HSC Public Health Agency

Improving Your Health and Wellbeing

NI Frailty Network Launch

28th March 2019

#FrailtyNetworkNI

HSC Public Health Agency

Improving Your Health and Wellbeing

Eleanor Ross
Assistant Director of Nursing
Public Health Agency

Ambition for frailty NI..

'Frailty is Everybody 's Business and Everybody should know what to do next when presented with a person living with frailty'

Health and Social Care

Frailty Network : frailtynetwork@hscni.net

- Virtual Network
- Totally inclusive
- Share Best Practice
- Consult
- Populate Task and Finish Groups
- Updates on progress
- Events

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Improving Your Health and Wellbeing

LAUNCH OF THE NI FRAILTY NETWORK

Dr Michael McBride, Chief Medical Officer, Department of Health
Mr Robert Ferguson, Service User

HSC Public Health Agency

Improving Your Health and Wellbeing

The NI Frailty Journey So Far

Sandra Aitcheson
Nurse Consultant Older People
Public Health Agency

Context

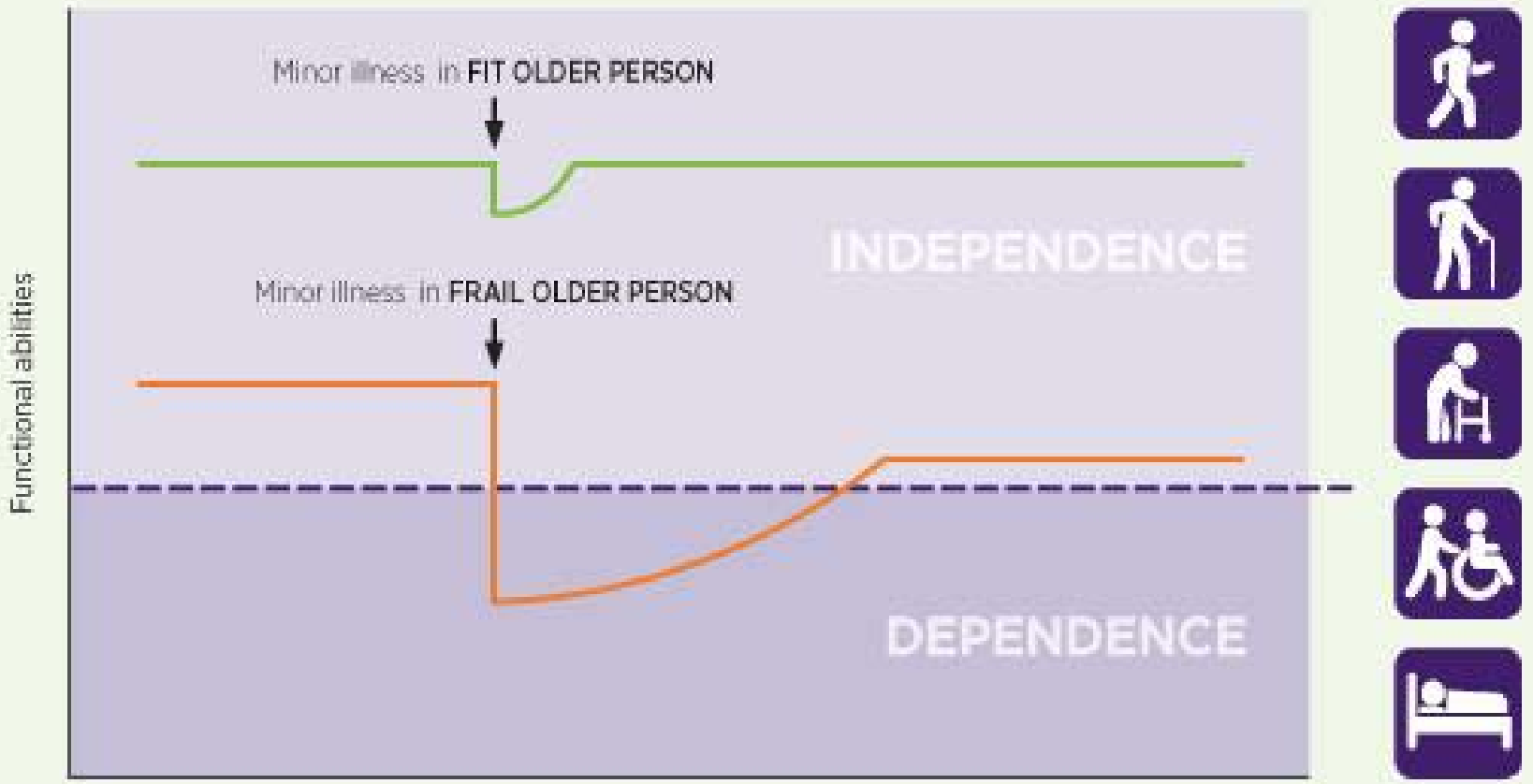
What is Frailty?

WHO Definition of Frailty (2015)

"*frailty is a progressive age-related decline in physiological systems that results in decreased reserves of intrinsic capacity which confers extreme vulnerability to stressors and increases the risk of adverse health outcomes*"

What does this mean?

- Reduced resilience and increased vulnerability to decompensation after a stressor event
- A state where multiple body systems lose their reserves
- Strong predictor of adverse outcomes including
  - Reduced mobility,
  - Loss of independence and greater dependency on care/24hr care,
  - Hospitalisation
  - Death
- Distinctive health state related to the ageing process
- Now recognised as a Long Term Condition


Minor illness in FIT OLDER PERSON
INDEPENDENCE
Minor illness in FRAIL OLDER PERSON
DEPENDENCE
Functional abilities

What does frailty look like?
The Frailty Phenotype

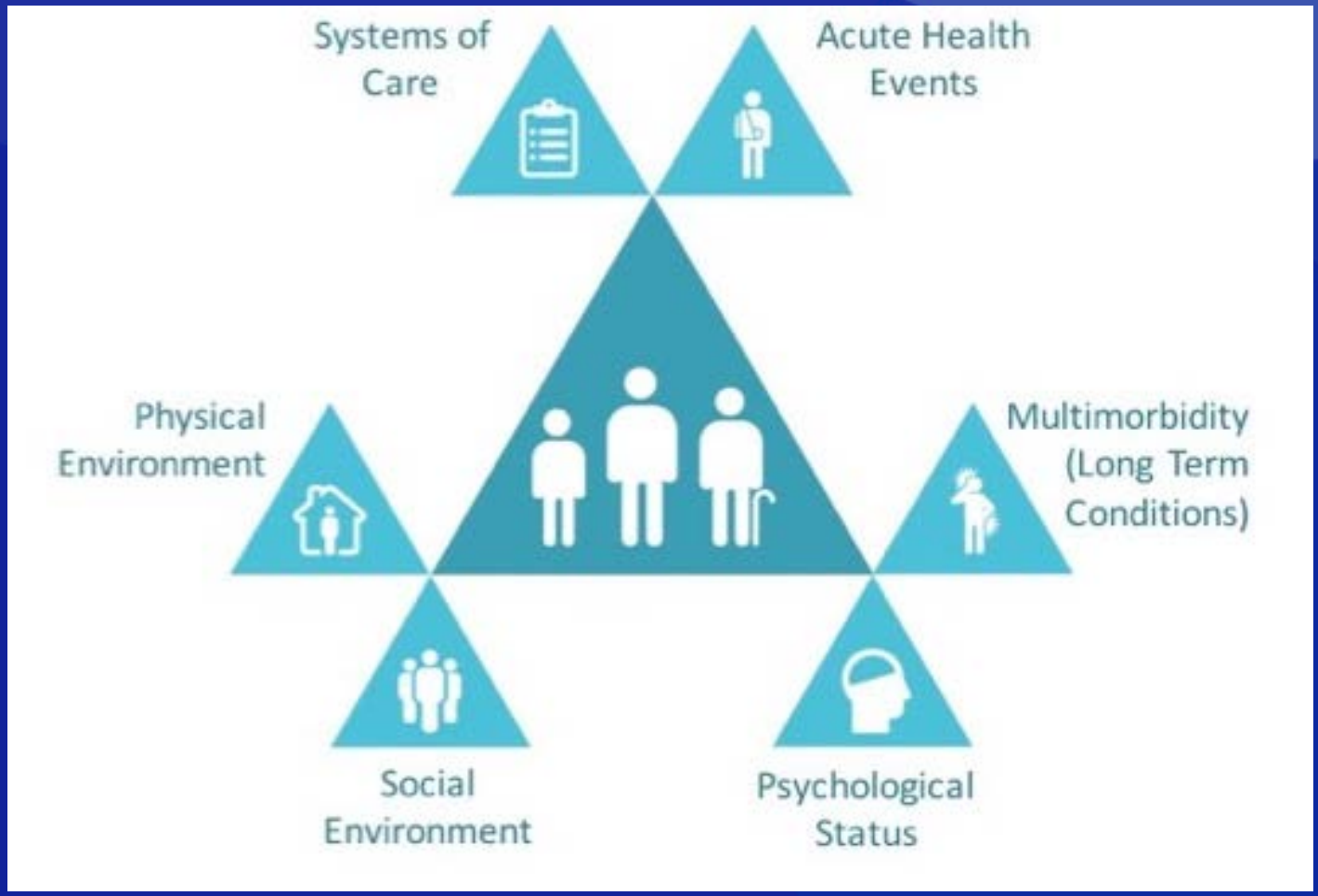
Syndrome characterised by 3 or more criteria

