

# THINK FRAILTY



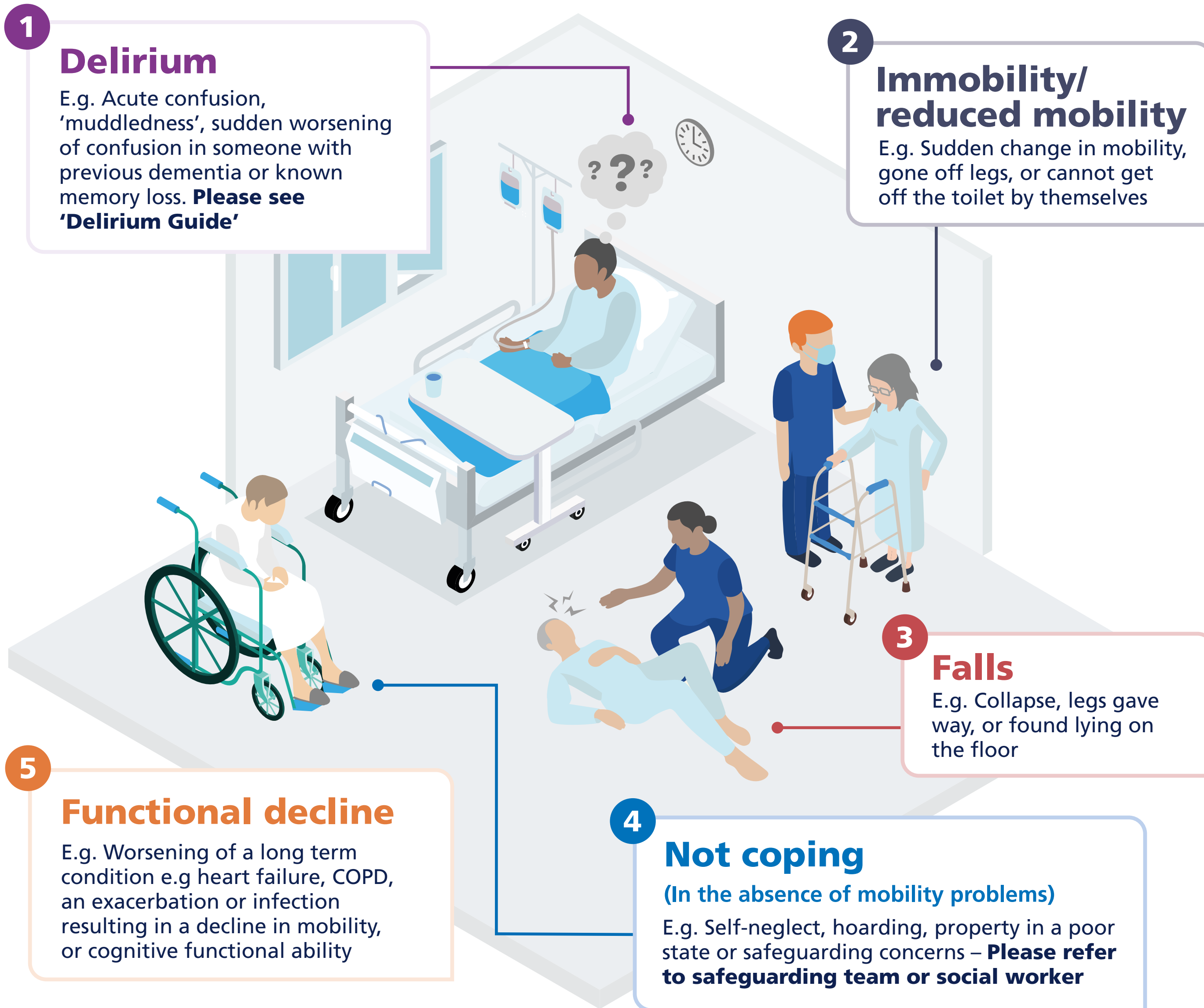
Oxford University Hospitals  
NHS Foundation Trust

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

## 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

## 2 RECORD AND MOBILISE

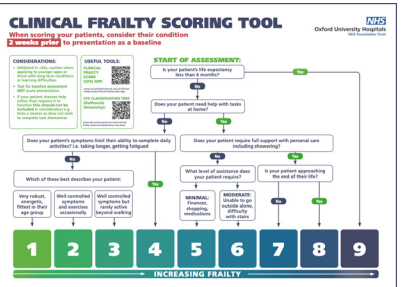
For ALL patients with a frailty presentation, please ensure the following:

### 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

### 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



### 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

### Age UK

For help with shopping, transportation, domestic tasks, befriending service, dementia advisor, advice on benefits

07827 235 417 Bleep 4642

### 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

## 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

### 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

### HomeFirst

Short term reablement care package.

8:30am - 5:00pm (Mon-Fri)

General Enquiries: 01865 328794

Discharge Planning: 01865 328795