

Please complete the Clinical Frailty Scale (under Assessments) - **remember it is about their baseline**

IN-HOSPITAL SERVICES

Does your patient require a review **PRIOR** to discharge (or to determine appropriateness for discharge)?

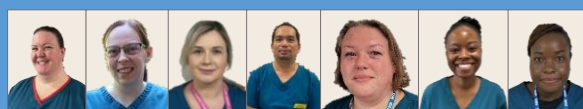
Consider using one of these services for patients presenting with an acute frailty syndrome or **CFS ≥ 6** who do not necessarily need acute hospital admission

OUTPATIENT AND COMMUNITY SERVICES

Would your patient benefit from a review **AFTER** discharge?

Remember the available services may depend on locality - patient's home address for care needs or GP surgery for health needs:
<https://www.gov.uk/find-local-council>

Frailty Practitioners



- 8am-8pm, 7 days a week
- Triage all patients aged 75+ in cubicles in zones A, B & C, brought in by ambulance
- Can also accept direct referrals from ED
- Start the Comprehensive Geriatric Assessment with aim to facilitate discharge home or to alternative (e.g. community hospitals) from ED
- Contact via Alertive: Frailty Team (ED)**

OPED Geriatricians



- 8am-4pm, Monday to Friday
- Reactive review of patients identified by frailty practitioners / ED team and proactive review of appropriate patients
- Advice service to SCAS/GP also
- Contact via Alertive: Elderly Care Interface Consultant - OPED**

Other Hospital Services

- Palliative care CNS: ext. 7826, via EPR or Alertive: Palliative Care Clinical Nurse Specialist Front Door (in hours) or Palliative Care Nurse Coordinator (weekend)
- Parkinson's CNS: ext. 6855, via EPR (CAT 10)
- Learning Disability liaison nurses: ext. 8159
- Safeguarding: ext. 7482

ED Therapies

- 8am - 8pm, 7 days a week (also cover AMU/SSU)
- Any age if acute functional change, or acute fracture/injury
- Contact via Alertive: Emergency Department Therapy Team**
- Out of hours - put note in ED Therapies referral book for a follow up phone call

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.

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Urgent Community Response (UCR)

- Berkshire - Care home or own home
- Multidisciplinary team with input from a Community Geriatrician
- Seen within 2 hours (capacity dependent)
- Can do IV fluids/antibiotics, reviews, repeat bloods
- Referral: 0300 365 1234**

RACOP

- Geriatrician led rapid access clinic
- Seen within 7 days
- Located in SDEC
- Can see immobile patients (depending on transport)
- Please give RACOP leaflet to patient at time of referral
- Referral: EPR Communicate (RACOP)**

Falls Clinic

- Weekly clinic (Tuesday afternoon)
- Multi-disciplinary assessment
- Please see poster for more details
- Referral: rbft.falls@nhs.net**

RACU

- Multidisciplinary clinic based at Townlands Hospital (Henley)
- Only if South Oxfordshire / West Berkshire GP
- Mon-Fri. Seen < 2 days
- Referral: 01865 903 071**

Other Community Services / Resources

- District nurses :
Berkshire - 0300 365 1234
Oxfordshire - 01865 903750
Referral forms in Master Copies folder
- Care Directory (Berkshire or Oxfordshire) which has info for: Age UK, Dementia Berkshire, Red Cross, Social Services

If you're not sure - speak to the Frailty Practitioners, the interface Geriatricians, or out of hours the medical registrar

