

Frailty: what's it all about?

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What is frailty?

1. an inevitable consequence of aging
2. A state due to multiple long term conditions
3. A condition in which the person becomes fragile
4. A state associated with low energy, slow walking speed, poor strength
5. A condition for which nothing can be done

- Answer: 4- low energy, slow walking speed, reduced strength
- So the other are untrue-
 - not inevitable,
 - associated with multiple LTC, but can occur in the absence of these
 - amenable to treatment
 - unlike “fragility” frailty is a specific syndrome with characteristic features, and a rapidly expanding research base

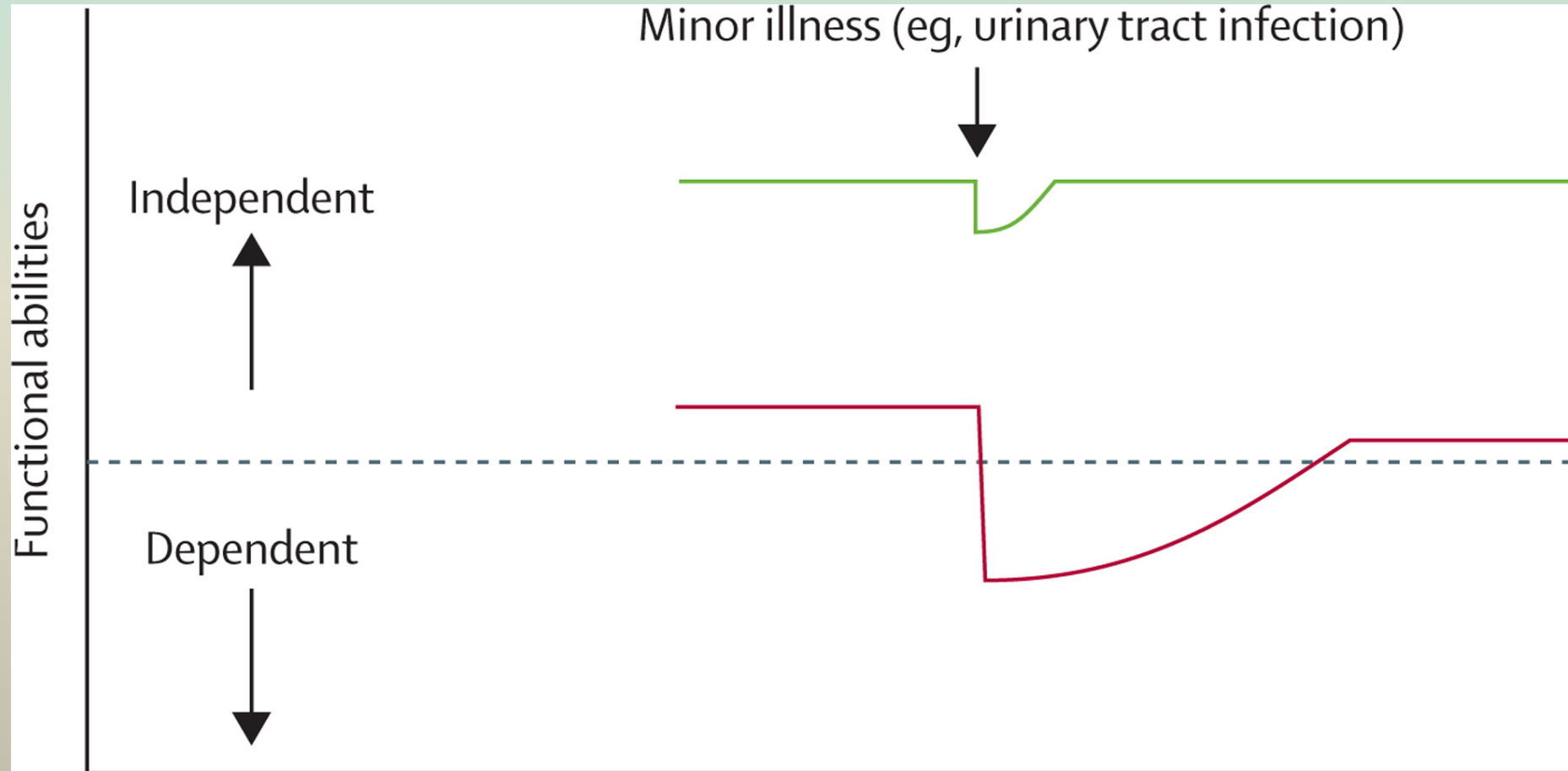


Frailty: why is it important

- Definition: a state of increased vulnerability to poor resolution of homoeostasis after a stressor event
- Condition associated with increased risk of deterioration:
 - “acute frailty syndromes” – falls, delirium (or acute confusion), “off legs” may result from a relatively minor insult
 - Higher risk of acute hospital admission
 - Care home admission
 - Death

Response to an adverse event in a non- frail vs frail older person

(Clegg et al, Lancet 2013)



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How is frailty diagnosed?

