

[HOSPITAL / HEALTH AUTHORITY NAME]

# FRAILTY, FALLS, AND ACUTE FUNCTIONAL DECLINE PATHWAY

Protocol 44: Delirium, Occult Illness and Injury, Medication Burden, Mobility, Pressure Risk, Caregiver Capacity, Comprehensive Geriatric Assessment, and Safe Disposition

DRAFT FOR EMERGENCY MEDICINE, INTERNAL / GERIATRIC MEDICINE, NURSING, PHYSIOTHERAPY, OCCUPATIONAL THERAPY, PHARMACY, SOCIAL WORK, DIETETICS, PALLIATIVE CARE, PRIMARY / COMMUNITY CARE, RADIOLOGY, ORTHOPAEDICS, AND CLINICAL GOVERNANCE

**STATUS:** This is a draft clinical-governance document. It must be adapted to local staffing, frailty and therapy services, medication formularies, delirium and falls tools, imaging access, observation capability, pressure-injury prevention, community nursing, rehabilitation, home-care and residential-care resources, safeguarding law, transport, and referral pathways before implementation.

**OLDER-PERSON SAFETY RULE:** A fall, confusion, weakness, reduced mobility, poor intake, incontinence, or "not coping" is a presentation - not a diagnosis. Do not label a fall as mechanical, attribute acute confusion to age or dementia, or discharge on the basis of normal initial observations until serious illness, injury, medication harm, delirium, functional loss, and an unsafe care environment have been actively considered.

| Document control  | Details   |
|-------------------|---|
| Document owner    | Emergency Department / Medical Services Directorate / Nursing Services / Internal or Geriatric Medicine / Clinical Governance   |
| Clinical leads    | Emergency Medicine; Internal / Geriatric Medicine; Nursing; Physiotherapy; Occupational Therapy; Pharmacy; Social Work; Dietetics; Palliative Care; Primary / Community Care; Radiology; Orthopaedics   |
| Applies to        | Adults, usually aged 65 years and older, and younger adults with frailty, multimorbidity, cognitive impairment, mobility limitation, recurrent falls, or acute functional decline. Age alone must not determine treatment access or disposition.  |
| Interfaces        | Protocol 1 Patient Journey; Protocol 2 Triage; Protocol 3 Resuscitation / Sepsis / Shock; Protocol 4 Clinical Assessment and Documentation; Protocol 17 Altered Mental Status; Protocol 18 Stroke / TIA; Protocol 21 Syncope / Collapse; Protocol 23 Hypertensive Emergency; Protocol 26 Dehydration / Electrolytes; Protocol 27 Glycaemic Emergencies; Protocol 28 AKI / Electrolytes; Protocol 29 Poisoning / Withdrawal; Protocol 31 Major Trauma; Protocol 32 Head / Spinal Injury; Protocol 34 Limb Injury; Protocol 42 Mental-Health Crisis; Protocol 43 Safeguarding; Protocol 46 Immunocompromised / Oncology; Protocol 47 Renal Failure; Protocol 51 Capacity / Refusal; Protocol 52 Palliative Emergencies; Protocol 53 Observation Care. |
| Version / status  | Draft 1.0 for local multidisciplinary validation  |
| Review cycle      | After any death or serious harm related to a missed injury, delirium, medication error, inpatient or ED fall, pressure injury, unsafe discharge, delayed transfer, caregiver failure, or at least every 2 years.  |
| Required approval | Emergency Department; Internal / Geriatric Medicine; Nursing; Therapies; Pharmacy; Social Work; Dietetics; Palliative Care; Radiology; Orthopaedics; Primary / Community Care; Safeguarding; Clinical Governance.   |

## 1. Purpose

To provide a standardized emergency-department pathway for recognizing frailty, identifying dangerous causes of falls and acute functional decline, diagnosing and managing delirium, preventing avoidable deconditioning and pressure injury, assessing medication and caregiver risk, and arranging a safe, goal-concordant disposition.

## 2. Scope

- Use for any older adult presenting after a fall, collapse, new confusion, reduced mobility, weakness, poor intake, incontinence, recurrent attendance, caregiver concern, or loss of ability to manage usual activities.
- Use for younger adults with established frailty, severe multimorbidity, neurodegenerative disease, lifelong disability with new decline, or high dependency, while avoiding inappropriate use of age-based frailty tools.
- This protocol supplements, rather than replaces, condition-specific pathways for sepsis, stroke, syncope, trauma, head injury, fracture, acute kidney injury, hypoglycaemia, poisoning, safeguarding, capacity, and palliative emergencies.
- The protocol covers ED assessment and the first 24 hours of observation or transfer. It does not replace a full inpatient comprehensive geriatric assessment, rehabilitation plan, or community falls programme.

## 3. Core policy statements

- Assess physiological instability first. Frailty does not reduce the urgency of reversible life-threatening illness and must not be used alone to withhold resuscitation, imaging, surgery, intensive care referral, or transfer.
- Screen adults aged 75 years and older, and any adult with acute cognitive or functional change, for delirium, falls risk, and frailty using locally approved methods. Act on positive findings.
- Determine baseline cognition, mobility, activities of daily living, continence, nutrition, medication use, living arrangements, supports, and goals from the patient and a reliable collateral source whenever possible.
- Use the Clinical Frailty Scale only as an adjunct, based on the person's usual function about 2 weeks before the acute illness. Do not score the current crisis, and do not substitute CFS for clinical judgement.
- Do not use a numerical falls prediction score to declare a person safe. Identify and address the person's modifiable risk factors and the reason for the fall.
- Treat delirium as an acute medical syndrome. Search for one or more causes, including pain, infection, hypoxia, dehydration, constipation, urinary retention, metabolic disturbance, medication toxicity or withdrawal, and environmental stress.

- Protect basic needs throughout the ED stay: orientation, hearing and vision aids, pain relief, hydration, nutrition, regular medicines, toileting, warmth, mobility, sleep, pressure-area care, and family or caregiver communication.
- Discharge requires more than a negative scan or improved vital signs. The person must have a safe destination, feasible mobility and self-care plan, medication plan, adequate supervision, transport, follow-up, pending-results ownership, and clear return instructions.

