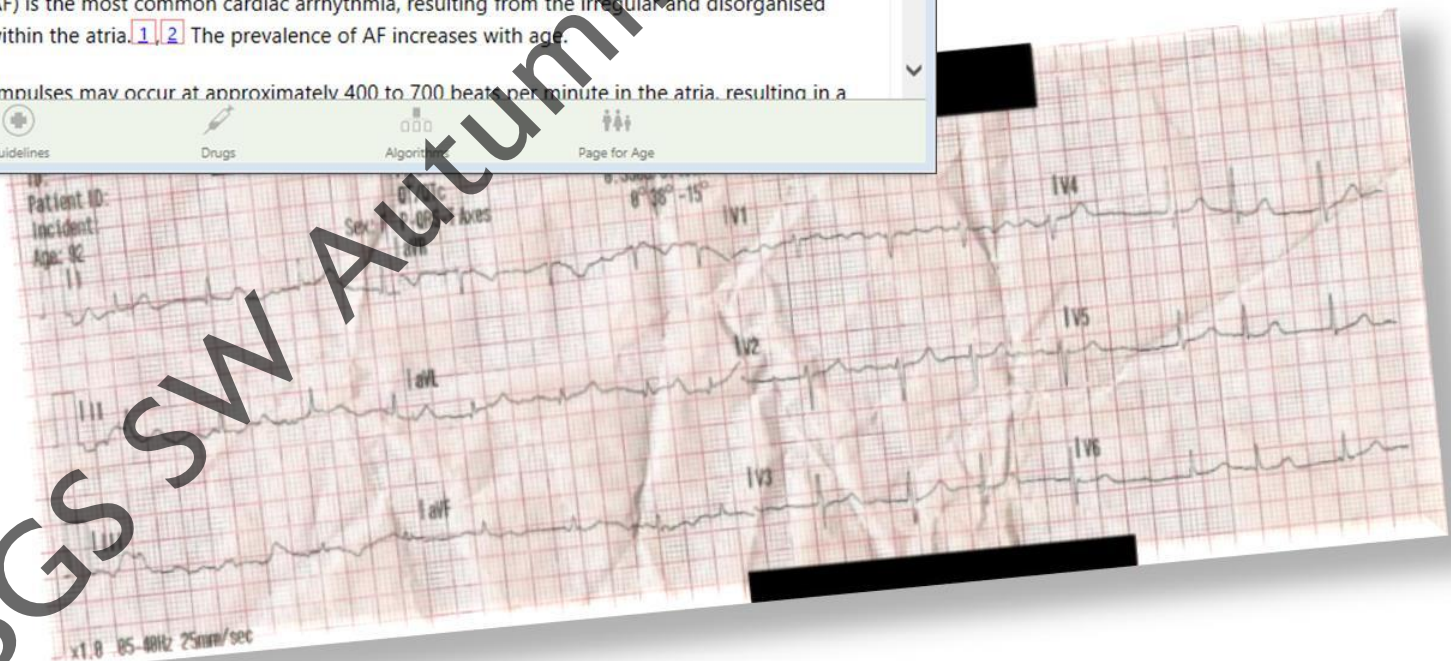
2.1 Atrial fibrillation (AF) is the most common cardiac arrhythmia, resulting from the irregular and disorganised electrical activity within the atria. 1 2 The prevalence of AF increases with age.

2.2 The rapidly firing impulses may occur at approximately 400 to 700 beats per minute in the atria, resulting in a

Dashboard Guidelines Drugs Algorithms Page for Age

AF

BGS SW Autumn Meeting 2019

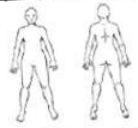






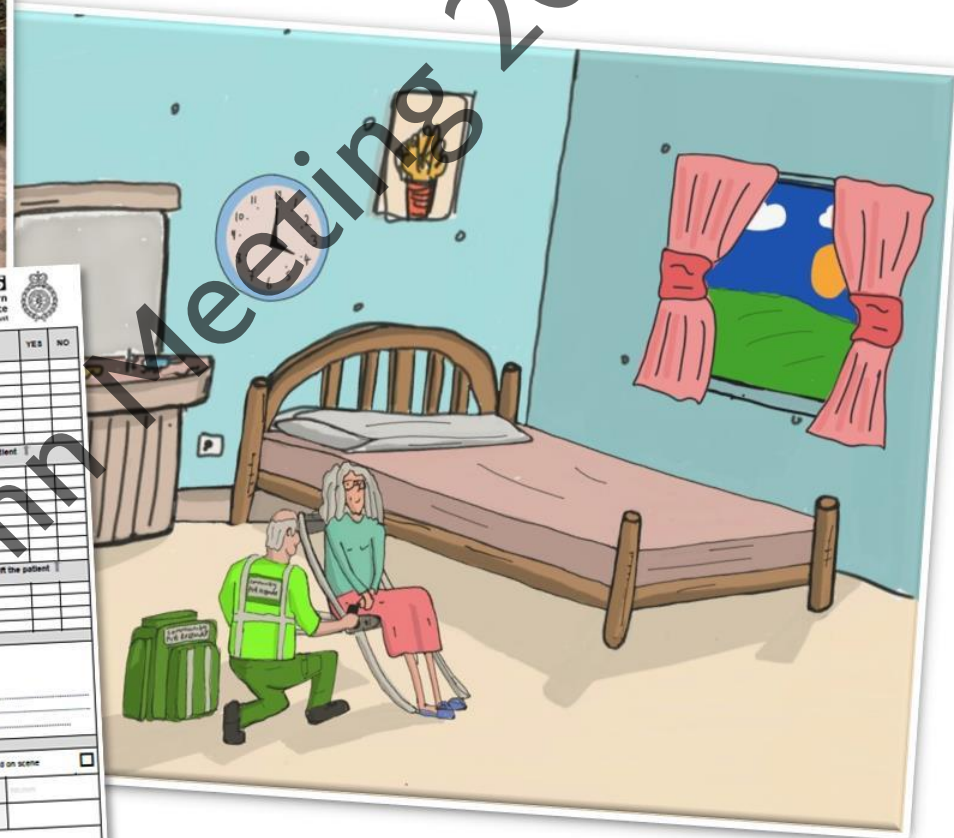
# Community First Responder Falls Clinical Record

