Acute Frailty Network

NHS Specialised Clinical Frailty Network

Front door experience during the COVID pandemic

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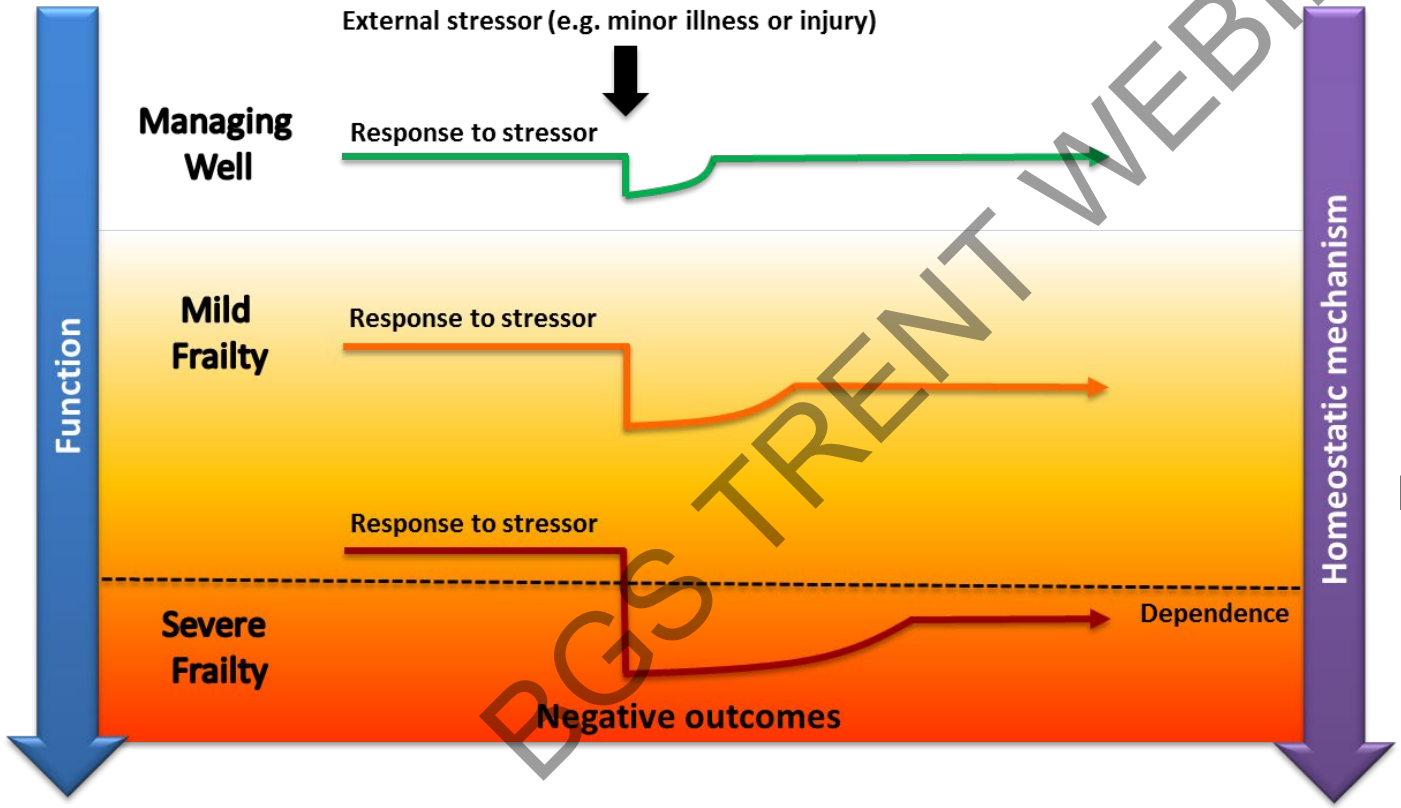
Caring at its best

BGS British Geriatrics Society Improving healthcare for older people

University of Leicester

Frailty concept



Manifestations of frailty

Delirium (dementia)
Falls & fractures
Immobility & pressure sores
Incontinence & dipstick +ve 'UTI'
Iatrogenesis

Causal pathways

Clinical Frailty Scale/Frailty Index

Rockwood K, et al. A global clinical measure of fitness and frailty in elderly people. CMAJ Canadian Medical Association Journal. 2005;173(5):489-95.

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.

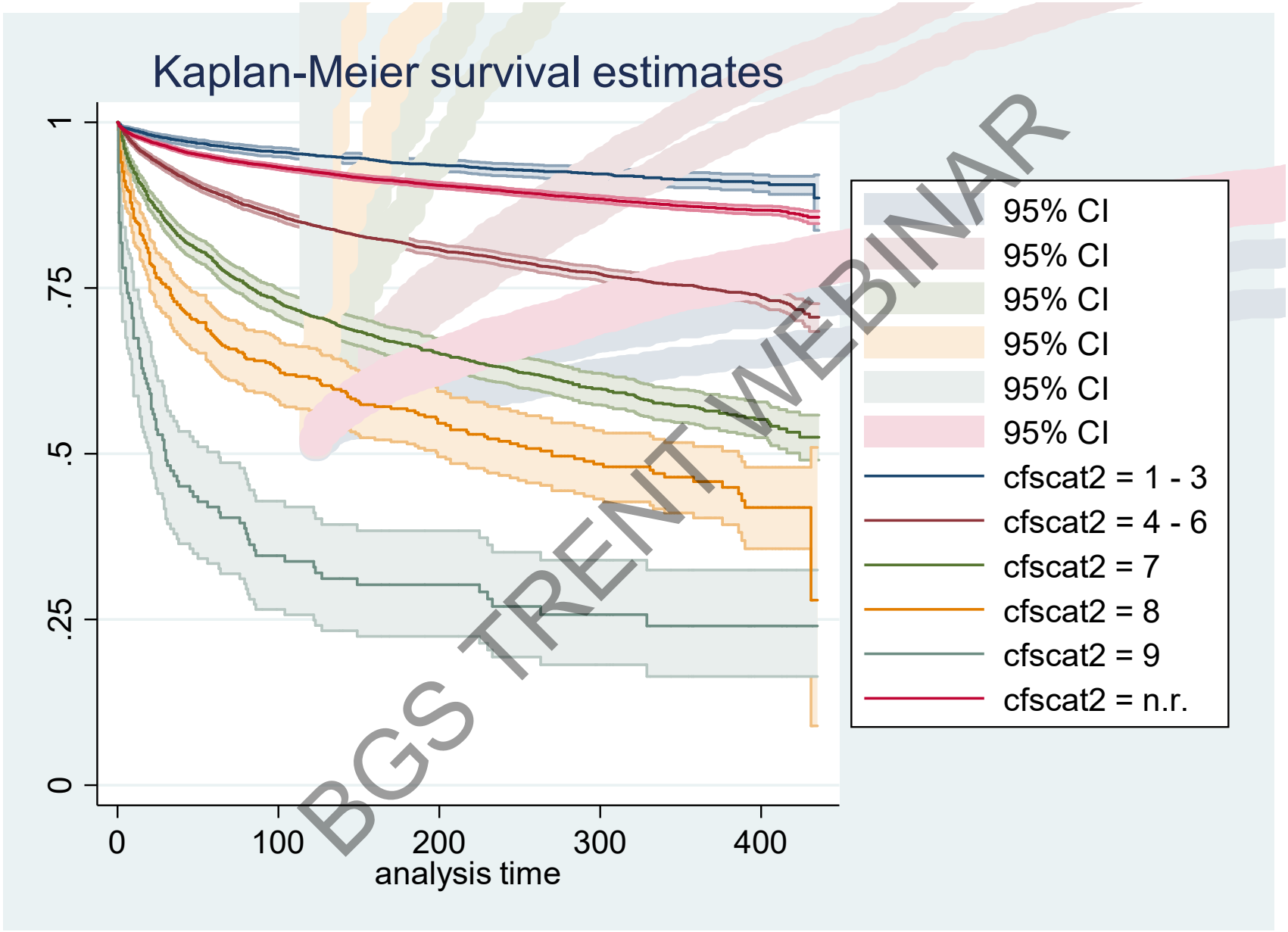
In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