## 4. Definitions and clinical framework

| Term  | Operational definition  |
|---|---|
| <b>Frailty</b>                                  | A multidimensional state of reduced physiological reserve and increased vulnerability to disproportionate decline after an apparently minor illness, injury, medication change, or environmental stressor.                        |
| <b>Clinical Frailty Scale (CFS)</b>             | A 9-point judgement-based scale for people generally aged 65 years and older, scored from baseline function before the acute illness. Use the official locally approved chart and training material.                              |
| <b>Acute functional decline</b>                 | A new or rapidly worsening loss of mobility, transfers, feeding, toileting, continence, medication management, communication, or other activities compared with the person's usual baseline.                                      |
| <b>Delirium</b>                                 | An acute and fluctuating disturbance of attention, awareness, cognition, perception, or behaviour due to an underlying medical cause or causes. It may be hyperactive, hypoactive, or mixed.                                      |
| <b>Comprehensive geriatric assessment (CGA)</b> | A coordinated multidisciplinary process evaluating medical, psychological, functional, medication, social, environmental, and goal-of-care domains, followed by a shared plan and accountable follow-up.                          |
| <b>Fall</b>                                     | An event in which a person unintentionally comes to rest on the ground, floor, or lower level, whether or not injury is apparent. The event may represent syncope, seizure, stroke, infection, medication harm, or other illness. |
| <b>Long lie</b>                                 | A prolonged period on the floor or ground after a fall, increasing the risk of pressure injury, rhabdomyolysis, hypothermia, dehydration, aspiration, and psychological trauma.   |
| <b>Silver trauma</b>                            | Trauma in an older or frail person where low-energy mechanisms can produce major injury and where cognitive impairment, osteoporosis, anticoagulation, comorbidity, and altered physiology may obscure severity.                  |
| <b>Polypharmacy</b>                             | The use of multiple medicines. Risk depends on appropriateness, interactions, renal and hepatic function, adherence, anticholinergic and sedative burden, and the person's goals - not the number alone.                          |
| <b>Caregiver capacity</b>                       | The practical and emotional ability of the available caregiver or service to provide the required supervision, transfers, medication support, nutrition, hygiene, and monitoring safely and sustainably.                          |

## 5. Roles and accountability

| Role  | Minimum responsibilities  |
|---|---|
| <b>Triage nurse</b>                                       | Identify physiological instability, injury, delirium, falls risk, dependence, communication needs and safeguarding concerns; obtain baseline information; initiate falls precautions and basic care.        |
| <b>ED clinician</b>                                       | Treat immediate threats, establish cause and injury burden, assess delirium and frailty, reconcile medicines, document baseline and current function, initiate CGA domains, and determine safe disposition. |
| <b>Nurse in charge</b>                                    | Coordinate observation, safety rounds, nutrition, hydration, toileting, medicines, pressure care, mobility assistance, family access, bed allocation and escalation during delay.                           |
| <b>Internal / geriatric medicine or frailty clinician</b> | Support diagnostic uncertainty, CGA, multimorbidity, delirium, prognosis, treatment escalation, admission avoidance, rehabilitation and continuity planning.  |
| <b>Physiotherapist</b>                                    | Assess transfers, gait, balance, strength, walking aids, stairs and immediate rehabilitation needs; recommend safe mobility level and equipment.  |
| <b>Occupational therapist</b>                             | Assess activities of daily living, cognition in function, home hazards, equipment, carer support and environmental barriers; coordinate home-based interventions where available.                           |
| <b>Pharmacist</b>   | Complete medication reconciliation, identify adverse effects and interactions, review high-risk and duplicate medicines, adjust for organ function, and communicate intentional changes.                    |
| <b>Social worker / discharge coordinator</b>              | Assess living arrangements, caregiver capacity, finances, access, neglect, abuse, placement and community services; coordinate safe discharge or protected placement.                                       |
| <b>Dietetics / speech and language support</b>            | Assess malnutrition, swallowing and feeding risk when indicated; guide safe nutrition and hydration.  |
| <b>Clinical governance</b>                                | Maintain approved tools, referral pathways, equipment, education, audit, incident review and cross-sector agreements.   |

## 6. Required readiness

| Capability             | Minimum standard   |
|------------------------|--|
| Environment            | Quiet, well-lit, visible area with clocks and signage, reduced unnecessary moves, accessible toilet, chairs with arms, hospital beds, pressure-relieving surfaces, safe footwear and space for family / caregivers.                  |
| Equipment              | Appropriate wheelchairs, walking frames and sticks, transfer aids, hoist access, hearing amplifier, spectacles storage, large-print materials, blankets, continence supplies, pressure-relieving devices and low-height bed options. |
| Assessment tools       | Locally approved 4AT form, official CFS chart and training, mobility / transfer assessment, nutrition and pressure-risk tools, medication reconciliation form, CGA prompt and safe-discharge checklist.                              |
| Specialist access      | Senior ED clinician, internal / geriatric medicine or frailty advice, physiotherapy, occupational therapy, pharmacy, social work, mental health, safeguarding, palliative care, orthopaedics, radiology and community services.      |
| Observation capability | Serial vital signs and cognition, cardiac monitoring where indicated, hydration and intake-output monitoring, assisted toileting, mobility observation, pressure care and senior reassessment.                                       |
| Community interface    | Current contacts for primary care, home nursing, rehabilitation, falls service, equipment delivery, home hazard assessment, social care, care homes, hospice, transport and rapid follow-up.   |

## 7. Triage and immediate danger recognition

| Finding  | Immediate response  |
|--|---|
| Airway compromise, severe respiratory distress, shock, major bleeding, ongoing seizure, GCS reduction, focal deficit, severe hypoglycaemia or hyperthermia / hypothermia | Move to resuscitation and manage under the relevant emergency protocol.   |
| Fall with head strike or uncertain head strike while anticoagulated / antiplatelet-treated, new neurology, persistent vomiting, seizure or reduced consciousness         | Urgent head-injury assessment and imaging decision under Protocol 32; do not rely on absence of headache.                                     |
| Suspected hip fracture, pelvic injury, spinal injury, open fracture, neurovascular compromise or inability to weight bear after trauma                                   | Provide analgesia, immobilize as appropriate, obtain timely imaging and activate trauma / orthopaedic pathway.                                |
| Chest pain, palpitations, exertional event, loss of consciousness, unexplained fall, new murmur, bradycardia or tachyarrhythmia  | ECG, cardiac monitoring and syncope / cardiac pathway.  |
| New delirium, marked drowsiness, agitation, hallucinations, sudden inability to walk, reduced intake or rapid decline  | High-priority medical assessment. Check glucose, oxygenation, temperature and medications; seek collateral history and start delirium bundle. |
| Long lie, pressure injury, dark urine, muscle pain, hypothermia, dehydration or prolonged inability to summon help   | Assess for rhabdomyolysis, AKI, electrolyte disturbance, pressure injury, aspiration and safeguarding / living-alone risk.                    |
| Unsafe home situation, caregiver exhaustion, suspected neglect / abuse, unexplained injuries, repeated missed medicines or inability to provide essential care           | Activate social work / safeguarding. Do not discharge until a safe plan is verified.  |

**TRIAGE COMMUNICATION:** Ask the patient and accompanying person, "Is this normal for you?" and "What could you do two weeks ago that you cannot do today?" A normal-looking older adult may have a major change from baseline.

