

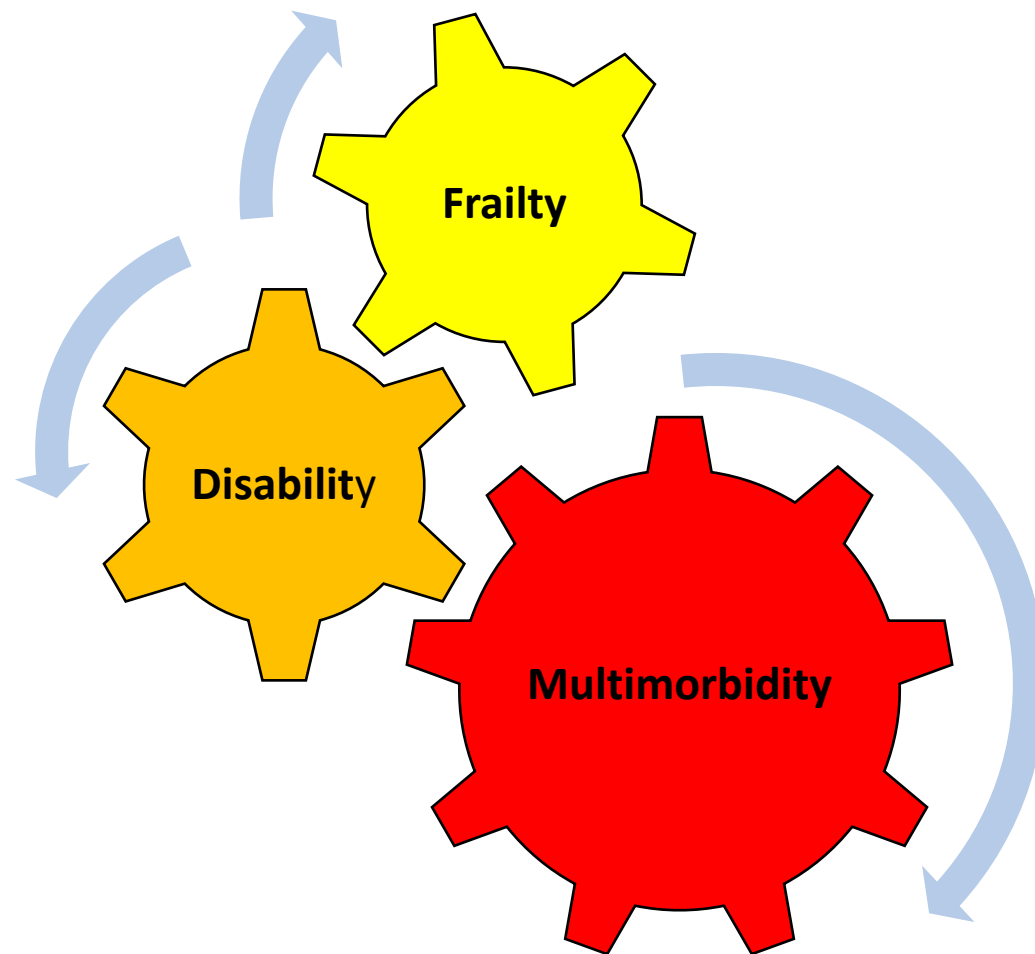
Meeting the Needs of Patients with Frailty and Multimorbidity: “Frailty rarely travels alone”

