

Face up to Frailty

“ Until now, we have built a lot of health care services on the paradigm of caring for people with one thing wrong at a time. Population ageing means that we will be faced with unprecedented numbers of people who have many things wrong all at once. These people are frail, and they challenge how health care is delivered. The face of modern health care increasingly and inevitably will be the face of frailty. And we must face up to it. *Professor Kenneth Rockwood, Division of Geriatric Medicine, Dalhousie - University, Halifax, Nova Scotia, Canada*

Frailty, as defined by Rockwood, is **“a decreased ability to withstand illness without loss of function”** *CMAJ 1994; 150:489-495.*

Campbell et al describe frailty as “A condition or syndrome which results from a multi-system reduction in reserve capacity to the extent that a number of physiological systems are close to or past the threshold of symptomatic failure. As a result the frail person is at risk of disability or death from minor external stresses.” *Age Ageing (1997) 26:315–8.*

Frail people have frequently changing care and support needs and require a proactive multi-professional and multi-agency response. They commonly present with falls, immobility and confusion, are frequently admitted to hospital and are susceptible to complications while in hospital resulting in longer lengths of stay and high rates of mortality and institutional care. For a frail older person, a hospital admission should be timely and add value. Too often, however, it becomes a critical life event that is compounded by complications, poor recovery and subsequent transfer to long term institutional care.

The human costs of complications such as healthcare-acquired infections, delirium, pressure sores, malnutrition, dehydration and side effects of medication are potentially preventable and treatable. System costs can be reduced and quality of care enhanced through effective interventions across primary, community and acute sectors to prevent avoidable admissions, reduce length of stay, prevent complications and premature admissions to institutional care.

A Frailty Pathway

We propose a generic pathway for the frail older person with multiple long term conditions. Using a tiered approach, care approaches and settings are matched to the complexity of need and trajectory of the person on the pathway. This frailty pathway has been adapted from work by Stuart Cumming and colleagues in Forth Valley.

Frailty Pathway

Increasing Complexity ↑

Care Approaches

Tier 5: CGA and Palliative care including use of the Liverpool Care Pathway

Tier 3 and 4: Comprehensive Geriatric Assessment (CGA), Anticipatory Care Planning and care management
Proactive integrated team based multidisciplinary assessment rehabilitation, telehealthcare support and monitoring

Tier 2: Assessment, care planning, support and review
Care co-ordination, support rehabilitation, telehealthcare and carer support as required

Tier 0 and 1: Self Management
Information, advice and support to self manage

Care Settings

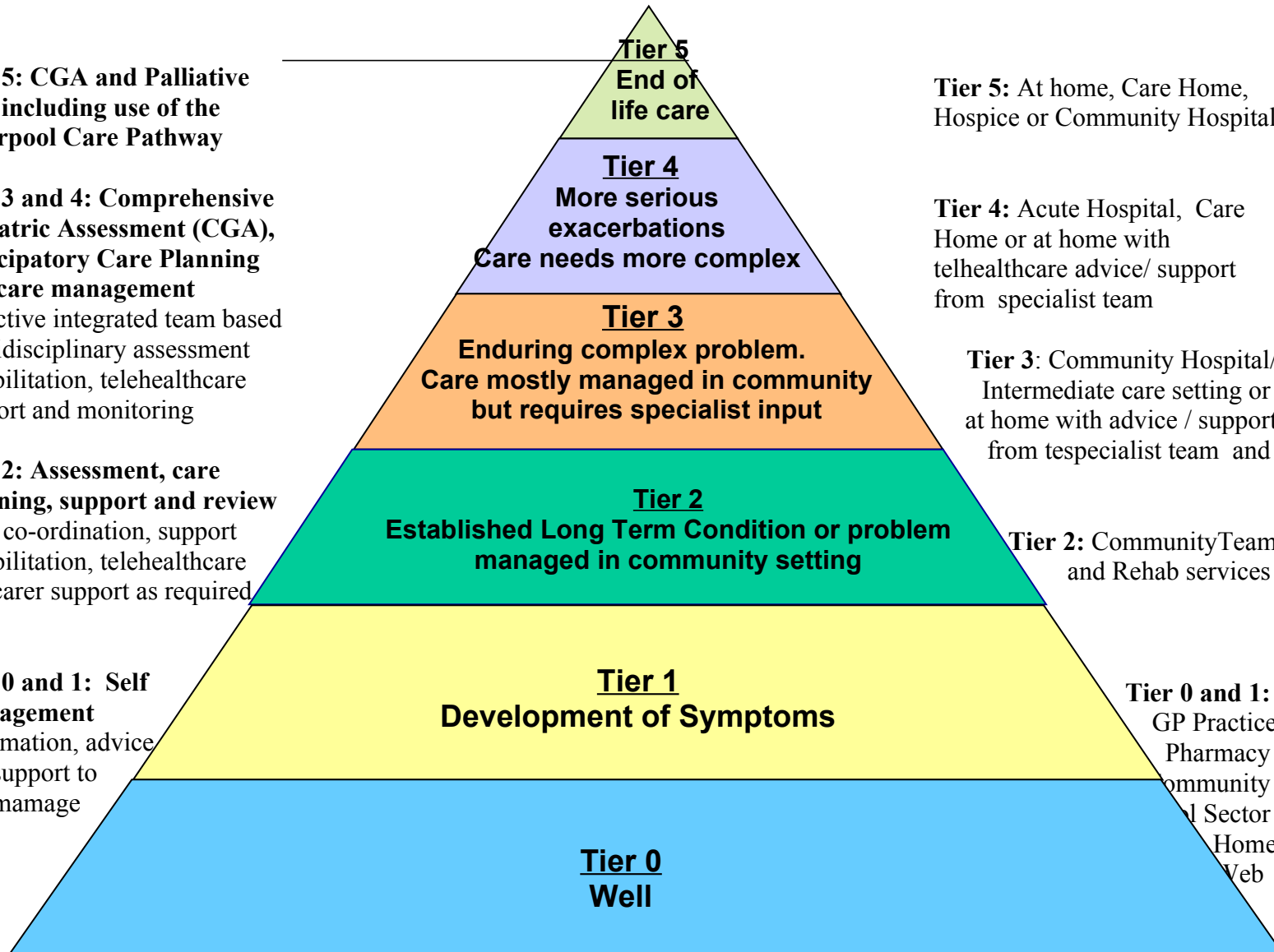
Tier 5: At home, Care Home, Hospice or Community Hospital