## 8. The first 15 minutes

1. Complete ABCDE assessment, full vital signs, oxygen saturation, temperature, bedside glucose, pain score and early warning score. Repeat observations when the history or appearance is concerning even if initial values are normal.
2. Identify injury, anticoagulant / antiplatelet use, time on the floor, loss of consciousness, chest pain, focal symptoms, fever, poor intake, vomiting, diarrhoea, bleeding, urinary symptoms and recent medication changes.
3. Place the person in a safe, observable and quiet location. Provide the usual hearing aids, glasses, walking aid, dentures, interpreter and family presence where helpful.
4. Establish baseline cognition, mobility, transfers, continence, feeding, activities of daily living, living arrangement and supports from the patient and a reliable collateral source.
5. Screen for delirium using 4AT in adults aged 75 years and older and in any patient with acute cognitive or functional change. Record the score and clinical interpretation.
6. Score frailty using the official CFS chart when appropriate, based on function about 2 weeks before the illness. Record the source of the baseline information.
7. Initiate falls mitigation: communicate risk, place call bell and walking aid within reach, use safe footwear, document required assistance and observation, and avoid unsupervised toileting or mobilization.
8. Provide analgesia, warmth, hydration and food when safe; reconcile time-critical regular medicines; assess need for a hospital bed and pressure-relieving surface.
9. Contact senior ED and frailty / internal medicine support early for severe frailty, delirium, uncertain diagnosis, recurrent falls, major functional loss, complex polypharmacy, or difficult disposition.
10. Document immediate priorities, tests, mobility status, level of assistance, observation frequency, pressure and continence plan, responsible clinician and next review time.

## 9. Baseline and collateral history

| Domain   | Questions to establish   |
|--|--|
| Acute timeline   | Exact last-known baseline; onset and fluctuation; precipitating illness, injury, procedure, travel, heat exposure or medication change.                        |
| Cognition  | Usual memory and communication; diagnosed dementia; new inattention, altered alertness, hallucinations, sleep reversal or personality change.                  |
| Function   | Usual and current walking distance, aids, transfers, stairs, dressing, washing, toileting, feeding, shopping, cooking, finances and medicine management.       |
| Falls  | Number in past year; recent near-falls; circumstances; prodrome; loss of consciousness; ability to get up; time on floor; injuries; fear of falling.           |
| Medical burden   | Heart, lung, neurological, renal, endocrine, musculoskeletal, sensory and psychiatric conditions; recent admission or infection.                               |
| Medicines  | Actual medicines taken, recent additions / omissions, over-the-counter or herbal products, alcohol, sedatives, insulin, anticoagulants, opioids and adherence. |
| Nutrition / hydration  | Recent intake, swallowing, weight loss, dentition, vomiting / diarrhoea, access to food and fluids, and who prepares meals.                                    |
| Continence   | Usual pattern; new urgency, incontinence, retention, constipation or diarrhoea; catheter and stoma status.   |
| Social / environment   | Lives alone or with whom; stairs, bathroom access, hazards, telephone / alarm, transport, caregiver availability, home-care schedule and recent failures.      |
| Goals and plans  | Advance care plan, resuscitation or treatment-escalation decisions, preferred decision-maker, acceptable outcomes and what matters most to the person.         |
| <b>COLLATERAL HISTORY IS CLINICAL DATA: Document who provided it, relationship, contact details, reliability, and the specific baseline and change described. "Known dementia" does not explain a new fluctuation.</b> |  |

## 10. Frailty recognition and Clinical Frailty Scale use

- Use the official, locally approved CFS chart and training material. Do not recreate the scale from memory.
- Score the person's usual health and function approximately 2 weeks before the acute illness, not their current ED state.
- Base the score on mobility, activity, independence in personal and instrumental activities, cognition, and burden of symptoms. Verify with collateral history where possible.
- CFS is designed primarily for people aged 65 years and older. Use caution in younger adults, people with stable lifelong disability, and people with an acute catastrophic injury; seek specialist advice rather than equating disability with frailty.
- A higher CFS should trigger a proportionate response: early senior review, CGA domains, delirium prevention, medication review, rehabilitation and goal-of-care discussion. It must not become a rationing or automatic non-escalation score.
- Record both the numerical score and the evidence supporting it. If unable to score reliably, document why and proceed with functional and multidisciplinary assessment.

## 11. Initiating comprehensive geriatric assessment

| CGA domain              | ED minimum action  |
|-------------------------|--|
| Medical                 | Identify acute illness / injury, multimorbidity interactions, pain, organ dysfunction and treatment priorities.                        |
| Mental                  | Assess delirium, baseline cognitive impairment, mood, anxiety, psychosis, substance use and decision-making capacity.                  |
| Medication              | Reconcile actual use; identify time-critical medicines, toxicity, withdrawal, interactions, adherence and renal / hepatic dose issues. |
| Functional              | Compare current with baseline mobility, transfers, self-care and continence; determine assistance and equipment needs.                 |
| Nutrition / hydration   | Assess intake, weight loss, swallowing, dentition, dehydration and ability to obtain / prepare food.                                   |
| Skin / pressure         | Inspect pressure areas and injuries, especially after a long lie or prolonged ED stay; start prevention and treatment.                 |
| Sensory / communication | Restore glasses, hearing aids, dentures, interpreter and communication support.  |
| Social / environment    | Assess home, caregivers, dependants, transport, finances, hazards, neglect, abuse and service reliability.                             |
| Goals / prognosis       | Clarify values, acceptable burdens, advance plans, escalation and palliative needs without assuming that frailty equals futility.      |
| Plan / accountability   | Record problems, actions, responsible team, review time, destination, pending results and communication with primary / community care. |

