Seniors Health Strategic Clinical Network™

Frailty

Elder Friendly Care
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Care of older adults requires some unique considerations. All older adults have normal aging changes. Many have long term chronic diseases and cognitive impairment. They are more likely than a younger adult to use multiple medications and to require assistance with activities of daily living.

When older adults present with complexities such as these, they are considered frail. How is frailty defined?

Merck Manual: “Frailty is loss of physiologic reserve, which makes people susceptible to disability due to minor stresses”.

Frailty Resources

Edmonton Frail Scale
https://www.albertahealthservices.ca/assets/about/scn/ahs-scn-bjh-hf-frail-scale.pdf

Clinical Frailty Scale
http://camapcanada.ca/Frailtyscale.pdf
What does the "Tsunami of Aging" mean to you?

Health spending on elders does have the potential to overwhelm the current system. But:
- We can lessen this impact by changing practice
- Not everyone who is old is unhealthy
- Not everyone who is old needs to be in acute care

Reference
Cartoon by Greg Perry, used with permission
This graphic presents a more accurate picture of the impact of aging on acute care spending.

60% of hospital spending is on 14% of patients 65 and older: frail older adults.

Frail older adults are more likely to:
- fall
- develop delirium
- have more medication errors
- develop hospital acquired disabilities
- have extended hospital stays

When we improve outcomes for frail older adults, we contribute toward a more sustainable health system.

References
Stats Canada
- Samir Sinha on Whether the Aging Population Will Bankrupt the Health Care System https://www.youtube.com/watch?v=qKhNbTRRuOw
When older adults are hospitalized for injury, surgery, illness or dementia, the risk of unintended consequences is increased by the environment and routines. E.g. It can be difficult to sleep. We wake people up for assessments, vital signs and weights. There are equipment beeps, bells and alarms. We restrict movement to prevent falls and deliver pills and injections round the clock.

References
Unintended consequences can occur with any age, but older adults are at much higher risk. And the risk of permanent physical and cognitive consequences is a true danger.

The complications older adults experience not only impact their quality and length of life, they affect the system and us – the care giving staff.
Here are some of the common unintended consequences for frail patients. Can you think of others?
Unintended consequences to the older patient lead to extended stays in acute care, and result in reduced independence/increased care needs on discharge.

Older adults with increased care needs often wait in hospital for facility beds in the community. Once discharged, they may return to the Emergency department or be readmitted after discharge. Of discharged patients over age 80, more than 15% of them are re-admitted within 30 days.
These unintended consequences also impact staff. Workload, stress and injuries increase. Morale might take a nose dive. We are distressed when patients experience unintended consequences under our care.
When we consider the consequences to the patient + the system + ourselves we potentially have quite a storm.

Elder Friendly Care is an “umbrella” of knowledge and care approaches we can employ to protect our patients, the system and ourselves.
We’ve identified that hospital admissions are risky for frail older adults. Hospitalization is actually risky for everyone - riskier than flying in an airplane, driving a car or bungee jumping. When you consider
- Number of lives lost per year (Left/vertical axis from 1–100,000) and
- Number of encounters per death from 1 to 10 million. (Bottom axis)

So, reducing the danger of health care for frail older adults requires intentionality, planning and practice change.

Supplementary Information
Green area – safest activities. railways are very safe with over 1 million encounters to have ~ 60 deaths. Red area – most dangerous.
There are 2 vertical lines one at 1000 encounters per death and one at 100,000 encounters per death. These divide the chart into levels of regulatory oversight. Railways are highly regulated and controlled. Bungee jumping is not.

References
One of the risks in health care occurs during transitions. The World Health Organization recognizes that patient transitions are important to ensure quality health care.

- Each transition is a point of great risk.
- Older patients have the most transitions – therefore most risk
- Transitions from home to hospital and back to home are not typical for frail older adults
• Older adults tend to bounce around from setting to setting, unit to unit, shift to shift. They might go from home to emergency, to inpatient units, transfers within the hospital, discharge to previous setting or to a new setting (e.g. LTC, lodge, supportive living)

• Communication is the most influential component of a good or poor transition. Communication involves the patient, family, covering doctor, weekend staff, day staff, night staff, relief staff.