- Unintentional weight loss (4.5kg in last year)
- Self reported exhaustion
- Weakness (grip strength)
- Slow walking speed (<0.8 metres/second)
- Low physical activity

5 Frailty warning signs/syndromes that might alert you to Frailty?

- Falls
- Continence issues
- Poly Pharmacy (more than 5 medications)
- Mild Cognitive disorder
- Social Isolation/Loneliness

Frailty Fulcrum



What else do we know about Frailty

- Progressive (5 to 15 years)
- Episodic deteriorations (delirium; falls; immobility)
- Potential to impact on quality of life
- Expensive
- Gradable
  - Fit
  - Mild
  - Moderate
  - Severe

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.

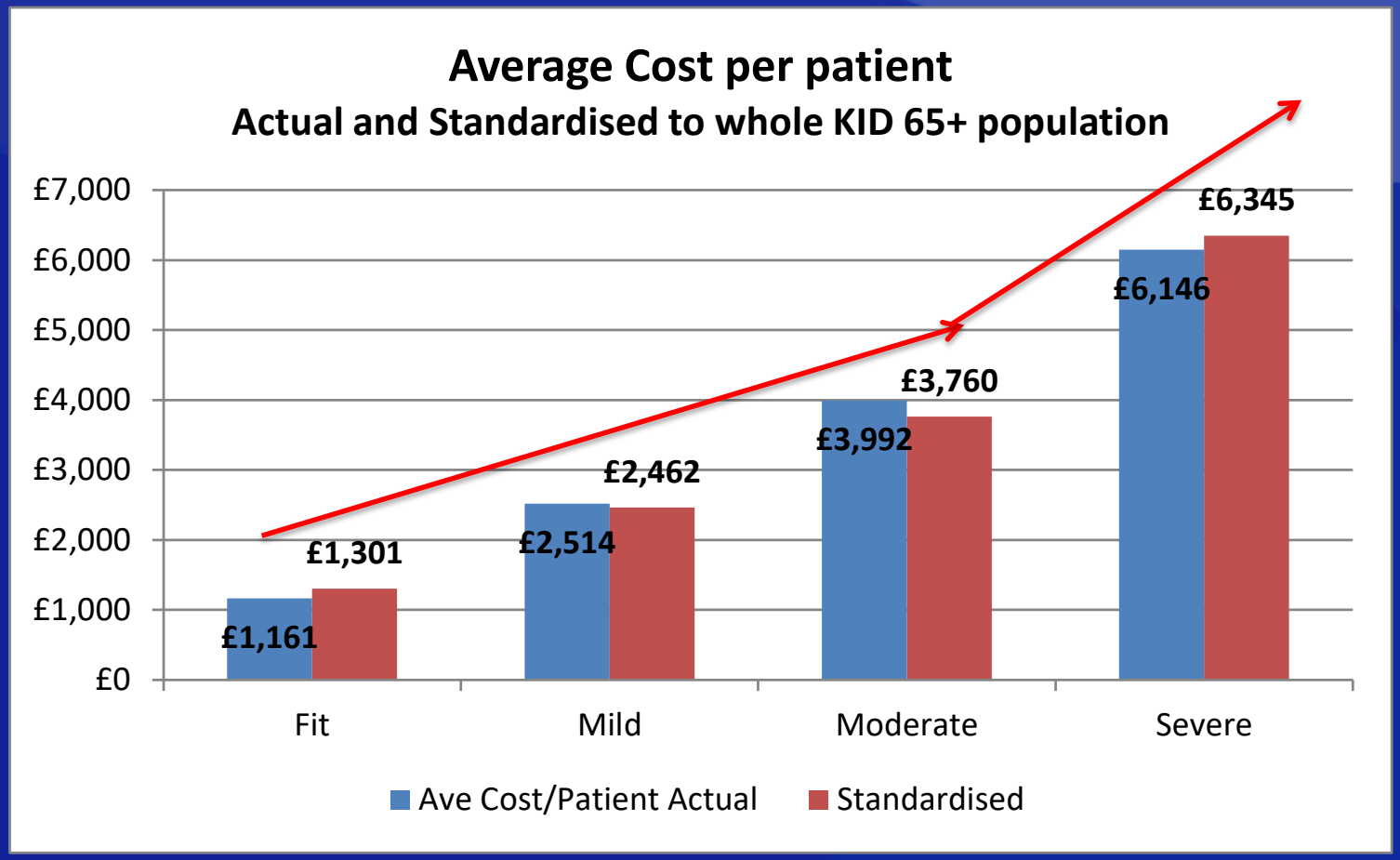
* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY *Inspiring Minds*

BUT WE ALSO KNOW

- Frailty is preventable
- Frailty is reversible
- Can prevent deterioration
- **Reduce dependence**
- **Can improve quality of life**
- **Reduce costs**

Frailty is expensive when severe



Intervention	Outcome
Group-based education (supported self-management)	40% more likely to be living at home
Falls prevention	8% reduction in falls
Exercise interventions	Improved function
Comprehensive geriatric assessment for older people	14% reduction in nursing home admission 24% reduction in falls
Comprehensive geriatric assessment for older people with frailty	10% reduction in hospital admission
Community-based post-discharge care	13% reduction in nursing home admission 10% reduction in hospital admission