## 12. Falls, collapse, and the cause of the event

**Do not write "mechanical fall" unless a plausible environmental mechanism is established and medical causes have been reasonably excluded. Even then, document the contributing risks and injury assessment.**

| Potential cause      | Assessment clues and actions   |
|----------------------|--|
| Syncope / arrhythmia | Prodrome, exertional or supine event, palpitations, chest pain, family history, murmur, ECG abnormality, postural BP and monitoring. |

|                                  |   |
|----------------------------------|---|
| Orthostatic hypotension          | Symptoms after standing, dehydration, autonomic disease, antihypertensives / diuretics. When safe, measure lying and standing BP with repeat readings during 3 minutes and record symptoms. |
| Neurological event               | Focal deficit, ataxia, new visual / speech change, seizure features, postictal state or acute vestibular syndrome. Follow stroke / seizure pathway.   |
| Infection / systemic illness     | Fever or hypothermia, cough, hypoxia, abdominal symptoms, skin infection, sepsis, reduced intake or delirium; older adults may lack typical symptoms.                                       |
| Metabolic / endocrine            | Hypoglycaemia, sodium / calcium disturbance, renal failure, anaemia, thyroid or adrenal disorder where clinically indicated.  |
| Medication / substance           | Sedatives, opioids, psychotropics, antihypertensives, hypoglycaemics, anticholinergics, alcohol, withdrawal, recent dose change or duplication.   |
| Gait / balance / musculoskeletal | Weakness, neuropathy, Parkinsonism, arthritis, foot pain, unsuitable footwear, visual impairment, deconditioning or incorrect walking aid.  |
| Environmental / behavioural      | Trip hazard, poor lighting, rushing to toilet, unsafe transfer, climbing, pets, unfamiliar environment, inaccessible call bell or inadequate supervision.                                   |

### 13. Post-fall injury assessment and silver trauma

- Obtain a clear mechanism, height, surface, body impact, head strike, anticoagulants, ability to weight bear, time on floor and pre-fall symptoms. Do not rely on recall when delirium or dementia is present.
- Perform a deliberate head-to-toe examination including scalp, face, cervical spine, chest, abdomen, pelvis, hips, long bones, hands, feet, skin, pressure areas and a full neurological and neurovascular assessment.
- Provide early analgesia and reassess. Pain, guarding, immobility and delirium may be the only signs of fracture or internal injury.
- Use a low threshold for imaging when examination is unreliable, there is focal pain, inability to weight bear, anticoagulation, osteoporosis, prior surgery, or persistent functional loss. Apply Protocols 31, 32 and 34.
- After a long lie, check temperature, hydration, skin, CK, renal function, potassium and urine appearance as clinically indicated. Treat hypothermia, rhabdomyolysis, pressure injury and AKI promptly.
- If initial radiographs are negative but the person remains unable to weight bear or has focal hip / pelvic pain, arrange further imaging or specialist review rather than discharging on the basis of the first film.

### 14. Delirium and acute cognitive change

| Step                           | Required action   |
|--------------------------------|---|
| Recognize                      | Look for acute or fluctuating inattention, altered alertness, slow responses, withdrawal, reduced mobility, agitation, hallucinations, sleep change, appetite change or inability to follow requests. Hypoactive delirium is easily missed.   |
| Screen                         | Use 4AT when indicators are present and routinely for adults aged 75 years and older according to local policy. A tool supports but does not replace clinical diagnosis.  |
| Establish baseline             | Ask a collateral source about usual cognition and the exact change. Delirium may coexist with dementia.   |
| Find causes                    | Complete history, medication review, top-to-toe examination, pain assessment and targeted tests for hypoxia, infection, dehydration, retention, constipation, metabolic disturbance, organ failure, injury, withdrawal or toxicity.   |
| Treat causes                   | Correct reversible contributors promptly while avoiding fluid overload, unnecessary catheterization, sleep disruption and avoidable transfers.  |
| Protect and orient             | Provide calm communication, clock, daylight, family, glasses, hearing aids, hydration, nutrition, mobility, toileting, pain relief and sleep support.   |
| Manage distress                | Use verbal and non-verbal de-escalation first. Remove unnecessary lines and noise. One-to-one observation may be safer than restraint or sedation.  |
| Medication only when necessary | For severe distress or immediate risk after other measures, use the locally approved lowest-dose, shortest-duration regimen with ECG and adverse-effect precautions. Avoid haloperidol in Parkinson's disease or dementia with Lewy bodies and use Protocol 42 for behavioural emergencies. |
| Reassess                       | Repeat cognition, vital signs, pain and cause review. Document delirium in the medical record and communicate it at handover and discharge.   |

**URINE SAFETY: Do not diagnose a urinary infection from a positive dipstick or bacteriuria alone in an older adult. Seek urinary or systemic clinical evidence, exclude other causes of delirium, obtain culture when indicated, and follow the local antimicrobial guideline.**

### 15. Acute functional decline and nonspecific presentations

- Treat new weakness, reduced walking, inability to transfer, poor intake, incontinence, drowsiness, recurrent falls or caregiver concern as possible manifestations of serious acute illness.
- Compare current performance with baseline and observe an actual transfer and mobilization when safe. Self-report alone may overestimate ability.
- Consider occult infection, cardiac disease, stroke, subdural haemorrhage, fracture, anaemia or bleeding, dehydration, renal failure, electrolyte disturbance, hypoglycaemia, medication toxicity, pain, depression and social crisis.
- Do not use the label "social admission" or "acopia". Define the medical, functional, cognitive, medication, environmental and caregiver problems that have produced the unsafe state.
- If function remains below baseline after initial treatment, initiate therapy and CGA review. A person who cannot safely transfer, toilet, obtain food, take medicines or summon help usually requires admission, supported observation or a verified increase in care.