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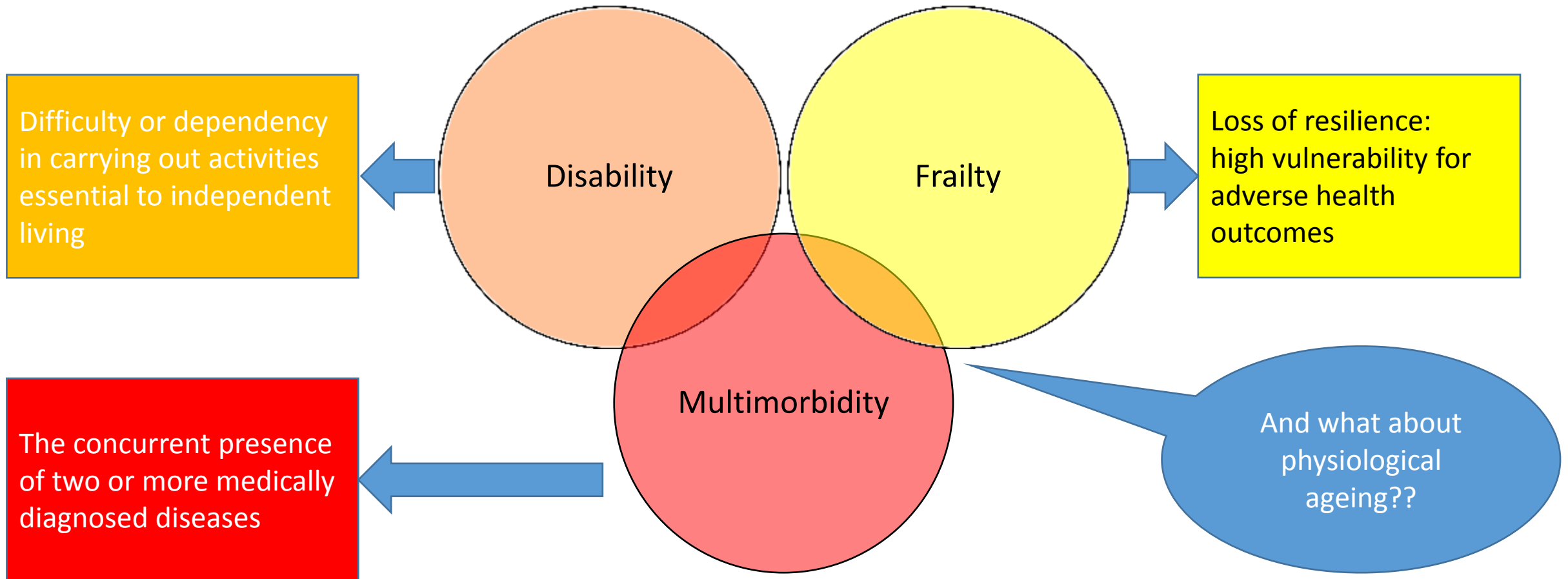
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Frailty V Multimorbidity, does it matter?



Three terms are commonly used interchangeably to identify vulnerable older adults.....



Health Care Implications of Frailty, Disability and Multimorbidity

Multimorbidity

- Complexity of managing multiple LTCs
- Fragmented care, multiple providers and settings
- Potential for prevention, minimizing severity, interactions

Disability

- Need for rehabilitative, supportive community services
- Minimise risk of social isolation, dependence, mortality
- Potential for primary and secondary prevention

Frailty

- Vulnerability to stressors, frailty syndromes
- Need to address underlying conditions e.g. malnutrition, sarcopenia
- Minimise risk of falls, disability, hospitalisation

And its complicated....

Physiological Ageing:

- All body systems show a decline in function with age
- Can be difficult to distinguish between normal ageing and disease

And...

- Frailty and multimorbidity predict disability
- Disability may exacerbate frailty
- Multimorbidity contributes to developing frailty
- Disability is a consequence of multimorbidity and frailty

But all of this varies between individuals



So, what can we do?

