Challenges and Opportunities in Frailty Care

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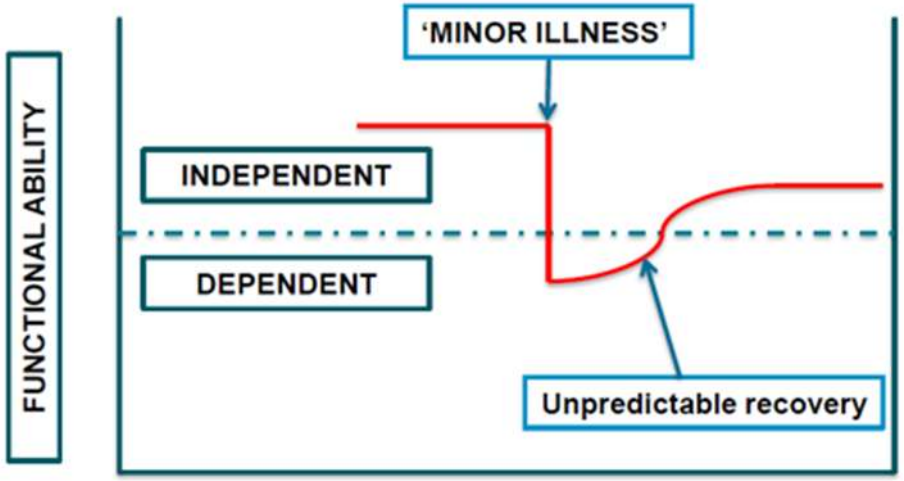
Thames Valley ICB Deputy CMO

NHSE SE Regional Clinical Advisor for Frailty

What is frailty

Frailty definition

- ***A long-term condition characterised by lost biological reserves across multiple systems and vulnerability to decompensation after a stressor event***



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.

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Inspiring Minds

Open the Mac App Store to buy and download apps.

CFS

Clinical Frailty Scale (CFS) 12+
NHS Elect
Designed for iPhone
★★★★★ 4.8 • 21 Ratings
Free

The 5 frailty syndromes

- Falls
- Reduced mobility
- Altered cognition - Delirium
- Incontinence
  - Acute change – new or worsening
- Susceptibility to side effects of medications or Lots of medications

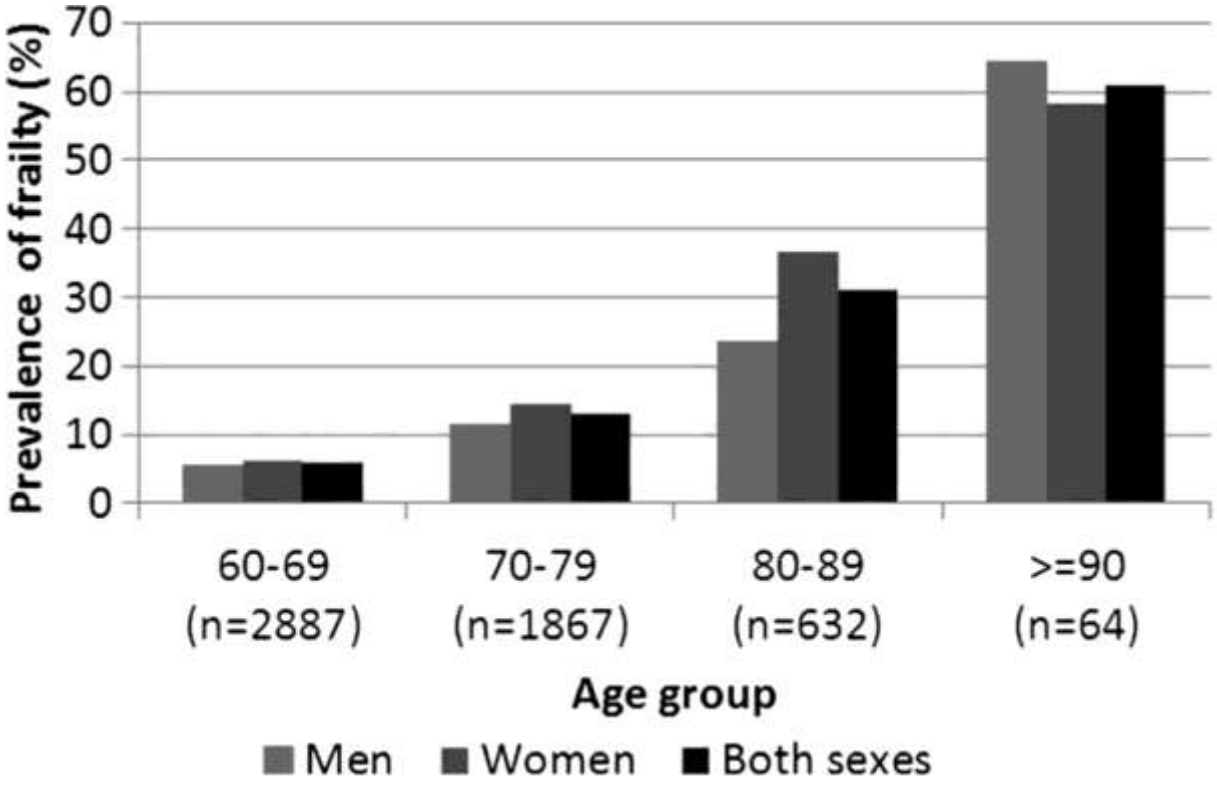
- These are all markers of underlying frailty
- Often result in 999 call