## 16. Occult illness and atypical physiology

| Clinical issue                | Older-person considerations   |
|-------------------------------|---|
| Sepsis / infection            | Fever, tachycardia and leukocytosis may be absent. Delirium, reduced mobility, falls, anorexia, hypothermia or new incontinence may be presenting features. Apply sepsis criteria and obtain cultures / imaging based on clinical evidence. |
| Acute coronary syndrome       | May present with dyspnoea, weakness, nausea, syncope or delirium without chest pain. Use ECG and troponin pathway when clinically plausible.  |
| Stroke / subdural haemorrhage | May present as falls, confusion or gait change. Establish last-known-well, perform neurological examination and consider head imaging.  |
| Abdominal disease             | Pain may be mild or poorly localized. Examine for obstruction, ischaemia, perforation, retention, constipation, bleeding and hernia; use imaging when concern persists.   |
| Dehydration / AKI             | Dry mouth may be nonspecific. Assess intake, losses, weight, postural symptoms, urine output, creatinine trend and medicines; resuscitate cautiously in heart or renal failure.   |
| Hypoxia / respiratory disease | Dyspnoea may be under-reported. Check saturation, work of breathing and chest findings; interpret borderline oximetry in context and confirm when readings are inconsistent.  |
| Pain                          | Dementia or delirium may mask verbal reporting. Look for grimacing, guarding, resistance, reduced mobility, altered behaviour and autonomic signs.  |

## 17. Medication reconciliation and medication-related harm

| Medication task              | Required action   |
|------------------------------|---|
| Reconcile                    | Use at least two reliable sources where possible: patient / caregiver list, containers, pharmacy record, primary-care record, care-home chart or recent discharge summary. Record what is actually taken.   |
| Time-critical medicines      | Identify insulin, anti-Parkinson medicines, anticonvulsants, steroids, anticoagulants, antiarrhythmics and other medicines where omission may cause harm.   |
| High-risk review             | Look for sedatives, benzodiazepines, Z-drugs, opioids, antipsychotics, antidepressants, anticholinergics, antihypertensives, diuretics, hypoglycaemics and medicines affecting electrolytes or QT interval. |
| Organ function               | Adjust or withhold medicines when indicated by AKI, dehydration, hepatic dysfunction, hypotension, bradycardia or poor intake. Document the rationale and review plan.                                      |
| Duplication / interaction    | Check duplicate agents, combination products, recent prescriptions, alcohol, OTC antihistamines, NSAIDs and herbal products.  |
| Adherence and administration | Assess vision, cognition, dexterity, swallowing, packaging, cost, access and caregiver support. Simplify only through an intentional shared plan.   |
| Deprescribing                | Do not abruptly stop medicines with withdrawal risk. Structured deprescribing should consider indication, benefit horizon, symptom control, goals, and follow-up.   |
| Communication                | Every change must state: medicine, action, reason, duration, monitoring, restart criteria and responsible clinician.  |

## 18. Hydration, nutrition, swallowing, and renal safety

- Assess recent intake, losses, weight change, mouth and denture problems, swallowing, food access, feeding assistance and fluid restrictions.
- Use oral fluids and food when safe. Provide assistance, appropriate texture and dentures. Do not leave meals out of reach or assume refusal when the person could not open packaging or hear instructions.
- When intravenous fluid is required, prescribe a clear indication, type, volume, rate, reassessment point and stop criteria. Use smaller aliquots with frequent review in heart failure, renal failure or severe frailty.
- Monitor electrolytes, renal function, glucose and urine output according to severity. Review diuretics, renin-angiotensin medicines, NSAIDs, metformin and nephrotoxic agents when AKI or dehydration is present.
- Consider speech and language or specialist swallowing assessment for coughing, wet voice, recurrent aspiration, neurological disease or inability to manage oral intake. Balance aspiration risk with hydration, comfort and goals of care.
- Constipation and urinary retention can precipitate delirium and falls. Assess clinically and treat without unnecessary catheterization.

## 19. Mobility, deconditioning, falls prevention, and pressure care in the ED

| Need             | ED action  |
|------------------|--|
| Safe mobility    | Document whether the patient is independent, requires supervision, one-person / two-person assistance, transfer aid, hoist or must not mobilize pending review.  |
| Falls mitigation | Communicate risk, place call bell and walking aid within reach, provide safe footwear, ensure adequate lighting, keep route to toilet clear, and select observation level. Use bed / trolley sides only under local individualized policy. |
| Activity         | Once injury and instability are excluded, avoid prolonged bed rest. Support sitting out, dressing, transfers and short supervised walks according to ability and therapy advice.   |
| Toileting        | Offer regular assisted toileting and continence care. Urgency and unfamiliar environments increase falls risk. Avoid unnecessary catheters.  |
| Pressure care    | Inspect sacrum, heels, hips and other pressure points on arrival when risk is present, after a long lie, and during prolonged stay. Offload, reposition and use pressure-relieving surfaces according to local policy.                     |

| Need                        | ED action  |
|-----------------------------|--|
| Lines and equipment         | Remove unnecessary monitoring wires, catheters and IV lines. Secure essential equipment to reduce trip, agitation and restraint risk.  |
| Prolonged stay safety round | For extended ED stays, document repeat observations, food / drink or NBM reason, regular medicines, analgesia, hospital bed, pressure areas, toileting, orientation and mobility plan. |

## 20. Pain assessment and analgesia

- Assess pain at rest and movement, including non-verbal signs. Reassess after treatment and before mobilization or imaging.
- Use multimodal analgesia tailored to renal, hepatic, respiratory, bleeding and cognitive risk. Avoid both undertreatment and automatic dose reduction that leaves severe pain uncontrolled.
- Titrate opioids cautiously when indicated, with respiratory, sedation, constipation and delirium monitoring. Review concurrent sedatives and renal function.
- Avoid routine NSAIDs in significant renal impairment, dehydration, heart failure, active bleeding or high gastrointestinal risk unless senior review supports use.
- Consider regional analgesia for hip fracture where trained staff and governance exist. Do not delay definitive fracture care because of age or frailty.

## 21. Dementia, capacity, consent, and communication

- Dementia does not automatically remove capacity. Assess capacity for the specific decision at the time it is required and support understanding with hearing aids, glasses, familiar persons, simple explanations and time.
- Delirium can cause fluctuating capacity. Treat reversible causes, repeat assessment when feasible, and use the least restrictive lawful approach when urgent decisions cannot wait.
- Identify any legally authorized substitute decision-maker, advance directive, power of attorney or prior expressed wishes according to local law. Family members provide essential information but do not automatically have legal authority.
- Use plain language, one speaker, short steps and teach-back. Avoid infantilizing language and do not discuss the person as though they are absent.
- For refusal or departure before assessment is complete, follow Protocol 51, address pain and communication barriers, explain specific risks, involve the senior clinician and document the safe alternative plan.

