Ageing Well Toolkit

A practical guide for staff in the Western Isles

Purpose of this toolkit

This toolkit provides practical guidance for the early identification and proactive management of frailty to support healthy ageing.

It is designed for use in routine care, opportunistic consultations, and multi-disciplinary assessments.

How to use this toolkit:

1) Screen across physical activity, falls risk, nutrition, hydration, social connection and cognitive/mental wellbeing - please consider these aspects for carers too where appropriate.

2) Triage using CFS and checklist.

3) Plan goals and interventions.

4) Review in 6 months.



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Improving Adult Care Together

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Physical activity

Clinical rationale

Reduced physical activity contributes to deconditioning, frailty, falls and loss of independence. Strength and balance training is one of the most effective interventions for preventing functional decline.

Assessment prompts

- Has the person reduced their activity recently?
- Can they walk safely indoors and outdoors?
- Do they struggle with transfers (sit-to-stand, stairs, bed mobility)?
- Are they avoiding activities because of fatigue, breathlessness or fear of falling?

Red flags

- New inability to rise from a chair.
- Rapid functional decline.
- Acute shortness of breath or chest pain.
- Recurrent falls.

Intervention guidance

- Provide a tailored strength and balance plan (10 reps, 2-3 times a day), (e.g sit-to-stand, heel raises, marching).
- Encourage graded activity, pacing and goal setting.
- Refer to: community physiotherapy, chair-based exercise, walking groups, third sector.

Key messages to share

- “Strength can be improved at any age.”
- “Short, frequent bouts of movement are as effective as long sessions.”

Fall risk reduction

Clinical rationale

Falls are a marker of underlying health changes and predict future morbidity.

Assessment prompts

- Has the person fallen in the last 12 months?
- Is there imbalance, dizziness, foot pain or visual impairment?
- Are medications contributing (sedatives, antihypertensives)?
- Is hydration, nutrition or continence an issue?
- Are there home hazards (rugs, poor lighting, clutter)?

Red flags

- Head injury, loss of consciousness, and anticoagulation use.
- Sudden new balance or neurological symptoms.
- Unexplained falls or collapse.
- Extremely low blood pressure or orthostatic hypotension.

Intervention guidance

- Pharmacist-led medication review.
- Strength/balance training and appropriate footwear.
- Refer to: community OT for environmental assessments, physiotherapy for balance assessment, vision or hearing services for sensory review.
- Promote hydration and review continence needs.

Key messages to share

- “Falls are not an inevitable part of ageing.”
- “Early assessment prevents decline.”

Nutrition and malnutrition risk

Clinical rationale

Undernutrition impacts strength, immunity, wound health and independence of older adults.

Assessment prompts

- Unintentional weight loss, clothes looser.
- Reduced appetite, difficulty preparing food, swallowing or dental issues.
- Physical signs of malnutrition or frailty.

Red flags

- Continued weight loss.
- Suspected dysphagia.
- BMI < 18.5 or MUST score > 2.
- Complex comorbidities affecting nutrition.

Intervention guidance

- Encourage higher-protein, nutrient-dense diets (e.g eggs, dairy, beans, lentils).
- Promote small, frequent meals if appetite is low.
- Discuss community meal services, home support for shopping or meal prep, fortified foods or dietitian referral.

Key messages to share

- Protein supports strength.
- Small, frequent meals help with appetite.

Hydration

Clinical rationale

Dehydration contributes to UTIs, constipation, confusion, falls, delirium and medication toxicity.

Assessment prompts

- Is fluid intake adequate (dark urine, constipation, persistent dehydration)?
- Are there cognitive, functional or mobility barriers to accessing drinks?
- Are continence concerns leading to self-restriction?
- Are medications increasing fluid loss?

Red flags

- Acute confusion.
- Extremely low urine output.
- Persistent dehydration.

Intervention guidance

- Promote regular, small sips, aim 6-8 drinks per day.
- Promote hydrating foods (fruit, soups, yoghurt).
- Support environmental adjustments: drinks within reach, easy-to-use cups, straws or lidded cups.
- Fluids linked to daily routine.

Key messages to share

- Hydration protects the brain, bowel and balance.
- All fluids count.

Social connection

Clinical rationale

Loneliness is associated with increased mortality, cognitive decline, depression and reduced functional recovery.

Assessment prompts

- Does the person see people regularly?
- Have they withdrawn from hobbies?
- Do they report loneliness, low mood or anxiety?
- Does transport or mobility limit participation?

Red flags

- Severe low mood/self-neglect.
- Safeguarding concerns.
- Acute social crisis.

