Fit for Frailty

Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings

A report by the

British Geriatrics Society

in association with the Royal College of General Practitioners and Age UK

June 2014

The British Geriatrics Society

The British Geriatrics Society is the professional body of specialists in the health care of older people in the United Kingdom. Membership is drawn from doctors, nurses, allied health professionals, scientists and others with a particular interest in the care of older people and the promotion of better health in old age. It has 3,000 members worldwide and is the only society in the UK which draws together experts from all the relevant disciplines in the field.

The BGS uses the expertise of its members to inform and influence the development of health care policy in the UK and to ensure the design, commissioning and delivery of age appropriate health services. The BGS works closely with other specialist medical societies and allies itself with age-related charities.

The BGS strives to promote better understanding of the health care needs of older people. It shares examples of best practice to ensure that older people are treated with dignity and respect and that wherever possible, older people live healthy, independent lives.

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Fit for frailty consensus best practice guidance for the care of older people living with frailty in community and outpatient settings

This guidance is intended to support health and social care professionals in the community, in outpatient clinics, in community hospitals and other intermediate care settings and in older people's own homes. Guidance for professionals encountering older people with frailty in acute hospitals has been published in the Silver Book [1] and work to develop a checklist to support the management of older people with frailty in acute hospital settings is ongoing [2] under the auspices of the FRAILsafe programme.

It was produced by the British Geriatrics Society in association with Age UK and the Royal College of General Practitioners.

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Foreword

In the jargon she was "FLOF" (or "Found lying on the Floor"). That is to say the home care staff had found Mrs Greenaway lying on the floor next to her bed at 8 a.m. on a Saturday morning. "It was a fall waiting to happen," they said. A couple of telephone calls later and Mrs Greenaway found herself under the unforgiving lights of the local Accident and Emergency (A&E) department. No injuries or notable illnesses detected but the A&E staff felt insecure in their clinical decision making: a paucity of background medical details; uncertain even of current medication or allergy status. And the A&E department was as busy as always. Easiest by far to admit and sort things out downstream on a ward. Not at all what Mrs Greenaway was expecting.

Mrs Greenaway has frailty and is a single story but of more general concern. Over 640,000 older people present to A&E departments each year after a fall. Serious injuries and illness are fortunately uncommon. In some ways everything was done just as might have been expected. She was given timely, safe, efficient care - the emergency care system at its best. But the outcome - admission to hospital - seems disproportionate to the predicament. Might a more community based approach have been possible? Perhaps a home based assessment by a Crisis Response Team? Or more robust proactive and preventative care that targeted the modifiable components of frailty before the health crisis occurred?

These possible alternative responses are successful realities in some areas in the UK but they are far from widespread. And therein lies our challenge: to take what is a reality in some places and to make it routine throughout the NHS. In part, this will require new capacity and resilience within primary, community and social care, not forgetting the essential role of the housing and voluntary sectors. But there is also an important need for the workforce to be appropriately skilled to meet the needs of older people who have frailty, and for the appropriate organisational systems and processes to be in place. These aspects are addressed fully within this important report developed by the British Geriatrics Society in association with Age UK and the Royal College of General Practitioners. The core principle of distinguishing people who have frailty from fit and well older people is placed centre stage, followed by practical guidance on how high quality and safe community care can be provided. Follow up guidance is planned shortly aimed specifically at commissioners to encourage a robust community-based response to older people who have frailty.

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Full list of BGS recommendations for the recognition and management of frailty in community and outpatient settings

▶ Older people should be assessed for the presence of frailty during all encounters with health and social care professionals. Gait speed, the timed-up-and-go test and the PRISMA questionnaire are recommended assessments.

▶ Provide training in frailty recognition to all health and social care staff.

▶ Do not offer routine population screening for frailty.

▶ Look for a cause if an older person with frailty shows decline in their function.

▶ Carry out a comprehensive review of medical, functional, psychological and social needs based on the principles of comprehensive geriatric assessment.

▶ Ensure that reversible medical conditions are considered and addressed.

▶ Consider referral to geriatric medicine where frailty is associated with significant complexity, diagnostic uncertainty or challenging symptom control.

▶ Consider referral to old age psychiatry for those people with frailty and complex co-existing psychiatric problems, including challenging behaviour in dementia.

▶ Conduct evidence-based medication reviews for older people with frailty (e.g. STOPP START criteria).

▶ Use clinical judgment and personalised goals when deciding how to apply disease-based clinical guidelines to the management of older people with frailty.

▶ Generate a personalised shared care and support plan (CSP) outlining treatment goals, management plans and plans for urgent care. In some cases it may be appropriate to include an end of life care plan.

▶ Where an older person has been identified as having frailty, establish systems to share health record information (including the CSP) between primary care, emergency services, secondary care and social services.

▶ Develop local protocols and pathways of care for older people with frailty, taking into account the common acute presentations of falls, delirium and sudden immobility. Wherever the patient is managed, there must be adequate diagnostic facilities to determine the cause of the change in function. Ensure that the pathways build in a timely response to urgent need.

▶ Recognise that many older people with frailty in crisis will manage better in the home environment but only with appropriate support systems.

Introduction

This guidance is intended to support health and social care professionals in the community, in outpatient clinics, in community hospitals and other intermediate care settings and in older people's own homes. Guidance for professionals encountering older people with frailty in acute hospitals has been published in the Silver Book [1] and work to develop checklist to support the management of older people with frailty in acute hospital settings is ongoing [2].

1. What is frailty?

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years [3].

Living with frailty typically means a person is at a higher risk of a sudden deterioration in their physical and mental health.

Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. The purpose of this guidance is to advise about action which can be taken to prevent these adverse outcomes and help people live as well as possible with frailty.

Frailty is distinct from living with one or more long-term conditions and/or disability, though there may be overlaps in their management.

It is important to understand the difference between frailty, long term conditions and disability. Many people with multiple long term conditions (so called multi-morbidity) will also have frailty which may be masked when the focus is on other disease based long term conditions. Likewise, some people whose only long term condition is frailty may be low consumers of health care resources and not regularly known to their GP (until they become bed bound, immobile or delirious as a result of an apparently minor illness). There may be overlap between the management approaches for people with multi-morbidity and those with frailty but these conditions are not identical and this guidance looks primarily at frailty. Similarly, there is overlap between frailty and physical disability – many people with frailty also have disability, but lots of people with a long term disability do not have frailty. Frailty may be the cause of disability in some patients and the consequence in others.

Older people living with frailty can be low users of health services until a relatively minor event precedes a major change in their level of need.

The language and management of frailty can act as barriers to engaging with older people who may not perceive themselves, or wish to be defined, by a term that is often associated with increased vulnerability and dependency. Older persons may not recognise themselves as living with frailty and there is evidence that older people do not want to be considered as 'frail', although happy to accept that they are an older person [4]. For an older person, living with frailty can mean living with various 'losses' and it is easy, as a professional, inadvertently to collude with the loss of control over everyday life that results from an extensive care package, social isolation or the rapid fluctuation in mental state that sometimes accompany frailty. Research has demonstrated [5] that many older people living with frailty develop ways of coping and make other compensatory choices. As a group 'frail older people' encompasses a diversity of individual people each with different expectations, hopes, fears, strengths and abilities, as well as different types and levels of

need and support. It is our job to ensure that these are, as far as is possible, accommodated, thus restoring control, preserving dignity and facilitating person-centred care to the older person living with frailty and those close to them.

Within these guidelines we look at the condition of frailty (Section 2) and then how to recognise it in the older people we encounter (**Section 3**). Recognition will mean understanding that people with frailty can appear to have a straightforward problem or need (where frailty might not be apparent unless actively sought) or can present with one of a number of so called frailty syndromes which should raise suspicions of the vulnerability of the individual. **Section 4** details how frailty can be managed.

Background - causes and prevention of frailty

There are two broad models of frailty – these are documented for clarity. The first, known as the **Phenotype model** [6], describes a group of patient characteristics (unintentional weight loss, reduced muscle strength, reduced gait speed, self-reported exhaustion and low energy expenditure) which, if present, can predict poorer outcomes. Generally individuals with three or more of the characteristics are said to have frailty (although this model also allows for the possibility of fewer characteristics being present and thus pre-frailty is possible). The second model of frailty is known as the Cumulative **Deficit model** [7]. Described by Rockwood in Canada, it assumes an accumulation of deficits (ranging from symptoms e.g. loss of hearing or low mood, through signs such as tremor, through to various diseases such as dementia) which can occur with ageing and which combine to increase the 'frailty index' which in turn will increase the risk of an adverse outcome. Rockwood also proposed a clinical frailty scale for use after a comprehensive assessment of an older person; this implies an increasing level of frailty which is more in keeping with experience of clinical practice.