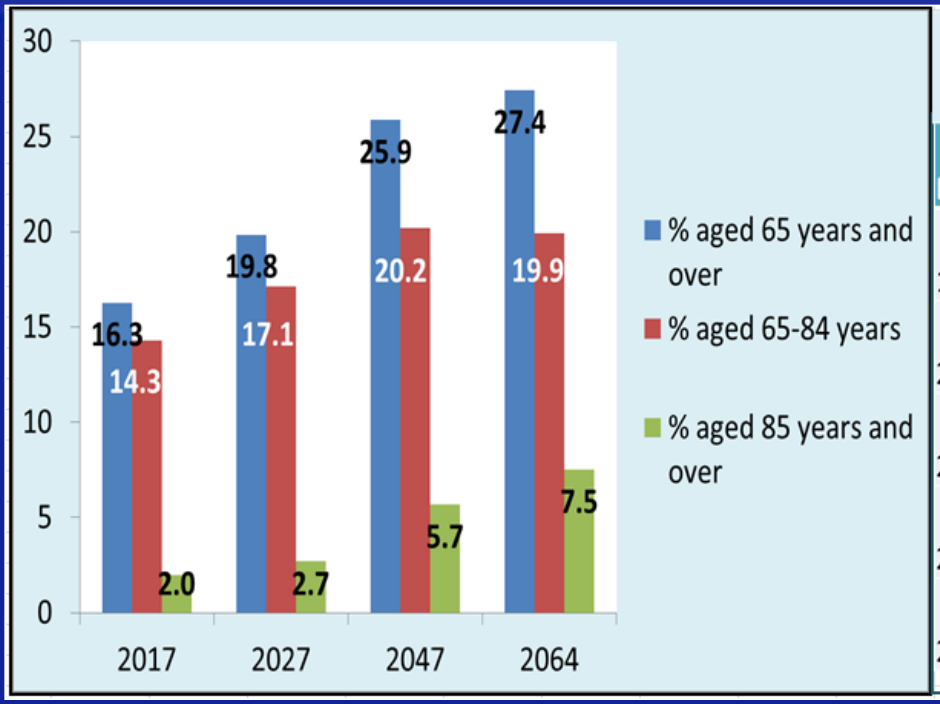
Clegg RCG 2011, Beswick Lancet 2008

Frailty Prevalence: Estimates

- 65-69 = 4%
- 70-74 = 7%
- 75-79 = 9%
- 80-84 = 16%
- > 85 = 26%

Collard et al. JAGS 2012: 60; 1487-92

Demographics NI



Ageing population

Projection Year	65+ years n (%)	85+ years n (%)
1974	170,884 (11%)	10,061 (< 1%)
2017	304,302 (16%)	37,361 (2%)
2039	499,000 (25%)	89,000 (4%)
2047	530,023 (26%)	116,114 (6%)
2064	564,832 (27%)	154,489 (8%)

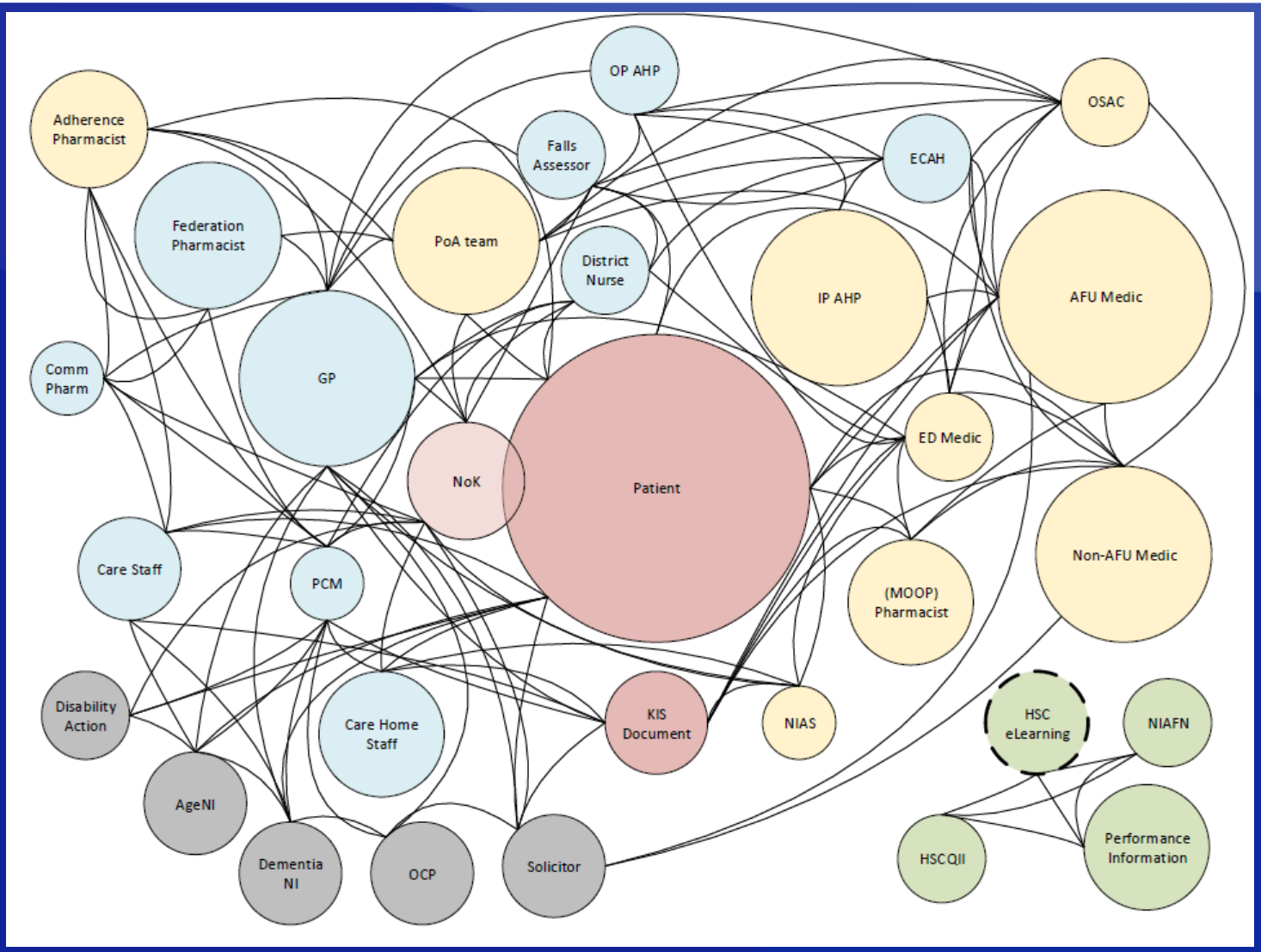
Health Status of our Older People

- Total life expectancy is outpacing growth in healthy life expectancy
  - Most' people over the age of 65 have at least 1 long term condition
  - Most people over the age of 70 years have 2 or more co-morbidities
  - Significant increase in Dementia
- 2/3 hospital beds occupied by older people
- 50% of health service budget
- 2039: NI number of **over 85 year olds** will have increased by **157% !**

'The most problematic expression of human ageing facing the NHS today'
(Clegg 2013)

Northern Ireland Context

- Frailty relatively new concept
- No agreed definition
- No clear vision/roadmap
- No mechanism to identify those who are frail currently
- Care of frail elderly fragmented/silo working
- Still tend to operate from a medical model
- We focus on conditions, rather than the 'whole' person
- Service tends to be reactive
- Pockets of isolated excellent care


OP AHP
Adherence Pharmacist
Falls Assessor
OSAC
ECAH
Federation Pharmacist
PoA team
District Nurse
IP AHP
AFU Medic
Comm Pharm
GP
ED Medic
NoK
Patient
Non-AFU Medic
Care Staff
PCM
(MOOP) Pharmacist
Disability Action
Care Home Staff
KIS Document
NIAS
HSC eLearning
NIAFN
AgeNI
Performance Information
Dementia NI
OCP
Solicitor
HSCQII