- Phenotype model:
- Walking speed reduced, grip strength low, immune deficits, reduced ability of withstand an “insult”
- Useful in clinical trials, difficult to implement on large scale,
- Walking speed
- timed up and go test (TUGT) used

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Frailty assessment tools

Gait speed <0.8m/s

Timed-up-and-go test <12s

Grip strength

PRISMA 7 questionnaire

Clinical frailty scale

Edmonton frail scale

Clinical frailty scale

Reported Edmonton frail scale

ISAR tool

(Gait speed)

Cumulative deficits model

- Proven to correlate with comprehensive geriatric assessment
- Theoretical background to the development of the electronic frailty index (eFI); searches in the primary care record for 36 variables (diagnoses, symptoms, sensory impairments, disabilities)
- Proven to identify risk of hospital admission, care home admission, death

Using the eFI

- Proven statistically to identify a cohort of people who are highly likely to be frail
- Like any other statistical tool will identify false positives, hence clinical correlation is essential
- Clinical knowledge of patient, TUGT or other frailty assessment

Is frailty amenable to prevention and treatment?

- Yes
- “healthy ageing” reduces the risk of developing frailty:
- Good nutrition
- Not too much alcohol
- Staying physically active
- Remaining engaged in local community/ avoiding loneliness
- Patients can be signposted to the NHS England and Age UK publications

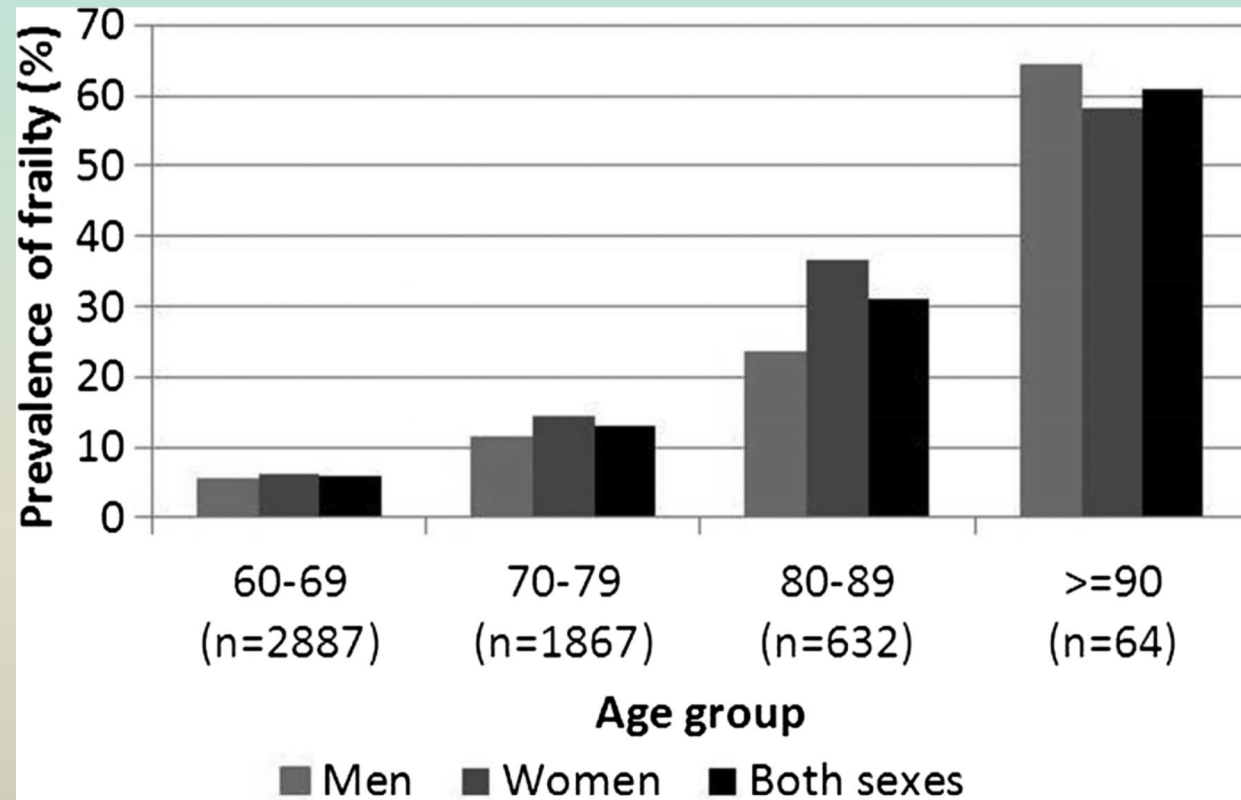
What about established frailty?