DO NOT INCLUDE ANY PATIENT IDENTIFIABLE DATA

<b>Call Details</b>		<b>Incident number</b>									
Case		CPR Name									
CPR Call sign		Time Mobile									
Time of Call		Time Clear									
Time on Scene											
<b>History of Presenting Complaint</b>											
<p>H</p> <p>A</p> <p>L</p> <p>A</p> <p>T</p> <p>T</p>											
<b>Allergies</b>		<b>Medications</b>									
<p>Past Medical History</p>		<p>Medications</p>									
<b>Clinical assessment and observations</b>											
	Time	ADULT	Blood pressure	Heart rate	SPO <sub>2</sub> Air	SPO <sub>2</sub> Oxygen	Cap. Refl.	Bowel Sounds	Heart rate	Temp	Pain
Before lift											
After lift											
F.A.S.T.	Facial droop	Y/N	One sided arm weakness or drift	Y/N	Speech easy?	Y/N	Any facial, which side is affected?	Y/N	Left / Right		
<p>Body chart relates to physical assessment</p> <p>Indicate location of visible injury or pain</p> <p>Key</p> <p>B= Bruise</p> <p>P= Pain</p> <p>W= Wound</p> <p>S= Swelling</p>											

NHS  
South Western  
Ambulance Service  
and Foundation Trust

FALLS DECISION SUPPORT TOOL		YES	NO
Respondent Line: 0300 369 0094			
Select appropriate hub and then option 6 for hub clinician			
SECTION 1	Abnormal primary survey?		
	New neck or back pain?		
	New incontinence, numbness, swelling, extensive bruising, deformity or pain to a limb?		
	Did the patient fall from more than 1 metre or 5 steps?		
	Reduced level of consciousness or loss of consciousness?		
SECTION 2	Any loss of memory before or after the fall?		
	Is the patient unable to recall the fall and communicate history adequately?		
	ACTION: If yes or unknown to any question in section 1, do not lift the patient. Contact hub clinician to report findings.		
	Consent pain before or after fall?		
	Vomiting or nausea since fall?		
SECTION 3	Did the patient hit their head?		
	Any headache pre or post fall?		
	Has the patient previously had brain surgery?		
	Does the patient take anticoagulants or have a history of bleeding/clotting disorders?		
	Suspected intoxication or drug use?		
SECTION 4	Any sounds or bleeding?		
	ACTION: If yes or unknown to any question in section 2, you may continue to lift the patient. Contact hub clinician for reassessment.		
	Has the patient been incontinent?		
	Does the patient have an irregular pulse on palpation?		
	Is there a history of osteoporosis, osteopenia or fractures from previous falls?		
<b>Treatment Summary</b>			
<input type="checkbox"/> Secondary survey completed <input type="checkbox"/> Dressing applied to wound <input type="checkbox"/> Patient able to get up with or without guidance <input type="checkbox"/> Lifting equipment used?		<input type="checkbox"/> Oxygen therapy provided? <input type="checkbox"/> Other, please specify:	
<b>Outcomes (please tick to complete)</b>			
<input type="checkbox"/> Patient discharged by hub clinician		<input type="checkbox"/> Back-up required/ arrived on scene	
<input type="checkbox"/> Time to hospital contacted:		<input type="checkbox"/> Time back-up arrived:	
<input type="checkbox"/> Time to ambulance:		<input type="checkbox"/> Back up call sign:	
<input type="checkbox"/> Confirm hub clinician has given authorisation to leave?		<input type="checkbox"/> Other comments:	
<input type="checkbox"/> Confirm hub clinician has provided advice to patient?			
<input type="checkbox"/> Is the hub clinician making onward referrals?		Y/N	



# CFR lifting scheme





Bristol, N Somerset & S Gloucestershire

**Healthcare Professional Guide to Patient Transport**

Please consider these options to get your patient to hospital safely

	<b>SELF DRIVE SELF</b> Patient makes their own way to hospital
	<b>LIFT LIFT FROM FRIEND</b> Patient gets a lift from friends or family
	<b>TAXI TAXI (SELF PAID)</b> Patient pays for a taxi or uses public transport
	<b>03007 776688* EZEC PATIENT TRANSPORT AMBULANCE</b> Some day and planned appointments When your patient can wait over 4 hours and does not clinically need paramedic level care en-route to hospital
	<b>03003 690096* SWASFT AMBULANCE</b> Urgent within 1-4 hours When your patient's clinical condition requires an ambulance for an urgent hospital admission
	<b>999 SWASFT EMERGENCY AMBULANCE</b> Life-threatening conditions e.g. Cardiac arrest, suspected stroke, heart attack, severe bleeding, seizure, not fully conscious or short of breath

<https://www.swast.nhs.uk/welcome/hcps> for full details

Urgent and emergency ambulance resources are limited.  
Requesting an urgent or emergency ambulance when an alternative exists, may put lives at risk in your local community  
\* Telephone numbers not for public use

**Choose well.**

© South Western Ambulance Service NHS Foundation Trust 2019

Interfacility transfers and HCP calls



katy.richards@swast.nhs.uk

alex.sharp@swast.nhs.uk