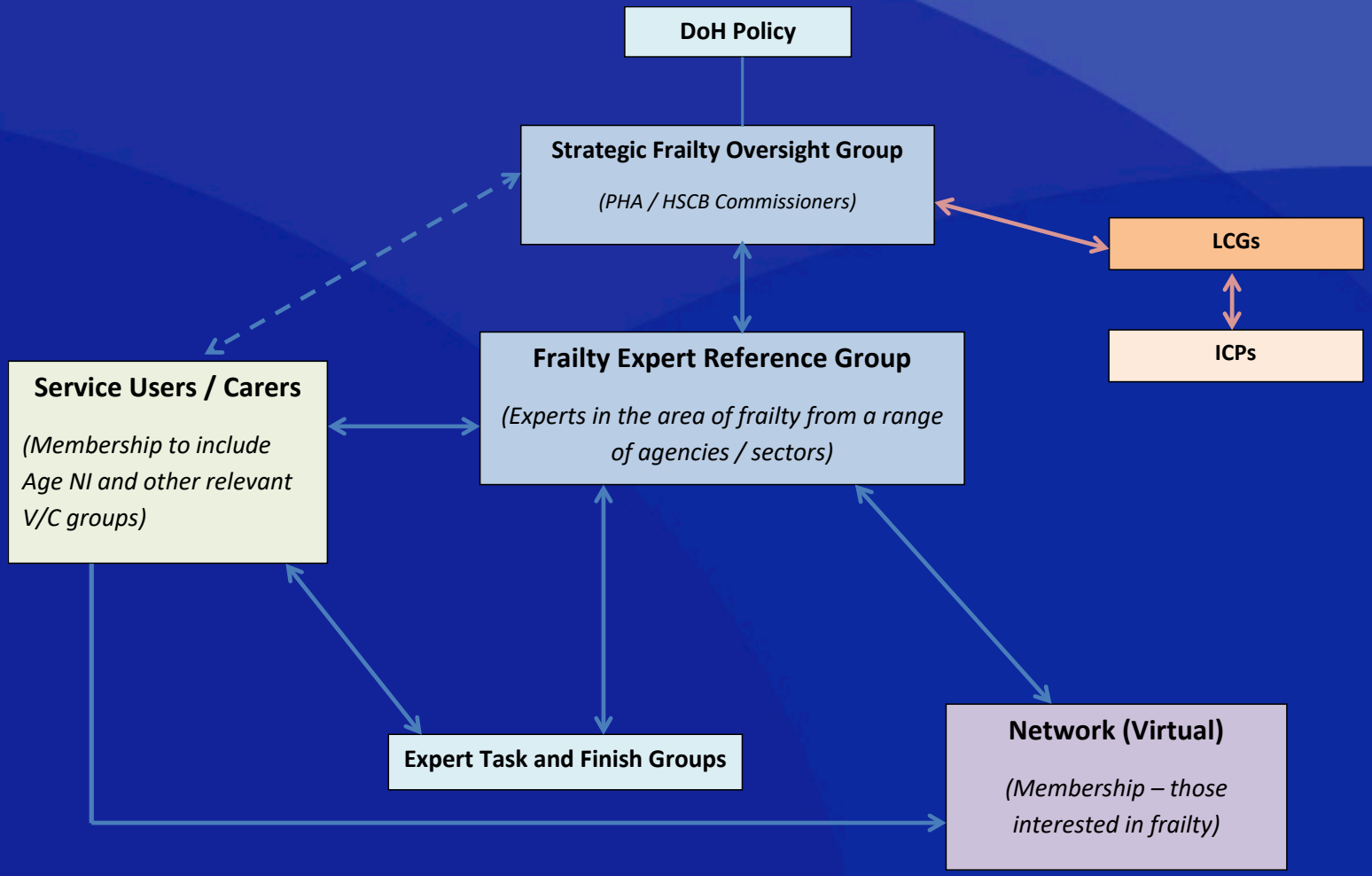
Good things are happening…

- Age NI Report: **Rethinking Frailty: What Really Matters to Older People:**700 service users views gathered (2018)
- PHA Frailty Symposium March 2018
- Joint Frailty event BGS/PHA Oct 2018
- EU Frailty Project: Advantage: 32 Member States
- National links

Progress to date…..

- CEC Multi professional Frailty Awareness Training
- PHA Funding – 5 Prototypes
- Transformational Funding over 2 years
  - Evidence Review
  - Scoping Exercise
  - Frailty Co-ordinator
  - **Frailty Network**
  - Economic Modelling
  - ECHO
- National Bench Marking Audit Frailty
- PHA/HSCB Frailty Oversight Group
- Partnership with Advantage Work
- Expert Panel for Frailty

Proposed Frailty Structure for NI



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Advantage Joint Action

Professor Anne Hendry, Clinical Lead for Integrated Care, NHS Scotland

Insert video link ….

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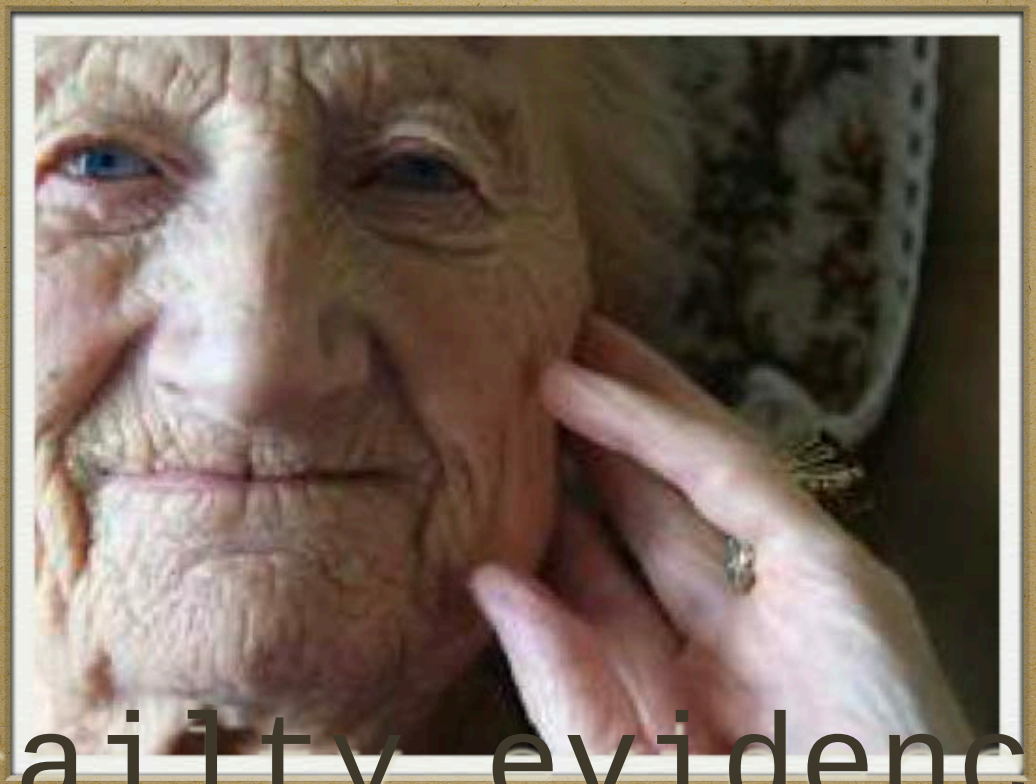
What does the Evidence say on Frailty?

Dr Helga Sneddon
Director Outcome Imps



Frailty evidence review

Dr Helga Sneddon
@helgasneddon

What is frailty?

- WHO (2015): 'frailty is a progressive age-related decline in physiological systems that results in decreased reserves of intrinsic capacity which confers extreme vulnerability to stressors and increases the risk of adverse health outcomes'
- Strong predictor of relevant adverse outcomes
- Separate, but causally related to, multi-morbidity & disability
- Frequent: 1 person out of every 10 after 65+ years is frail
- Potentially reversible, particularly in the early stages

Evidence review

- Use systematic approaches to identify effective interventions for the slowing or reversal or frailty across mild, moderate & severe gradings
- Examine a variety of factors & outcomes
- Examine different settings

EU recommendations at Population level

- Make frailty prevention a public health priority
- Ensure policy is both person centred & population focused
- Use systematic screening & Comprehensive Geriatric assessment
- Deliver integrated, person-centred models of support & services
- Support adoption of ICTs & technological solutions
- Invest in workforce development, research & evaluation

Screening & Diagnosis

- Opportunistically screen those aged 70+ at any level of system
- Recommended screening tools: Clinical Frailty Scale (CFS); Edmonton Frail Scale (EFS); Fatigue, Resistance, Ambulation Illness, Loss of Weight Index (FRAIL Index); Inter-Frail; Prisma-7; Sherbrooke Postal Questionnaire; Short Physical Performance Battery (SPPB) or Study of Osteoporotic Fractures Index (SOF)
- To diagnose frailty in individuals without disability use Frailty of Accumulative deficits, the Frailty Phenotype of the Cardiovascular Health Study (CHS) or the Frailty Trait Scale

Comprehensive Geriatric assessment (CGA)

- Improved rates of independence at discharge, decreased institutionalisation and mortality
- Important for identifying medication issues
- Common outcome is physical rehabilitation which can improve mobility and physical function

Effective responses

- Promote healthy lifestyle:
  - Be physically active
  - Follow Mediterranean diet
  - Avoid being overweight
  - Avoid tobacco
  - Reduce alcohol consumption

Individual interventions

- Exercise and physical activity
- Nutrition
- Review of medication and adherence
- Multidomain interventions
- Integrated care
- Incontinence
- Falls
- Social isolation
- Cognitive
- Mental health and emotional wellbeing