The two broad models of frailty use changes in a person's weight, muscle strength etc. or identification of "deficits" such as sensory loss, dementia etc.

Frailty exists on a spectrum, reinforcing the importance of person-centred care.

Physical exercise and maintaining a healthy diet can help to prevent and minimise the impact of frailty.

A central feature of physical frailty, as defined by the phenotype model is loss of skeletal muscle function (sarcopenia) and there is a growing body of evidence documenting the major causes of this process. The strongest risk factor is age and prevalence clearly rises with age. There is also an effect of gender where the prevalence in community dwelling older people is usually higher in women. For example a UK study from 2010 using the phenotype approach to defining frailty found a prevalence of 8.5% in women and 4.1% in men aged 65 –74 years [8].

In terms of modifiable influences, the most studied is physical activity, particularly resistance exercise, which is beneficial both in terms of preventing and treating the physical performance component of frailty. The evidence for diet is less extensive but a suboptimal protein/total calorie intake and vitamin D insufficiency have both been implicated. There is emerging evidence that frailty increases in the presence of obesity particularly in the context of other unhealthy behaviours such as inactivity, a poor diet and smoking.

Other areas of interest include the role of the immune-endocrine axis in frailty. For example a higher white cell count and an increased cortisol: androgen

ratio predicted 10 year frailty and mortality in one recent study [9].

However the inter-relationship between prescribed medication and frailty independent of co-morbidity is a relatively under-exploited area. There is some evidence that aside from myopathy, some drugs may have more subtle adverse effects on muscle function [10].

The cumulative deficit approach to defining frailty is broader than the phenotype approach, encompassing co-morbidity and disability as well as cognitive, psychological and social factors. The potential causes are therefore wider and include the multiple risk factors which are implicated in the various diseases and conditions.

3. Recognising and identifying frailty in individuals

Recommendations

▶ Older people should be assessed for the possible presence of frailty during all encounters with health and social care professionals. Slow gait speed, the PRISMA questionnaire, the timed-up-and-go test are recommended as reasonable assessments. The Edmonton Frail Scale is recommended in elective surgical settings.

▶ Provide training in frailty recognition to all health and social care staff who are likely to encounter older people.

▶ Do not offer routine population screening for frailty.

3.1 Why do we need to identify frailty?

Frailty should be identified with a view to improving outcomes and avoiding unnecessary harm.

Identifying people living with frailty can help improve outcomes both in relation to a specific intervention as well as with the long-term management of health needs.

Relatively simple tests can be used to indicate frailty but should be followed up by a more detailed clinical assessment where necessary.

The central problem with frailty is the potential for serious adverse outcomes after a seemingly minor stressor event or change. This could mean anything from a simple episode of 'flu to a major intervention like a joint replacement. Even apparently simple interventions like a move to a short term residential placement for respite, a trip to the local emergency department after a fall or the trial of a new analgesic can have unforeseen and adverse outcomes. Thus for an individual, the knowledge that they have frailty can help health and social care professionals to take action to prevent the poor outcome for a particular intervention (or even to avoid the intervention) and to start a pathway of care to address the issues contributing to frailty.

It is important to remember however, that:

▶ Frailty varies in severity (individuals should not be labelled as being frail or not frail but simply that they have frailty).

▶ The frailty state for an individual is not static; it can be made better and worse.

▶ Frailty is not an inevitable part of ageing; it is a long term condition in the same sense that diabetes or Alzheimer's disease is.

3.2 In what circumstances does it help to understand that the patient has frailty?

Any interaction between an older person and a health or social care professional should include an assessment which helps to identify if the individual has frailty.

This includes (but is not limited to) the following:

- Routine outpatient appointments in all departments, including surgical (orthopaedic, GI, vascular and ophthalmic departments), medical and mental health (memory clinics).

- Social services assessment for care and support.

- Review by the community care teams after referral for community intervention.

- Primary care review of older people (either medical intervention or medicines review or any other interaction such as one of the long term conditions clinics).

- Home carers in the community.

- Ambulance crews when called out after a fall or other urgent matter.

Planning any intervention (e.g. starting a new drug, conveying to the emergency department or an elective joint replacement) in an individual who has frailty, without recognising the presence of the condition and balancing the risks and benefits, may result in significant harm to the patient.

It is self-evident that the type of assessment will differ when dealing with an individual who is currently unwell (and therefore a short screening assessment may be of limited benefit) instead of being in a stable situation. Professional discretion will need to drive the nature of the assessment. However planning any intervention (e.g. starting a new drug, conveying to the emergency department or an elective joint replacement) in an individual who has frailty, without recognising the presence of the condition and balancing the risks and benefits, may result in significant harm to the patient.

3.3 How can we recognise frailty in an individual?

3.3.1 Frailty syndromes (could also present in a crisis situation)

Sometimes frailty means that individuals can present with what appears to be a straightforward symptom masking a more serious or complex underlying medical problem. This gives rise to the concept of 'frailty syndromes' (previously known as the geriatric giants).

Broadly there are 5 frailty syndromes and encountering one of these should raise suspicion that the individual concerned has frailty. However, it is possible to have any of these problems without frailty and sometimes there can be a very straightforward explanation for the problem. Nonetheless, frailty can mean, for example, that myocardial infarction, stroke, pneumonia or even spinal cord compression due to infection could all manifest themselves in a patient with frailty as a sudden change in mobility. Likewise a fall could indicate serious underlying illness and it will not be possible to make this decision without reviewing the patient (**see section 4.2.3 - Management of a patient in an urgent situation**).

Table 1: Frailty syndromes

1] Falls (e.g. collapse, legs gave way, 'found lying on floor').

2] Immobility (e.g. sudden change in mobility, 'gone off legs' 'stuck in toilet').

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

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

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

3.3.2 Recognising frailty in a more routine situation

A range of tests for identifying frailty are available, but the accuracy of these is uncertain. A review was undertaken to investigate the diagnostic accuracy of some simple tests for identifying frailty. The full detail of the review is available [11] but in summary, it searched for all studies that compared simple tests for identifying frailty (e.g. walking speed, grip strength, simple questionnaires) against a phenotype model, cumulative deficit model or comprehensive geriatric assessment.

The review found three studies that investigated seven simple methods for identifying frailty; these were:

▶ **PRISMA 7 Questionnaire -** which is a seven item questionnaire to identify disability that has been used in earlier frailty studies and is also suitable for postal completion. A score of > 3 is considered to identify frailty.

▶ **Walking speed (gait speed) -** Gait speed is usually measured in m/s and has been recorded over distances ranging from 2.4m to 6m in research studies. In this study, gait speed was recorded over a 4m distance.

▶ **Timed up and go test -** The TUGT measures, in seconds, the time taken to stand up from a standard chair, walk a distance of 3 metres, turn, walk back to the chair and sit down.

▶ **Self-Reported Health -** which was assessed, in the study examined, with the question 'How would you rate your health on a scale of 0-10'. A cut-off of < 6 was used to identify frailty.

▶ **GP assessment -** whereby a GP assessed participants as frail or not frail on the basis of a clinical assessment.

▶ **Multiple medications (polypharmacy) -** where frailty is deemed present if the person takes five or more medications.

▶ **The Groningen Frailty Indicator questionnaire -** which is a 15 item frailty questionnaire that is suitable for postal completion. A score of > 4 indicates the possible presence of moderate-severe frailty.

Slow walking speed (less than 0.8m/s or taking more than 5 secs to walk 4m); the PRISMA 7 questionnaire and the timed-up-and-go test (with a cut off score of 10 secs) had very good *sensitivity* but only moderate *specificity* for identifying frailty. This means that there are many fitter older people who will have a positive test result (false positives). For example, only one in 3 older people (over 75 years) with slow walking speed has frailty.

