Healthcare Improvement Scotland

# Foundations for front door frailty

**Sudden deterioration in health**

Older people with frailty can deteriorate quickly. Management of a sudden deterioration should be in line with expressed wishes and any future care plan.
When admission to hospital is required, treating people with frailty in a frailty unit can improve outcomes, shorten length of stay and reduce readmission.[1]

### Urgent community response to deterioration in health

- Enhanced community support or hospital at home for older people with frailty.
- Management in line with expressed wishes and future care plan.

**Decision to convey** to acute hospital

### Reliable identification and triple assessment

- Frailty screening within one hour of presentation.
- Frailty identification recorded electronically.
- NEWS2.
- 4AT.

### Frailty in unscheduled care

- Access to specialist frailty team in unscheduled care within four hours (12 hours if presenting out of hours).
- Initiation of **CGA. ***
- Locally agreed admission criteria to frailty assessment beds.

**Decision not to admit**

**Decision to admit** to frailty assessment beds

### Care coordination and proactive discharge

- MDT huddle or board round at least twice a day to plan coordinated care.
- Discharge without delay:
  - Planned date of discharge.
  - Integrated discharge hubs.
  - Discharge to assess.
  - Access to rehabilitation.
- Access to reablement.

### Core features of a front door frailty service

- Dedicated multidisciplinary (MDT), multiagency and integrated (across acute and community) frailty team.
- Dedicated 24/7 frailty assessment area within unscheduled care.

**Key enablers**

- Integrated leadership of the service across operational management, medicine, nursing, allied health professionals and adult social care.
- Executive leadership sponsor.
- Continuous data led improvement in partnership with patients, families and carers.

**Implementation in remote and rural contexts will require locally designed approaches, that use their infrastructure, workforce and access to frailty expertise to best meet their population needs.**

### *Comprehensive Geriatric Assessment (CGA) of:

- Mobility and function.
- Mental health - delirium and cognition.
- Medicines reconciliation and polypharmacy review.
- Multimorbidity.
- Social and environmental.
- Diagnosis and treatment plan.
- Future care plan and ‘What matters to me’.

[1]Healthcare Improvement Scotland. Ageing and Frailty Standards. 2024.