- Adverse effects of frailty can be mitigated- for example:
- Falls risk can be reduced
- Timely medication review can reduce risk of ADR, drug interaction, non-compliance
- ...hence BGS delighted to see the new GP contract

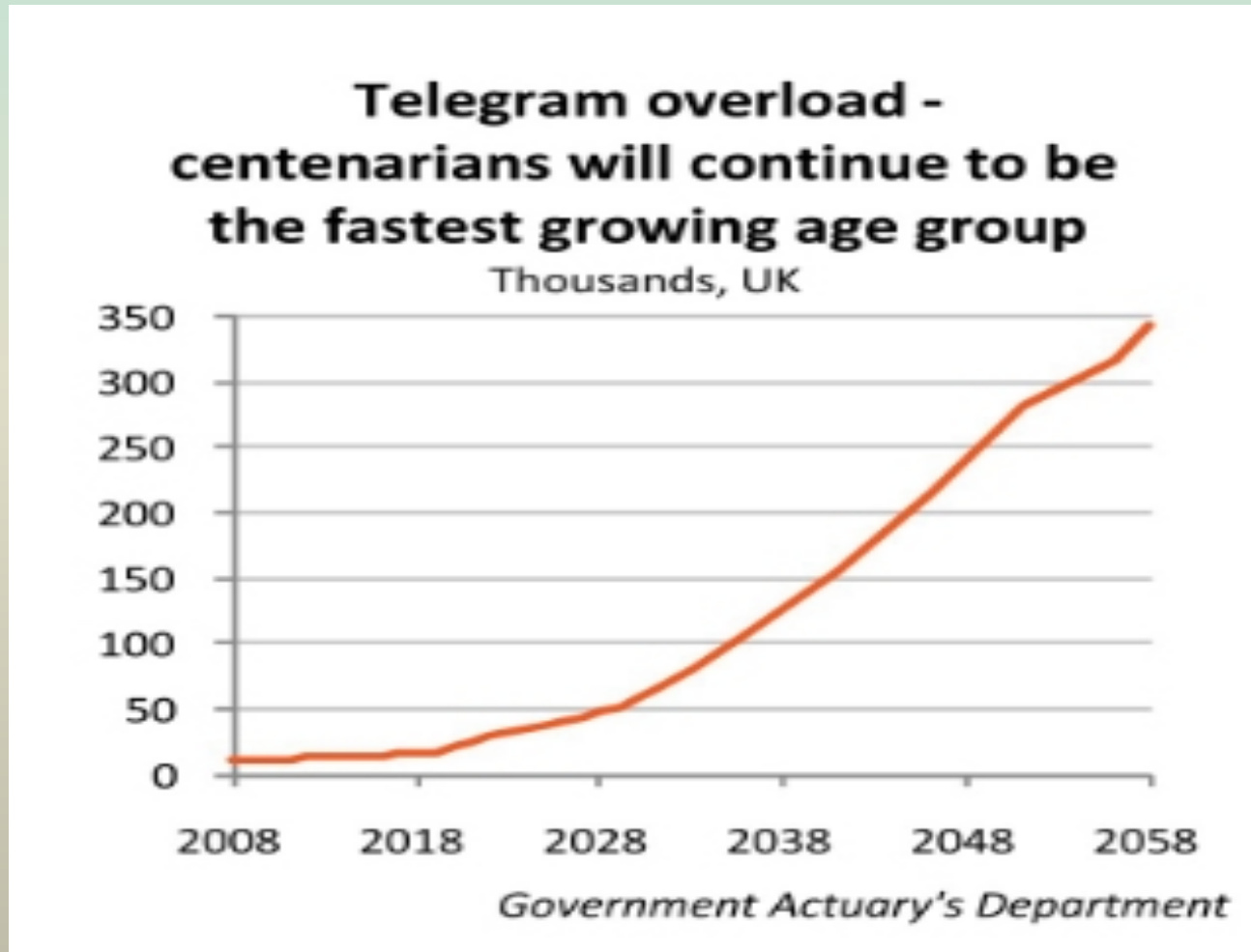


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Frailty prevalence at various ages



Ageing population



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Turning around years of Medical Practice

The Past

- Single organ specialties
- Disease focused goals
- Non- integrated services
- Reactive care



The Future

- Patient centred care
- Principles of Comprehensive Geriatric Assessment
- Proactive person centred care planning

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New GP contract

- Identify and code for moderate and severe frailty
- Ask for consent to share further information using the Summary Care Record
- For severely frail patients:
 - Falls assessment
 - Medication review