However, the accuracy of a test is related to the prevalence of a condition in a population. For example, older people who attend outpatient clinics, receive social services assessments or require ambulance crew attendance are more likely to have frailty. This means that the tests are likely to be more accurate in these situations, which supports a case finding approach to identifying frailty. The BGS therefore recommends, as the most suitable tests, the use of gait speed (taking more than 5 seconds to walk 4 m using usual walking aids if appropriate) or the timed up and go test (with a cut off score of 10s to get up from a chair, walk 3m, turn round and sit down). The PRISMA 7 questionnaire (with a cut-off score of ≥3) could be considered as an alternative for self-completion, including as a postal questionnaire.

Prisma 7 Questions

1] Are you more than 85 years?

2] Male?

3] In general do you have any health problems that require you to limit your activities?

4] Do you need someone to help you on a regular basis?

5] In general do you have any health problems that require you to stay at home?

6] In case of need can you count on someone close to you?

7] Do you regularly use a stick, walker or wheelchair to get about?

Use of a two-step approach to diagnosis (for example the Prisma questionnaire followed by a gait speed test) would potentially improve accuracy but requires further investigation. Where possible, the BGS also advocates a brief clinical assessment to confirm the presence of frailty. This would help exclude some false positives (e.g. otherwise fit older people with isolated knee arthritis causing slow gait speed).

It is inappropriate to use the (Rockwood) Clinical Frailty Scale (CFS) [7] as a method of identifying frailty without a formal clinical assessment. The CFS was designed to be used to measure severity of frailty after a comprehensive geriatric assessment. It is not validated for measuring improvement in individuals after an acute illness for example.

Health and social care staff will therefore need to be familiar with the tests which might be used for recognising frailty and should be trained to use them.

If an older person is ill and there is reason to believe that their illness will affect their gait speed or ability to get up from a chair, the PRISMA 7 questionnaire based on their usual health status will identify those who are likely to have frailty (scoring yes to 3 or more questions). It can also be used for self-completion, including as a postal questionnaire.

There is some evidence that grip strength (using a hand held dynamometer) may be useful in situations where it is not feasible for the patient to get up and walk. However this measurement has not yet been tested for diagnostic accuracy of frailty [12].

In outpatient surgical settings, there is a lack of consensus on which tool should be used to identify frailty. Gait speed may help predict adverse outcomes, however, evidence is emerging for the use of the Edmonton Frail Scale [13]. The strengths of this tool include brevity, clinical feasibility and identification of aspects of frailty amenable to preoperative optimisation (e.g. cognition, nutrition).

3.4 Is there any value in looking for frailty on a population or practice basis?

Systematic screening for frailty would be an expensive venture and there is currently no evidence for improved outcomes despite it being a recommendation in earlier international guidance[14]. Like systematic screening for dementia, there would be a degree of "public unacceptability" (for example; people may be fearful of being diagnosed with dementia and therefore be reluctant to submit to a test for dementia unless it was specifically indicated by their life circumstances). Age UK research [4] has shown that in a series of filmed case studies of 'frailty', none of the participants classified themselves as "frail". Some of them mentioned finite periods where they "had been frail", but they did not see it as a lifetime condition or as defining them.

These tools interrogate a primary care practice computer to identify high risk individuals based on past use of resources, drug prescriptions or particular diagnoses. Unfortunately there is no evidence that focussing resources on these individuals improves outcomes.

Additionally, these tools, which were not designed to look for frailty, often highlight individuals who have high cost conditions not amenable to modification (such as immunosuppression after organ transplant).

A current approach seeks to break down a practice population according to risk of using future health care resources including hospital admission. It uses computer based tools, for example Advanced Clinical Groupings (ACG), Prediction of individuals At Risk of Readmission (PARR) or Scottish Prevention of Admission and Readmission (SPARRA). These tools interrogate a primary care practice computer to identify high risk individuals based on past use of resources, drug prescriptions or particular diagnoses. Unfortunately there is no evidence that focussing resources on these individuals improves outcomes. Additionally, these tools, which were not designed to look for frailty, often highlight individuals who have high cost conditions not amenable to modification (such as immunosuppression after organ transplant).

Some areas and practices have adopted a localised approach to identify frailty, e.g. in Warwickshire, Age UK has trained volunteers to administer the Easy care tool[23] which starts the process of identifying needs and developing an individualised care plan. This is similar to an approach in Gnosall, Staffordshire (winner of an NHS innovation award) where everyone receives a questionnaire on their 75th birthday, seeking to identify those who might have, or be developing, frailty. They have achieved a response rate of over 85% and those who respond are then visited at home by an elder care facilitator before undergoing a comprehensive geriatric assessment at the surgery by a GP.

Thus the BGS does not currently support routine population screening for frailty because of the likely considerable cost of completing assessments and the low specificity of available tools. A suitably validated electronic frailty index constructed using existing primary care health record data may enable

future routine identification and severity grading of frailty, but requires additional research.

4. Managing frailty in an individual

Recommendations

▶ Carry out a comprehensive and holistic review of medical, functional, psychological and social needs based on comprehensive geriatric assessment principles in partnership with older people who have frailty and their carers.

▶ Ensure that reversible medical conditions are considered and addressed.

▶ Consider referral to geriatric medicine where frailty is associated with significant complexity, diagnostic uncertainty or challenging symptom control. Old age psychiatry should be considered for those with frailty and complex co-existing psychiatric problems including challenging behaviour in dementia.

▶ Conduct personalised medication reviews for older people with frailty, taking into account number and type of medications, possibly using evidence based criteria (e.g. STOPP START criteria).

▶ Use clinical judgement and personalised goals when deciding how to apply disease based clinical guidelines in the management of older people with frailty.

▶ Generate a personalised shared care and support plan (CSP) which documents treatment goals, management plans, and plans for urgent care which have been determined in advance. It may also be appropriate for some older people to include end of life care plans.

▶ Establish systems to share the health record information (including the CSP) of older people with frailty between primary care, emergency services, secondary care and social services.

▶ Ensure that there are robust systems in place to track CSPs and the timetables for review.

▶ Develop local protocols and pathways of care for older people with frailty, taking into account the common acute presentations of falls, delirium and sudden immobility. Ensure that the pathways build in a timely response to urgent need.

▶ Recognise that many older people with frailty in crisis will manage better in the home environment but only with support systems which are suitable to fulfil all their health and care needs.

Comprehensive Geriatric Assessment (CGA) is a detailed process for identifying a person's health, social and environmental needs and then planning interveions to address those needs.

It is not always possible to undertake a full CGA; however, a holistic review when frailty is indicated is a vital part of care planning.

Care planning is extremely important to help avoid crises; to help older people maintain the best possible quality of life when living with sometimes complex needs; and to inform decision-making with regard future treatments.

