THINK FRAILTY

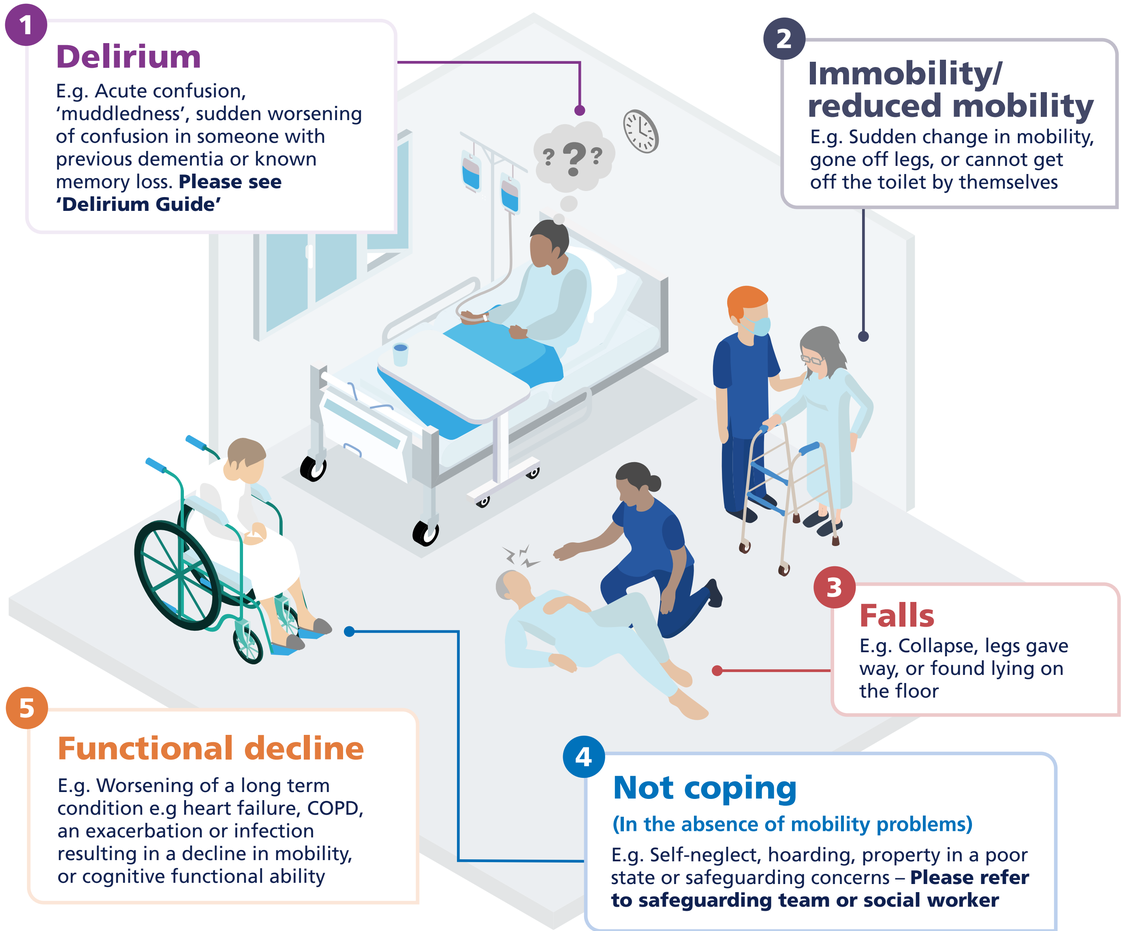
AMBULATORY ASSESSMENT UNIT (AAU)
ASSESSMENT AND MANAGEMENT OF PATIENTS LIVING WITH FRAILTY

NHS
Oxford University Hospitals
NHS Foundation Trust

1 OBSERVE

IS YOUR PATIENT:

- **Over 65 years and presenting with...**
- **OR under 65 years with multiple co-morbidities / frequent hospital attendance and presenting with...**



1 Delirium
E.g. Acute confusion, 'muddledness', sudden worsening of confusion in someone with previous dementia or known memory loss. **Please see 'Delirium Guide'**

2 Immobility/ reduced mobility
E.g. Sudden change in mobility, gone off legs, or cannot get off the toilet by themselves

3 Falls
E.g. Collapse, legs gave way, or found lying on the floor

4 Not coping
(In the absence of mobility problems)
E.g. Self-neglect, hoarding, property in a poor state or safeguarding concerns – **Please refer to safeguarding team or social worker**

5 Functional decline
E.g. Worsening of a long term condition e.g heart failure, COPD, an exacerbation or infection resulting in a decline in mobility, or cognitive functional ability