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

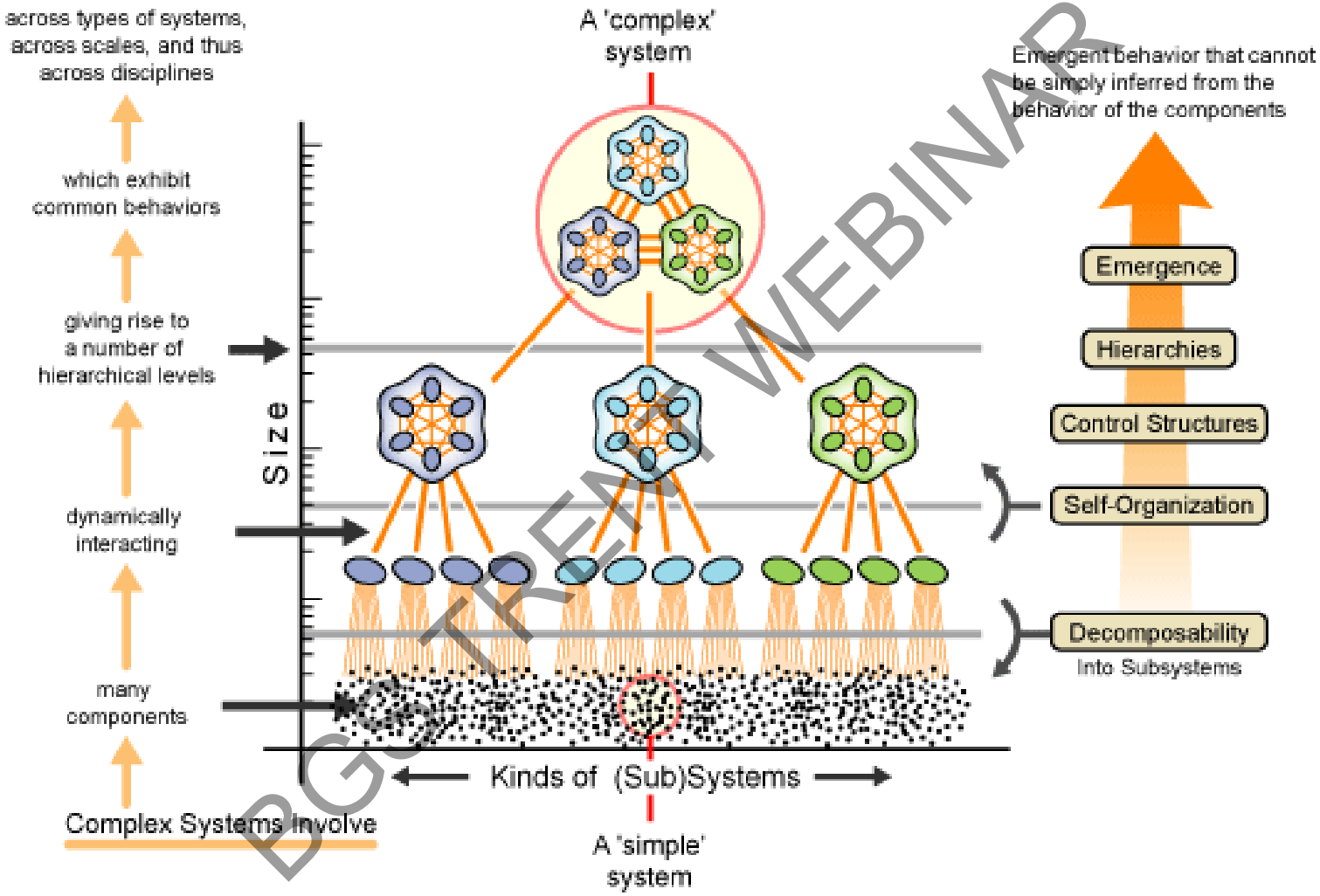
* 1. Canadian Study on Health & Aging. Revised 2008.
2. K Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY Inspiring Minds

CFS grade	Length of Stay	Readmission rate	In-patient mortality
1	4	4%	2%
2	5	7%	2%
3	7	11%	2%
4	8	13%	3%
5	10	15%	4%
6	12	15%	6%
7	13	14%	11%
8	12	10%	24%
9	10	13%	31%