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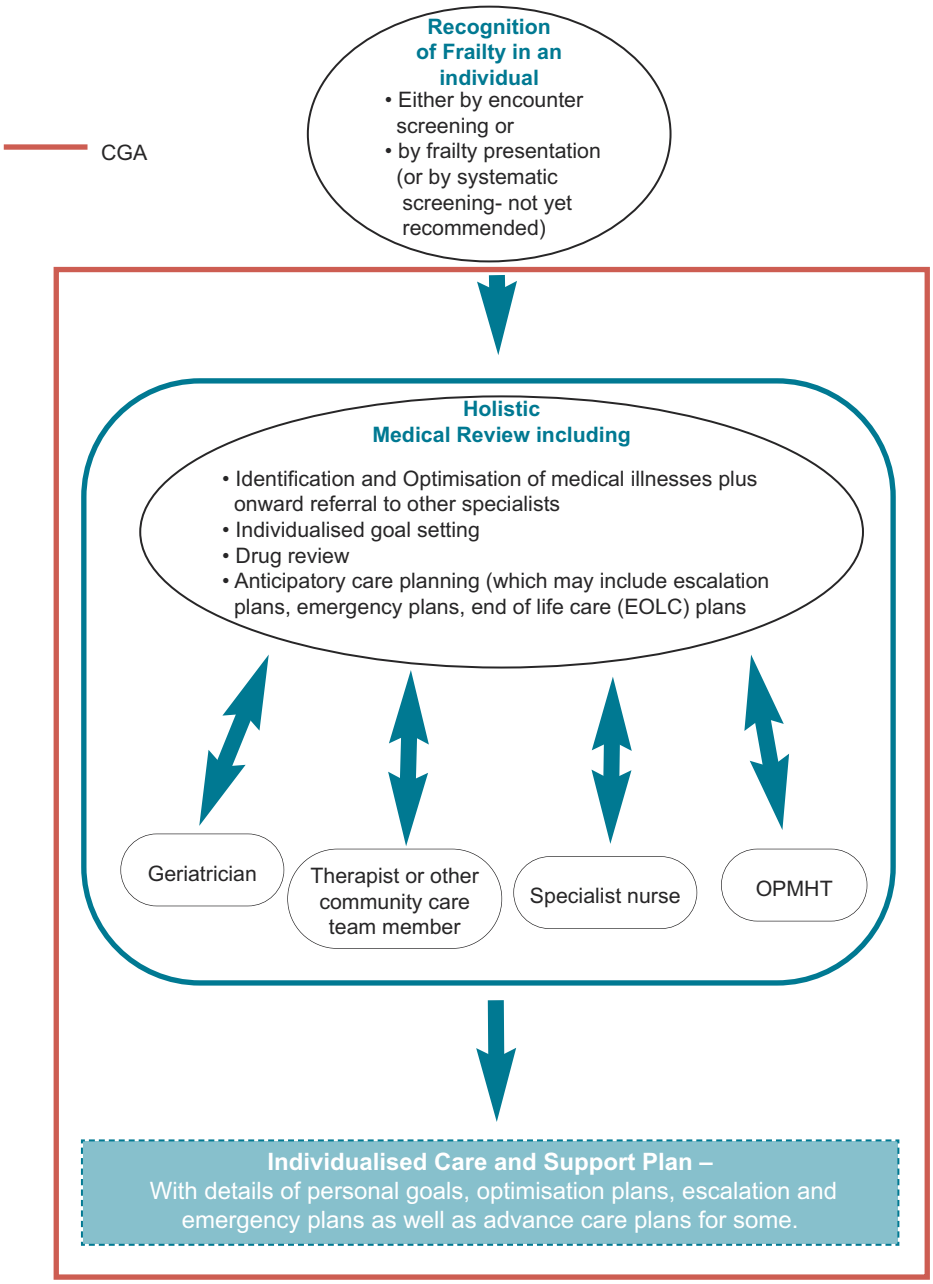
people maintain the best possible quality of life when living with sometimes complex needs; and to inform decision-making with regard future treatments.

4.1 Comprehensive Geriatric Assessment (CGA)

Fig. 1



The gold standard for the management of frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA). It involves an holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health and has been demonstrated to be associated with improved outcomes in a variety of settings [16].

CGA is a clinical management strategy which will give a framework for the delivery of interventions which address relevant and appropriate issues for an individual patient.

After CGA it will be possible to use the Rockwood Clinical Frailty index to demonstrate the level of frailty of the individual [7]. However, it is not a rapid process. The initial assessment and care planning for a full CGA is likely to take at least 1.5 hours of professional time, plus the necessary time for care plan negotiation and documentation (likely total of 2.5 hours, plus there is a need for ongoing review). Therefore it is simply not feasible for everyone with frailty (from mild up to severe life limiting frailty) to undergo a full multidisciplinary review with geriatrician involvement. Nevertheless, all patients with frailty will benefit from a holistic medical review (see detail below) based on the principles of CGA. Some people will need to be referred to a Geriatrician for support with diagnosis, intervention or care planning and others will also need to be referred to other specialists in the community such as an Old Age Psychiatrist, therapists, specialist nurses, dieticians and podiatrists.

Whatever level of input is needed for an individual, the resulting process of assessment, individual care and support planning (see detail below) and regular review is vital to provide an evidence based management plan for frailty.

The processes outlined in this section are described as a flow chart in figure 1 above.

Further information about CGA is contained in **appendix 1**.

4.2 Providing better care for an individual who is found to have frailty

4.2.1 Holistic Medical Review by the GP

Once a person has been identified as frail, a holistic review will allow for optimisation of the person's health and for considered forward care planning. It may involve onward referral for a more Comprehensive Geriatric Assessment by an interdisciplinary team (see appendix 1 and figure 1 above for flow chart). An appropriate period of time should be put aside to allow for this holistic review (it is likely to take at least 45 – 60 mins - depending on how well the individual is known to the GP or specialist nurse doing the assessment). It may be appropriate to invite relatives and carers to be present at the assessment as well as any care workers involved with the individual. The setting of the review can be agreed with the patient; however the physical examination needed as part of this assessment will limit choice.

Common problems in frailty which need to be addressed to reduce the severity and improve outcomes

- Falls
- Cognitive impairment
- Continence
- Mobility
- Weight loss and poor nutrition
- Polypharmacy
- Physical inactivity
- Low mood
- Alcohol excess
- Smoking
- Vision problems
- Social isolation and loneliness

Underlying diagnoses and reversible causes for these problems must be considered and addressed as part of the assessment. [**See case example A in list - Eric's Story**]

In looking for cognitive impairment, it is helpful to use a standardised cognitive assessment such as the 6-CIT cognitive test (which has been validated in primary care) (www.patient.co.uk) or the Montreal Cognitive Assessment (http://www.mocatest.org/).

New medical problems, which can present atypically, should be enquired about in the structure of a systems review. Previous diagnoses and long term conditions and their management should be reviewed. As patients with frailty commonly have other long term conditions, it is important to assess the impact of these as a whole and consider if national and local guidance is appropriate for the individual. A medication review is also important in this context (see below). A complete physical examination including eyes, ears and a neurological examination is vital.

The assessor (whether the patient's GP or another) must ensure that there is a diagnosis or explanation for all newly discovered symptoms and signs. It is vital to look for reversible medical problems and to ensure that the agreed care plan (see next section) includes the appropriate investigations needed to look for treatable disease - as agreed with the patient.

In some situations, it might be helpful to consider an assessment structured under the domains used in Easycare (ref www.easycare.org.uk) which are;

- Seeing hearing and communication
- Getting around
- Looking after yourself
- Housing and finances
- Safety and relationships
- Mental wellbeing
- Staying healthy

However this less medical centred approach does not remove the obligation on the person doing the assessment to look for reversible medical problems and underlying diagnoses.

Assessment of Capacity. If there are concerns about cognitive function, it is important to consider mental capacity which might influence subsequent care and support planning. The principles of the Adults with Incapacity (Scotland) 2000 and Mental Capacity Act (England and Wales) 2005 are:

- Assume Capacity
- Help people to have capacity in all practical ways before deciding they do not have capacity
- People are entitled to make unwise decisions
- Decisions for people without capacity should be in their best interest and the least restrictive possible.

The 4 point capacity test is:
- Can they understand the information given?
- Can they retain the information given?
- Can they balance, weigh up or use the information?
- Can the person communicate their decision?

If the answer to any of these is 'no' then the person does not have capacity.

However it is also important to remember that capacity may fluctuate and that it is time and decision specific. All health and social care professionals must recognise their responsibilities with respect to mental capacity and be prepared to reassess capacity if the situation changes.

Drugs/Medicines Review. Medication reviews are important – many drugs are particularly associated with adverse outcomes in frailty such as:

- antimuscarinics in cognitive impairment
- long acting benzodiazepines and some sulphonylureas, other sedatives and hypnotics increase falls risk
- some opiate based analgesics increase risk of confusion or delirium
- NSAID can cause severe symptomatic renal impairment in frailty

Conversely, some drugs which would offer symptomatic benefit are omitted because of concerns about frailty, when with careful monitoring they would be safe to use (such as ACE inhibitors in heart failure).

With ageing the metabolism of drugs changes and this needs to be taken into account when prescribing as it may affect dosage.

The use of multiple medications by older people with frailty is likely to increase the risk of falls, adverse side effects and interactions, hence the need to individualise the interpretation of national guidelines for single long term conditions in the context of multimorbidity in general and frailty in particular.

A discussion about the stopping of preventative chronic disease medication such as statins and warfarin for atrial fibrillation and sedatives and antihypertensives should include the potential impact on the hoped for long term outcomes for the individual in question. It might be appropriate to consider using validated medication appropriateness checklists such as the STOPP and START Guidelines [17].

At the end of the assessment, which should also have included a discussion about individual goals and aspirations, the person doing the assessment should help the individual and, if relevant, their carers should draw up an **individualised care and support plan**. There is more information about this in the next section.