THERAPY CONTACT DETAILS:

Beverley Greensitt
Specialist Physiotherapist (for older people living with frailty):
9:30am – 5:30pm (Mon-Fri)
Bleep: **4335**
In Bev's absence, please call Frailty Intervention Team (FIT)

Frailty Intervention Team (FIT):
8am – 8pm (7 days a week)
Bleep: **1586** or **6280**
Please be aware that FIT's capacity is determined by their caseload in ED and EAU

2 RECORD AND MOBILISE

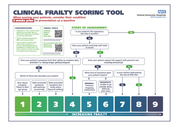
For ALL patients with a frailty presentation, please ensure the following:

1 Gather a Social History

1. **Type of accommodation** *(If they live in a house or upstairs flat, can they get up and down stairs?)*
2. **Who do they live with?**
3. **Do they have a care package?**
4. **What do they normally use to mobilise with and how far do they normally walk?**
5. **Do they have any equipment at home to make things easier for them** *e.g. Riser recliner chair, hospital bed, toileting equipment?*
6. **Any patient/family/carer concerns?**
7. **Are they experiencing difficulty with their daily tasks at home?**
8. **Have they or their family/carers noticed any changes in their behaviour or their ability to process or remember information?**

2 Clinical Frailty Scoring Tool

Refer to Clinical Frailty Scoring Tool and assign your patient with a frailty score. Record score on EPR under 'interactive view'



3 Mobilise

ONLY MOBILISE IF SAFE FOR THE PATIENT

1. **If unsure whether to mobilise the patient, liaise with medical staff**
2. **Mobilise the patient using the walking aid that they would normally use**
3. **If the patient requires therapy, then hand over the previous information to the therapist (see 'Therapy Contact Details' below)**
4. **Patients are to be mobilised by nursing and/or medical staff regardless of whether the patient needs to be seen by therapy**

Early mobilisation in patients living with frailty helps to reduce the risk of deconditioning whilst in the acute hospital setting

3 NEXT STEPS

Community services available to support patients after hospital attendance:

Urgent Community Response (UCR)
Available 7 days a week, 8am-8pm
Provides urgent assessment of a patient's needs in their own home with a view to avoiding admission. Patients seen within 2 hours of referral.
01865 904 966
spa.communityreferrals@oxfordhealth.nhs.uk

Community Therapy Service (CTS)
Available 7 days a week, 8am-8pm
Provides a therapy assessment and rehabilitation within the patient's own home.
Response times: 'Same day' (24 hours), **'Urgent'** (2 days), **'As soon as possible'**, and **'Routine'** (within 12 weeks).
01865 904 966
spa.communityreferrals@oxfordhealth.nhs.uk

CARe (Care and Reablement)
A crisis response care service
Provides short term care packages for 7-10 days. Can also provide bridging visits to existing care packages. **Open 7 days a week 7am-10pm.**
01865 572917 (duty desk) / ext 72917

Access Team
Telephone advice if patients / relatives have concerns and want further information re: equipment, care packages, care support and blue badges
0345 050 7666

Live Well Oxfordshire
livewell.oxfordshire.gov.uk/
Or provide patient with an information booklet

Age UK
For help with shopping, transportation, domestic tasks, befriending service, dementia advisor, advice on benefits
07827 235 417 Bleep **4642**

HomeFirst
Short term reablement care package.
8:30am - 5:00pm (Mon-Fri)
General Enquiries: 01865 328794
Discharge Planning: 01865 328795

RIPEL (Rapid intervention for palliative and EOL care):

Hospital Palliative Care Team:
Available 7 days a week, 9am-5pm
Refer via EPR requests and prescribing 'Refer to Palliative Care Team'.
Ext 21741 for queries

Community Palliative Care Team:
Available 7 days a week, 9am-5pm
Refer via EPR requests and prescribing 'Refer to Palliative Care Team'.
01865 857036

Home Hospice:
Available 7 days a week, 8am-10pm Refer via:
PalliativeCareHub@oxnet.nhs.uk
01865 857036

Discharge Liaison Nurses
They will source a community hospital (CH) bed or Short Stay Hub Bed (SSHB) for patients.
ext **21658 / 23137**

Social Workers (SW)
For social concerns, especially in the absence of mobility issues e.g. Self neglect, hoarding, safeguarding concerns.
Duty SW:
Mon-Thurs: 8:30am - 5pm
Fri: 8:30am - 4pm
Bleep **4027**
ext **21208**
For Duty SW at weekends and out of hours: 10am - 6pm
Bleep **1967**
Out of hours:
0800 833 480

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