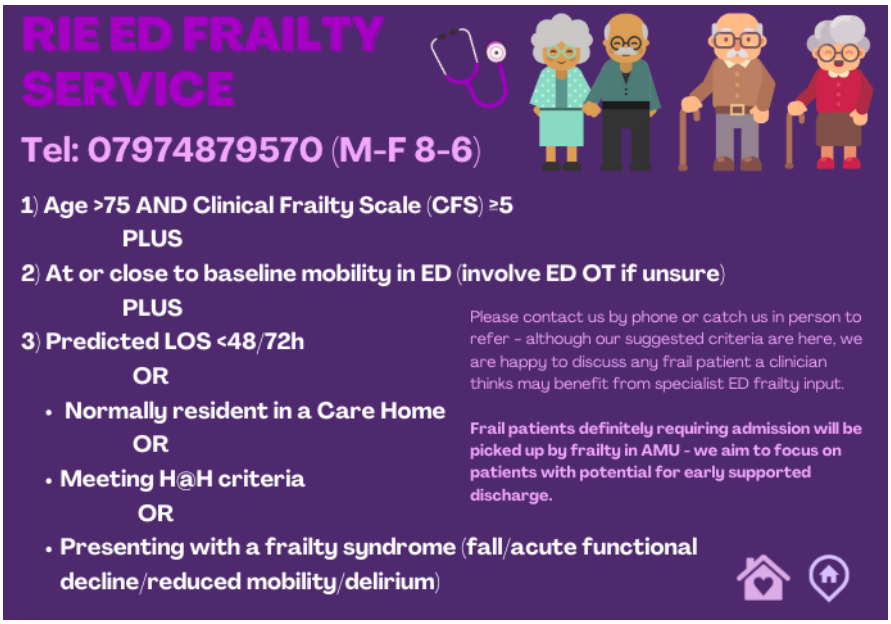
Author: Dr Amy Armstrong
Published: August 2024
Review Date: August 2025

RIE ED Frailty Summary/Front Door Frailty Contacts

1. RIE ED Frailty Service

The ED frailty service is focussed on providing patient centered care to frail older adults attending RIE ED. We aim to do this by instituting timely and responsive MDT comprehensive geriatric assessment and providing decision support to the wider ED team, with a strong emphasis on utilising available alternatives to admission.

A frailty consultant or ANP are generally available Monday to Friday from 8am-6pm on 07974879570, (currently cover is a patchy as we do not currently have prospective cover for leave are recruiting more ANPs). Our referral criteria are summarised in the poster below. We focus on seeing patients aged >75 who can likely be discharged from the ED following specialist frailty input (with appropriate follow up), but are happy to provide advice/decision support on all other frailty-related matters.



We work very closely with the ED OTs (available Monday to Sunday from 8am-8pm) who are often critical in deciding if our patients are at a suitable mobility/functional level for discharge. They can provide equipment (Zimmer Frames, walking sticks, toilet frames etc.), give advice about e.g. falls alarms, arrange day hospital referral, arrange urgent community therapy follow up if required and much more! To refer, please use the Trak order menu to select 'Referral to OT' and fill in the short form then press update. If review is urgent, then please bleep them on 5384. The same online referral form should be used for OOH referrals.

Many of our patients go home with either Hospital at Home (H@H) or Day Hospital (which is essentially geriatric OP clinic) follow up. Referral criteria and information about how to refer directly to these services for each locality can be found below, but in-hours we are happy to help you with this too.

A final useful contact is our Home First Coordinator for Edinburgh City patients. Lukas is available on 07596886540 from Monday to Friday 8am-4pm and can help to navigate all questions around packages of care and community services available locally, provide direct access to hospital and community social work teams, request falls alarm/key safes or phone support installation, request

bridging team input to reduce/minimise LOS and even provide food parcels for discharge and follow up home deliveries where required.

2. The Day Hospital (aka Urgent Geriatric Outpatient Clinic)

The Day Hospital is essentially an urgently accessible outpatient geriatric clinic for patients who live in North Edinburgh, South Edinburgh, Midlothian, or West Lothian. Unfortunately there are no Day Hospital Services for East Lothian. Urgent referrals to the Day Hospitals can be seen within a week (esp. if not needing hospital transport), whilst routine referrals are typically seen in 4-6 weeks.

Guidance about what is suitable for each Day Hospital/who to refer can be found on the MOE refhelp page here (scroll to 'Day Hospital' section about halfway down and click link):
https://apps.nhslothian.scot/refhelp/guidelines/medicineoftheelderlygeriatrics/

To access the generic referral form which works for all 3 day hospitals, click here:
http://intranet.lothian.scot.nhs.uk/Directory/medicineoftheelderly/Community%20Services/Pages/Day-Hospitals.aspx

Once completed, please save it and email to relevant address found on the form. To check which council area your patient belongs to look at the Hospital at Home Area Map (found here:
For North Edinburgh patients if you unsure whether they are North East or North West then email it to both with a brief apology in the text of your email and they will kindly sort it out!

If you have any questions pertaining to the above then please feel free to ask any member of the ED Frailty Team for further clarification.

3. Hospital @ Home

Edinburgh and the surrounding areas are served by four separate Hospital @ Home services – IOPS or Edinburgh H@H, ELSIE or East Lothian H@H, MERRIT or Midlothian H@H and REACT in West Lothian. They essentially provide hospital level care and treatment for frail older adults in their own home.

Further information about the H@H concept and referral guidance can be found here: Integrated Older People's Service (IOPs) Hospital @ Home Update (scot.nhs.uk).There is also an area map to guide you with which service to refer to available in the 'Medicine' folder on EMIBANK - a quicker option is to ask them which council collects their bins!

It is important to note that patients must be able to manage Activities of Daily Living, e.g. bathing/ meals/toileting for themselves (or with assistance from pre-existing carers or family) as there is no nursing care/carer component to the H@H service. Please also note that living with householders who smoke or vape is an absolute contraindication to oxygen supplementation at home.

All the H@H team co-ordinators are friendly and helpful and are happy to take phone calls to discuss potential referrals further – their contact numbers and hours of operation can be found below.

East Lothian: 01620642798/07824527003 (M-S 8am–8pm)
Edinburgh: 07989170797 (M-S 8am-8pm)
Mid Lothian: 07773 193921 (M-S 8am-6pm)
West Lothian: 01506524149 (M-S 8am -6pm)

4. Top Frailty Resource Recommendations:

A summary of best practice in managing frailty at the front door - combined BGS/RCEM publication known as 'the Silver Book II' – published Feb 2021 and available from: https://www.bgs.org.uk/resources/resource-series/silver-book-ii.

Below are QR codes for the Clinical Frailty Scale and 4AT Apps – both of which the frailty team highly recommend!

CFS Apple

CFS Android

4AT Apple

4AT Android

If anyone wants to come and spend some time with the team to upskill in the management of frailty at the front door (e.g. using EDT time), please email amy.e.armstrong@nhslothian.scot.nhs.uk and the team would be delighted to facilitate this.