Exercise and physical activity

- Physical activity is most promising intervention for preventing or improving frailty
- Frailty is not a reason not to prescribe activity
- Improves body composition, dietary intake, muscle function, upper and lower body flexibility, and reduces depression
- Multicomponent interventions **x** > 5 months **x** 5 times per week **x** 30–45 minutes per session

Specific improvements

- Tai Chi reduces risk of falling, particularly amongst younger and less frail:
  - Yang's style with 12 or fewer forms **x** > 12 weeks **x** >2 times per week **x** > 45 minute sessions
- Whole-body vibration exercise improves muscle strength & physical performance
- Exercise + nutritional supplements show short-term improvements in physical performance & gait speed
- **First step treatment may be resistance and balance exercise, followed by nutritional supplementation if required**

Multicomponent physical exercise

- Can include resistance training, balance training, endurance training, coordination training and Tai Chi
- Most effective overall when they include resistance training
  - Muscle power and functional performance improves with resistance training **x** 1-6 sessions per week **x** 1-3 sets of 6-15 repetitions and intensity of 30-70% 1-RM
- Effective multicomponent programmes tend to be 60-90 minute sessions **x** repeated daily or weekly **x** 3-12 months

Exercise recommendations

- Provide physical exercise programmes in groups to pre-frail or frail older adults who are institutionalised or that live in the community
- Combine with home-based practice
- Don't assume more expensive means more effective
- Make it fun, social and achievable!
- Insufficient evidence to support recommending individual physical exercise programmes to prevent progression of pre-frailty or frailty

Nutrition

- Inadequate nutritional intake is a key modifiable risk factor, particularly low Vitamin D status
  - Recommend a minimal serum 25-hydroxyvitamin D level of 75nmol/l for frail elderly patients. Doses required for this are between 800 and 2000 IU/ day
- Mediterranean diet (olive oil and ≥3 servings of veg) **x** consuming protein above current dietary requirements **x** resistance exercise = maintained muscle mass, strength and enhanced functional capacity
- Specific nutritional supplementation for pre-frail and frail older adults improves physical activity, reduces long-term exhaustion and improves energy intake. No impact on body weight

Review of medication

- Comprehensive Geriatric Assessment (CGA) is useful
- STOPP/ START Screening Tool improves prescribing quality, clinic, quality of life and economic outcomes
- One study found:
  - 3 most common potentially inappropriate medications discontinued are proton pump inhibitors, anti-dementia drugs, and antipsychotics
  - most common potential prescribing omissions are Vitamin D and B12 supplements and antidepressants
- Recommended that reduction of polypharmacy could be a cautious strategy to prevent and manage frailty, but more research needed

Multidomain interventions

- Interventions targeting ≥2 domains (physical, exercise, nutritional, pharmacological, psychological or social interventions)
- More effective than mono-domain interventions on frailty status, muscle mass and strength, and physical functioning
- Results inconclusive for cognitive, functional abilities, falls or quality of life, and social and mental wellbeing outcomes
- Physical exercise appears to be an essential component of any multi-domain intervention

Integrated care

- Two models of integrated care:
  - Smaller, community model - cooperation across care providers, focuses on home and community care, and plays an active role in health and social care coordination
  - Large-scale model - regional level, has a single administrative authority and single budget, and includes both home/ community and residential services
- Some evidence of improved wellbeing and life satisfaction, and better care processes. Often no effect on other health outcomes. Big variance in study focus and quality
- Need to consider how care can be coordinated effectively across different types of services and how all care provider organisations can be coordinated to ensure continuity of care

Incontinence

- Pelvic floor exercises together with other physical training is effective and increases quality of life
- Attention training and toilet assistance reduce leakage episodes
- Additional functional exercise seems to add positive effects on continence as well as quality of life

Falls

- Special emphasis on sarcopenia, polypharmacy, multimorbidity, Vitamin D status and home hazards. Not all strategies useful for all patients so tailor response
- Effective exercise interventions include resistance, balance or flexibility training
- Perturbation based balance training effective, particularly
  - Treadmill-based systems and therapist applied perturbations in clinical settings
  - Including multiple perturbation types and directions

Practice management of falls

- Consider Vitamin D and calcium supplementation if required
- Conditionally recommend hip protectors for frail elderly in the appropriate environment
- Evidence-based exercise programmes
- Physical environment modification
- Frailty screening
- Risk stratification with targeted comprehensive risk-reduction strategies tailored to particular high-risk groups

Social isolation

- In person group support activities such as social support groups and community-based exercise programmes effective
- Limited evidence for befriending and home visits
- Technology-assisted interventions such as phone or computer mediated support groups effective
- Enablers include training study facilitators or coordinators, involving older people in planning and execution, involving existing community resources and aim to build community capacity, including some form of group activities that have educational or training input, and run social activities that target specific groups of people
- Interventions that improve self-esteem and locus of control are mediating factors for decreasing loneliness

Cognitive

- Individual RCTs show moderate intensity physical activity can be helpful
- Cognitive training has biggest cognitive benefits and is recommended to pre-frail and frail older adults in the community
- Nutritional and physical interventions singly associated with modest short-term or no cognitive benefits, but combined effects on visuospatial construction are unclear
- Problem solving therapy for preventing progression of pre-frailty and frailty in the community not supported by existing evidence

Mental health & Emotional wellbeing

- Exercise improves mental wellbeing
  - Effective interventions tend to be delivered in groups by trained leaders in a community setting **x** ≥2 sessions per week **x** 45 minute duration
- For older adults with mild frailty:
  - Psychotherapy effective in preventing depression
  - Psychosocial interventions show significant improvements but less effective than psychotherapy
  - Social activities important
  - Approaches using only behavioural methods or lasting <3 months not so effective in older people

Summary

- Consider using 2 stage screening & diagnostic procedures
- Holistic assessment is important, not just treating the presenting problem
- Most effective responses include physical activity & exercise, nutrition & reviewing medication
- Health & social care provision need to evolve to deliver well-defined, individualised, technologically supported & coordinated multi-professional interventions across the continuum of care
- Workforce needs to be well-trained & supported to change existing practice and work in this way

Thank you for listening!

- Helga Sneddon
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- Twitter: @outcomeimps @helgasneddon
- www.outcomeimps.com

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Frailty Expert Panel

Dr Lynne Armstrong
Consultant Geriatrician,
South Eastern HSC Trust and
Co-Chair of Frailty Expert Panel

HSC Health and Social Care

Role of Expert Panel

- Meet quarterly
- Represent entire frailty pathway
- Service user at the fore
- Agree key topics – workplan
- Select ‘task and finish’ groups
- Agree key indicators/ outcome measures
- Advise on learning from prototypes
- Expert advisors to PHA/HSCB Oversight Group