Relationship between frailty and age

Frailty and ageing

- Frailty is not an inevitable part of ageing
- Younger people can have frailty

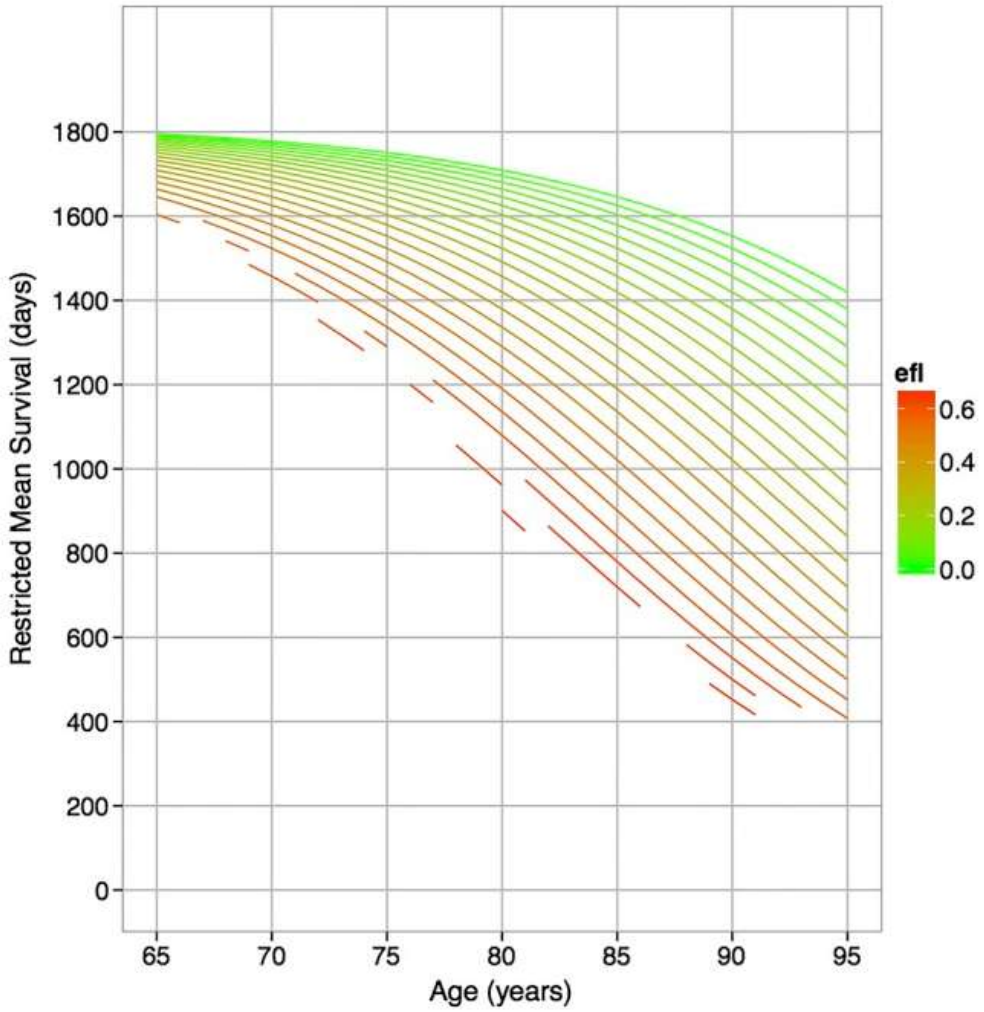




Relationship between age and frailty











Why is it important to provide frailty attuned care?

