Frailty Pathway

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Introduction

Identifying frailty in an older person can help us predict:

- who is likely to have a fall
- become dependent on other people to help with basic care tasks
- experience an unplanned admission to hospital or a care home
- or die within the next year

- Frailty is also associated with anxiety, depression and a poorer quality of life

Frailty will alter how we approach our potential interventions

Some Definitions:

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. BGS (2014)

Accelerated loss of physiological reserves which characterises frailty can lead to wide range of common healthcare problems, such as:
loss of strength;
reduction in mobility and subsequent falls;
reduced appetite and undernutrition;
Incontinence;
sensory decline;
depression and anxiety

Frailty is a distinct health state where a minor event can trigger major changes in health from which the patient may fail to return to their previous level of health. Effectiveness Matters (2017)

Identify Frailty

Comprehensive assessment

Personalised Plan

Interventions

Evaluate effectiveness

Annual Review

Identify Frailty

Training
https://www.e-lfh.org.uk/programmes/frailty/

Workforce
https://www.skillsforhealth.org.uk/info-hub/frailty-2018/

Rockwood (Clinical frailty Scale)

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

Comprehensive assessment:

Physical (Medical)

Functional

Psychological

Environmental/ Social

Advanced planning

Medication review

Interventions:

Pre Frail e.g. Healthy Ageing; Smoking; Weight; Exercise; Self care

Mild frailty e.g. Public Health; Advice and support; Strength and balance; Social prescribing; Loneliness and isolation; Housing; Community support

Moderate frailty e.g. Appropriate prescribing; Comprehensive assessment; Manage conditions well; Planning ahead; Care needs; Escalation wishes

Severe frailty e.g. Focus on symptoms and support; End of life; Supportive environment

Frailty syndromes

Falls (e.g. collapse, legs gave way, ‘found lying on floor’)

Immobility (e.g. sudden change in mobility, ‘gone off legs’ ‘stuck in toilet’)

Delirium (e.g. acute confusion, sudden worsening of confusion in someone with previous dementia or known memory loss)

Incontinence (e.g. change in continence – new onset or worsening of urine or faecal incontinence)

Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants)

Themes throughout:

Education
Integrated Working
‘MDT’
Sharing information/ documentation
Proactive/ anticipatory care
‘What Matters to You’
Shared decision making
Recognising deterioration
Appropriate care at the appropriate time/ Services that support the person

Community Wellbeing Hub trial – Anticipatory Frailty MDT

Identify Frailty - CWH voluntary services; Referral form and MDT

Comprehensive assessment - MDT/ CGA – Frailty module

Personalised Plan – Agreed; Letter to Person - copied to GP

Interventions – GP; CWH, Integrated Record

Evaluate effectiveness - ONS 4; Feedback

Frailty pathway for BSW - development

Frailty Tips

Prevent Well

Healthy Ageing. Encourage self-care and resilience — Keep active, Keep safe —Manage conditions and medicines well — Care for vision and hearing — Good oral and foot care

Diagnose Well

Rockwood frailty scale. Look for slowing down, weight loss, weakness, immobility—Ask about memory concerns, low mood, anxiety or withdrawal — Notice multiple medications or a decline with even minor illness and delayed or incomplete recovery —Investigate delirium, incontinence, falls or skin breakdown

Support Well

Comprehensively assess Physical, Functional, Psychological, Social and Environmental issues. Be pro-active and work together for person-centred plans — Involve professionals, services, voluntary and community groups—Share information such as capacity, choices and care plans — Plan ahead for carer breakdown, urgent illness and crisis points

Living Well

Manage conditions well and optimise medicines. Focus on abilities and resilience — Follow best practice guidance appropriate for level of frailty; BGS, NHS England and B&NES frailty pathways — Involve family and friends and carers, consider I.T. solutions for support and communication — Regular reviews of medicines and clinical interventions

Dying Well

Start conversations early (CHAT). Notice decline or features such as aspiration, reduced intake, recurrent infections or hospital admissions/ attendances — Confirm and share personal goals and wishes — Adapt treatment goals and medicines for supportive care — Document ReSPECT and ACP — Plan bereavement support for families, friends and carers

To view the Frailty Pathway - http://bit.ly/Frailtypathway

Any Questions?

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- British Geriatric Society

https://www.bgs.org.uk/resources/frailty-hub-frailty-in-specific-settings

- Core Frailty Framework

https://www.skillsforhealth.org.uk/info-hub/frailty-2018/

- Frailty Learning

https://www.e-lfh.org.uk/programmes/frailty/

- NHSE

https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/frailty-resources/

- Frailty:

http://www.bgs.org.uk/campaigns/fff/fff_full.pdf
http://www.bgs.org.uk/frailty-explained/resources/campaigns/fit-for-frailty/frailty-what-is-it
https://www.rcn.org.uk/clinical-topics/older-people/frailty

- Clinical Frailty Scale:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1188185/pdf/20050830s00025p489.pdf
http://ihub.scot/media/3023/frailty-screening-and-assessment-tools-comparator.pdf

- Polypharmacy:

https://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation
https://www.sps.nhs.uk/wpcontent/uploads/2014/12/Patient20Centred20Approach20to20Polypharmacy20summary20formerly20seven20steps.pdf

- Falls:

https://www.uhb.nhs.uk/Downloads/pdf/PiOtagoStrengthBalance.pdf

- Diabetes and frailty:

https://www.guidelines.co.uk/diabetes/type-2-diabetes-frailty-in-older-people/454600.article
https://www.ncbi.nlm.nih.gov/pubmed/29633351
https://www.guidelinesinpractice.co.uk/diabetes/key-learning-points-diabetes-in-older-people-with-frailty/454910.article

- EOLC (2018)

https://www.diabetes.org.uk/resources-s3/2018-03/EoL_Guidance_2018_Final.pdf

- BGS support:

https://www.bgs.org.uk/resources/coronavirus-current-information-and-advice
https://www.bgs.org.uk/resources/frailty-hub-frailty-in-specific-settings

- What Matters to You

https://www.england.nhs.uk/blog/how-putting-people-first-and-asking-what-matters-to-you-can-shape-the-future-of-healthcare-for-professionals-and-people/

https://www.e-lfh.org.uk/programmes/frailty/

https://www.judiciary.uk/subject/care-home-health-related-deaths/

https://www.ruh.nhs.uk/For_Clinicians/departments_ruh/Palliative_Care/advance_care_planning/index.asp?menu_id=2

https://www.uptodate.com/contents/frailty/abstract/80

https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/frailty-resources/

https://www.skillsforhealth.org.uk/info-hub/frailty-2018/

https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(19)30226-9/fulltext

https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.16716

https://www.karger.com/Article/FullText/512049

https://evidence.nihr.ac.uk/alert/routine-measurement-of-grip-strength-can-help-assess-frailty-in-hospital/

https://bsw.icb.nhs.uk/document/a-brief-guide-diagnosing-frailty-in-primary-care-and-using-the-pathfields-tool-to-case-find-frailty-in-your-practice-population/

https://awttc.nhs.wales/medicines-optimisation-and-safety/medicines-optimisation-guidance-resources-and-data/prescribing-guidance/polypharmacy-in-older-people-a-guide-for-healthcare-professionals/