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Frailty Prototypes

Southern Health and Social Care Trust

Quality Care - for you, with you

Health and Well-Being Screening for Over 75 Year Olds

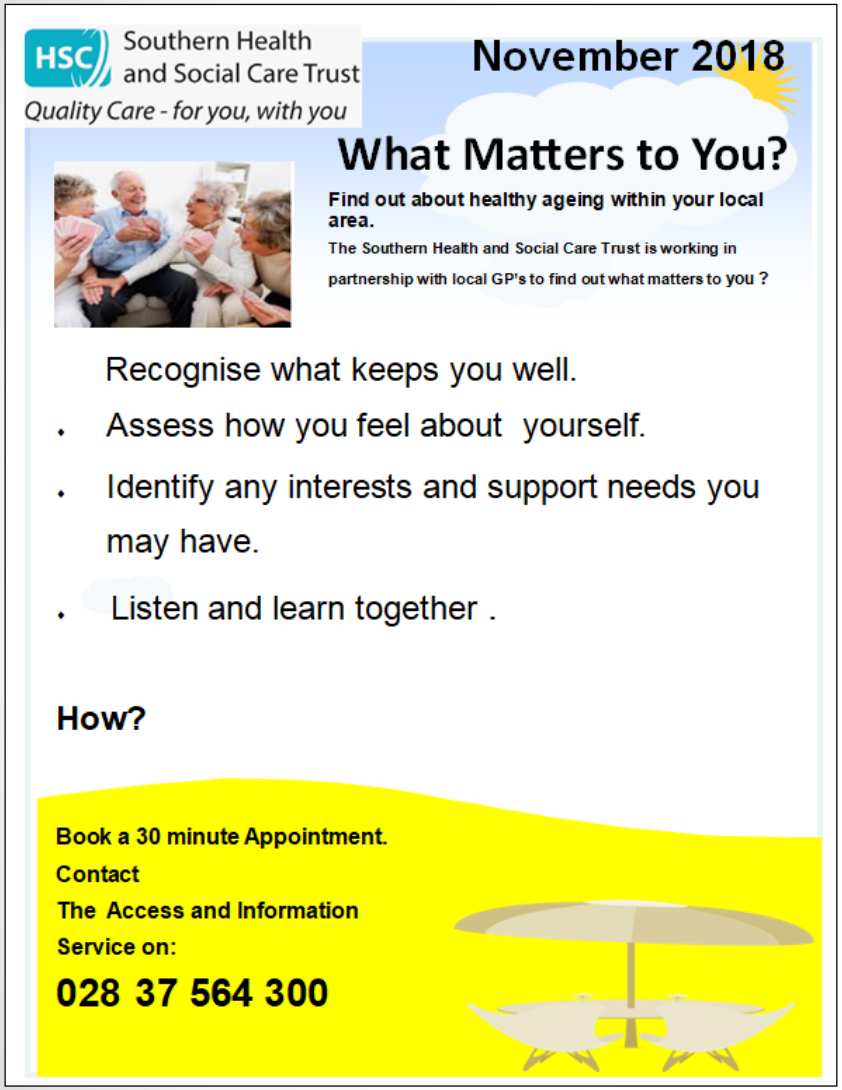
Introduction of a Frailty Clinic

Ann King: Specialist Nurse Acute Care at Home
Jane Morrison: Occupational Therapist, Intermediate Care

Key Aims

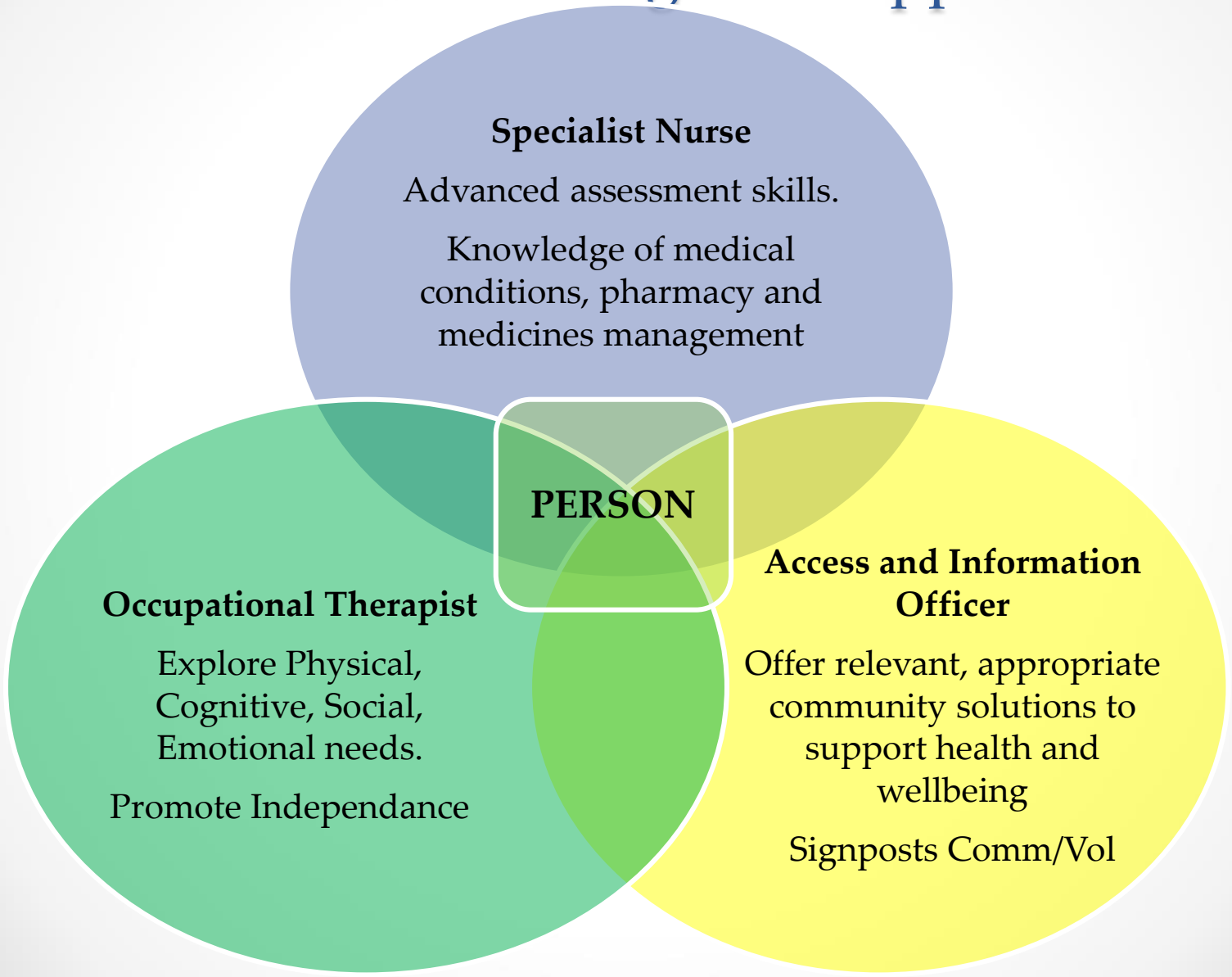
- Enhance awareness of frailty across services - ‘What Matters to You’
- Connectivity between Primary and Statutory, Community and Voluntary services
- Proactively identify patients with mild to moderate frailty
- Provide upstream early/earliest interventions and signposting enabling transformation
- Shift focus of frailty from Secondary to Primary Care facing
- Frailty through a different lens: recovery orientated strength based approach - “What’s Strong not What’s Wrong”
- Holistic to meet individual needs – Emphasis on self-management = choice and independence, Living Well with…..

What we did



- All over 75 year old patients on GP list received invitation letter and flyer to attend clinic appointment.
- Guided conversation led by Specialist Nurse, Occupational Therapist and Access and Information Officer
- Rockwood Frailty Score completed
- Integrated teams and working addressing bio medical, psychological, social and educational (whole person)