The plan may include referrals to other community services such as intermediate care, mental health, a geriatric service or a falls service. This plan may therefore feed into a larger review which would constitute full CGA (**see appendix 1**).

It is also important to develop an escalation plan which helps individuals and their carers identify what they should look out for and when and who they should call for help and advice. It should include an urgent care plan which, at a time of future crisis, could guide the emergency or out of hours services as to the appropriate decisions to take around emergency department conveyance and hospital admission.

It may be appropriate to start to explore, sensitively, issues around end of life planning. If there are advance directives, it would be important to review and record this in locally agreed systems for future reference.

4.2.2 Individualised Care and Support Plans

Much of the output of a holistic medical review based on CGA principles will be in the form of individualised care and support plans (CSP). The same format for a CSP will be used whether or not the individual is managed within primary care or referred to specialist services for a full CGA. [**See case example B – Phyllis's story for an example of this in use**].

There will be common themes to the plans which should include:

▶ **The named individual** who is responsible for coordinating care on behalf of the patient and who will be the patient's main point of contact in the community teams. For someone who has not been referred to the community teams and who has had a holistic medical review by their GP, it is likely that their GP will be the named individual.

▶ **A health and social care summary** (including symptoms, underlying diagnoses, medications and current social situation).

▶ **An optimisation and/or maintenance plan** which includes:

- What the individual's goals are
- What the actions are that are going to be taken
- Who is responsible for doing what (including the patient, their carers, their relatives, the doctor and other health professionals)
- What the timescale is and how and when review will happen

▶ **An escalation plan** which describes

- What a patient and or their carer might need to look out for
- Who to call or what to do if it happens

▶ **An urgent care plan** – which summarises what the individual wants to happen if a crisis occurs in either their own health (i.e. do they want to go to hospital, under what circumstances would they want to stay at home, whether there is a DNACPR order in place) or in the health of their carer. This carer's emergency plan can sometimes be facilitated in advance by the Princess Royal Trust for Carers (www.carers.org) who will visit the patient and their carers to discuss contingency plans.

For many patients it will also be appropriate to have in place:

▶ **An advance care plan or end of life care plan** – which could describe the patient's wishes with respect to their preferred place of dying and whether they have 'just-in-case' medications in place.

Some areas have developed an Ambulance Anticipatory care plan which allows communication with the ambulance service. However, we recommend that this could easily form part of the overall care and support plan, thus avoiding the need for multiple different plans for one individual.

National Voices has developed a proforma for a care and support plan on which it has recently finished a consultation. However it should be noted that this guidance is mainly geared towards people with one or more long term conditions who might not have frailty. The final version is available on http://www.nationalvoices.org.uk/what-care-and-support-planning. Another example of a care and support plan can be seen in **Edgar and Mary's story – case example C in List**.

The agreed management plan should be recorded and shared with the individual together with a review date. The review may be made by other health care professionals or by the GP undertaking the assessment. A robust system for identifying these patients and tracking these review plans should be developed within the local health care network.

The format of the CSP will vary depending on local arrangements and local IT systems.

Ideally it would be shared electronically with appropriate others (ambulance, social worker, emergency department etc.). However even if this were always possible, which it is not currently, there is no guaranteed ability to access the appropriate health record when needed due to variable mobile internet access and the changeover of staff with varying IT skills in the different settings. It is appropriate, therefore, that the individual keeps a dated copy of their own plan in a standard place which can be accessed in an emergency. If possible, the person should also have a duplicate of the plan which then can take to hospital if needed. (www.lions105ea.com/specialist_officer/miab.html).

4.2.3 Assessment and management in an urgent situation

As noted above, the presentation of an older person with frailty in an urgent situation is not always straightforward. Frailty syndromes can mask serious underlying illness and the response to a crisis call from an older person with frailty should reflect the potential underlying illness and not the symptom itself. It is not acceptable for 'just a fall' to be regarded as a non urgent situation without reviewing the patient in person.

A health and social care professional being asked to attend an older person with frailty in an emergency situation will therefore need to act according to the clinical condition of the patient. However, prior knowledge that the person has frailty- because of access to their previously agreed care and support plans - will help make appropriate decisions. Although ideally such plans will be shared electronically, it is important always to check with the person being assessed (and their carers if appropriate) to determine if there are any care plans and advance directives in the house.

▶ **Assess clinical condition** – measure vital signs and consider if any red flags are present which suggest the patient needs acute hospital care - such as hypoxia, significant tachycardia or hypotension (if possible compare readings with what is usual for the patient – these should be recorded in the care and support plan).

▶ **Assess current function** - can they get out of bed, can they walk, have they been able to use the toilet? Is there any evidence of a frailty syndrome – falls, immobility, new onset incontinence?

▶ **Are they confused** – is this usual (may need help from carers to assess this) or worse than usual? The patient may have delirium even if they have a prior dementia. This would also signal frailty.

If the patient is stable and at their usual level of function but has a temperature or evidence of delirium, they will need timely medical review but will not necessarily need immediate conveyance to hospital.

If a patient is not severely unwell but is unable to maintain their usual status quo in the community due to a temporary change in their care needs, it is good practice and better for an older person with frailty to transfer care to a responsive community service rather than admission to hospital. This could be either a rapid response type 'hospital at home', or a community based intermediate care service such as a 'step up bed'. There will be some variation in local schemes.

A doctor assessing an older person with frailty as an emergency needs to strike a balance between being alert for serious underlying illness masquerading as a frailty syndrome and over medicalisation of common problems such as falls and dementia. For example, over diagnosis of urinary tract infection as a single cause for falls, immobility and

delirium in older people with frailty is common and a judicious clinical assessment is required. If in doubt (i.e. the patient is not febrile and appears to be otherwise well) then a set of bloods to look for raised inflammatory markers should be done without necessarily conveying the patient to hospital.

There are many national guidelines on managing these problems; for example SIGN guidance for diagnosing UTI [18] and there should be local protocols which direct people to the local alternative for hospital admission.

4.2.4 Managing frailty in the outpatient surgical setting

Increasing numbers of older people are undergoing elective surgery. Studies examining older patients undergoing elective procedures have reported frailty prevalence of 40-50%. Frailty is an independent risk factor for post-operative major morbidity, mortality, protracted length of stay and institutional discharge.

It is important to identify frailty preoperatively in order to manage risk, inform shared decision making and highlight areas for potential modification.

Whilst there is a lack of consensus on which tool should be used to identify frailty in surgical settings, as noted above, evidence is emerging for the use of the Edmonton Frail Scale [13]. The strengths of this tool include brevity, clinical feasibility and identification of aspects of frailty amenable to preoperative optimisation (e.g. cognition, nutrition). Furthermore, the association of preoperative gait velocity with postoperative morbidity and mortality makes this a potentially useful frailty measure in the elective preoperative setting.

There are no proven strategies for pre-operative management of frailty in surgical patients, however there is increasing evidence for exercise, nutritional and multi-component interventions to improve outcomes in this group [19]. The translation of such approaches into routine clinical care requires close collaboration between surgeons, anaesthetists and geriatricians working as part of a multidisciplinary team. Examples of such working include proactive care of older people undergoing surgery [20] and systematic care of older people undergoing elective surgery [21]. This will need to be factored into the commissioning of surgical pathways and has significant policy implications but has been endorsed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the British Geriatrics Society (BGS).

4.2 Managing the physical features of frailty - what is the evidence that frailty can be reversed and what interventions are effective?

A central feature of physical frailty, as defined by the phenotype model, is loss of skeletal muscle mass and function (sarcopenia). There is a growing body of evidence for beneficial interventions to address this aspect of frailty and this has been reviewed recently [22]. The benefits of exercise in older people with frailty shows that home-based and group-based interventions result in improvement in both mobility and functional ability. Strength and balance training is a key component although a wide range of approaches have been employed and the optimal exercise regimen remains uncertain.

The place of nutritional interventions also needs to be considered although evidence remains limited. Recommendations currently include optimising protein intake and correcting vitamin D insufficiency. A number of drug interventions have been proposed to improve muscle mass and function. Testosterone improves muscle strength but is also associated with adverse effects, particularly on the cardiovascular system. Growth hormone probably improves mass more than function. There is also interest in the idea

of ‘new tricks for old drugs’ such as the angiotensin-converting enzyme inhibitors which appear to improve the structure and function of skeletal muscle. Currently there is not sufficient evidence for this to be translated into clinical practice.

