Centre for Perioperative Care

British Geriatrics Society
Improving healthcare for older people

Frailty Pathway

Emergency admission

Assess and document frailty (CFS).

Consider atypical presentations of surgical pathology associated with frailty.

Obtain timely collateral history.

Establish presence of ACD, ADRT, DNAR decisions and LPA for health and welfare, and agree treatment escalation plan.

Refer to perioperative frailty team/other services for optimisation, or use frailty intervention tool.

Assess, document and modify risk factors for delirium.

Undertake SDM and consider involving relatives and/or carers.

Follow emergency care pathways.

Primary care referral for elective surgery

Start SDM including discussion about non-surgical options.

Make Every Contact Count; medical and lifestyle optimisation.

Referral to include:

- frailty score (CFS/eFI)
- presence, severity and management of comorbidities
- presence of ACD, ADRT, DNAR decisions and LPA for health and welfare.

Surgical and preoperative assessment out-patient services

Use information from primary care.

Reassess and document frailty.

Refer to perioperative frailty team/other services for optimisation, or use frailty intervention tool.

Establish and review existing ACD, ADRT, DNAR decisions and LPA for health and welfare, and agree treatment escalation plan.

Undertake SDM including discussion about non-surgical and palliative surgical options.

Consider involving relatives and/or carers.

Plan admission and discharge.

In theatre and recovery

Consultant surgeon and anaesthetist involvement for high-risk cases.

Identify frailty and co-existing conditions at the WHO team briefing.

Employ strategies for positioning and moving cognisent of frailty.

Ensure physiological homeostasis cognisent of frailty.

Informed by frailty status and agreed treatment escalation plans, anticipate postoperative care requirements and setting, and review again at the end of surgery.

Surgical wards providing care for emergency and/or elective patients

Assess and document frailty.

Anticipate, prevent, and treat:

- delirium
- pain
- medical and surgical complications
- hospital acquired deconditioning.

Review treatment escalation plans.

Promote recovery and timely discharge:

- review discharge plans
- regular multidisciplinary team meeting
- proactive communication with patients and consider involving relatives and carers.

Transfer of care to the community

Ensure timely and comprehensive written discharge information to patient and GP, including:

- diagnoses
- treatment (operative and/or non-operative)
- complications
- continuing medical and/or functional impairments
- medication changes
- follow up plans and referrals
- safety-net advice and points of contact
- patient and carer education
- agreed escalation and advance care plans.

Underpinning principles

Iterative Shared Decision Making; Streamlined communication and documentation; Comprehensive Geriatric Assessment and optimisation; Multispecialty, multidisciplinary working.