Appendix 1: Service self-assessment

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Frailty Screening

Are we delivering high-quality care for frail older people?

We are **assessing for frailty** in people aged 65+ at every entry into the service using a recognised tool.

In people with frailty, we routinely screen for the presence of **common geriatric syndromes** in addition to our usual assessments:

Pain	Delirium and dementia
Depression	Nutrition and hydration
Skin integrity	Sensory loss
Falls and mobility	Activities of daily living
Continence	Vital signs
Safeguarding issues	End of life care issues

How to fill in the gaps

Tool	*Settings in which the tool has been tested*	*Time to complete*	*Predictive proprieties*
Rockwood Clinical Frailty Scale (CFS)	ED/AMU	41 seconds	AUC for mortality = 0.72 (18)
Identification of Senior At Risk (ISAR)	ED/AMU	66 seconds	AUC for functional decline, readmission or death = 0.68 (19)
Silver code	ED/AMU	54 seconds	When predicting mortality in the ED setting, area under the curve = 0.70 (20)
PRISMA-7	ED/AMU	52 seconds	Sensitivity = 78%, specificity = 75% for moderate-to-severe functional decline (21)
Edmonton Frail Scale	Surgery (pre-op)	Less than 5 min	Validated for use among non-geriatricians (22)
'Comprehensive assessment of frailty'	Routine cardiac surgical practice	Includes laboratory and other tests - 10–20 min	Identifies patients at high risk of post-operative death (11)

Learning Resources

Consider the language used when addressing and managing older people with frailty: https://www.youtube.com/watch?v=8HPVpH0JiGU

Also be aware that frailty is associated with so-called atypical presentations: https://www.youtube.com/watch?v=6oEFtzdoiRM

Quick bite learning on an arrange of geriatric emergency medicine topics can be found here:

https://em3.org.uk/foundation/collapse-and-elderly-care/?rq=gemcon

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Medical	We are aware that **pain** is under-reported and undertreated in people with frailty, we have adapted our pain assessment process with this in mind, specifically we use adapted pain scale for people with cognitive impairment.	Abbey pain scale can be used for people with cognitive impairment.	For more detailed information see: https://www.britishpainsociety.org/static/uploads/resources/files/book_pain_older_people.pdf
	We routinely assess the **risk of pressure sores** and generate a specific action plan to care for skin in people at risk.	Waterlow or SSKIN score can be used to assess the risk of pressure sores.	http://www.e-lfh.org.uk/programmes/preventing-pressure-ulcers/open-access-session/
	We ask all older people with frailty about faecal and urinary **continence** issues; we undertake initial basic assessments, and we are able to refer into continence services when needed.	Initial basic assessment includes e.g. identification and management of constipation.	https://www.bgs.org.uk/resources/clinical-guidelines-on-urinary-incontinence-in-women https://www.youtube.com/watch?v=IcCs7_ju4lY https://www.youtube.com/watch?v=a4npFPnYdmQ
	We are aware of the prevalence of **asymptomatic bacteriuria** in older people with frailty from various settings. We are aware of the positive and negative predictive values of urine dips in older people, with and without lower urinary tract symptoms. Accordingly, we do not use urine dips in older people other than to exclude UTI in people with Lower Urinary Tract Symptoms or otherwise unexplained delirium.	An audit can establish whether urine dips are used in older people.	https://www.youtube.com/watch?v=JPzz6fcmxoI
	We are aware of the dangers of **urinary catheterisation** in older people (catheter associated sepsis, detrusor instability, falls), we only catheterise patients where it is critical to their care – for example for urinary retention. We have a nurse led protocol that allows early withdrawal of catheters by default.	The nurse led protocol can be found in many services nationwide. Peer learning can support developing one locally.	http://qualitysafety.bmj.com/content/early/2013/09/27/bmjqs-2012-001774.full http://bji.sagepub.com/content/13/2/44.full
	We routinely check for **safeguarding** concerns and have an agreed pathways for assessment of people for whom abuse might be an issue.		

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We routinely undertake **nutritional assessments**, and initiate feeding charts for people at risk, and can refer on to dietetics where necessary		
We always check people's **hearing and vision**, and have access to hearing and visual aids in our service.		https://www.elderabuse.org.uk/
We are aware of the frequency of **polypharmacy** in people with frailty, especially those with multiple comorbidities; we are aware of the risk of drug-drug and drug-disease interactions, and we have undertaken an initial medicine rationalisation, guided by evidence based criteria.	MUST score can be used in nutritional assessments.	https://www.youtube.com/watch?v=B6G7LUsDICs
Having undertaken the initial assessment and management, we are able to gain access to a clinician with appropriate skills in **managing complexity**, diagnostic uncertainty or challenging symptom control,	A local supply of reading lenses, and hearing aids and batteries can support implementation. STOPP-START checklist can be used to undertake medicine rationalisation. The anticholinergic burden scale is also useful to identify drugs that can cause side-effects – you will find some that you might not have expected! One option is to consider referral to geriatric medicine.	https://www.youtube.com/watch?v=jJjjRBUBd8g http://www.polypharmacy.scot.nhs.uk/ APP: https://itunes.apple.com/gb/app/polypharmacy-guidance/id1072829127?mt=8 https://www.youtube.com/watch?v=jXcRHxl9qWw https://www.uea.ac.uk/documents/3306616/10940915/Anticholinergics/088bb9e6-3ee2-4b75-b8ce-b2d59dc538c2