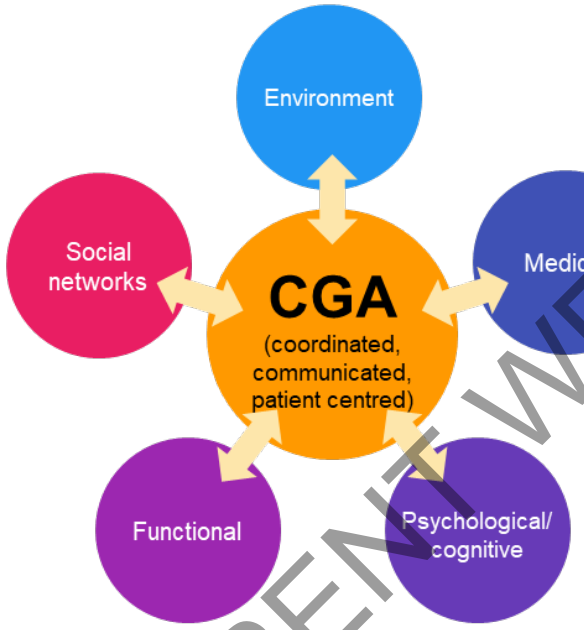
Characteristics of Complex Systems



New England Complex Systems Institute

Comprehensive Geriatric Assessment

"A multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up."



CGA allows a **care plan** to be generated that can modify trajectories

- At 6 months, NNT of:
  - 17 (1 unnecessary death or deterioration);
  - 20 (1 institutionalisation)
- NNT 25 at 12 months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Comprehensive geriatric assessment for older adults admitted to hospital
Published:
12 September 2017
Authors:
Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O, Harwood RH, Conroy SP, Kircher T, Somme
What is the aim of this review?
The aim of this Cochrane Review was to find out if organised and co-ordinated specialist care (known as comprehensive geriatric assessment, or CGA) can improve care provided to older people admitted to hospital. Researchers at Cochrane collected and analysed all relevant studies to answer this question and included 29 trials in the review.
Am score 130
Who is talking about this article?
Cochrane Crowd

Specific issues related to COVID

- Reduced access to care & support – social distancing/shielding
- Immunoparesis – frailty, comorbidities, polypharmacy
- Non-specific presentations
  - Older people are less likely to present with cough, fever, or influenza-like illness
  - Presentations may include: delirium (assess with 4AT); anorexia; vomiting or diarrhoea; abdominal pain; low-grade fever or absence of fever; fatigue; falls; acute kidney injury
- Frailty & critical care
- End of life care

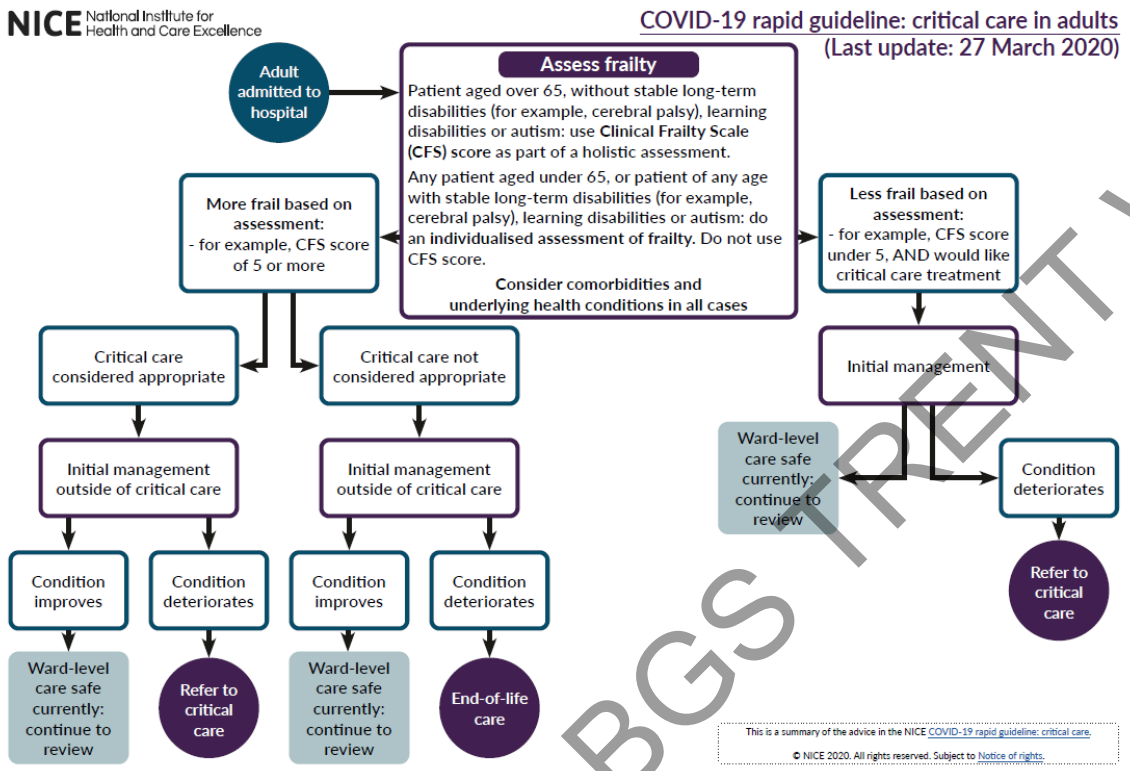
Front door frailty – the primary care perspective

- Organisational shift to **remote consulting** for approx. >90% of contacts
  - How is this working for our older patients?

