<table>
<tr><td colspan="2">Consent<br>- Summary Care Record consent<br>- Consent to contact carers/family?<br>- Emergency contact details:</td><td></td></tr>
<tr><td colspan="2">Capacity<br>- Any concerns regarding capacity?</td><td></td></tr>
<tr><td><u>Frailty Screening Tool</u></td><td><u>Result</u></td><td><u>Action taken</u></td></tr>
<tr><td>1. <u>Memory</u></td><td>1.</td><td>Memory referral?</td></tr>
<tr><td>2. <u>Urinary Incontinence</u></td><td>2.</td><td>DNs?</td></tr>
<tr><td>3. <u>Depression</u></td><td>3.</td><td>GDS/Depression screen?</td></tr>
<tr><td>4. <u>Physical Functional Capacity</u></td><td>4.</td><td></td></tr>
<tr><td>5. <u>Recall 3 words</u></td><td>5.</td><td>6CIT?</td></tr>
<tr><td>6. <u>Falls</u></td><td>6. __ in 12 months</td><td>TUGT?<br>Falls clinic/specialist?</td></tr>
<tr><td>7. <u>Nutrition</u></td><td>7.</td><td>Food First?</td></tr>
<tr><td>8. <u>Bowels</u></td><td>8.</td><td>DNs?<br>Stool Sample?</td></tr>
<tr><td>9. <u>Vision</u></td><td>9.</td><td>Specsavers?</td></tr>
<tr><td>10. <u>Skin Integrity</u></td><td>10.</td><td>DNs?</td></tr>
<tr><td>11. <u>Safety</u></td><td>11.</td><td>Keysafe? Careline?</td></tr>
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| **Medication**<br>- Understanding – Does patient understand why they are taking their medication?<br>- Compliance – Is patient compliant in taking their medication?<br>- Management – Is patient able to manage their medication?<br>- Dosette Box – Does patient use a dosette box? Own dosage system? Self-administration? | Knows what their medications are for and what they are, knows the correct doses, although can get confused with the times of<br><br>Has a Dosette box and is able to get them out on their own and is able to telephone the Drs to talk about the medication or renew prescription. |
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| **My Life, My Plan (Care planning)**<br>- What do you feel is going well in your life?<br>- Is there anything you are worried about/feel could be better?<br>- What are your main priorities? | *What help and support do you need for this? What could get in the way?*<br>*What are you going to do to reach your goal?*<br><br>Love having my family around me<br><br>I do worry that I am on my own a lot and I might fall<br><br>To stay at home for as long as possible, I don't want to go into hospital. |
| **Falls Assessment**<br>- Have you had a fall in last year? How many? Location and details?<br>- Are you on four or more medications?<br>- Do you have Parkinson's or have you had a stroke?<br>- Do you feel unsteady or have problems with balance?<br>- Do you struggle to get up from a chair? Can you stand from sitting without using arms to assist?<br>- Has a pendant alarm?<br>- Able to get off of floor?<br>- Does patient use any mobility aids?<br>- Does patient require falls clinic referral?<br><br>**Mobility Assessment**<br>- Upper limb strength?<br>- Lower limb strength?<br>- Appropriate footwear?<br>- Able to manage stairs?<br>- Housebound? Bedbound? Confined to chair?<br>- Do they require mobility aids indoors and outdoors?<br>- Are they able to adjust their clothing for the toilet? | Referral to falls specialist? Falls clinic? Community physio?<br><br>3 Falls in the last 12 months – Fallen in the kitchen, Livingroom, and bedroom.<br>Went a little dizzy when I stood up, just trying to rush around to do things.<br><br>Can get in and out of chair – No rise recliner.<br><br>Does have an alarm and is able to call for help if needed.<br><br>Not able to get off the floor.<br><br>Uses a zimmer frame around the home, which has a caddy<br><br>TUGT? ____secs |

| **Depression, Anxiety and Isolation**<br>- Depression screen?<br>- Living conditions<br>- Employment/financial status<br>- Alcohol/Drug intake?<br>- Loneliness and social isolation<br>- Family history of depression?<br>- Social support<br>- Suicidal ideation? | Does live alone – Lost husband 4 years ago |
|---|---|
| **Barthel**<br>1. Bowels<br>2. Bladder<br>3. Grooming<br>4. Toilet use<br>5. Feeding<br>6. Transfer<br>7. Mobility<br>8. Dressing<br>9. Stairs<br>10. Bathing | 1. Incontinent? Occasional accident? **Continent?**<br>2. Incontinent? Occasional accident? **Continent?**<br>3. Needs help? **Independent** with face/hair/teeth/shaving?<br>4. Dependent? Needs help with some? **Independent?**<br>5. Unable? Needs help with some? **Independent?**<br>6. Unable? Major help? Minor help? **Independent?**<br>**7.** Immobile? Wheelchair independent? AO1? **Independent?**<br>8. Dependent? Needs help but can do some? **Independent?**<br>9. Unable? Needs help? **Independent?**<br>10. Dependent? **Independent** or showers? **Although doesn't like to shower when on her own** |
| **Driving**<br>- Does the patient drive?<br>- Have they been advised about driving? Advised not to drive?<br>- Advised to inform DVLA? Advised to inform insurance company?<br>- Do they need SAGE? | No longer driving<br><br>Daughter lives in the other village and is able to get her to the shops once a week or can do online shopping |