Tier 4: Acute Hospital, Care Home or at home with telhealthcare advice/ support from specialist team

Tier 3: Community Hospital/ Intermediate care setting or at home with advice / support from specialist team and

Tier 2: Community Team and Rehab services

Tier 0 and 1: GP Practice
Pharmacy
Community
Third Sector
Home
Web



Diagnosing Frailty

Frailty is a multi-dimensional syndrome with functional, affective, cognitive and physical components. It is not defined by chronological age but by a set of characteristics:

- Weight loss
- Low grip strength
- Slow timed get-up-and-go
- MMSE ≤ 24
- FEV₁ $\leq 30\%$ predicted
- Disability
- Co-morbidity

Applying simple assessment tools to case finding, screening or triage of older people we can identify those who are most frail and at greatest risk of admission to hospital or to institutional care. This is a group that will benefit from targeted health and social care interventions such as Comprehensive Geriatric Assessment (CGA) and palliative and end of life care.

Frailty Risk Prediction Tools

Ravaglia et al (*Age Ageing (2008) 37:161–66*) developed a frailty score that includes 9 independent predictors of admission to hospital, fracture risk, new or worsening disability and mortality. The predictors include :

- Age > 80
 - Male gender
 - Low physical activity
 - 3 + medications
 - Co-morbidities, including cognitive impairment
 - Sensory deficits (blindness, deafness)
 - Calf circumference < 31 cms
 - ADL disability
 - Gait and balance Tinetti test of < 24

Improving Outcomes

Risk prediction tools, applied in community or hospital settings, help us target the interventions that deliver better outcomes. Delivered along the pathway of care, these interventions improve communication, co-ordination and more proactive and integrated care across professionals, teams and care settings. They have been summarised as three themes :

- **Proactive anticipatory care**
- **Effective care at times of transition**
- **Interventions that maximise return home from hospital**

Our Principles

The Pathway will

- Support older people to remain or return home where possible
- Promote a shift in the balance of care
- Improve the safety, experience, effectiveness and quality of care
- Enhance performance against relevant HEAT targets
- Help partnerships deliver on Community Care Outcomes

To make this happen we need to.....

- Deliver co-ordinated team based care across sectors
- Enhance outreach of specialist support in community settings
- Streamline access to services, both in and out of hours
- Build workforce capability through enhanced skill mix and joint working
- Use the opportunities from emerging ehealth and telehealthcare solutions
- Share information across agencies, both within and out of hours

We will deliver this through quality improvement and leadership that.....

- Spreads effective practice within and across NHS Boards
- Promotes efficiency and productivity by reducing waste and variance
- Adopts a redesign and invest to save approach to new developments
- Embeds and sustains improvements in mainstream services
- Makes best use of existing financial, contractual and professional levers
- Embraces an ethos of care that is

Holistic

Assessment, care and support planning considers the whole person and their roles and responsibilities including family, relationships, housing and leisure.

Person centred

Care planning is led by the individual through an equal partnership with the professional and promotes choice and control.

Anticipatory

A proactive approach that supports people and teams to plan ahead for anticipated flare ups and foreseeable crises to reduce escalation of dependency.

Outcomes focused

Care planning is based on goal setting, negotiation, shared decision making and focuses on the outcomes that are important to people and their carers.