Benefits of an Integrated Approach

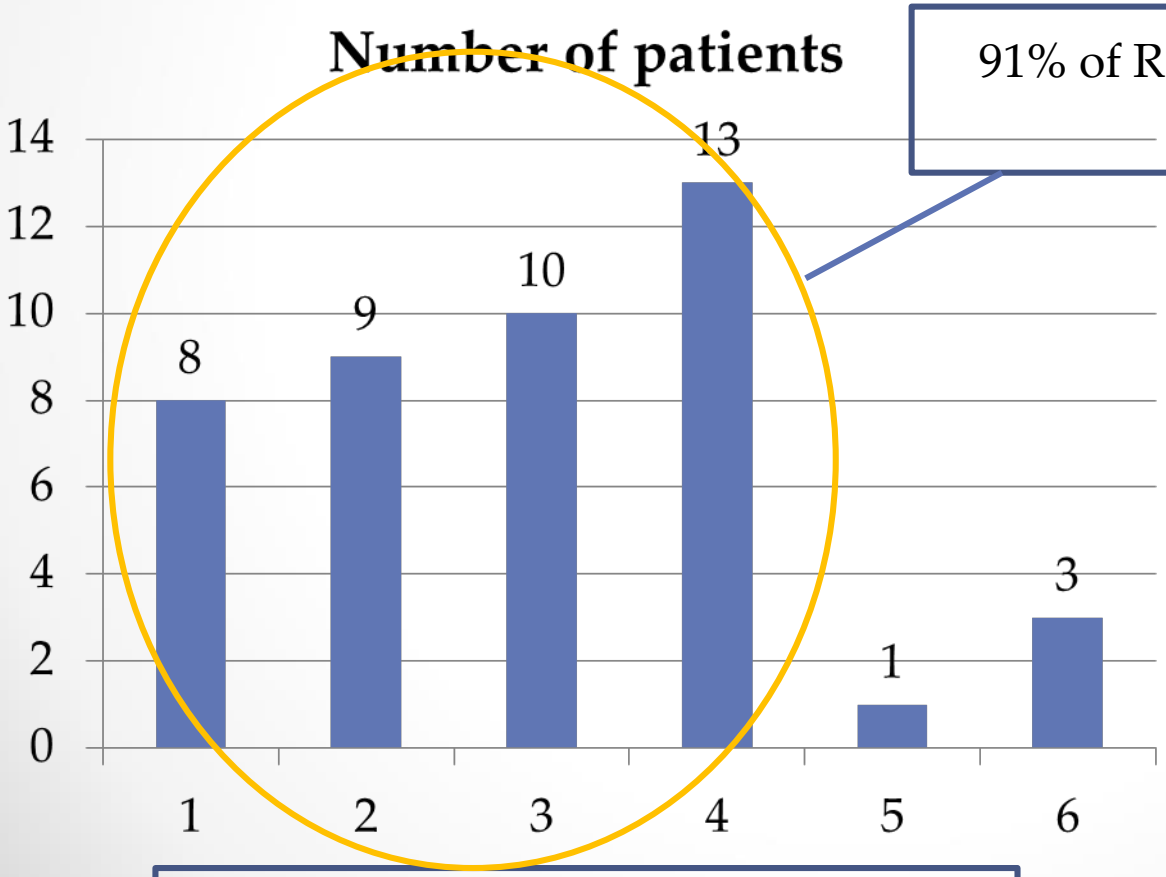


Overview of Clinic

- Specialist Nurse, OT and Access and Information Officer
- Very informal
- OT meets and greets client in reception - to begin functional/cognitive Ax from off set
- Begin clinic with introductions and nurse gives an explanation of why they are attending
- Discussion led by OT initially in regards to home environment and social circumstances
- Nursing discussion re general health including trigger questions to enable person to disclose any concerns
- Onward referrals made with consent
- Completion of Rockwood Scale
- Completion of Warwick Scale
- Access and Information discussion re community connections and support
- Complete questionnaire/follow up

Activity

- 210 eligible over 75year old patients in practice
- 51 patients screened approx. 25%



91% of Rockwood scores recorded were 4 or less

Rockwood Score

1. Very Fit
2. Well
3. 3. Managing Well
4. Vulnerable
5. Mildly Frail
6. Moderately Frail

** 7 patients had no Rockwood score recorded

Case Study

- 76 year old lady
- Recommended by husband - one of our first clients
- Access to NICER, PARIS- able to gather history before client attends
- Past Medical History included

  - Osteoporosis
  - Fall
  - Arthritis
  - Diverticulitis
  - Dislocation Left hand
  - Anxiety

- Lives with her husband and daughter.
- Main carer for her daughter who has a mild learning disability.
- Very tearful throughout appointment.
- Main concern is chronic pain Left hand.

Case Study continued

- **Occupational Therapy**: Issues identified related to function–

  - Difficulty with fine motor tasks due to arthritis/pain Left thumb.

  - Difficulty with stairs/steps.

  - Difficulty with showering.

- Outcome: Referral to Intermediate Care for OT review and follow up. Visit completed within 1 week.

- Same OT completed home visit as clinic assessment – continuity of care

- Provision of shower stool; second stair rail; grab rails at front and back door; thickened cutlery; Futura splint; home exercise programme for hand.

Case Study continued

- **Specialist Nurse Review**

  - Identified urge incontinence ➡ Referred to Continence service for further assessment and intervention.

  - Rockwood Score completed – scored 4

  - Discussed pain management for hand.

- Patient Attended clinic on 15/02/19. Nurse spoke to GP practice regarding pain and low mood and client was offered and attended GP appointment on 27/02/19 for further assessment.

Case Study continued

- **Access & Information Officer**
  - Offered transportation information as client relies on her husband for same.
  - Offered local social group information.
  - Lifeline number given for emotional support due to anxiety noted throughout assessment.
  - Offered carers assessment on the basis she is main carer for her daughter and stress/anxiety evident. Client declined same.
  - Information on carers assessment posted out for future consideration.
- Access and information contact details provided.

Clinic Highlights

Direct access to Practice Nurse, GP to follow up concerns

Lady previously known to AC@HT attended clinic – good to see progress and improvement

New wig: lady with alopecia, lost in system, Frailty clinic able to follow up and expediate referral.

Chance Meeting in local chemist with OT: client on waiting list for OT assessment. Able to attend frailty clinic within same week as was belonging to GP practice

Ulsterbus: lady dropped to door of health centre on way to clinic appointment

Lady who relied on family for transport and delighted to be signposted to transport options to enable her independence

Benefits to patients

- Attending the clinic promotes feeling of well being, being listened to, given a choice, reassurance and they feel valued
- Looking at person from physical, cognitive, emotional and social perspective
- Made aware of the support networks within their local community
- Fast-track onward referrals
- Given knowledge, contact details and information on how to seek help in the future
- Everyone attending clinic left feeling supported and glad they attended.

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Improving Your Health and Wellbeing

Northern HSC Trust

Mary O’Boyle

Justin O’Neill

Northern Health and Social Care Trust

innovation Quality improvement

ramp
REFORM AND MODERNISATION PROGRAMME

Frailty Model
Pilot : Oct 18-March 2019

Mary O'Boyle

Project Lead March 2019

Stakeholders

- 2 community hospitals(Dalriada and Robinson)
- 9 Nursing Homes in the Causeway Area
- Geriatrician in reaching (2 Pas/week)
- Local GPs
- Service users
- Carers
- Advanced Nurse Practitioner
- District Nurse Palliative care key worker
- Voluntary services, Community Navigator
- Community re-ablement team
- M'D Team : Continence, Falls Team, TVN, Dietician, Dental, Respiratory, PPT, podiatry palliative care team, REaCH
- Pharmacists

Location: Robinson Community Hospital

Progress to date

- Engagement and communication with key stakeholders
- Networking with available statutory, community and voluntary agencies in Causeway
- Justin O'Neill, Trainee Advanced Nurse Practitioner in post
- Attendance at MD Community Hospitals, Robinson and Dalriada
- Visits to all Causeway Nursing Homes complete. Visits to other Trusts
- Rockwood piloted, initially in the Robinson community hospital
- 1/12 Model of Care Meeting and 2/52 working group established-MDT
- Weekly staff awareness sessions
- Mapping of patient's journey through the Robinson-working group
- Training arranged-signpost staff to elearning

Rockwood CFS

Clinical Frailty Scale

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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).