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| **Residence, Care & Support**<br>- Does the patient live in their own home?<br>- What is their home environment like? Equipment? Tidy?<br>- Heating? Keysafe? Easy access to home? Stairs?<br>- Do they live with anyone?<br>- Do they already have support services in place? SS, telecare, OT, PT, DN, specialist?<br>- Do they have a package of care? Any help from family/friends? Neighbour/cleaner? | Lives on own, but daughter not to far away<br><br>Property is a 1 bed flat (ground floor) does have warden and communal areas, although doesn't use them<br><br>No POC – Independent – Will have a shower once a wk when daughter visits as doesn't like to be on own when showering incase of falling<br><br>Does have a cleaner once a week who changes the bed and ensures bathroom and everything is clean |
| **Diet, fluid and nutrition**<br>- Current/Ideal body weight – Calculate MUST score!<br>- Appetite? Increased? Decreased? Cannot face food?<br>- Consider Food First leaflet<br>- Fluid intake? Increased? Reduced?<br>- Nausea and vomiting (number of episodes and duration)<br>- Swallowing ability?<br>- Dentures? | Weighs 60kg<br><br>No change in food, still likes her food and little snacks (biscuits) Now having to do microwave meals but does do extra veg with them (when can be bothered)<br><br>Will drink tea all day – occasionally will have a glass of water, prefers tea<br><br>Has dentures and visits the dentist at least once a yeat |
| **Speech and hearing**<br>- Does patient wear a hearing aid?<br>- Any hearing problems? Unable to hear different volumes of voice?<br>- Any speech problems? Aphasia? Dysphasia? Stammer/stutter?<br>- Does the patient require a referral to audiology? Speech and language? | No aids<br><br>No problems with hearing.<br><br>Able to get words out although sometimes can struggle |
| **Smoking and Drinking**<br>- Does patient smoke?<br>- Does patient require Smoking Cessation Intervention?<br>- How many units of alcohol a week?<br>- Does patient need to be referred to community alcohol team? | Not smoked in 40 years<br><br>Has occasional drink at a weekend |
| **Sleep**<br>- How is the patients sleeping pattern?<br>- Are they sleeping well? | Rubbish – Cat naps throughout the day<br>Will go to bed at 10pm and watch TV and then awake to go to the toilet 3/4x a night and struggle to go back to sleep |

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| **<u>Treatment escalation planning</u>**<br><br>1. Do you want life prolonging treatment and full escalation of care including transfer to acute hospital?<br><br>2. Do you want life prolonging treatment including hospital admission only for fully reversible conditions where you are expected to return to preceding quality of life?<br><br>3. Would you be for life prolonging treatment priorities against harms?<br><br>4. Would you NOT want any life prolonging treatment or not want treatment other than for symptom control?<br><br>5. Would you consider hospital transfer if essential for symptom control where this cannot be achieved at home?<br><br>6. Or would you avoid hospital transfer in all but the most exceptional circumstances?<br><br>What are your treatment priorities?<br><br>Who was this discussed with? | Doesn't want to go to hospital<br><br>Doesn't want heart started again if it stops<br><br>Would prefer community help rather than going to Gloucester Hospital |
| DNAR status?<br><br>ACP?<br><br>Already planned funeral? | |

**My story:**
*(Me at my best)*

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|---|---|
| PAM completed (or left with patient) | Yes / No |
| Consent form completed | Yes / No |
| Frailty template completed | Yes / No |
| Care plan completed | Yes / No |
| Medication review *(if appropriate)* | Yes / No |
| DNAR completed *(if appropriate)* | Yes / No |
| Referrals made *(if appropriate)* | Yes / No |
| Leaflets given *(if appropriate)* | Yes / No |
| Carers information given *(if appropriate)* | Yes / No |
| Attendance allowance/Blue badge form requested *(if appropriate)* | Yes / No |
| **Plan:** | |