Aim to improve quality of life by reducing treatment burden, adverse events, and unplanned care

Improve coordination of care across services



Establish the person's individual needs, preferences for treatments, health priorities, lifestyle and goals

Discuss the benefits and risks of following recommendations from guidance on single health conditions

Find out how the person's health conditions and their treatments interact and how this affects quality of life

Person Centred Care Routines



1) Establishing an individual's narrative by active listening/appreciative enquiry



2) Agreeing and formulating a plan together based on shared decision making and the preferences of the individual:
working the partnership



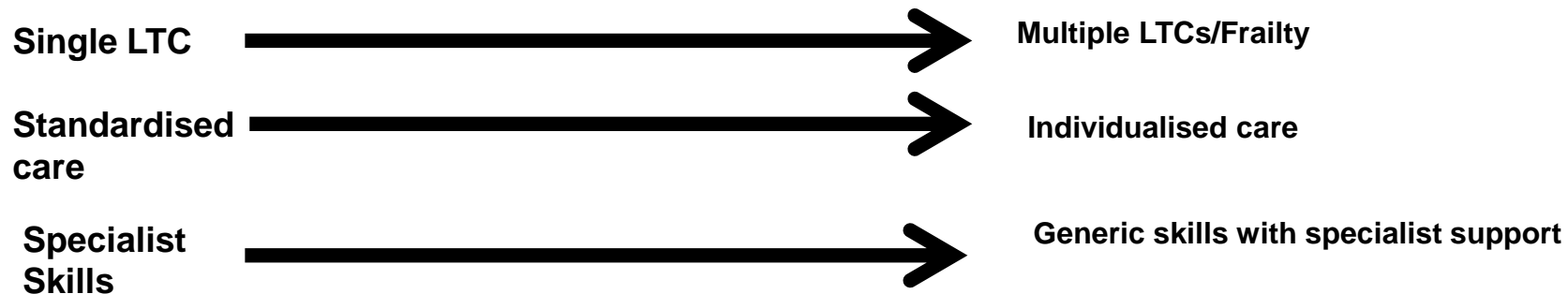
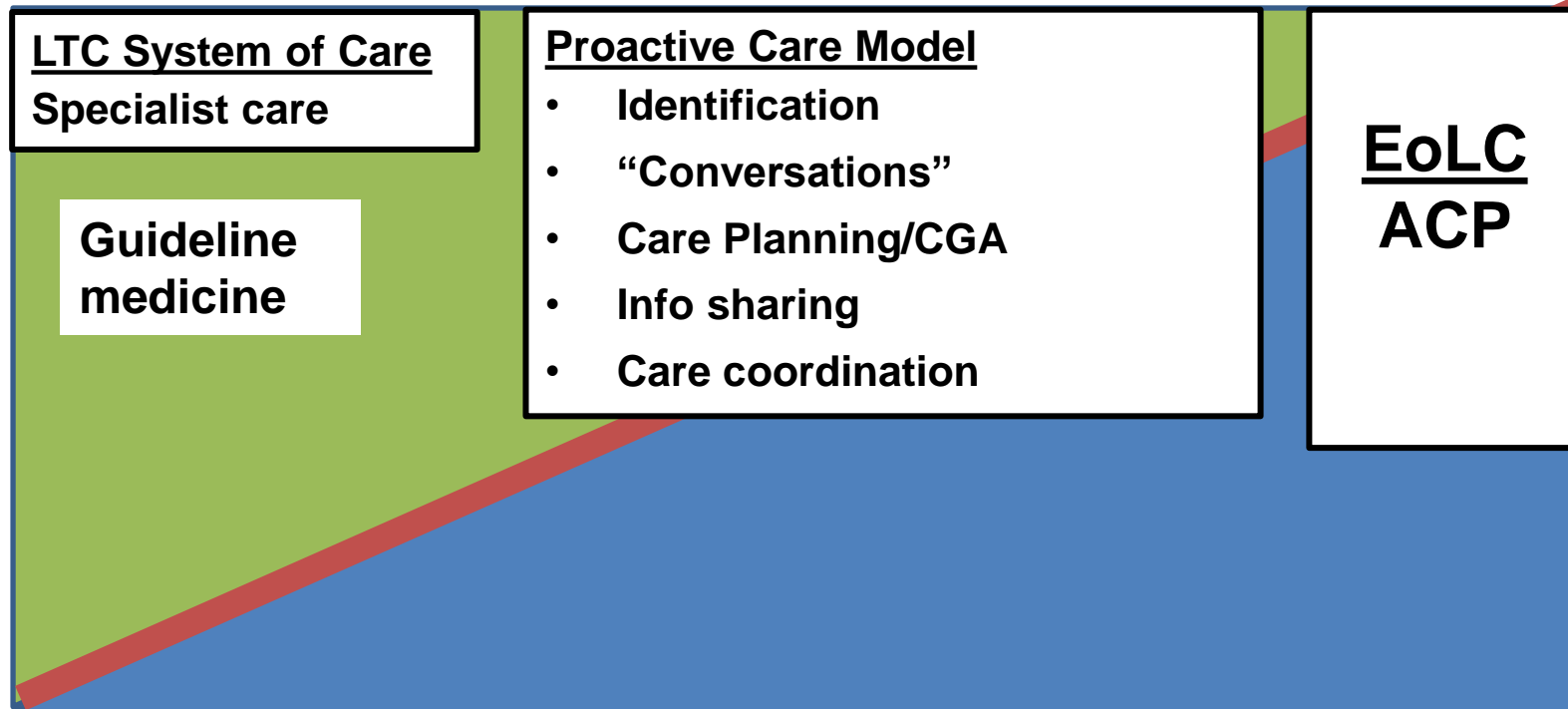
3) Safeguarding this contract by documenting it in a co-created care or support plan