- Ageing population, frailty is increasing, multiple comorbidities
- Realistic medicine
- Better experience for our residents
- Person and family expectations
- Research evidence that standard treatments can be harmful eg outcomes of resuscitation, aggressive treatment of blood pressure
- Better use of healthcare resources and minimising long waits in ED

- Modern Service Framework for Frailty and Dementia awaiting publication

Risks associated with hospital admission

- Long ED waits and prolonged admissions
- Delirium
- Deconditioning – physical, psychological, social
- Healthcare acquired harm
  - Infections
  - Falls
  - Pressure damage
  - Medication errors

Where do we have opportunities to do things differently?

- Working together with system partners to provide care at home
  - Primary and community care
  - Care homes support teams
  - Ambulance providers
  - Urgent community response
  - Hospital frailty teams and geriatricians providing outreach support
  - Single point of access for help in a crisis

  - Building trust, shared governance and risk management
  - Upskilling our workforce to work in a different way

Care home residents who fall – SE region pathway

Aim of pathway

- To support the assessment of care home residents who have fallen
- Enable a community based approach to falls and appropriate follow up.
- Ensure appropriate conveyance to ED when required and minimise conveyances that may result in unwarranted harm or distress for the resident.

Stakeholders

- Care homes association
- Therapists
- Geriatricians
- Care homes matrons/support teams
- Age UK
- CQC
- Safeguarding
- SECAmb
- SCAS
- Community providers – UCR
- Berks, Surrey, Kent, Hants, Sussex

POST FALL PROTOCOL FOR CARE HOME RESIDENTS

RESIDENT HAS A FALL

Before moving the resident, complete an Airway, Breathing and Circulation Assessment.
Maintain dignity, check for injury, consider communication difficulties, review ReSPECT form or advance care plan
& take action as below:

Level 1
No apparent injury sustained

- No bruising
- No apparent head injury
- No pain
- Mobility unaffected
- No wounds or bleeding
- No limb deformity

- Assist resident to a comfortable place (using hoist/handling aid as appropriate)
- Observe resident for 24 hours using Restore2 chart
- Complete local 'Post Falls Assessment'
- Consider referral of resident to care home MDT for review and onward falls assessment if available locally

Inform relatives and document all actions

Level 2
Minor Injury sustained

- New signs of bruising
- Minor wounds to skin inc. face
- Slight discomfort
- Isolated injury to upper limb
- No apparent injuries but taking anticoagulant / blood thinning medication
- Laid on floor over one hour

- Administer first aid and assist resident to a comfortable place (using hoist/handling aid as appropriate)
- Refer to your local urgent care pathway eg SPOA, UCR *am-pm 111 or GP *pm-am
- Complete 'Post Falls Assessment Tool' and observe resident for 24 hours (inc. vital signs) using Restore 2
- Complete 'body map' and document on care plan
- Inform relatives and

UCR/SPoA contact details - 0*** *** ****

Level 3
Major / Serious injury sustained

- Airway or new significant breathing problems
- Loss of consciousness or unresponsive
- Any seizure activity
- New confusion
- Suspected head injury to resident taking anticoagulant / blood thinners
- Obvious injury to any body region including:
  - Causing significant pain or distress to the resident
  - Significant bleeding or bleeding which can't be managed with first aid
  - Unable to move due to inj
  - Obvious deformity

Call 999 for ambulance service
DO NOT MOVE THE RESIDENT (unless Resuscitation required or concerned about long lie or preventing other harm eg burns)

Follow instructions from Ambulance Control
(If/when ambulance crew arrive meet at door and escort to resident)

Inform relatives and record discussion

ANY Change in condition/deterioration causing concern - call back to UCR / 111 / GP to update
Contact 999 should any symptoms in RED box arise

Complete incident report form and consider safeguarding referral

Head injuries and anticoagulation

- It is common for older people to be taking blood thinning medication.
- NICE guidance suggests that patients who sustain a head injury whilst taking blood thinning medication should be assessed and considered for a CT scan.
- However, majority of scans are normal and patients who have moderate or severe frailty unlikely to be offered neurosurgical intervention.
- New decision support tool promotes a patient centred, individualised approach to care and senior decision making.