- Impact of shielding/lockdown
  - *"Muddling along"*
  - Isolation – physical, cognitive impact; mental health - mood, anxiety, confidence and self-efficacy?
  - Contact with lay 'advocates' (e.g. relatives in care homes)
  - Increase in 'risk' perception for any healthcare contact (including hospital, entering long term care)
  - Delayed presentation: fewer contacts, higher acuity

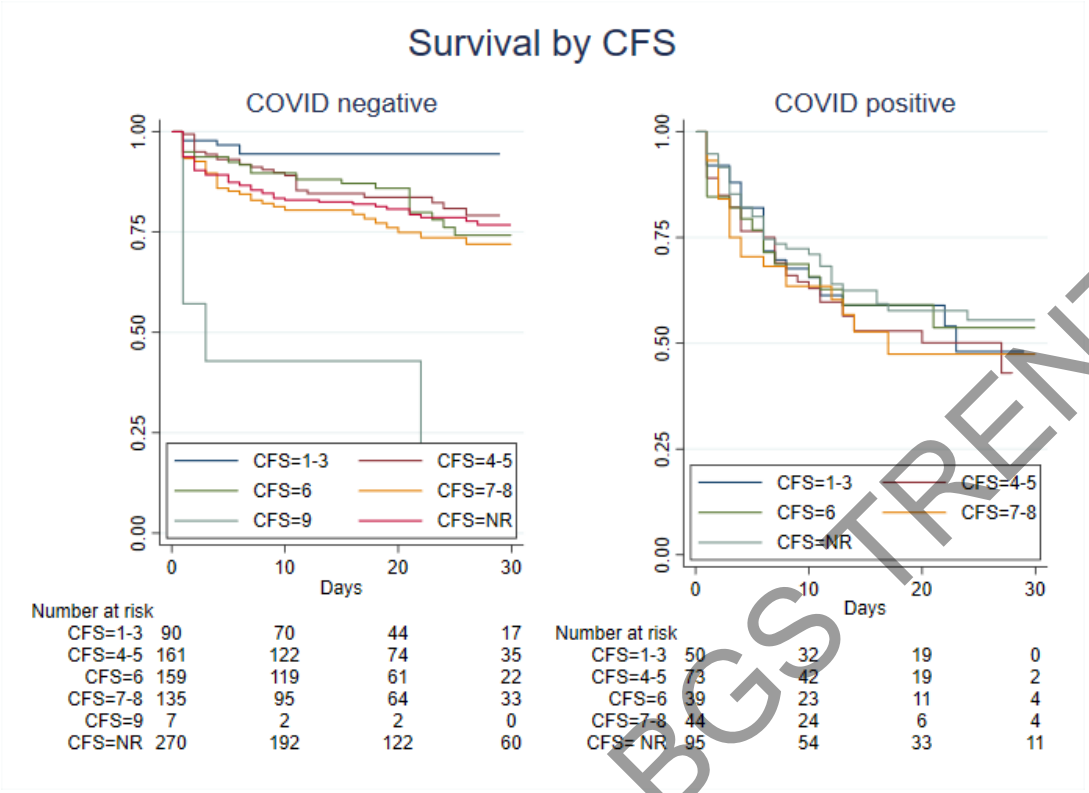
- Challenges our whole approach to Advance Care planning
  - Who should develop the care plan?
  - Are wishes still current? How often to review?
  - Some plans developed during Covid might be considered 'nihilistic' in 'normal times'
  - Importance of context: community *vs* hospital; Covid *vs* usual times

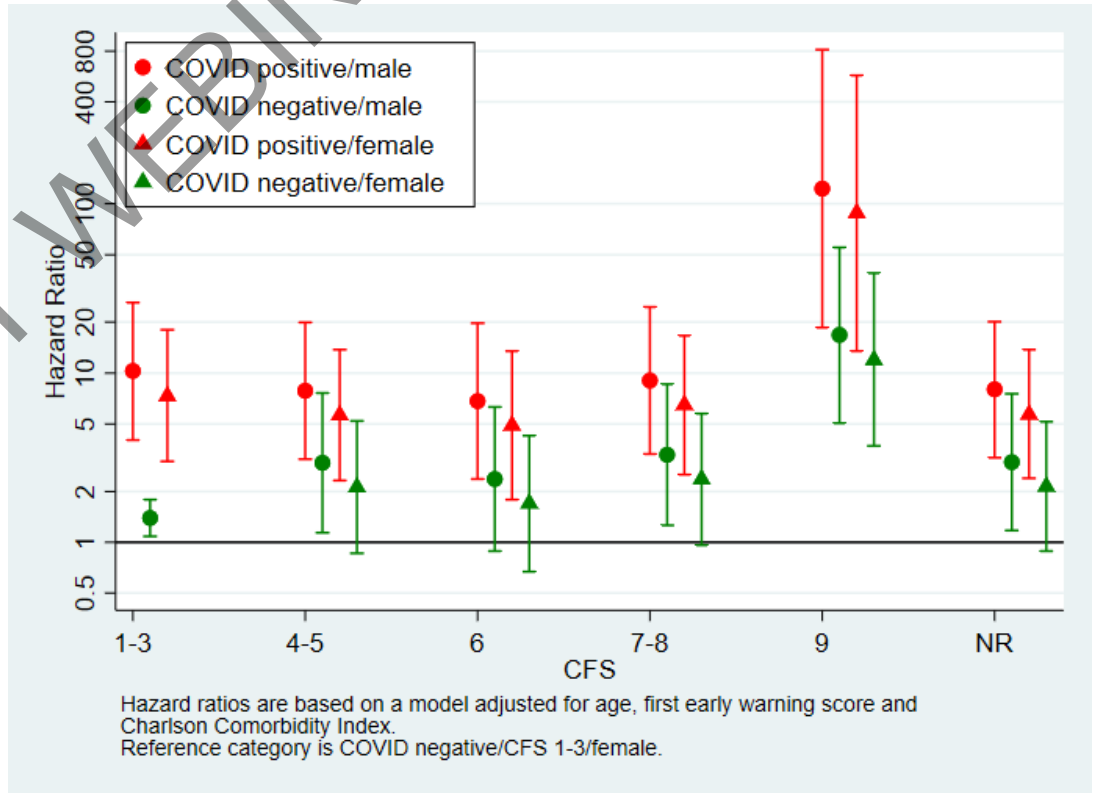
Frailty & critical care



- Resources: https://www.criticalcarenice.org.uk/
- Patient information
- Clinical decision making
- Frailty
- End of life care
- Documents, guidance & videos to support clinicians

Emerging data on COVID related outcomes





Pre-conveyance Clinical Discussion and Assessment (PTCDA) Care Home Pilot

Another front door to urgent care

PTCDA – the model

- Support model accessed by East Midlands Ambulance Service professionals or primary care professionals for *any care home residents* in whom they are considering hospital admission
- (PTCDA) model involves three integrated stages:
  - Immediate access to a consultant geriatrician or geriatric emergency medicine consultant for crews and GPs considering admission, i.e. a ‘pre-transfer clinical discussion’ function
  - This leads to one of three responses leading to one of four responses:
    - Community management plan, including engagement with usual GP.
    - Follow-up visit by a dedicated GP with interest in care home medicine, (i.e. an ‘assessment’ function) – visiting doctor has access to primary care notes.
    - Admission with active case management
- In all cases, handover to the usual GP for information.

