Effective Front Door Intervention for Older People

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Emergency Care Improvement Programme
Current State

One patient may have 3-5 ‘organisational hand-offs’ before reaching their required destination

This is in addition to internal waits e.g. diagnostics, AHP assess

Ward teams are required to fill in different paperwork for different destinations

Need to ‘prescribe goals’ and determine destination before acceptance
Start at the beginning

• Move assessment from wards to front door!
• Ask questions in a different way
• Listen rather than tell
• Understand the person – ask questions differently
  – How do they normally live their lives?
  – What matters to them?
  – What concerns do they have?
  – How can we help
### Hospital Rapid Discharge Team / Frailty Team Initial Screening Tool

**Frailsafe Criteria:**
- Reduced mobility
- Confused
- Lives in Care Home

**Consent to share information / contact NOK:**
- Yes
- No
- Unable

**Patient Name:**

**DOB:**

**NHS No / Hosp No:**

**Tel No:**

**Place of residence:**
- Home
- R. Home
- N. Home
- Comm. Rehab Bed
- Hostel
- Sheltered
- Assisted Living
- Extra care
- NFA

**Social Situation:**
- (Type of property, layout of property, access, who else is at home, social support)

**Is patient a carer:**
- Yes
- No

**Are there children involved:**
- Yes
- No

**Are there pets involved:**
- Yes
- No

**Package of care:**
- YES
- NO

**Agency:**
- Telephone no:

**Previous level of function:**
- Mobility:
  - Indoor, outdoors, stairs, walking aids, wheelchair user, distance
- Transfers:
  - Chair, bed, toilet
- Personal care:
  - (Shower, bath, stripwash, dressing, toileting, night time)
- Domestic tasks:
  - (meal preparation, shopping, housework, laundry)

**Falls history:**
- (falls in last 6 months)

**Medication Info:**
- (tick as appro.)
  - Self-administer
  - Blister pack
  - Requires prompting
  - Administered by carers
  - Locked box

**Cognition / AMT / Mood:**

**Equipment in place:**
- Lifeline / Carelink: Yes / No
- Keysafe Yes / No

**Recommendation / Discharge Plan / Treatment Plan:**
- (Outcome of functional assessment, Social Work input)

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### 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 (ADLs: 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, standing) 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.

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### 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.
**Ready to transfer to Short Term Community Services**

Any additional information on social history received since admission to hospital

Current needs regarding mobility/transfers (please include type of supervision and aids required e.g. transfers with 2, hoist, WZF)

Current care support needs (washing/dressing/eating/drinking/toileting assistance). Please include day and night needs and level of supervision for confusion/wandering required

Current needs regarding emotional/mental health support (Confusion, depression, CPN) Please include day and night needs

Current needs regarding medication support (Blister packs/assistance to self-medicate) Insulin or other injectable medication requirements

Any care or nursing issues noted (please include issues with continence/ wounds/pressure areas/pain)

Any equipment requirements (special mattress/bariatric equipment/commode)

**Additional Information**

Please include:
- Any relevant medical/nursing interventions and diagnosis since admission
- Changes to the person’s pre admission history
- Any functional assessment outcomes
- Any pathology results

Referral advised for a Bed

Referral advised for assessment at home

Referral advised for short term support at home

If referral is for support or assessment at home what is the predicted home care needs required to support discharge (include additional needs if patient having a restart)

Original care package restarted if appropriate Y/N

Name: Signature Date: Time:
Improvement from simplified process
Impact on out of hospital care

Home First patients May-Dec 2016

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Total Recommended Hours vs Actual Hours Provided

- Recommended Hours: 5669.07
- Hours Provided: 4260.15

Figure One: Recommended Hours vs Coastal Homecare Hours provided
Key Principles

• Reduce duplication
• Reduce paperwork
• Reduce Hand Offs

This simplifies the process and delivers better outcomes for everyone
Keep the person at the centre
Contact details

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  – #homefirst
  – #last1000days
  – #red2green
  – #endpjparalysis

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