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Severe frailty:

- Average practice list per GP:
- 2,000 (significant variation around the country)
- 7% of the population over 65 yrs are likely to be severely frail
- In an average practice this is about 27 patients per GP

- “Pulse” estimate 0.5% of practice population

Comprehensive Geriatric Assessment

- Multidisciplinary assessment of physical, psychosocial, functional and environmental factors
- Multidisciplinary team come together to agree a plan with the patient (and where appropriate their family)
- Plan enacted; team can ensure actions implemented
- Review with agreement of any further actions
- Patient receiving CGA 12 times more likely to be alive and living at home 6 months after intervention NNT 24

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Falls assessment

- Evidence is for multidisciplinary assessment, commonly several factors identified:
- Eg 87 yr lady with dementia, hypertension, ischaemic heart disease, diabetes (type II), osteoarthritis
- 3 falls in the last 4 months.
- One known about by practice when fractured radius

- Taking night sedation (long acting benzodiazepine), gliclazide, enalapril, isosorbide mononitrate, paracetamol, amlodipine, GTN spray
- Urgency, frequency, nocturia- falling at night trying to get to the toilet
- Painful OA, disuse wasting of quads
- Wearing spectacles- no vision check for 2 yrs
- HbA1C 52

- L/S BP: postural drop- enalapril dosage reduced
- HbA1C too tight- on gliclazide 80mg once daily- stop
- Night sedation slowly weaned
- Over active bladder symptoms identified and treated
- Commode next to the bed supplied
- Family arranged optician check- specs updated (no bi-focals)
- Improve analgesic treatment of knees- encourage and support to attend local gentle exercise group
- Extra rail on the stairs fitted

NICE guidance: multifactorial assessment (re falls)

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review

NICE: multifactorial interventions

- strength and balance training
 - home hazard assessment and intervention
 - vision assessment and referral
 - medication review with modification/withdrawal
-
- One study (2016) found that 65% people admitted to hospital after a fall were taking at least one medication associated with falls

Medication review

- 23% of all over 75 yr olds taking inappropriate medications
- Recent paper analysing primary care patient safety incidents highlighted medication issues
- High risk medications: warfarin, insulin/ sulphonyl ureas, opiates
- Problematic combinations: NSAIDs and ACE inhib
- NSAIDs and warfarin



Guides to support deprescribing

- www.polypharmacy.scot.nhs.uk/
- O'Mahony et al STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. Age Ageing. 2014 October 16, 2014.
- NICE. Managing medicines in care homes (SC1). London: NICE, 2014.
- <https://www.york.ac.uk/inst//crd/pdf/effectiveness-matters-January-2015-frailty.pdf>
- <https://www.york.ac.uk/media/crd/effectiveness-matters-aug-2017-polypharmacy-pdf>
- <https://www.nice.org.uk/guidance/ng56>



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Useful resources from BGS and others



BGS Commissioning Guidance
High Quality Health Care for Older Care Home Residents

Introduction
Nearly 400,000 older people live in care homes in the UK, nearly 20% of those aged 85+. Their health and social care needs are complex. All have some disability, many have dementia, and collectively they have high rates of both necessary and avoidable hospital admissions. Standard healthcare provision meets their needs poorly, but well-tailored services can make a significant difference.

The British Geriatrics Society (BGS) report Quest for Quality describes current NHS support for care homes and makes recommendations as to how care home residents' quality of care can be improved. This guide describes the clinical and service priorities for meeting care home residents' needs. It details the outcomes needed from commissioned services and suggests how these can be achieved.

A more detailed version of this guide is available on the BGS website along with reference material and links to useful resources.

Why special commissioning for older people in care homes?

Health needs are different: Most residents have a mix of comorbidities affecting both physical and mental health. Dementia is prevalent, the majority of residents in most care homes being affected to some degree, and depression is common.

Managing disability: The physical aspects of conditions which are common in care home residents (such as late stage neurodegenerative conditions including Parkinsonism and dementia, and severe stroke disease) are complicated. Care ne staff need support from specialist health services to identify, understand and respond to the everyday impact of providing

What are the outcomes needed from commissioned services?

For residents themselves?

- Improved experience through high quality essential care – reducing distress from depression, disorientation, agitation, pressures sores, contractures, constipation, pain and sleeplessness.
- Minimisation of predictable acute events - urinary infections, aspiration and pneumonia.
- Avoidance of unnecessary progression of long term conditions coupled with a reduction in adverse drug events and the unnecessary burdens of irrelevant treatments.
- Reduced risks of falls, fractures and other injuries.

NHS England

QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS

Safe, compassionate care for frail older people using an integrated care pathway:

Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders

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