• The only common element in transition is the patient and their families or care partners (e.g. neighbours and friends)
Unintended consequences during transitions can result in physical and/or cognitive decline so the person cannot return to their prior setting. Or, patients might go to their prior community setting but be readmitted within a week or month (15%)

- Patients can lose up to 10% of their muscle strength per day by lying in bed.
- Patients are not well prepared for the care they will be receiving in the next setting or the self care they will be required to carry out (Coleman/Macdonald)
- 23% of recently admitted patients suffer an adverse event in the first week they are home - mostly related to medications. This can be due to:
  - multiple prescribers across various settings.
  - few family physicians follow their patients through the course of a hospital admission.
  - Lack of communication with the family physician about what medications have been discontinued, added or continued.
  - Medications are reconciled but not reviewed to determine if the number or types of medication are appropriate

- When older adults are assessed for their care needs in hospital, they may appear to need more resources on discharge. A top reason person goes to into a care facility is that they were assessed in hospital. A slowly clearing delirium can make dementia look more severe.

References
Definition: The AHS Clinical Knowledge Topic definition for frailty: “…the central feature is increased vulnerability, with reduced physical reserve and loss of function across multiple body systems. Frailty is most obvious under stress, and is evident by exaggerated and rapid changes in health status.”

There are different ways to define and measure frailty. Two methods recommended by AHS are:

- Clinical Frailty Scale
- Edmonton Frail Scale

Activity
Use both scales to assess a patient you know.

What do you notice from these two frailty scales?
What are some of the components of frailty?
Older adults may not appreciate being labeled as ‘frail’, but that is the terminology being used in the research / literature

According to the Clinical Frailty Scale, where might this person fit?
Compare this case study with the pictures on the Clinical Frailty scale.
This is Ed Whitlock who was a marathon champion in his 80s.

This demonstrates that identifying frailty is deliberate & requires assessment – we can't always tell just by looking at a person.
Based on the AHS Clinical Knowledge Topic: Frailty

- **Get information**
  - **Consult an expert** if frailty is moderate to severe
  - **Previous work-up and/or plan of care in community**
  - **Review the person’s goals** re medications or invasive procedures (risks, benefits, alternatives)
  - **Review needs and develop care plan** based on Comprehensive Geriatric Assessment

- Involve an expert if frailty is moderate to severe: Geriatric Specialist such as:
  - Geriatrician, care of the elderly Physician or Nurse Practitioner
  - Clinical Nurse Specialist or Advanced Practice Nurse in geriatrics

- Find out what has already been done, or what is already known. The attending team in acute care should seek what prior work-up was done in community. Obtain Plan of Care from community if possible e.g. from the family physician, the case manager if they are a home care client, or from the Long Term Care or Supportive Living Facility.

- Review the goals of the patient and family. Discuss risks, benefits and alternatives of medications and treatments.

- Get more information (Comprehensive Geriatric Assessment)
Assessment serves as the foundation for a person-centered care plan. The SENIORS CARE acronym prompts us to notice crucial considerations for older adults, so that we can identify and coordinate actions to address frailty components.

Notice things like falls, incontinence, appetite and confusion… ways frail older adults tell us they’re sick

Medications: are they on a lot, any pharmacological restraints? Sedatives? Anticholinergics?

Environment: noise, sleep disruption, clutter, activity, boredom

For more information on SENIORS CARE see the Elder Friendly Care Toolkit.

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P.I.E.C.E.S.™ is a best practice learning and development initiative that provides an approach to understanding and enhancing care for individuals with complex physical and cognitive/mental health needs and behavioural changes. The P.I.E.C.E.S.™ model helps us to understand the whole person.

P.I.E.C.E.S.™ is an acronym that stands for:

**Physical:** pain and physical conditions can cause changes in behaviour

**Intellectual:** dementia affects the person’s memory, thinking, language, self-awareness

**Emotional:** a person may experience problems adjusting to changes occurring in his/her life

**Capabilities:** knowing what the person can and can’t do will help to build in his/her strengths

**Environment:** a supportive environment will help the person maintain his/her abilities

**Social & Cultural:** each person has unique social and cultural needs that can be met only through an individualized approach
The 5 M’s is a model being promoted with family physicians in Alberta.

1. What matters most to the patient?
2. Mind: Is cognitive impairment a concern? What can be done to optimize and protect cognition?
3. Mobility: E.g. driving, walking, getting out and around
4. Medications: avoidance of polypharmacy (5 or more medications) and anticholinergic burden
5. Multiple co-morbidities: What is the plan to optimize physical & cognitive function and quality of life?
Summary

- Hospitalized older adults are at high risk for unintended consequences
- Unintended consequences impact older adults, the system and staff
- Elder Friendly practices can improve outcomes and transitions for frail older adults
- Frailty assessment and care planning is an important part of Elder Friendly Care

For more information on care planning, see the Elder Friendly Care Toolkit
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<td>Greg Ferry (artist)</td>
<td>The Grey Tsunami</td>
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<td>Mr. Ed Whitlock (Senior Citizen and holder of many Age Group World Records in the Marathon)</td>
<td>Victor Sailer/Canada Running Series</td>
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