“Frailty Pathway”
A patient centred approach
Guidance for Clinicians

Prompt Cards
June 2015 following a CCG sponsored County wide frailty Summit the Edmonton Frailty Scale was agreed as the tool to, identify and communicate dependency and need of Frail Older People across services

This prompt guide is aimed at clinicians to systematically assess patients, provide good care planning and be able to consider and review effectively once a patient is identified as frail.
Frailty is a distinctive health state related to ageing process in which multi body systems gradually lose their built in reserves. Older people with Frailty are at risk of unpredictable deterioration in their health resulting from minor stressor events. (BGS 2014/15)

British Geriatrics Society recommend older people who come into contact with health and social care practitioners they should be assessed for frailty (BGS silver book 2014)

Approximately 10% of people aged over 65, and 25 - 50% of those aged over 85, are living with frailty.

Currently frailty is not recognised until it presents in a crisis such as fall, infection or delirium

Across the UK 1.2 million people end up in A&E after a fall costing the NHS £ 1.6 billion.

Dementia / Delirium
Falls
Immobility
Poly-pharmacy
End of Life
Incontinence

6 Syndromes
## Frailty Pathway Guide Stage 1

### EDMONTON Frail Scale

**Must be done with patient OR SIGNIFICANT OTHER**

<table>
<thead>
<tr>
<th>Frailty domain</th>
<th>Item</th>
<th>0 points</th>
<th>1 point</th>
<th>2 points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognition</td>
<td>Please imagine that this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions then place the hands to indicate a time of ‘ten past eleven’.</td>
<td>No errors</td>
<td>Minor spacing errors</td>
<td>Other errors</td>
<td></td>
</tr>
<tr>
<td>General health status</td>
<td>In the past year, how many times have you been admitted to a hospital</td>
<td>0</td>
<td>1-2 times</td>
<td>More than 2 times</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In general, how would you describe your health?</td>
<td>Excellent/very good/good</td>
<td>Fair</td>
<td>Poor</td>
<td></td>
</tr>
<tr>
<td>Functional independence</td>
<td>With how many of the following activities do you require help: meal preparation, shopping, transportation, telephone, house-keeping, laundry, managing money, taking medications?</td>
<td>0-1</td>
<td>2-4</td>
<td>5-8</td>
<td></td>
</tr>
<tr>
<td>Social support</td>
<td>When you need help, can you count on someone who is willing and able to meet your needs?</td>
<td>Always</td>
<td>Sometimes</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>Medication use</td>
<td>Do you use five or more different prescription medications on a regular basis?</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>At times, do you forget to take your prescription medications?</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>Have you recently lost weight such that your clothing has become looser?</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood</td>
<td>Do you often feel sad or depressed?</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continence</td>
<td>Do you have a problem with losing control of urine when you don’t want to?</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional performance</td>
<td>I would like you to sit in this chair with your back and arms resting. Then when I say ‘Go’, please stand up and walk at a safe and comfortable pace to the mark on the floor (approx.. 3m away), return to the chair and sit down.</td>
<td>0-10 seconds</td>
<td>11-20 seconds</td>
<td>More than 20 seconds, patient unwilling or requires assistance</td>
<td></td>
</tr>
</tbody>
</table>

**Total**

Final score is the sum of column totals

### Scoring the Reported Edmonton Frail Scale (/17):

- **Not frail:** 0-5
- **Apparently vulnerable:** 6-7
- **Mild frailty:** 8-9
- **Moderate frailty:** 10-11
- **Severe frailty:** 12-17

See flow diagram Page 6
Edmonton Follow up-Community Pathway Stage 2 A

- Complete Edmonton scale using information gained from Holistic Assessment
- Offer referral to local wellbeing services
- Ensure score is sent to Patient’s GP
- Review Edmonton score on admission to caseload, monthly or as condition changes and on discharge.
- Request GP OR Dr review of medication.

**Not Frail: 0-5**

**Apparently vulnerable 6-7**

**Mild – moderate Frailty 8-11**

**Severe frailty 12-17**

**As above plus:**
- Review Edmonton score at each intervention
- If stable review monthly or on deterioration and on discharge
- Review full holistic, falls, MUST and Waterlow assessment
- Address issues contributing to frailty scale, (function, medications, continence, etc)
- Provide education to patients and carer
- Commence discharge planning if appropriate
- Develop self-management plans (My Plan)
- Signpost or refer to local services or integrated team on discharge
- Consider Carer’s assessment/significant others

**As above plus:**
- Review of Edmonton score- nursing and medical as appropriate
- Local MDT review
- Comprehensive geriatric assessment/medical review
- Commence Advance care planning
- Ongoing discharge planning if appropriate

**As above plus:**
- DNACPR discussions
- Preferred place of care/death/EPaCC’s/Gold Standard Framework
- 5 priorities of care
- Fast track
- Co-ordinating complex care services/neighbourhood teams.

- Reassess if condition changes
- Consider specialist services/therapy
- Consider further assessment tools (if in doubt ask, escalate or take to MDT)
- Carer’s Assessment
- MY PLAN (personalised patient care plan)
- Share information with other services- MY RIGHT CARE e.g. abbey pain, MoCA, responsive needs tool, karnofsky, Bartel, self- management plan etc.
- Refer to GP
- Mental Health
- Think! What Next?
Edmonton Tool Follow up - Inpatient Pathway Stage 2B

- Complete Edmonton scale using information gained from Holistic Assessment
- Offer referral to local wellbeing services
- Ensure score is sent to Patient’s GP on discharge
- Review Edmonton score weekly and on discharge
- Request GP OR Dr review of medication while in unit.

**As above plus:**
- Review Edmonton score daily for 3 days
- If stable review weekly or on deterioration and on discharge
- Complete/Review full holistic, falls, MUST and Waterlow assessment
- Address issues contributing to frailty scale (function, continence, medications etc)
- Provide education to patients and carer
- Commence discharge planning
- Develop self-management plans (My Plan)
- Signpost or refer to local services and ICT on discharge
- Consider Carer’s assessment/significant others

**Not Frail: 0-5**

**Apparently vulnerable 6-7**

**Mild – moderate Frailty 8-11**

- Daily review of Edmonton score- nursing and medical as appropriate
- MDT review
- Comprehensive geriatric assessment
- Consider referring to specialist teams/ nurses
- Advance care planning
- Ongoing discharge planning (consider/ discuss ‘Would this patient be suitable for a neighbourhood team referral?’)

**Severe frailty 12-17**

- Reassess if condition changes
- Consider specialist services/third sector
- Consider further assessment tools
- Carer’s Assessment
- MY PLAN (patient’s personalised care plan)
- Share information with other services- MY RIGHT CARE e.g. abbey pain, MoCA, responsive needs tool, karnofsky, Bartel, self-management etc.
- G.P Referral
- Mental health
- Think ! What Next

- DNACPR discussions
- Preferred priority of care/ EPaCC’s/ Gold Standard Framework
- 5 priorities of care
- Fast track
- Complex discharge planning

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Chair: Elaine Baylis, QPM
Chief Executive: Andrew Morgan