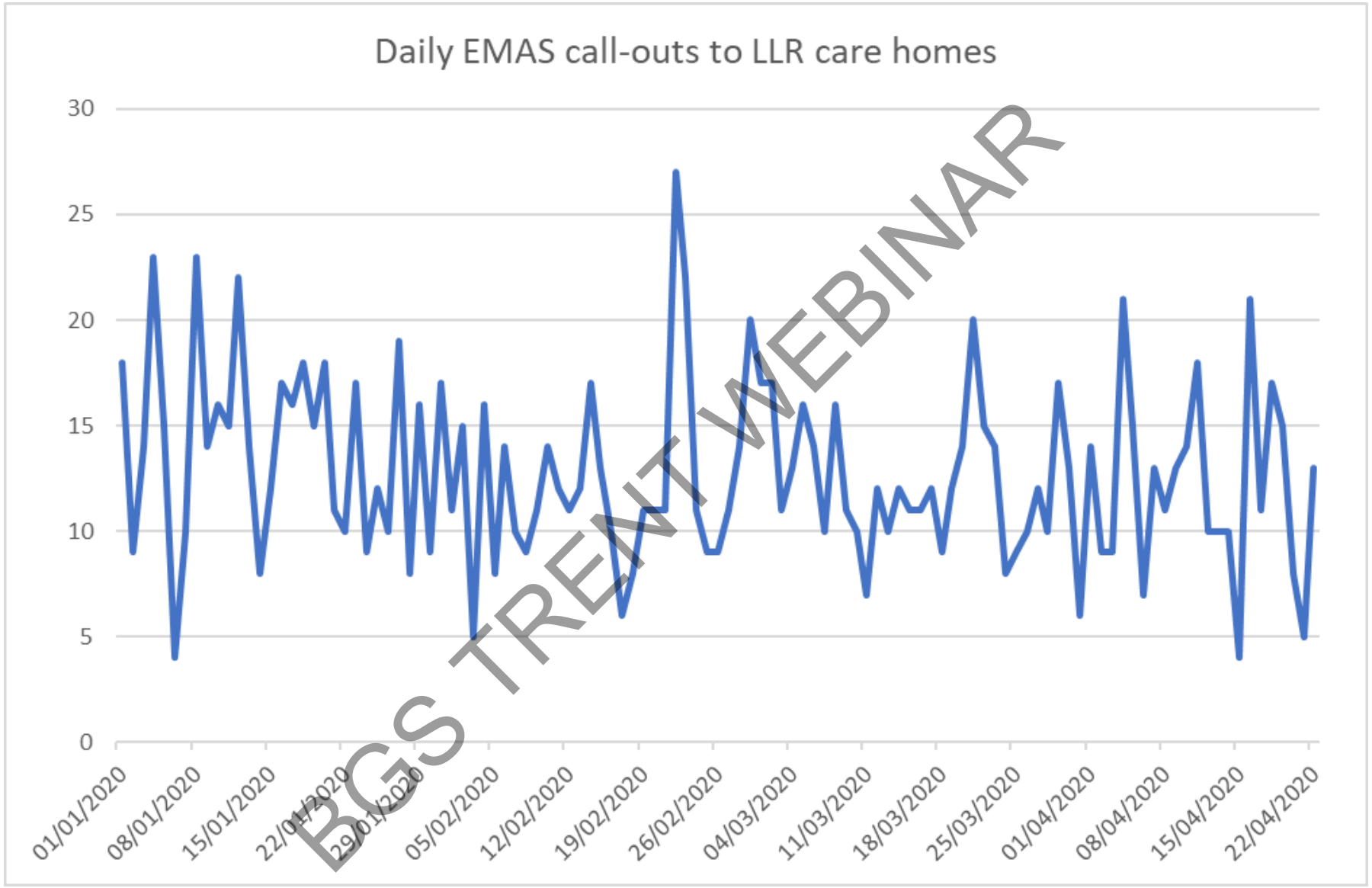
Geriatric Emergency Medicine

- Geriatric medicine competencies
  - Delirium vs dementia
  - Asymptomatic bacturia
  - Falls assessment
  - Medication reviews
  - Rehabilitation
  - Managing long term conditions
  - Palliation