5. Conclusion

Many older people live with frailty and its prevalence increases with age. Frailty varies in severity and some interventions like exercise which improves strength and balance and addressing nutritional deficiencies can help reduce it.

Frailty means that an individual is at greater risk of an adverse outcome after a minor change in their circumstances or health and it is important therefore that health and social care staff recognise it.

It is possible to recognise frailty either because of the clinical condition with which the individual presents or because it is actively looked for using gait speed, timed up and go test or a short questionnaire.

Once recognised, the best management strategy for frailty is comprehensive geriatric assessment. This comprises a holistic medical review and appropriate referral on to other specialist disciplines (including geriatricians) with comprehensive care and support planning. Each individual living with frailty should have their own care and support plan which should be made available to other health and social care professionals with whom the individual interacts.

6. References

1. **www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf**

2. **www.health.org.uk/areas-of-work/programmes/closing-the-gap-in-patient-safety/related-projects/frailsafe-a-safety-checklist-for-frail-older-patients-entering-acute-hospital-care/**

3. Clegg A; Young J; Iliffe S; Rikkert MO; Rockwood K. Frailty in elderly people. Lancet. 2013; 381 868):752-762.

4. **www.ageuk.org.uk/professional-resources-home/research/social-research/living-with-frailty/**

5. Nicholson C, Meyer J, Flatley M, Holman C. The experience of living at home with frailty in old age: a psychosocial qualitative study. Int J Nurs Stud. 2013 Sep;50(9):1172-9.

6. Fried LP1, Tangen CM, Walston J, Newman AB, Hirsch C, Gottdiener J, Seeman T, Tracy R, Kop WJ, Burke G, McBurnie MA; Cardiovascular Health Study Collaborative Research Group. Frailty in older adults: evidence for a phenotype. J Gerontol A Biol Sci Med Sci. 2001 Mar;56(3):M146-56.

7. Kenneth Rockwood, Xiaowei Song, Chris MacKnight, Howard Bergman, David B. Hogan, Ian McDowell, and Arnold Mitnitski. A global clinical measure of fitness and frailty in elderly people. CMAJ. Aug 30, 2005; 173(5): 489–495.

8. Syddall H, Roberts HC, Evandrou M, Cooper C, Bergman H, Aihie Sayer A. Prevalence and correlates of frailty among community-dwelling older men and women: findings from the Hertfordshire Cohort Study. Age Ageing. 2010 Mar;39(2):197-203.

9. Baylis D, Bartlett DB, Syddall HE, Ntani G, Gale CR, Cooper C, Lord JM, Sayer AA. Immune-endocrine biomarkers as predictors of frailty and mortality: a 10-year longitudinal study in community-dwelling older people. Age (Dordr) 2013;35(3):963-971.

10. Ashfield TA, Syddall H,Martin HJ, Grip strength and cardiovascular drug use in older people: finding from the Hertfordshire cohort study. Age Ageing 2010;39:185-91

11. **http://www.crd.york.ac.uk/PROSPERO/display_record.asp?ID=CRD42013005940**

12. Roberts HC, Denison HJ, Martin HJ, Patel HP, Syddall H, Cooper C, Sayer AA. A review of the measurement of grip strength in clinical and epidemiological studies: towards a standardised approach. Age Ageing. 2011 Jul;40(4):423-9.

13. **http://ageing.oxfordjournals.org/content/35/5/526.full**

14. Morley JE, Vellas Doehner W, Evans J, Fried LP, Guralnik JM, Katz PR, Malmstrom TK, McCarter RJ, Gutierrez Robledo LM, Rockwood K, von Haehling S, Vandewoude MF, Walston J.B, van Kan GA, Anker SD, Bauer JM, Bernabei R, Cesari M, Chumlea WC. Frailty consensus: a call to action. J Am Med Dir Assoc. 2013 Jun;14(6):392-7.

15. Philip KE1, Alizad V2, Oates A3, Donkin DB4, Pitsillides C5, Syddall SP6, Philp I7. Development of EASY-Care, for brief standardized assessment of the health and care needs of older people; with latest information about cross-national acceptability. J Am Med Dir Assoc. 2014 Jan;15(1):42-6

16. Stuck AE, Iliffe S. Comprehensive geriatric assessment for older adults. BMJ. 2011 Oct 27;343:d6799.

17. **www.networks.nhs.uk/nhs-networks/nhs-cumbria-ccg/medicines-management/guidelines-and-other- publications/Stop%20start%20pdf%20final%20Feb%202013%20version.pdf/view**

18. **http://www.sign.ac.uk/pdf/sign88.pdf**

19. Partridge JSL, Harari D, Dhesi JK. Frailty in the older surgical patient: a review. Age and Ageing 2012;41:142-147

20. Harai D, Hopper A, Dhesi J, Babic-Illman G, Lockwood L, Martin F. Proactive care of older people undergoing surgery ('POPS'): designing, embedding, evaluating and funding a comprehensive geriatric assessment service for older elective surgical patients. Age and Ageing 2007 36 ; 190-6

21. Gordon A, Woodard J, Morris R, Whynes D, Attenborough A, McIntyre J, Masud T. 2011. Evaluating the Edmonton Frail Scale as a screening tool for postoperative complications in older patients undergoing elective hip and knee surgery. European Geriatric Medicine; 2, Supplement 1:S1-S23.

22. Sayer AA, Robinson SM, Patel HP, Shavlakadze T, Cooper C, Grounds MD. New horizons in the pathogenesis, diagnosis and management of sarcopenia. Age Ageing. 2013 Mar;42(2):145-50

23. **http://www.nationalvoices.org.uk/care-planning-older-people-approach-stafford#comments**

Comprehensive Geriatric Assessment

Comprehensive Geriatric Assessment (CGA), also known in some countries as Geriatric Evaluation and Management (GEM), involves a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health.

CGA typically results in the formulation of a list of needs and issues to tackle, together with an individualised care and support plan, tailored to an individual's needs, wants and priorities.

It is usual to describe the domains which comprise 'multidimensional assessment' as follows:

- Physical Symptoms (which must include pain) and the underlying illnesses and diseases

- Mental Health Symptoms (including memory, mood and poor organisation) and the underlying illnesses and diseases

- Level of function in daily activity, both for personal care (washing, dressing, grooming continence and mobility) and for life functions (communication, cooking, shopping using the phone etc.)

- Social Support Networks currently available, both informal (family, friends and neighbours) and formal (social services carers, meals, day care). It needs to include the social dynamic between the individual and his/her family and carers (whilst trying to avoid too much judgement)

- Living Environment – state of housing, facilities and comfort. Ability and tendency to use technology. Availability and ability to use local transport

- Level of Participation and individual concerns, i.e. degree to which the person has active roles and things they have determined are of significance to them (possessions, people, activities, functions, memories). Will also include particular anxieties, for example fear of 'cancer' or 'dementia'. Knowledge of these will help frame the developing care and support plan

- The compensatory mechanisms and resourcefulness which the individual uses to respond to having frailty. Knowing this will allow the care and support plan to incorporate strategies to enhance this resilience

Extensive research has shown that CGA in hospital increases independence (individuals are more likely to go home after this process compared to standard medical care) and reduces mortality. A recent Cochrane review showed that those who underwent CGA on a ward had a 30% higher chance (OR 1.31 CI 1.15 – 1.49) of being alive and being in their own home at 6 months. This equates to a Number needed to treat of 13.[16]