For those with complexity of need there is also a 4th routine that should be emphasised and practiced across the systems and organisations involved in care and support for individuals, that is



4) An agreement to act in conjunction with other professionals and the individual patient to coordinate the care plan

A life course approach to frailty/multimorbidity



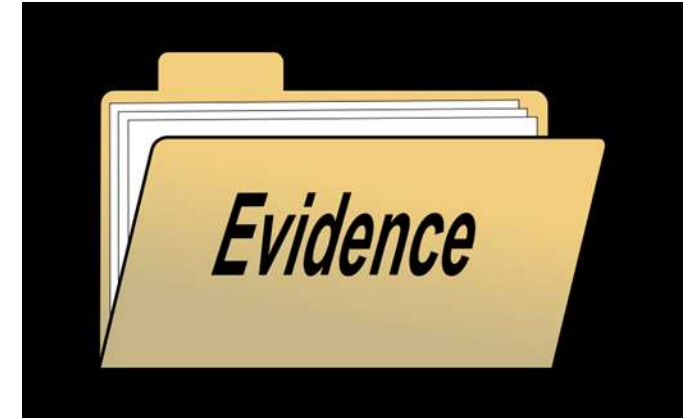
What does the evidence say?



- Need a consistent approach to frailty identification and targeting of the intervention
- Need for advanced practice skills in Nurses/other HCPs – assessment and managing complexity - +/- Geriatrician support
- Poor treatment fidelity – implement the intervention effectively
- Importance of the intervention focussing on person-centeredness, self-management, goal orientation
- Importance of building caring, supportive relationship between clinician and patient.

Bleinjenberg et al 2016, Suijker et al 2016, Imhof et al 2012, Hoogendijk et al 2016, Hertogh et al 2016

What does the evidence say?



- Assessment should include environmental, social support, housing and include non-medical solutions
- Components of the intervention need to be chosen carefully to have maximum effect. These studies suggest a focus on falls, pain, detailed LTC assessment and management
- May be an enhanced benefit to focus on the Oldest Old 85+
- Level of education of participants important - intervention may need to be tailored effectively to level of education

Bleinjenberg et al 2016, SuiJker et al 2016, Imhof et al 2012, Hoogendijk et al 2016, Hertogh et al 2016



Thank
You
for
Listening
Any Questions?

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