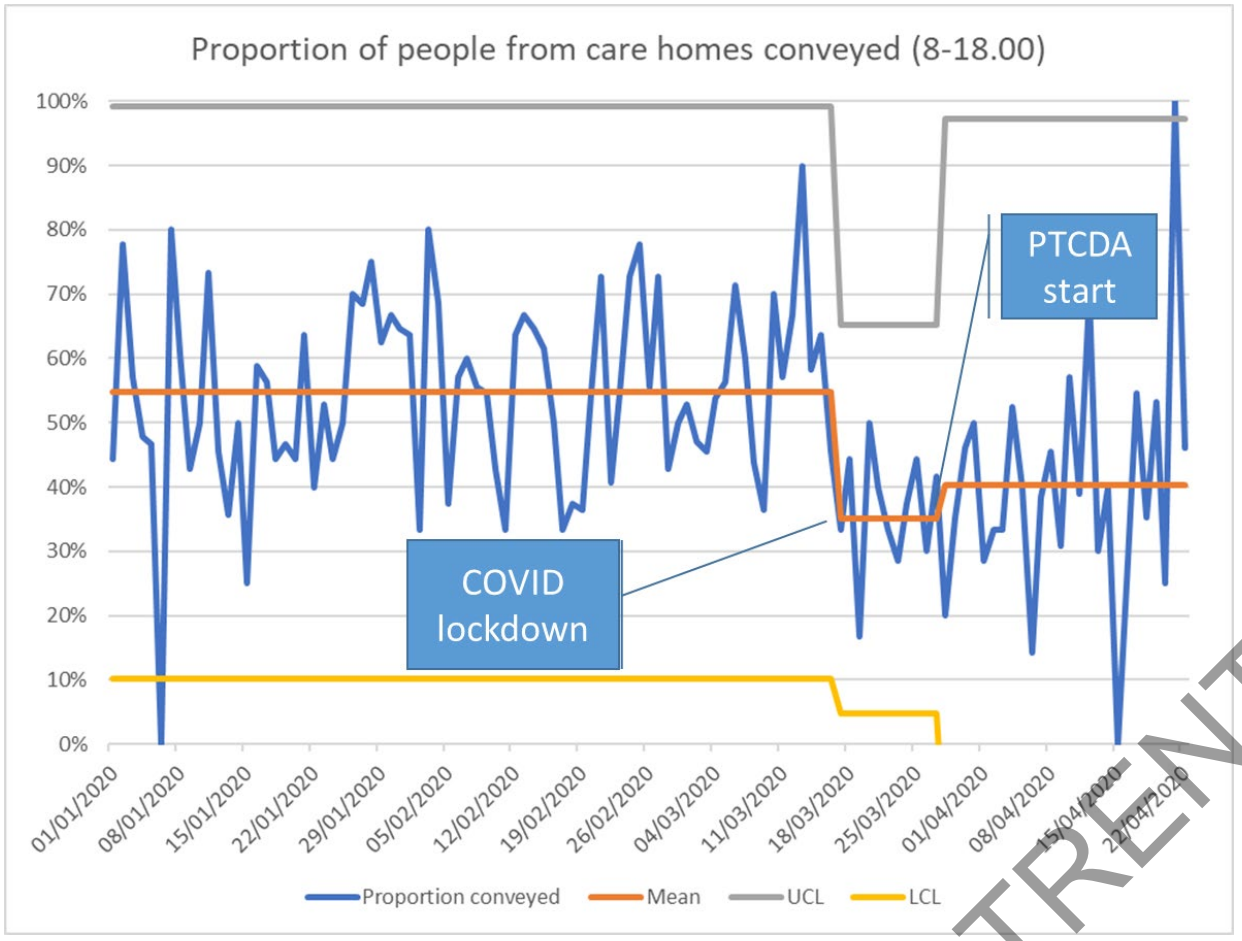
- Emergency medicine competencies
  - Assessing undifferentiated patients
  - Trauma
  - Resuscitation
  - Situational awareness
  - Rapid assessment
  - Risk assessment

Emerging data

- Based on 1st 250 logged ‘ambulance’ cases 31 March to 24 June:
  - 74% of residents could be managed in the community after telephone discussion.
  - In 53% of cases, this was possible after telephone discussion only.
  - In 21% of residents, a follow-up visit from the PTCDA team was offered; only one visited patient needed same day admission.
- Preventing avoidable conveyance OR just delaying conveyance
  - Only three patients have been repeat calls so far