Intervention guidance

- Signpost to local community groups (wellbeing cafes, exercise classes, walking groups, arts groups).
- Encourage weekly social goals.
- Promote online options for those housebound.
- Explore volunteer opportunities if appropriate.

Key messages to share

- “Connection is protective for physical and mental health.”

Cognitive stimulation and mental wellbeing

Clinical rationale

Mental stimulation supports memory, attention and emotional wellbeing and delays functional decline.

Assessment prompts

- Memory concerns or word-finding difficulties?
- Reduced motivation or loss of structure?
- Low mood, anxiety or sleep disturbance?
- Reduced engagement in activities they have previously enjoyed?

Red flags

- Sudden cognitive decline.
- Signs of delirium.
- Reduced ability to complete daily tasks.
- Marked personality or behavioural changes.

Intervention guidance

- Encourage mentally stimulating activities (puzzles, reading, games, hobbies).
- Support the development of routine and achievable daily goals.
- Promote physical activity as a cognitive enhancer.
- Encourage participation in social groups.
- Signpost to mental health, wellbeing or dementia services if needed.

Key messages to share

- “Small daily goals build confidence and brain health.”

Quick checklist and clinical tools

Topic	Key questions	Suggestion action
Function and mobility	Can they walk safely? Transfers? Fatigue?	Physio, strength programme
Falls risk	Any falls? Dizziness? Home hazards?	Medication review, OT assessment vision/hearing checks
Nutrition	Recent weight loss? Poor appetite?	MUST screen, dietitian referral, fortified foods
Hydration	Drinking enough? UTI risk?	Hydration plan, continence support
Social	Lonely? Lacking meaningful activity?	Community groups
Cognition	Memory changes? Low mood?	Cognitive screening, dementia pathway, wellbeing support

Clinical Frailty Scale (CFS) - 9-point

1 - Very fit (robust, active, energetic)
2 - Well (no active disease symptoms)
3 - Managing well (medical problems well controlled)
4 - Vulnerable (not dependent but slowed or fatigued)
5 - Mildly frail (needs help with higher-order ADLs)
6 - Moderately frail (needs help with basic ADLs)
7 - Severely frail (completely dependent for personal care)
8 - Very severely frail (completely dependent, approaching end of life)
9 - Terminally ill (life expectancy <6 months, not otherwise frail)
Use clinical judgement and the usual baseline (~2 weeks pre-illness).

MUST - Malnutrition Universal Screening Tool - 5 steps

Step 1 - BMI
Step 2 - % unplanned weight loss (3-6 months)
Step 3 - acute disease effect
Step 4 - sum scores to risk; Step 5 - management by risk category and local policy.

Ageing well and triage form

Patient details

Name:
CHI:
Date of birth:
Address:
Date of assessment:
Assessor name and role:
Setting:

Rockwood Clinical Frailty Scale (CFS)

Score (1-9): _____

1 - Very fit (robust, active, energetic)
2 - Well (no active disease symptoms)
3 - Managing well (medical problems well controlled)
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Clinical justification for score:

Mobility and physical activity

Independent mobility:
Uses aid:
Reduced activity:
Difficulty transfers:
Comments:

Falls risk

Falls in last 12 months:
Fear of falling:
Dizziness/balance issues:
Red flags:
Actions:

Nutrition

Appetite:
Weight loss:
Chewing/swallowing difficulty:
MUST score:
Actions:

Hydration

Fluid intake:
Signs of dehydration:
Actions:

Social connection

Lives alone:
Loneliness:
Limited contact:
Actions:

Cognition and mental wellbeing

Memory changes:
Low mood/anxiety:
Red flags:
Actions:

Overall risk summary

Overall risk level:
Key issues identified:
Agreed plan:
Review date:

Notes

You can use this space to keep any notes:

How was this pack created?

In 2025/26, IMPACT (Improving Adult Care Together) ran a project with the Western Isles Integration Joint Board and the NHS Western Isles on enabling people at risk of or living with frailty to Age Well in the Western Isles. The Western Isles Integration Joint Board is a Strategic Commissioning Board, who commission services with NHS Western Isles, Comhairle Nan Eilean Siar and third sector partners.

The shared aim of the Ageing Well project is to support older adults to remain at home, stay connected, and age well through local person-centred, community-driven support.

This guide was co-produced with the NHS Western Isles Frailty Group and our IMPACT project steering group.

Disclaimer

No liability is accepted for misinterpretation. All information was correct at the time of publication (July 2026).

Find out more about IMPACT:



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