## 22. Safeguarding, neglect, and caregiver capacity

| Concern                     | Action   |
|-----------------------------|--|
| Possible abuse or neglect   | Look for unexplained injuries, poor hygiene, pressure injury, malnutrition, fearfulness, controlling behaviour, medication withholding, financial exploitation or repeated delays in seeking care. Follow Protocol 43. |
| Self-neglect                | Assess cognition, capacity, depression, substance use, living conditions, nutrition, fire / fall hazards, medication management and ability to summon help.  |
| Caregiver strain            | Ask privately about sleep, physical ability, competing duties, conflict, burnout, finances and willingness to continue. Offer support without assuming blame.  |
| Care plan failure           | Verify that scheduled caregivers, equipment, transport, food, utilities and medicines are actually available - not merely listed in a record.  |
| Unsafe discharge pressure   | Clinical and social safety determine disposition. Bed pressure, family preference or a promise to "manage somehow" does not replace a feasible plan.   |
| Dependent caregiver patient | If the patient cares for another vulnerable person, establish who is currently providing that care and activate social support where needed.   |

## 23. Goals of care, treatment escalation, and palliative needs

- Ask what matters most now: survival, returning home, preserving cognition or mobility, symptom relief, avoiding burdensome treatment, or attending an important event. Use this to shape recommendations.
- Review existing advance plans and treatment-escalation decisions. Confirm that they apply to the present condition and are not being misused to deny reversible treatment.
- Explain prognosis and treatment options in relation to baseline function, current illness, likely recovery, burdens and uncertainty. Frailty informs risk but does not determine a single outcome.
- For severe frailty, recurrent crises or possible final months of life, involve internal / geriatric medicine and palliative care early. Continue active symptom relief, nursing care and family support.
- Document resuscitation and escalation decisions clearly, including who participated, the clinical reasoning, review conditions and what treatment will still be provided. Apply Protocol 52.

## 24. Investigations and imaging principles

| Investigation | Use   |
|---------------|---|
| Bedside       | Glucose for all acute cognitive / functional change; ECG for fall, collapse, cardiac symptoms, medication risk or unexplained event; bladder scan, ketones or blood gas when indicated.                             |
| Blood tests   | Target to presentation. Common tests may include FBC, electrolytes, renal function, calcium, glucose, liver tests, CRP, troponin, CK, thyroid or cultures. Avoid indiscriminate panels without a clinical question. |

| Investigation                  | Use  |
|--------------------------------|--|
| Urine                          | Use symptoms, signs and systemic evidence. Avoid routine dipstick-based UTI diagnosis in adults over 65. Culture when infection is clinically suspected or local policy indicates. |
| Imaging after fall             | Apply head, spine, chest, pelvic, hip and limb pathways with a low threshold when examination is unreliable, anticoagulation is present, or function remains impaired.             |
| Chest / abdominal imaging      | Use when occult pneumonia, heart failure, obstruction, ischaemia, bleeding, malignancy or other disease is plausible.  |
| Medication levels / toxicology | Use for specific suspected toxicity, overdose, interaction or adherence question.  |
| No-test pathway                | When examination and goals support conservative or palliative management, document the shared reasoning and symptom plan rather than omitting care silently.                       |

## 25. Observation and senior reassessment

- Observation is active care, not a waiting area. Set measurable goals: stable physiology, cause treated, delirium improving, oral intake adequate, pain controlled, safe transfer / walking, medicines reconciled and care plan verified.
- Document repeat vital signs, cognition, pain, fluid intake / output, mobility, skin, continence and adverse effects at intervals appropriate to risk.
- Review any failure to improve, new agitation or drowsiness, inability to mobilize, repeated hypotension, fever, hypoxia, oliguria, vomiting, chest / abdominal pain or caregiver concern immediately.
- Use Protocol 53 criteria and maximum observation duration. Convert to admission or transfer when goals are not met, the diagnosis remains uncertain, or required services are unavailable.
- A senior clinician must review before discharge after delirium, recurrent or unexplained falls, significant frailty with new functional loss, long lie, polypharmacy-related harm, or complex social risk.

## 26. Disposition decision

| Disposition                                     | Minimum criteria   |
|---|--|
| Resuscitation / critical care / urgent transfer | Unstable physiology, major trauma, stroke, sepsis, ongoing arrhythmia, severe metabolic disturbance, airway / respiratory failure or other time-critical condition. Frailty informs communication and goals but does not delay escalation.                             |
| Hospital admission                              | Persistent delirium, unresolved cause, new inability to transfer or mobilize, unsafe oral intake, ongoing oxygen / IV therapy, significant injury, uncontrolled pain, AKI, recurrent syncope, medication toxicity, pressure injury, unsafe home, or caregiver failure. |
| Observation / same-day frailty pathway          | Physiologically stable with a defined short treatment and reassessment plan, available therapy / pharmacy / social assessment, and a realistic same-day or next-day disposition.   |
| Supported discharge                             | Cause and injury addressed; cognition at baseline or delirium plan acceptable to receiving service; mobility and toileting demonstrated; medicines and equipment available; safe supervision, transport and follow-up verified.  |
| Residential / care-home return                  | Receiving nurse or responsible staff accepts handover; baseline and current function, delirium, medicines, wounds, mobility, observation, pending results and escalation plan are communicated.  |
| Palliative / hospice pathway                    | Goals and symptoms addressed; destination and medications confirmed; responsible team accepts care; family / caregivers understand whom to call and when to return.  |

## 27. Safe discharge bundle

- ☐ Acute diagnosis, serious alternatives and injuries addressed; senior review completed when required.
- ☐ Current cognition compared with baseline; delirium status and follow-up documented.
- ☐ Mobility, transfer, toileting and stairs assessed as relevant; required assistance and equipment available at destination.
- ☐ Pain controlled with a feasible medication plan; adverse effects and constipation prevention addressed.
- ☐ Medication reconciliation complete; every change and restart / monitoring plan communicated.
- ☐ Oral intake, hydration, swallowing and access to food / fluids are adequate for the plan.
- ☐ Pressure injuries, wounds and skin-care plan documented; community nursing arranged where needed.
- ☐ Caregiver / service capacity verified directly; patient is not being discharged to an unstaffed or inaccessible setting.
- ☐ Transport is appropriate for transfers, mobility, oxygen and supervision needs; key access confirmed.
- ☐ Primary care, frailty, falls, therapy, pharmacy, social care or specialist follow-up arranged with dates or responsible service.
- ☐ Pending results have a named owner, safe contact method and escalation plan.
- ☐ Written advice is readable and includes red flags, falls prevention, safe activity, who to contact and direct ED return route; teach-back completed.