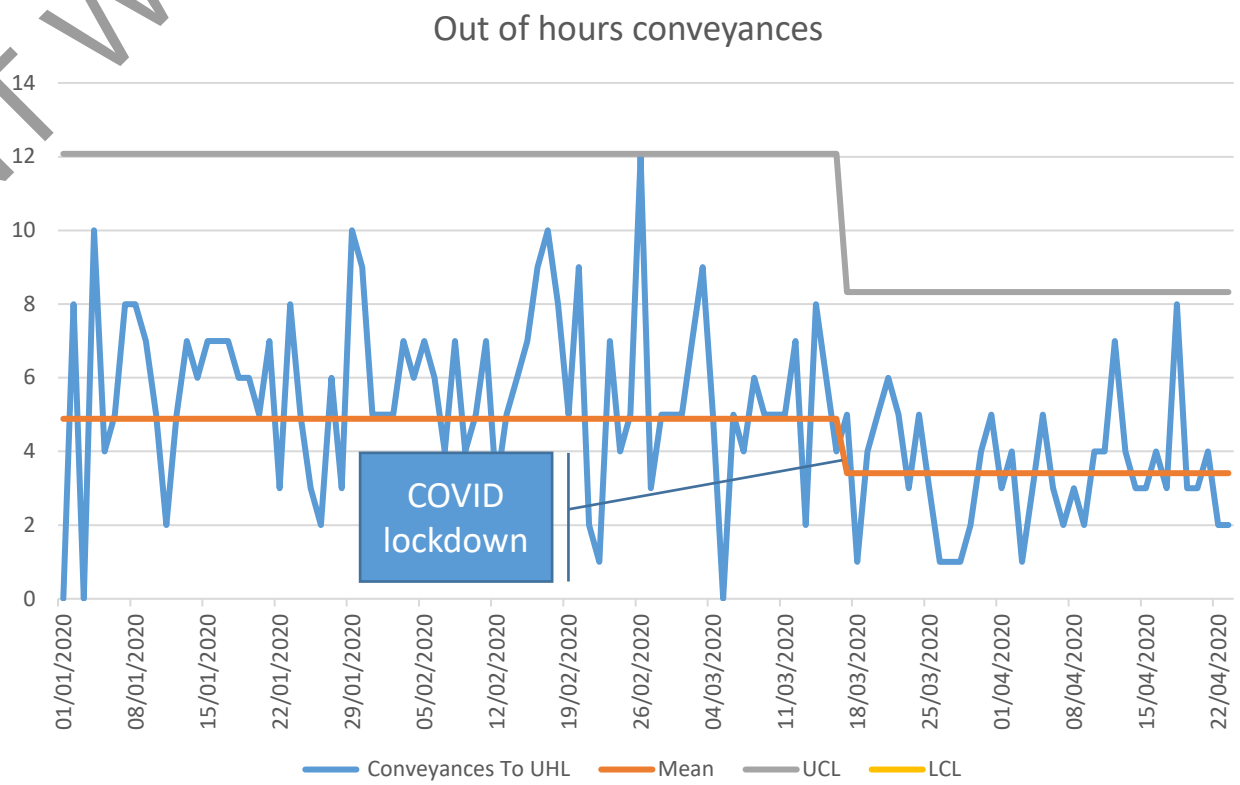


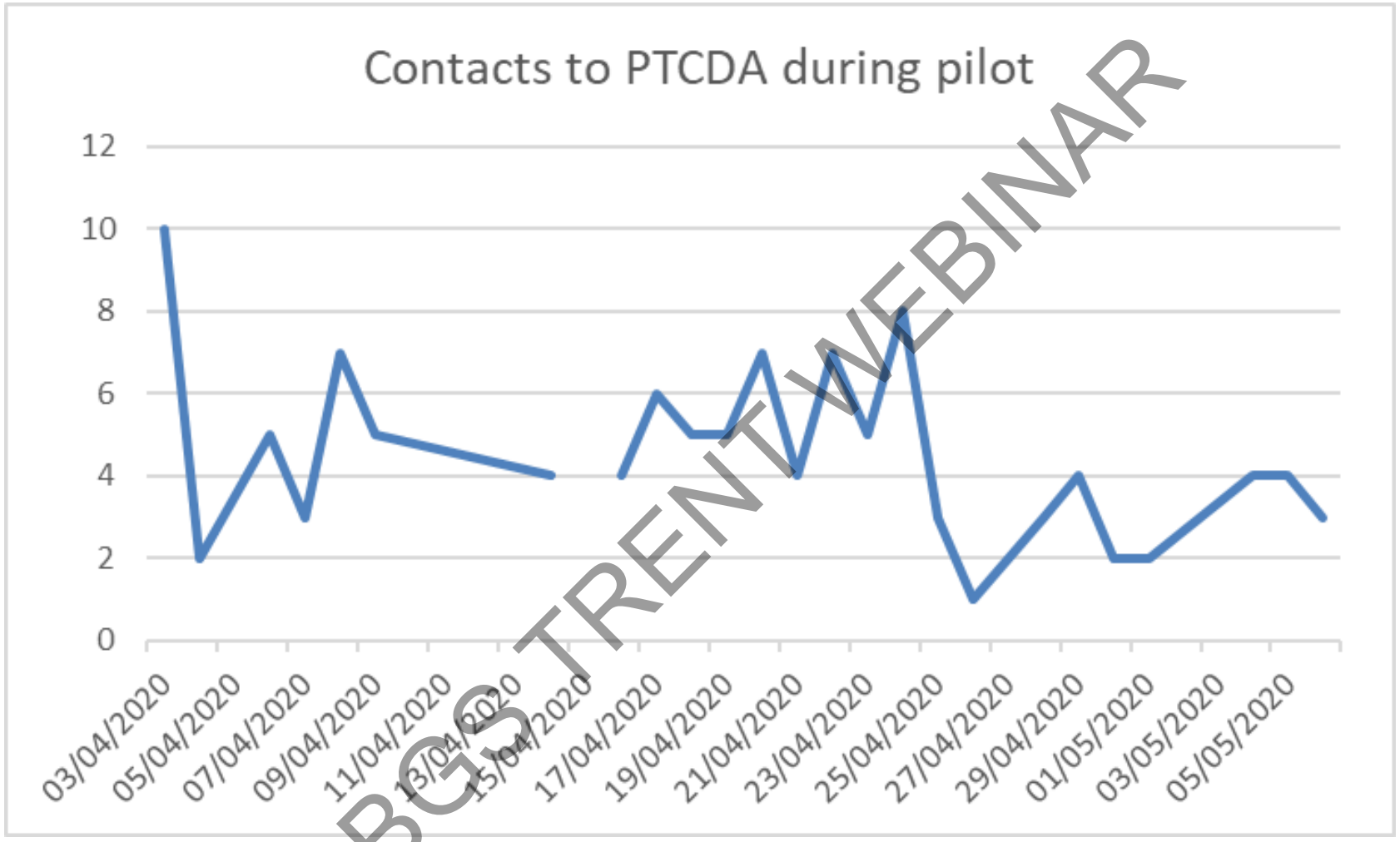
Mean 12.3/day (08.00-18.00 – time is crew on scene)