Stakeholders:

- Frailty/geriatricians
- Emergency Medicine
- Acute Medicine
- Primary care
- Community
- Care homes
- SCAS
- SECAmb
- ME service
- Regional trauma lead

- Review of guidelines in progress/use/previously tested
- Data review

NHSE South East Head Injury Guideline Template

NHS England South East

With thanks to Surrey Heartlands and Royal Berkshire for sharing their work

These guidelines are to support rather than overrule clinical decision making

Who is this guideline for?
Patients living with suspected/confirmed **frailty** with suspected/confirmed **head injury**

Patient origin may include:

999 Cat 3&4	UCR
Community 1st response	Rehab/Community hospitals
Care Homes	GP HCPs

Assessment of patient:
History & A-E: Include vital signs, GCS & identify any other injury
IF THIS CANNOT BE PERFORMED BY PERSONS IN ATTENDANCE, SEEK SUPPORT FROM UCR OR AMBULANCE SERVICE

Confirmed/Suspected Head Injury?

- Unsure → Review of care plan/Respect/discuss with family:
  - Is the patient for transfer to hospital?
  - Will the hospital offer care that isn't possible in the home?
- Yes → **Any of the following identified?**
  - Acute Injury
  - Acute Medical concerns
  - Unstable
- No → **Any NICE guideline indications for CT head within 1 hour? [See box 1]**
  Any NICE guideline indications for CT head within 8 hours? [See box 2]
- Yes → **Senior decision maker discussion**
  - Consider pausing anticoagulants [See box 3]
  - Anticipatory meds
  - Clear documentation of discussions and decision making
- No → **Is it within your skill set to leave patient in residence?**
- Yes → **Patient to remain in residence:**
  - ✓ HI advice and information
  - ✓ Wound care
  - ✓ Ensure respect form up to date
  - ✓ Define any monitoring needed***
- No → **TRANSFER TO HOSPITAL**

Caring for Someone After a Head Injury

Red Flags and Escalation

Call 999 immediately if:
They collapse and you cannot wake them
They have a new seizure or fit
They are vomiting repeatedly
There is clear fluid or blood leaking from nose or ears
They are unconscious or have a worsening headache

Call Local team or 111 for urgent advice

For any new symptoms which are not red flags
They are becoming less mobile or less able to do daily tasks
You feel you cannot safely supervise them any more

What to look out for

Sleepiness harder to wake or not themselves
Mobility new off legs or repeated falls
Neurology slurred speech or weakness in face or arms
Pain A severe headache that is getting worse
Watch for anything new or worse than usual

Immediate Care at Home

Stay Close do not leave alone for first 24hrs
Clear the Way remove rugs or items that could cause a fall
Be ready keep a phone nearby to call for help
Keep moving support gentle walking to prevent stiffness or weakness

Stop and check

- Are they harder to wake than normal
- Are they off their legs or less mobile
- Is there confusion or agitation new

DO NOT

- Leave them alone for the first 24hrs
- Do not stop blood thinners without medical advice
- Do not give Ibuprofen or Aspirin for pain relief

Special Situations
Blood thinners Anticoagulants and Antiplatelets
Medicines like warfarin, Aspirin, Clopidogrel and apixaban and rivaroxaban increase the risk of bleeding
Do not stop these medicines without speaking to a doctor.
If you call 999 tell the operator the name of the medicine

Follow up contacts:

Overnight: Continue supervision and check for anything worse

TV ICB implementation

- Well established in Oxford and RBH
- FHFT - live with SCAS/BHFT/Wexham and SECAmb/Frimley – MoU agreed with SECAmb
- BHT – in progress

- Outcomes:
  - Oxford – 12 month period – 133 patients, 21 conveyed, 17 had CT, 1 had subdural and neurosurgical intervention.
    - Review at 30 days – only one patient not conveyed had a 2nd fall, conveyed after 2nd fall and had subdural managed conservatively due to frailty
    - No deaths from brain haemorrhage
    - Pathway safely avoided 112 conveyances and scans
  - RBH – 93 patients over 3 months where admission avoided and no patient safety concerns – only one adverse event (PE due to stopping of anticoagulation – case reviewed and appropriate clinical decision making)
  - FHFT collecting data – no concerns so far

- There needs to be local governance arrangements to review the pathway and highlight any clinical concerns
- Oversight of implementation is through regional frailty community of practice

Care Plans and ReSPECT forms

- Proactive, holistic assessment eg falls, medication review, continence, nutrition, skin, cognition
- Advance care planning/ReSPECT

Why proactive care planning matters

Better decisions when a resident's condition changes

Good decisions are easier when staff can quickly find the resident's current plan, wishes, escalation arrangements and key clinical information.