## 28. Documentation and handover

- ☐ Last-known baseline and collateral source, including usual cognition, mobility, ADLs, continence and supports.
- ☐ Presenting event: prodrome, loss of consciousness, mechanism, head strike, time on floor, injuries and ability to get up.
- ☐ Full vital signs, glucose, pain, neurological findings, head-to-toe injury examination and serial changes.
- ☐ 4AT score and interpretation; delirium diagnosis / differential, causes considered and management bundle.
- ☐ CFS score based on function about 2 weeks earlier, evidence supporting it, or reason unable to score.
- ☐ Postural BP when indicated and safe, ECG, investigations, imaging and outstanding diagnostic uncertainty.
- ☐ Medication reconciliation sources, high-risk findings, omissions, changes and monitoring / restart plan.
- ☐ Current mobility and transfer status, required assistance, walking aid, therapy findings and falls mitigation.
- ☐ Nutrition, hydration, swallowing, continence, constipation / retention, pressure areas and basic-care interventions.
- ☐ Capacity, decision-maker, goals of care, escalation plan, safeguarding and caregiver-capacity assessment.



□ Destination, receiving person / service, transport, equipment, follow-up, pending-results owner, return advice and teach-back.

## 29. Quality indicators and audit

| Indicator                   | Suggested measure  |
|-----------------------------|--|
| Core screening              | Percentage of adults aged 75 years and older with documented 4AT, frailty assessment and falls risk / history.   |
| Action on findings          | Percentage with positive delirium, frailty or falls findings who receive a documented management plan, post-fall assessment or CGA initiation.         |
| Baseline / collateral       | Percentage with baseline cognition, function and living supports documented from a named source.   |
| Medication safety           | Medication reconciliation completion; time-critical medicines given; high-risk changes communicated.   |
| Basic care                  | For prolonged ED stays: repeat observations, food / drink or NBM reason, regular medicines, hospital bed, pressure check, toileting and mobility plan. |
| Trauma safety               | Missed fracture / head injury, reattendance with injury, and time to analgesia and imaging after falls.  |
| Delirium care               | Time to recognition; causes assessed; non-pharmacological bundle; antipsychotic / sedative use and adverse events.                                     |
| Functional safety           | Mobility / transfer documented before discharge; therapy involvement; falls mitigation and equipment provision.  |
| Disposition                 | Unplanned return within 72 hours / 7 days, failed discharge, delayed transfer, caregiver breakdown and destination-related harm.                       |
| Patient experience / equity | Communication, dignity, food, hydration, toileting, family involvement, disability and language access, and outcomes by age, frailty and residence.    |

## 30. Training and implementation

- All ED staff require recurrent education in frailty recognition, CFS use, 4AT, hypoactive delirium, post-fall assessment, silver trauma, medication burden, mobility, pressure care, communication and safe discharge.
- Use multidisciplinary simulation: anticoagulated fall with occult head injury; hypoactive delirium from sepsis; long lie with rhabdomyolysis; medication-related orthostatic hypotension; failed home-care package; and dementia with pain-related agitation.
- Competency must include obtaining collateral history, observing transfers, measuring postural BP safely, recognizing non-verbal pain, completing a safety round and documenting a goal-concordant plan.
- Provide rapid access to official CFS and 4AT materials rather than relying on memory or unapproved abbreviated versions.
- Review adverse events jointly with ED, medicine, nursing, therapy, pharmacy, social work, community care and patients / caregivers. Focus on system learning rather than blaming the individual who fell.

## 31. Local configuration before approval

| Local element  | Complete before approval |
|--|--------------------------|
| Age / clinical threshold for routine 4AT, falls and frailty screening        | _____                    |
| Official CFS chart version, licensing / attribution and staff training       | _____                    |
| 4AT form location and delirium management bundle                             | _____                    |
| Internal / geriatric medicine or frailty advice hours and contact            | _____                    |
| Physiotherapy / occupational therapy / pharmacy / social work access         | _____                    |
| Falls, home hazard, community rehabilitation and equipment pathway           | _____                    |
| Postural BP procedure and contraindications                                  | _____                    |
| Head injury, occult hip fracture and silver-trauma imaging pathway           | _____                    |
| Pressure-risk tool, mattress / offloading equipment and safety-round trigger | _____                    |
| Medication reconciliation sources and time-critical medicine list            | _____                    |
| Care-home and home-care handover / acceptance process                        | _____                    |
| Safeguarding and caregiver-failure escalation contact                        | _____                    |
| Palliative care, hospice and advance-care-plan access                        | _____                    |
| Observation-unit eligibility, goals and maximum duration                     | _____                    |
| Transport criteria for wheelchair, stretcher, oxygen and escort              | _____                    |
| Pending-result and post-discharge callback responsibility                    | _____                    |

## 32. Source guidance for local adaptation

| Source  | Use in local adaptation   |
|---|---|
| National Institute for Health and Care Excellence. Falls: assessment and prevention in older people and in people 50 and over at higher risk. NICE guideline NG249. Published 2025. | Individual risk-factor assessment, comprehensive falls assessment, medication review, mobility, home hazards and falls education. |
| National Institute for Health and Care Excellence. Delirium: prevention, diagnosis and management in hospital and long-term care. Clinical guideline CG103, updated 2023.           | Delirium risk, recognition, 4AT assessment, multicomponent prevention, cause treatment and cautious management of distress.       |
| Royal College of Emergency Medicine. Care of Older People in the Emergency Department Quality Improvement Programme, Year 4 Information Pack. 2026.                                 | ED screening for delirium, frailty and falls; action on findings; CGA initiation; basic-care safety rounds and quality metrics.   |

| Source  | Use in local adaptation  |
|---|--|
| Royal College of Emergency Medicine. Guidelines for the Provision of Emergency Medical Services. 2025.  | ED frailty capability, appropriate CFS use, staffing, pathways, environment and service standards.   |
| British Geriatrics Society. Silver Book II: Quality Care for Older People with Urgent Care Needs. 2021.   | First 72 hours of urgent care, frailty, holistic assessment, geriatric syndromes, transitions and age-attuned emergency care.  |
| British Geriatrics Society. Joining the Dots: A Blueprint for Preventing and Managing Frailty in Older People. 2023; and Reablement, Rehabilitation, Recovery: Everyone's Business. 2024. | Integrated frailty pathways, medication review, deconditioning prevention, rehabilitation, recovery and cross-sector continuity.   |
| UK Health Security Agency and NHS England. Diagnosis of urinary tract infections: quick reference tools for primary care. Updated 2025.   | Avoiding urine dipstick diagnosis and inappropriate treatment of asymptomatic bacteriuria in adults over 65.   |
| Dalhousie University / Geriatric Medicine Research. Clinical Frailty Scale, current official version and training materials.  | Use of the official CFS chart, scoring from pre-illness baseline and correct attribution.  |
| Local protocols and law   | Resuscitation, sepsis, stroke, syncope, trauma, head injury, fractures, AKI, medicines, capacity, safeguarding, pressure injury, palliative care and community referral. |