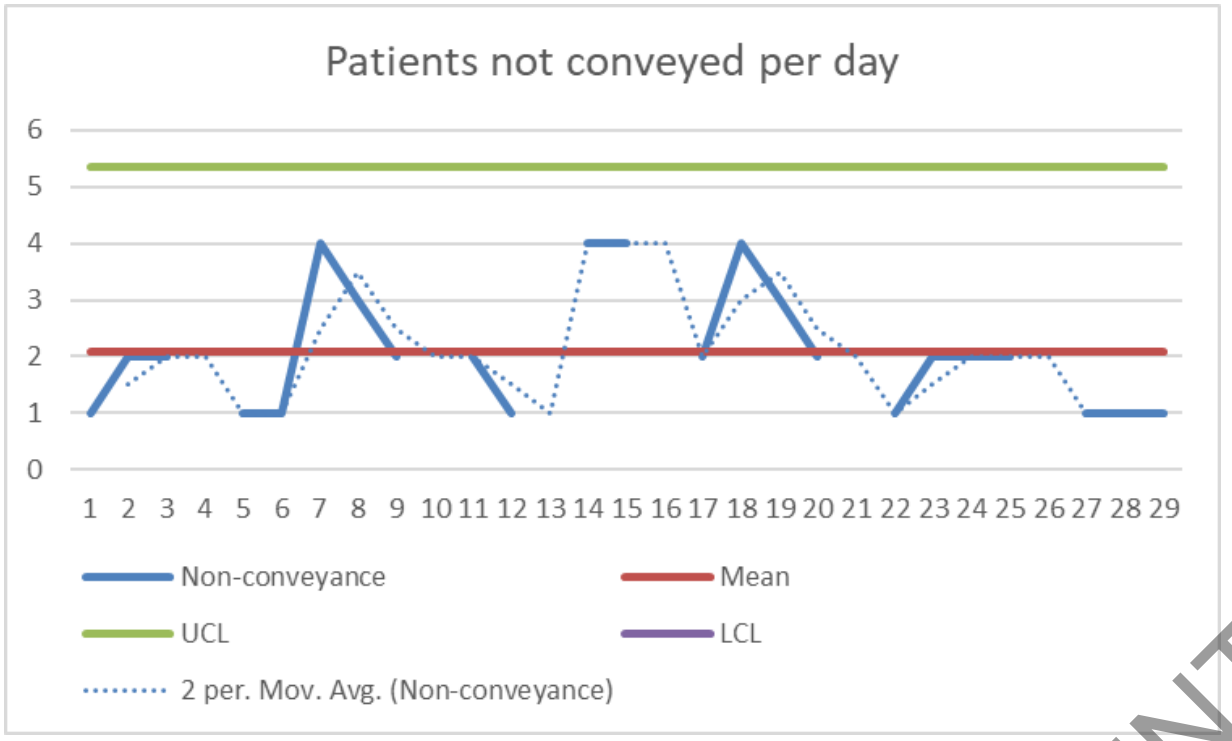
In hours: 55% → 35%; ARR 20%

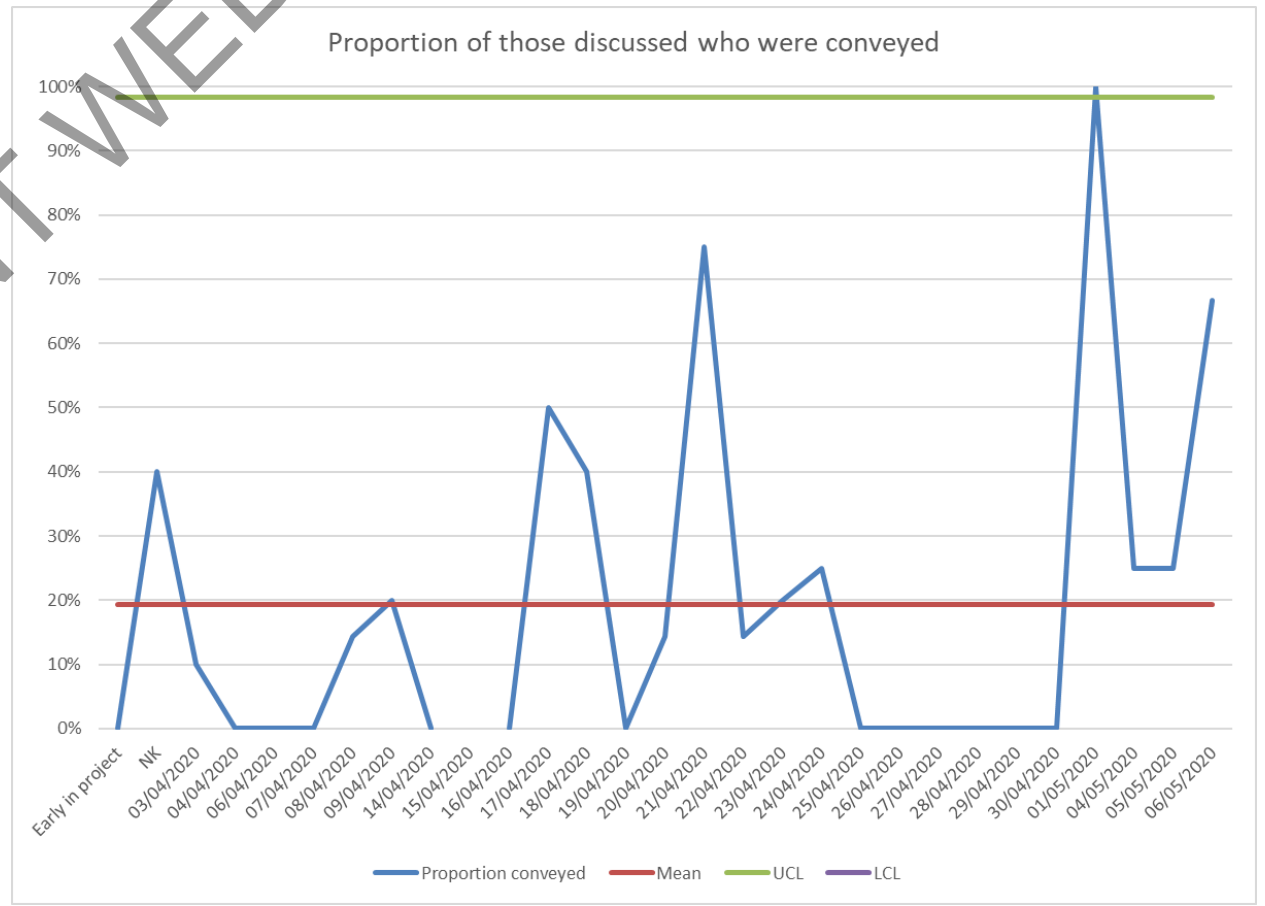
Out of hours: 54% → 42%; ARR 12%





Mean calls 4.3/day (total mean 12.3/day)





Comments from end-users

"This patient's grand-daughter was at the window (offered to come in with PPE but wanted to stay outside for understandable reasons). She brought a small bottle of Holy Water which she was given to drink by a Hindu member of staff while the paramedic held her head up. The family watched over Smart Phone that the daughter held to the window. She died about 15 minutes later. In other circumstances, she would have died in the ambulance."

- *Diary note from PTCDA team*

"I just wanted to let you know how impressed I am… so lovely with the resident and very assuring also with us. It was nice to have some support in this difficult situation, as we have at times, felt as though we're on our own with all of this."

- *Care home manager*

"What an excellent service the care home non conveyance line is turning out to be. 2 patients so far… both visited on scene… Both seriously unwell but helped tremendously."

- *Paramedic*

What have we learnt?

- Not *just* a palliative care service: for Covid and non-Covid cases → palliative, supportive and rehabilitative functions (especially adaptive rehabilitation)
- We have been working in a rapidly shifting landscape: unprecedented change in the way that primary, secondary and community care services are delivering services
- The quality of ReSPECT documents (and similar) is a key factor in whether escalation decisions can be made with telephone discussion
- Despite the warm reception for the PTCDA offer, keeping it on ambulance crews' radar so they use it consistently remains a significant challenge
- Suspected 'delirium' presents a significant challenge and further work on using the 'visiting' function in these cases is underway
- Rapid access to a wider range of supportive treatments in care homes would further reduce the need for admission

Additional benefits

- System transformation/developmental functions
- Leadership and training/professional development (closely with LOROS)
- Demonstrating/developing inter-organisational working

New approaches to test

- More consistent engagement with paramedics - mandatory discussions?
- Supportive treatment in care homes (subcutaneous fluids, oxygen, parenteral antibiotics)
- Rapid assessment of patients with delirium, acute behavioural disturbance, falls

Summary

- Principle of frailty identification and management at the earliest possible opportunity remains
- Specific issue for older people with frailty and COVID-19 infection
  - Critical care
  - Outcomes
- New ways of working that hold promise for ‘normal times’