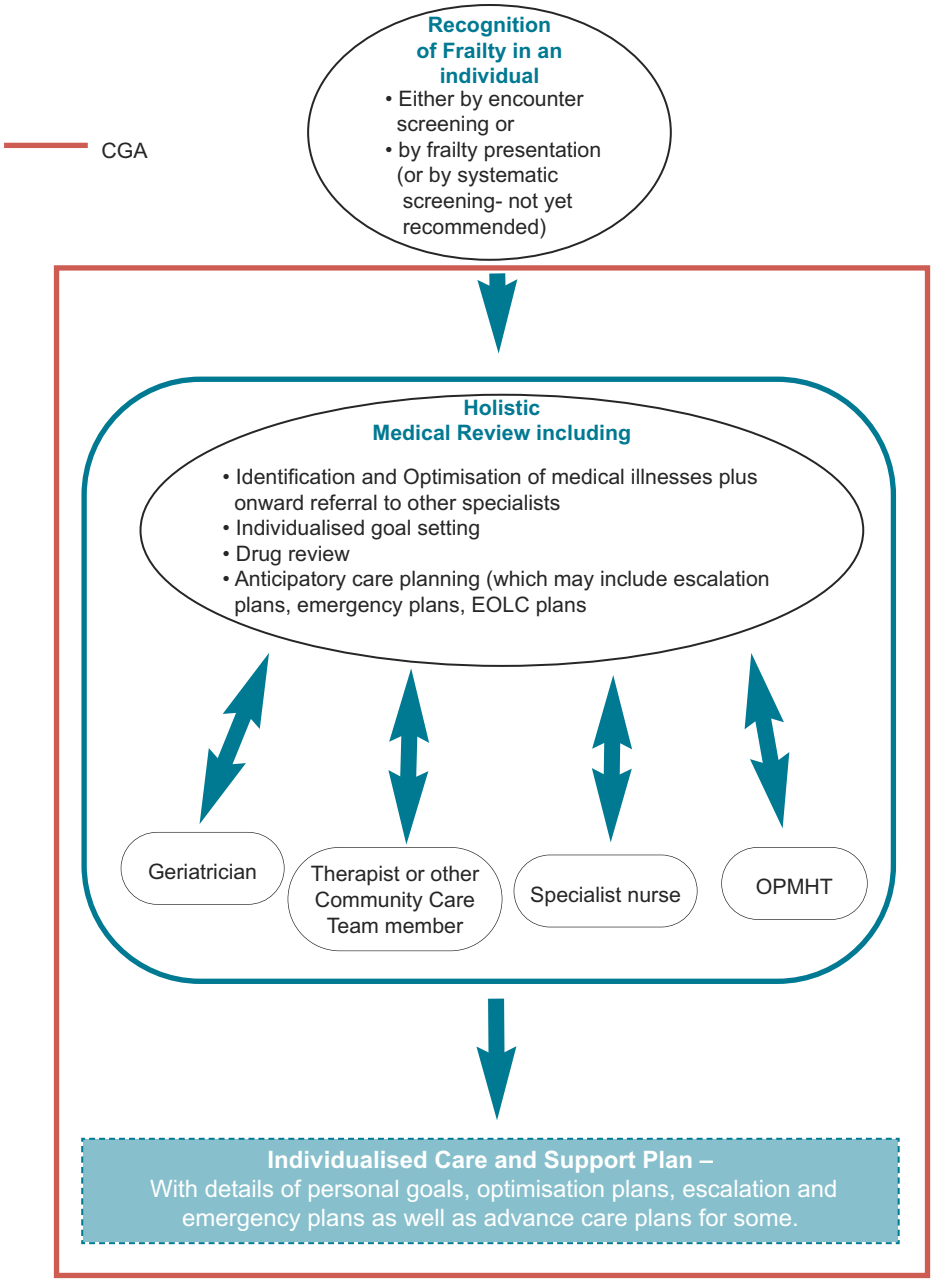
However, despite considerable evidence for CGA in community settings in the US[17], there is less evidence to support CGA in community settings in the UK because the research has not been done. Nonetheless a recent review[18] showed that CGA in the community which

focussed on older people identified with frailty could reduce hospital admissions.

The BGS believes that it is highly likely that CGA in any setting will be an effective intervention for an older person identified as having frailty. In the community there may need to be local flexibility in terms of what constitutes an interdisciplinary team and how the medical input is provided – neverthelss, the principle stands. The resulting individualised care and support plan must include information for older people and their carers about how and when to seek further advice and possibly information which defines advance planning for end of life care.

Readers who would like to learn more about Comprehensive Geriatric Assessment are advised to read 'Comprehensive Geriatric Assessment- a guide for the non specialist'. Welsh TJ.;Gordon AL.; and Gladman JR. Int J Clin Pract2013 doi: 10.1111/ijcp. 12313.

Fig. 1



Case Examples

A. Eric's Story

Eric, an 83 year old retired engineer went to his GP with falls and inability to use his right hand since a fall 4 months previously. He was being told by his family that he should not be driving. He had also had to give up gardening and was increasingly housebound. His GP thought he had frailty and that he probably had had a couple of strokes and referred him to the community geriatrician to help with diagnosis. Eric is diabetic and has a history of angina. He has also had an aortic aneurysm repair.

After a holistic assessment (which took almost an hour), it was found that Eric had pain and numbness in his right hand, but only affecting some of his fingers. A detailed discussion revealed that his falls were due to pins and needles in his right leg which went very numb when he stood in a certain position for too long and also because at times he became dizzy when he stood up. It was found that he had a marked fall in blood pressure on standing. The geriatrician discussed the possible diagnoses with Eric. A detailed investigation plan was put in place; Eric was found to have a carpal tunnel syndrome causing the problems in his hand –which is curable - and a trapped nerve in his lumbar spine which is being addressed by the physiotherapist. His medication has been adjusted to address the fall in blood pressure when he stands. Although Eric remains at risk of falls, he feels more comfortable understanding what has happened and he is now able to do the things which he wants to do and he is enjoying life again. At the moment he is no longer falling. A diagnosis is always important.

B. Phyllis's Story

Phyllis is 100 years old and lives with her daughter. She is largely housebound now, although until recently has been able to move around the house helping with some of the household chores. She had a bad cold and bronchitis at Christmas and needed to be admitted to hospital for a short period because she was very unwell and was unable to walk or look after herself for a while. She came home after a week and although she did quite well initially, after a fortnight she became very confused and had several falls getting in and out of bed in the night. After a couple of days, she was checked over by her GP but nothing was found. That night she became most unwell with a high fever and an emergency doctor visited. He prescribed antibiotics for an assumed infection but it was difficult for Phyllis to take the medication as she was so unwell. She had cut her leg during one of the falls so her daughter called the community nurse for advice about dressing the leg. The nurse, realising that the situation was rapidly deteriorating, arranged for urgent home care for Phyllis to support her daughter. She also arranged for a short term night carer so that there would be help for Phyllis when she needed the toilet in the night. Between them, the nurse and Phyllis's daughter managed to help Phyllis with the antibiotics and she started to improve. After two weeks she was no longer confused, although not walking anything like as much as was usual and she was spending long periods in bed. The community nurse arranged for a physio support worker to attend and gradually Phyllis started to regain her independence. It took some weeks. Phyllis and her daughter decided that it would be helpful for her to have carers permanently in the mornings to help her get washed and dressed.

A long term care and support plan was developed in consultation with Phyllis and her daughter, which outlined all the things needed on a day to day basis to help Phyllis remain independent, including the exercises that she needed to do. Her daughter was really pleased that there was a plan for escalation, which outlined the things she needed to look out for in her Mum (increasing muddledness, nausea and going off her food) and what she should do as soon as these were

apparent. The plan, with the agreement of her GP, also documented what the GP should do if they received a call from Phyllis's daughter. Of great importance to Phyllis however, was the plan to make sure she didn't need to go into hospital again. She was able, in the plan, to make it clear that she didn't want this to mean extra work for her daughter so the plan also outlined in detail that her daughter needed to call to ask for additional support. Phyllis has been doing very well at home for the last 6 months.

C. Ken's Story

A 74-year-old man called Ken was visiting the practice nurse at his GP surgery weekly for dressing changes for venous leg ulcers. He was mobile with a stick, lived at home with no formal carers, but had a helpful neighbour. His medical history included Parkinson's disease, high blood pressure and occasional falls. Over time, the practice nurse noticed that Ken was coming to his appointments later and later. On asking him about this, Ken said that it was taking him a while to get dressed and organised in the mornings. She offered to arrange for district nurses to come and do the dressings at home if it was becoming difficult, or arrange for carers but Ken said that he enjoyed the opportunity to get out and come to the practice for the visit and would prefer to leave things as they were.

A few weeks later, Ken fell at home and an ambulance was called. They offered to take him to hospital for evaluation, which he declined. The following week, his neighbour took him in his car to do some shopping and on getting out of the car he froze and fell. Again the ambulance crew attended and realising that Ken had frailty, this time they arranged a rapid access review instead of a hospital admission. This service is a multi-disciplinary day unit, including a geriatrician, which provides rapid access reviews and has direct access to inpatient elderly care and intermediate care beds should they be needed. They accept referrals from any professional encountering an older person they are concerned about including paramedics, district nurses, social workers.