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Mental health	We perform brief **cognitive screening** on admission/initial assessment, and then assess for delirium vs dementia in those with cognitive impairment, using standardised tools. We assess for **delirium** every day in people with cognitive impairment that are admitted to hospital. We are aware of the frequency and sometime atypical presentation of **depression** in older people; we ask all older people about their mood and we are able to manage or signpost people to local services that can help manage mood disorders.	AMT-4 or AMT-10 can be used to perform brief cognitive screening. CAM-4 or 4AT can be used to assess for delirium vs dementia. Staff in all areas of our service can use the 4AT or CAM Further guidance can be found at http://www.rcpsych.ac.uk/mentalhealthinfo/improvingphysicalandmh.aspx	Capacity assessment: https://www.youtube.com/watch?v=syhKx6pxkxw Keeping people with confusion safe in hospital: https://www.youtube.com/watch?v=f0TEYT--MCI Managing delirium out of hours: https://www.youtube.com/watch?v=1iKe-6lc5b0 http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/depressioninolderadults.aspx
Functional	We have identified patients who are at high risk of **future falls**, and have implemented our local falls prevention bundle and will consider referral to our local falls prevention programme. We use a framework for assessing people who **have fallen**. We differentiate between syncopal and non-syncopal falls. We construct a problem list that describes the specific factors leading to a non-syncopal fall. In frail people with a fall and postural dizziness we provide a **lying and standing blood pressure** (L+S BP). In frail people we provide a verified **walking stability** test if they can walk.	FALLsafe (excluding the erroneous advice about urine dips!) can be used as guidance (see https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original) Further guidance can be found at http://www.bgs.org.uk/index.php/topresources/publicationfind/goodpractice/195-gpgcgassessment Clarity about roles and time scales can enhance practice. L+S BP should be assessed against specific guidelines. The Get Up and Go test can be used to verify walking stability. There should be procedure clarifying by whom, and in what time.	https://www.youtube.com/watch?v=aIs5JBiTFrA http://em3.org.uk/latest/18/7/2016/lightning-learning-falls-risk https://em3.org.uk/latest/27/1/2016/lightning-learning-stealth-trauma?rq=gemcon https://www.youtube.com/watch?v=tnUZioIUFrA

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	We routinely asses for and manage **Activities of Daily Living**.	Various scales can be used to assess ADL. In managing ADL, patients can be referred to therapists to help manage functional decline. This might be in-patient services or community based services (e.g. reablement); we only refer people for supportive packages of care once we have reviewed all their needs and have tried to optimise their physical and mental health.	https://www.youtube.com/watch?v=j77QUMPTnE0
Social	We document current formal **social care provision** of people with frailty. We know how robust is the **support network** where people with frailty normally live — if there is a key person involved (loved one, carer), they have been part of the ongoing conversation. For frail people we contact a social worker to **review** the social care support plan and prepare for discharge, including meeting any new short term needs; the patient has access to engagement with their local community to prevent social isolation.	There is a process in place which allocates roles and responsibilities for documenting current social care provision, including by whom and by when.	
Environment	We assess **home environment** of frail people to ensure it is suitably adapted to support their needs. We do so as part of promoting independence.	Occupational health practitioners assess suitability of home environment.	
Multidisciplinary Care Co-ordination	We have regular **multidisciplinary team meetings** (MDTs) where the outcomes of the assessments listed above are discussed.	High-quality MDTs: • occur at a set time and place, • usually take no more than a minute or two for each patient. • generate a problems list, stratified in terms of urgency and importance which is record in the patent notes, and the team work towards delivering during the time patients spend in the service.	For further guidance see https://vimeo.com/237106864

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	A key worker or **care coordinator** follows though the treatment plan to ensure all is enacted, and we re-discuss when plans are not working as expected. We ensure that the person, their **carers** and all health and social care practitioners involved in someone's move between hospital and home are in **regular contact** with each other. This is to make the transition coordinated with all arrangements in place. We are aware that, for some older people with frailty in the acute care setting, **end of life care** may be more relevant than curative approaches. We consider whether care or cure are the priority through a shared decision making process, and can adapt our treatment accordingly. We are able to undertake or prompt the need for **advance care planning** or emergency care plans. These describe patients' priorities and might include actions and interventions to avoid hospital admission in the future.	There are established systems to share health record information between primary care, emergency services, secondary care and social services.	For further guidance see http://www.kingsfund.org.uk/publications/people-control-their-own-health-and-care?gclid=CjwKEAjwkPS6BRD2ioKR7K245jASJAD1ZqHOliD9lLWA9yq_1o-UNlXUm6OauAdr5kIpcRMVjyK6ZhoCCqXw_wcB https://www.youtube.com/watch?v=p-NJwaZ1d5c https://www.rcplondon.ac.uk/guidelines-policy/advance-care-planning https://www.youtube.com/watch?v=liyCebOTl5c
Overarching person-centred care	We routinely ask what is most **important to the patient** (as part of person-centred care). We understand the importance of focussing on 'what matters to you' over 'what is the matter with you'.	Use clinical judgment and personalised goals when deciding how to apply disease-based clinical guidelines to the management of older people with frailty.	http://www.health.org.uk/sites/health/files/PersonCentredCareMadeSimple.pdf