## Annex A. One-page older-person emergency workflow

| Stage                 | Action  |
|-----------------------|---|
| 1. Stabilize          | ABCDE, full observations, glucose, pain, temperature and urgent condition-specific pathway.   |
| 2. Detect change      | Ask what is different from 2 weeks ago; obtain collateral baseline for cognition, mobility, ADLs and supports.  |
| 3. Screen             | 4AT for age 75+ or acute change; official CFS from pre-illness baseline; falls history and current ED falls risk.   |
| 4. Find cause         | Injury plus medical causes: syncope, neurological, infection, metabolic, medication, dehydration, pain and environment.   |
| 5. Protect            | Quiet visible area, glasses / hearing aids, orientation, call bell, safe footwear, assistance level, food / fluids, toileting, pressure care and regular medicines. |
| 6. Initiate CGA       | Medical, mental, medication, functional, nutrition, skin, sensory, social and goals domains.  |
| 7. Reassess           | Serial physiology, cognition, pain, intake, mobility and response to treatment; senior review if not returning toward baseline.                                     |
| 8. Decide destination | Admission / transfer for unresolved illness, delirium or unsafe function; supported discharge only when care and equipment are verified.                            |
| 9. Close the loop     | Medication changes, mobility level, delirium, pending results, follow-up, caregiver handover and return advice documented.  |

## Annex B. Delirium assessment and care bundle

- ☐ Acute or fluctuating change confirmed from patient / collateral source; baseline cognition documented.
- ☐ 4AT completed using approved form; score and clinical diagnosis recorded.
- ☐ ABCDE, glucose, oxygenation, temperature, pain and neurological examination completed.
- ☐ Infection assessed clinically; dehydration, constipation and urinary retention considered.
- ☐ Medication toxicity, omission, interaction, anticholinergic / sedative burden and withdrawal reviewed.
- ☐ Injury, myocardial ischaemia, stroke, seizure, metabolic disturbance and organ failure considered.
- ☐ Glasses, hearing aids, dentures, interpreter, clock, daylight and familiar support provided.
- ☐ Food, fluids, toileting, mobility, pressure care and sleep plan documented.
- ☐ Unnecessary catheter, lines, moves, alarms and noise avoided where safe.
- ☐ De-escalation and observation used before medication; indication and monitoring documented if medication required.
- ☐ Repeat cognition and cause review planned; delirium communicated at handover and discharge.

## Annex C. Frailty and functional baseline record

| Domain                                      | Two weeks before illness | Current ED status / change                       |
|---|--------------------------|--|
| Clinical Frailty Scale using official chart | CFS: ____ Source: _____  | Current severity is not used to rescore baseline |
| Cognition / communication                   | _____                    | _____  |
| Walking and distance / aid                  | _____                    | _____  |
| Transfers / stairs                          | _____                    | _____  |
| Washing / dressing                          | _____                    | _____  |
| Toileting / continence                      | _____                    | _____  |
| Feeding / swallowing                        | _____                    | _____  |
| Shopping / cooking / housework              | _____                    | _____  |
| Medicines / finances / telephone            | _____                    | _____  |
| Living arrangement / care visits            | _____                    | _____  |
| What matters most / acceptable outcome      | _____                    | _____  |

## Annex D. Comprehensive post-fall assessment

- ☐ Event details: prodrome, posture, activity, environment, loss of consciousness, seizure features, head strike, impact and time on floor.

- ☐ Previous falls, gait / balance, fear of falling, footwear, vision, hearing, walking aid and ability to get up.
- ☐ Full observations, glucose, ECG and neurological examination.
- ☐ Head-to-toe injury and skin / pressure examination; anticoagulant / antiplatelet status.
- ☐ Cardiovascular examination and lying / standing BP when indicated and safe.
- ☐ Medication and alcohol review, including recent changes, sedatives, antihypertensives, diuretics and hypoglycaemics.
- ☐ FBC, renal profile / electrolytes, calcium and other targeted tests as clinically indicated.
- ☐ Imaging based on mechanism, pain, examination reliability and function; occult fracture plan if unable to weight bear.
- ☐ Delirium, cognition, nutrition, hydration, continence and osteoporosis / fragility fracture risk considered.
- ☐ Mobility / transfer observed; therapy, equipment, home hazard and falls-service referrals arranged.
- ☐ Cause, injury, mitigation and follow-up documented - not simply "mechanical fall".

## Annex E. Prolonged-stay basic-care safety round

| Care element   | Document                             |
|--|--------------------------------------|
| Repeat observations and clinical review                | Time: _____ Findings / action: _____ |
| Pain and analgesia                                     | _____                                |
| Food / drink or reason NBM                             | _____                                |
| Regular and time-critical medicines                    | _____                                |
| Toileting / continence / retention / constipation      | _____                                |
| Mobility level, walking aid and falls mitigation       | _____                                |
| Pressure areas, repositioning and surface              | _____                                |
| Glasses, hearing aids, dentures, orientation and sleep | _____                                |
| Family / caregiver update and concerns                 | _____                                |
| Next review time and responsible clinician             | _____                                |

## Annex F. Frailty transfer and discharge checklist

- ☐ Physiology stable for destination and transport; acute illness and injuries treated or accepted by receiving service.
- ☐ Baseline cognition and function, 4AT / delirium status and CFS communicated.
- ☐ Mobility, transfers, toileting and required assistance demonstrated and handed over.
- ☐ Walking aid, wheelchair, commode, pressure equipment, oxygen and other essentials are physically available.
- ☐ Medication reconciliation and intentional changes complete; time-critical doses and monitoring plan communicated.
- ☐ Nutrition, hydration, swallowing, continence, wounds and pressure care addressed.
- ☐ Capacity, decision-maker, goals of care and escalation plan documented.
- ☐ Caregiver / home-care / care-home acceptance verified by name and time; staffing and key access confirmed.
- ☐ Transport matches mobility, oxygen, cognition and supervision needs.
- ☐ Follow-up, falls / therapy / pharmacy / community referrals and appointment ownership confirmed.
- ☐ Pending results have named owner and safe contact method.
- ☐ Red flags and return route explained to patient and caregiver using teach-back.
- ☐ Clinical handover completed and responsibility transfer documented.

END OF PROTOCOL 44 - DRAFT 1.0 FOR LOCAL MULTIDISCIPLINARY VALIDATION