Better for residents

✓ Care aligned with wishes and preferences
✓ More personalised care
✓ Reduced disruption and distress
✓ Better continuity when care needs change

Better for staff

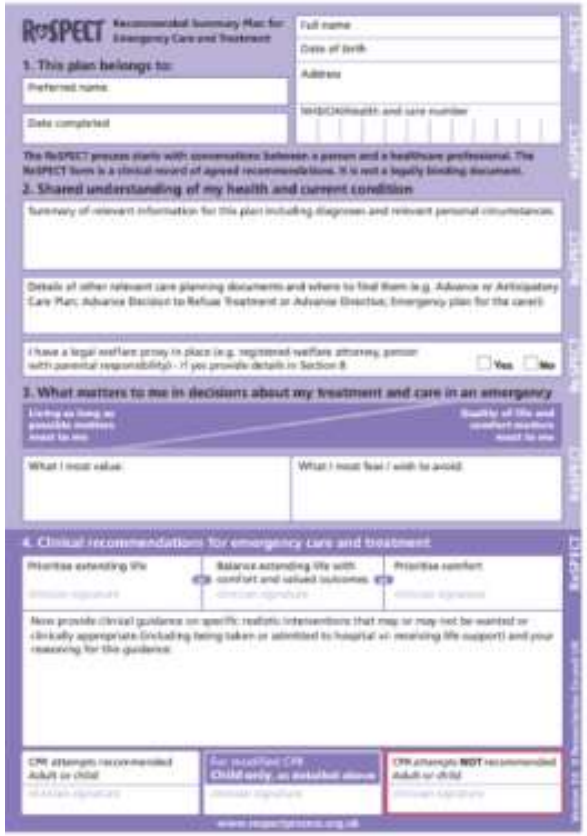
✓ Greater confidence in decision-making
✓ Clearer escalation decisions
✓ Better communication with families and professionals
✓ Less uncertainty when deterioration occurs

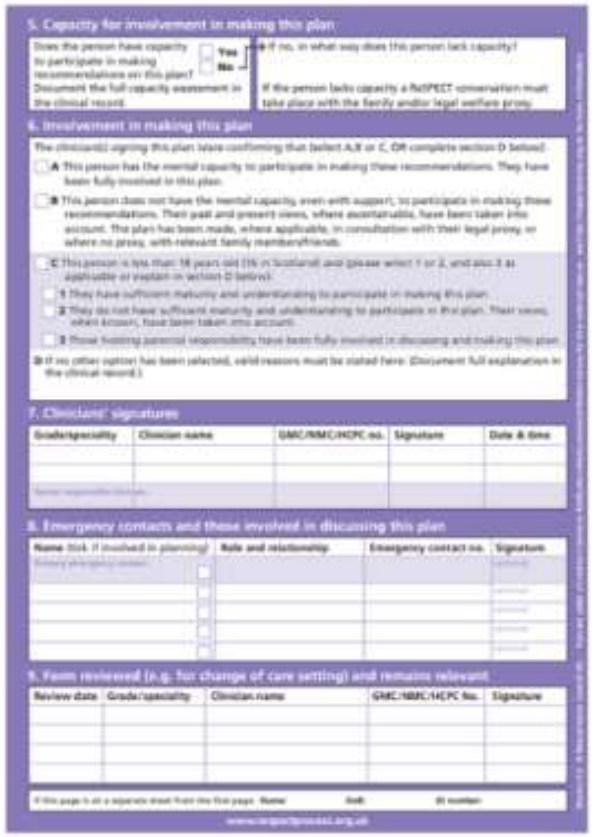
Better for the system

✓ More appropriate use of emergency services
✓ Better coordination between teams
✓ Improved use of community and specialist support
✓ Right care, right place, right time

Good planning does not prevent appropriate hospital admission. It supports better decisions about when hospital care is and is not needed.

ReSPECT





NHS Thames Valley

Would want to consider treatment of potentially reversible causes of deterioration, e.g. infection, in a community setting, including Hospital@Home. Not for readmission to hospital, except in the case of long bone fracture. Preferred place of care/death is home, however if care needs cannot be met at home would want to consider admission to nursing home or hospice.

Does not want treatment of any causes of deterioration, including potentially reversible causes such as infection as does not want any life-prolonging treatment. Preferred place of care is home. Priority is to be comfort and symptom control.

Questions

- Webinar to discuss the pathways in more detail 18/11/26 11am to 1pm