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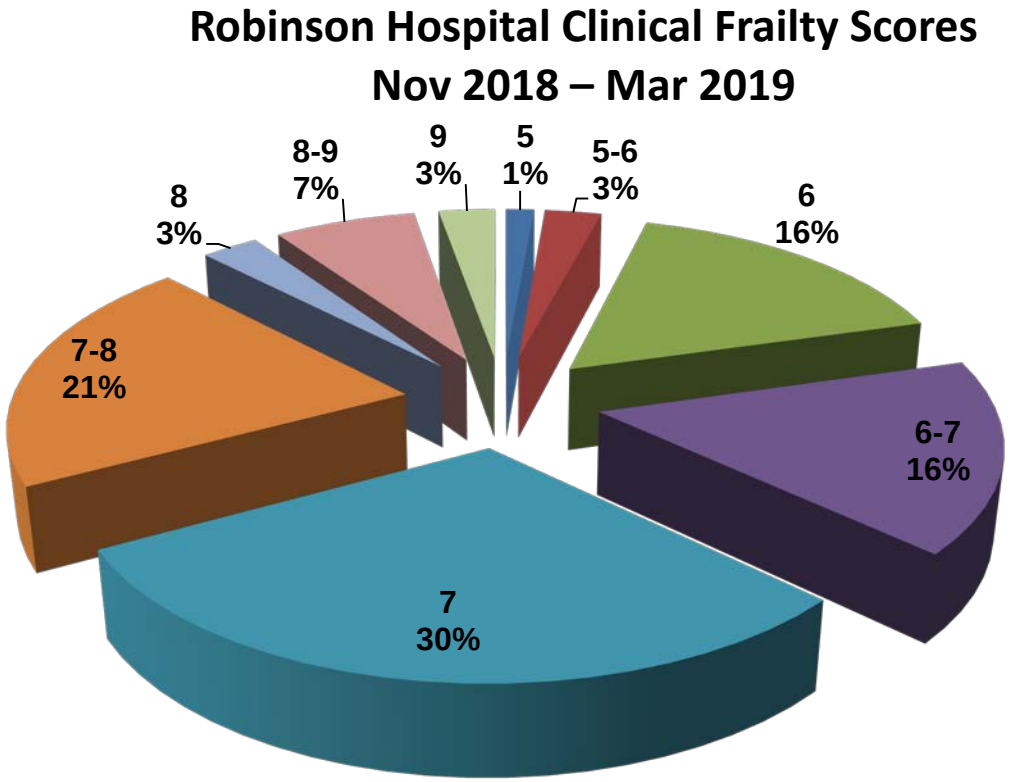
Scoring frailty in people with dementia

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.

Statistics to date



Mapping of patient's journey

- MDT approach- group meet 2/52
- What's working well- it demonstrates excellent work
- Areas where improvement
- Shared learning/key themes emerging
- Rockwood score of 7-9 what is this triggering?
- Starting the conversation/medicine optimisation/preferred
- Place of care/ACP/DS1500/carers/ assessment/communication with MDT onward referral

3 key messages

- Rockwood-objective measure on subjective information
- Interface with staff across Acute/Community
- Shared learning-changing attitudes-80% people-hearts and minds

Our vision

- ***Frailty is everyone's business***

The Role of the Advanced Nurse Practitioner (ANP) in Adult Medicine and Older people care

- "Advanced practice is a level of practice, rather than a type of practice. Advanced Nurse Practitioners are educated at Masters Level in advanced practice and have been assessed as competent in practice using their expert knowledge and skills. They have the freedom and authority to act, making autonomous decisions in the assessment, diagnosis and treatment of patients."

  RCN 2018

- Justin O'Neill
- Trainee Advanced Nurse Practitioner

Trainee ANP

Adult Medicine / Older People Pathway

- 1st year pathway introduced by Ulster University Sep 2018
- Entry criteria:
- Graduate level qualification
- Prescribing qualification (V300)
- NMC registration

- 11 Trainees enrolled in the course from all trusts in NI.

- Trainees all from different areas of practice.

- Allocated a clinical practice supervisor for training and to assess competence.

Role of Trainee ANP in the Community Hospital setting

- Under supervision until competencies achieved.
- Clerking new patients.
- Full health assessment.
- Formulating diagnosis / differential diagnosis.
- Person centred treatment and management plan.
- Prescribing.
- Supporting role for all staff.

Competencies to be achieved in adult medicine and older people 2020

- Core Competencies
- Direct clinical practice
- Leadership and collaborative practice
- Education and learning
- Research and evidence based practice.

- Competencies relevant to Adult medicine / Older people care
- Frailty screening and assessment
- Comprehensive geriatric assessment
- Rehabilitation, End of life /Palliative care
- Dementia, Delirium
- Continence, Nutrition, Skin integrity
- Tissue Viability, Mobility, Falls and stroke care

Clinical Practice Placement

- The Robinson Memorial Hospital Ballymoney
- Community Hospital with 25 bed capacity
- Adult / Older People admitted via step down from the acute hospital, step up from home or admitted for palliative care.
- Multi-disciplinary staff for medical management and rehabilitation.
- Excellent communication / MDT meetings – huddle every morning 9am and MDT discharge planning meetings every Wed 1pm

The Robinson Memorial Frailty Project

- Trainee ANP and clinical practice supervisor assess all patients for frailty using the Rockwood Clinical frailty scale.
- The Rockwood score is recorded on clerking / admission and on discharge.
- Community Hospital pharmacist undertaking a medication review on all patients.
- A Person centred management plan is implemented in collaboration with the multi-disciplinary team.
- Patients with high Rockwood scores are offered the opportunity of advance care planning discussions.
- The Frailty score and interventions are communicated to GP on discharge letter.

Further Research

- Frailty project in early stages
- Further interventions to be put in place with reference to Rockwood clinical frailty score
- Trainee ANP dissertation 2019/2020 looking at improved outcomes for patients with frailty.

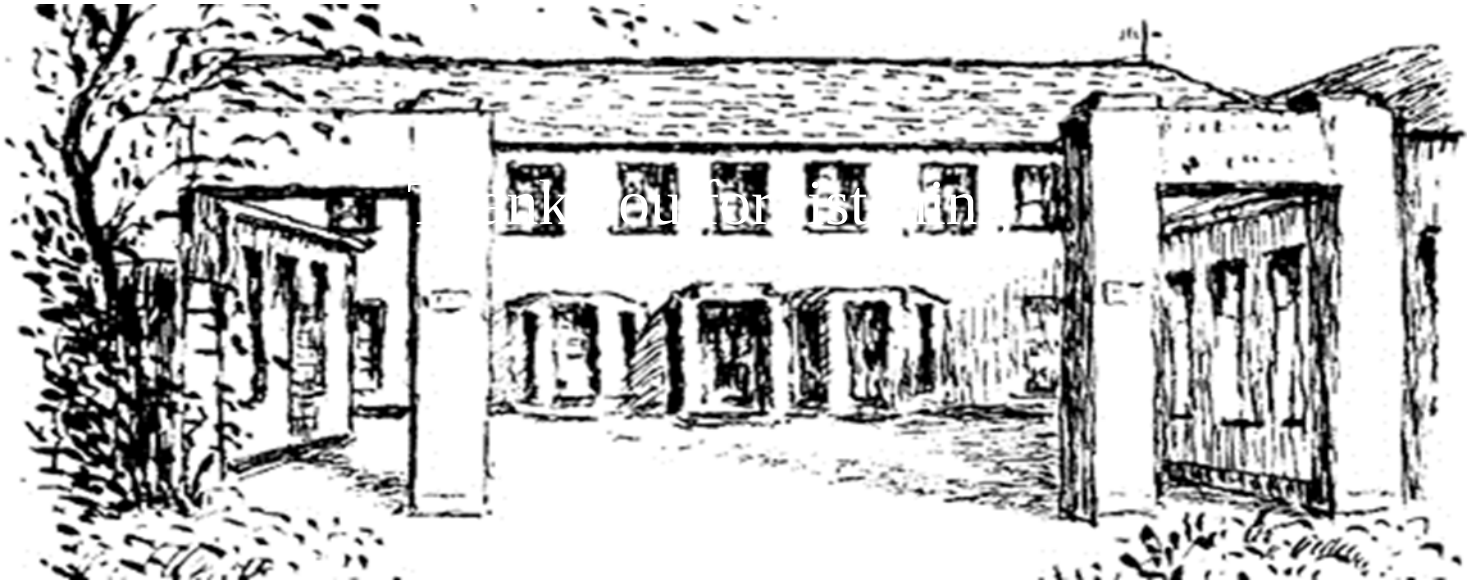
Northern Health and Social Care Trust

innovation Quality improvement

ramp
REFORM AND MODERNISATION PROGRAMME

Thank you for listening

The Robinson Memorial Hospital Ballymoney



COMPASSION OPENNESS RESPECT EXCELLENCE

C O R E

To deliver excellent integrated services in partnership with our community

HSC Public Health Agency

Improving Your Health and Wellbeing

Closing Remarks & Way Forward

Paschal McKeown,
Charity Director, Age NI

Ambition for frailty NI..

'Frailty is Everybody 's Business and Everybody should know what to do next when presented with a person living with frailty'

HSC Public Health Agency

Improving Your Health and Wellbeing

Thank you

frailtynetwork@hscni.net

#FrailtyNetworkNI