As part of the comprehensive geriatric assessment undertaken, a medication review found that Ken was not taking his Parkinson's medication correctly and that a care package was needed. Ken is now back to living virtually independently, with minimal falls - a 'new man' who is never late for clinic.

D. Edgar and Mary Smith's Story

Edgar has advanced dementia and is unable to walk or talk. He spends most of his days in a reclining chair or bed. Mary, his wife, is his main carer. She cooks their meals and helps Edgar eat, but they have carers coming to the house 3 times a day to help Edgar in and out of bed and for other personal tasks.

Unfortunately Edgar has episodes of 'fainting' – thought to be due to changes in blood pressure when he sits for long periods. Sometimes one of the carers has called an ambulance and Edgar has been taken to hospital although he is usually fully conscious when he arrives there and is sent straight home again (after several hours of waiting to be assessed and for return transport). Edgar's care is also complicated as he has a small and superficial pressure ulcer on the skin of his lower back. His appetite is much reduced and his swallowing is also very difficult, meaning that on occasions he coughs and splutters when drinking.

His GP has a long discussion with Mary and the community nurses. They all agree that Edgar does not have capacity to make the decision about his future care or his swallowing. However Mary feels that Edgar does not like travelling in the ambulance to hospital and since there is no obvious benefit to this she would like him to remain at home if he faints again. Edgar's doctor

also explains that Edgar is entering the end of his life and that they need to take account of this when making plans. In the light of this, no one feels it is in Edgar's best interest to be offered a tube for feeding (gastrostomy) because of his swallowing problems- often he declines food anyway. A comprehensive care and support plan is drawn up to reflect all this in full consultation with Mary who is greatly relieved that she will be able to care for Edgar until 'the end'. – see Care and Support Plan below:

Comprehensive Community Care Plan		
Patient Details Surname: Mr Edgar Smith First Name: Date of Birth: NHS number: Phone number: Mobile number: Address:	GP Details GP Name: Practice Name: Practice Code: Phone Number: Direct Number:	Community Team Involved: Hythe and Waterside Key Worker: Community nurses Telephone: 07781 456789 SPA number: Seen by Community Geriatrician: G Elliot Contact number:
Main Current Issues	Management/Maintenance Plan	Who is responsible for carrying out?
1. Known to have vascular dementia, fairly advanced, unable to speak or probably, understand	Current plan for care as per wife's management – has private care package	Wife but community nurses need to keep a watching brief as below
2. Recurrent blackouts sound like vasovagal episodes, secondary to changes in blood pressure. Currently has marginal postural hypotension - blood pressure 142/72 lying fully recumbent in reclining chair to 114/75 with significant head up tilt, rising to 129/74 after one minute	Wife aware of probable diagnosis of vasovagal episodes (fainting). Advised to lay Patient out flat when he does have an episode – important for feet to be as high as or higher than head.	Wife and carer – also Paramedics need to be aware as per escalation plan.
3. Increasing difficulty with swallowing liquids, although managing solids, likely related to advancing dementia, not in patient's interests to proceed with PEG -	Wife provides a diet which she believes he will enjoy. Because of difficulty with thin fluids need to thicken drinks to a runny honey consistency using thickener- 'Resource clear'	Wife– GP to prescribe thickener.
4. Small pressure sore over bottom,	Small pressure sore over bottom, being seen by District Nurses, needs pressure-relieving equipment- possibly hospital bed	Community Nurses will arrange
5. Type 2 Diabetes	Currently on Metformin 500mg bd – may need reducing if food intake reduces	Wife administers tablets; GP prescribes meds and will assess need.
Relevant Past Medical History or other information; Has Type 2 diabetes – well controlled. Unable to swallow tablets without chewing – DO NOT PRESCRIBE SLOW RELEASE MEDS OR CAPSULES		
Escalation Plan – What to look out for	What to do / Who to contact	
1. Increasing difficulty with moving or with standing	Call Hythe Community Team on above number 8.30 – 16.30 – afterhours if patient stuck call ambulance for help to get patient into bed until community team can see him next day.	
2. Blackout – if patient does not come round immediately	Call ambulance for advice – they will need to check blood sugar and help get him into bed – so can be reviewed by own doctor either then or next morning. Not for admission to hospital.	
3. Evidence of increased coughing or choking. Evidence of breathing difficulty	Call Hythe Community Team on above number. Call GP if patient very unwell. May need to have thicker fluids and or antibiotics	
4. Evidence of further skin problems	Call Hythe community care team on above number	
5. Significant Reduction in food intake over several days	Call GP as may need reduction in metformin dose.	
OVERALL AIM. Comfort – for palliative treatment only, even in life threatening situations		
DNACPR form completed: Yes	End of Life Plan agreed: Yes	
PATIENTS USUAL OBSERVATIONS if appropriate		
Pulse rate: normal Peak flow: N/A O2 saturation: >94%	Normal BP: As above BM Range: 4 - 15 Weight at points in time (record date):	

Suggest keep a current medicine sheet with this plan at patient's house and lodge electronically with NHS111/SCAS/OOH

Practice could flag the presence of this plan on main computer so as to guide reception staff about management of patient when call received requesting visit etc.

Advance Care Plan

Stage of Illness – Further Management Options	No further management options apart from palliative
Carer/Next of Kin/Primary Contact details	Wife at same address
Patient aware of Diagnoses?	No – does not have capacity to understand
Consent to share this information with OOH and Ambulance Service	Verbal YES/~~NO~~ In patient's best interest
Emergency Drugs Left At Home?	~~YES~~/NO not needed yet
Current Care at Home	Wife and care package – known to Community Care team
Wishes and Request of Patient and Preferred place of Death	At home

Voluntary sector

Many older people have needs vital to their ability to stay out of hospital and thrive in their own home but which fall outside the NHS and social care remit.

These include support to help them manage their homes and gardens, to maximise their finances and build meaningful relationships within their community, particularly following bereavement and other life changing events.

Investigating the commissioning expert sources of local information and advice ensures older people receive timely help to review their situation, identify their goals and learn about local services and support that can complement statutory services.

Useful information

Age UK has a range of practical guides and factsheets designed to help older people and their carers manage changes to their health and individual needs. The following list of relevant publications may be useful to people living with frailty or at risk of frailty and covers a range of health and non-health-related topics.

- Staying Steady
- Care at home
- Going into hospital
- Advice for carers
- More money in your pocket
- Dealing with debt
- Powers of attorney
- Factsheet 37 Hospital discharge
- Factsheet 76 Intermediate care and re-ablement
- Factsheet 22 Arranging for someone else to make decisions about your finance and welfare

Fit for Frailty project

The Fit for Frailty guideline was born out of workshop meetings held by the offices of the British Geriatrics Society and AGE UK in London.

The Project Lead and lead author of the guideline was **Dr Gill Turner**, Vice President for Clinical Quality, British Geriatrics Society.

Dr Andrew Clegg, Clinical Senior Lecturer, Leeds Institute of Health Sciences and Dr Jane Youde, Consultant Geriatrician, Nottingham were also active in authoring several sections of the guidance.

Other members of the workshop included:

Professor Avan Aihie Sayer - MRC Clinical Scientist and Professor of Geriatric Medicine, University of Southampton;

Dr Eileen Burns - Clinical Director Older People, St James Hospital, Leeds
Chris Beech - Nurse Consultant, NHS Forth Valley
Professor Tom Dening - Barchester and Nottinghamshire Healthcare and Professor in Dementia Research, Institute of Mental Health
Mr Tom Gentry - Age UK
Dr John Hindle - Consultant Geriatrician Clinical Senior Lecturer Bangor University and Llandudno Hospital, Wales
Professor Steve Iliffe - Professor of Primary Care for Older People at University College London
Professor Finbarr Martin - Consultant Geriatrician, Guy's & St Thomas' NHS Foundation Trust
Dr Christine McAlpine - Clinical Lead for Stroke for NHS Glasgow and Clyde
Dr Caroline Nicholson - Post Doctoral Research Fellow Kings College London
Dr Cathy Patterson - Consultant Geriatrician Royal Victoria Hospital, Belfast
Dr Joanna Preston - Trainee representative, Clinical Quality Steering Group, British Geriatrics Society
Professor John Young - National Clinical Director of Integration and Frail and Elderly Care

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