

NHS Dorset Clinical Commissioning Group

Helping People Thrive Not Just Survive

A Framework for Frailty in Dorset



Supporting people in Dorset to lead healthier lives

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Introduction

The Dorset Framework for Frailty has been developed by Dorset Clinical Commissioning Group (CCG) through multi-sectorial collaboration with health and social care providers, voluntary and third sector organisations, patients and their representatives. It is endorsed by the Dorset Frailty and End of Life Care Reference Group.

The development of the framework is a response to the request for a common approach to the early recognition and identification of frailty as a long term condition, promoting early detection through case-finding, appropriate assessment, risk stratification; and backed up by planned and coordinated care and support.

The British Geriatric Society (BGS) defines frailty as:

“A distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.”(BGS 2014:2)

The BGS definition goes on to state that around 10% of people aged over 65 years will be living with frailty and for those people a minor event can frequently trigger major health changes or deterioration and therefore it is important to recognise and identify these changes early.

- *Frailty is not an inevitable part of ageing; it is seen as a long term condition in the same way as diabetes or Alzheimer’s disease*
- *For people living with frailty the state for an individual is not static; it can be made better and worse.*
- *Frailty is a spectrum condition that spans from mild to severe*

In Dorset about 17,000 people would fall within this definition. Of Dorset’s estimated population of 765,700 some 173,000 are aged 65 and over. Of these around 6,200 are 85 or over; a figure which is said to rise to 9,300 in the next 25 years. (ONS 2015 Office of National Statistics accessed online March 2016)

See Appendix 1: Features of Frailty

The Vision

The vision for NHS Dorset CCG is that all people living with frailty have their condition recognised early and proactively managed within an integrated coordinated care pathway which meets the needs and expectations of the individual, their carers and advocates. Coordinated care defined by National Voices states:

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

The Framework

This Framework aims to provide all health and social care providers across Dorset with a *model* designed to support those living with frailty to not just survive but to thrive. It is designed for use by clinicians, in conjunction with the person, their carers / advocates and all members of the multi-disciplinary team to develop a co-ordinated plan of care that supports the person living with frailty to proactively manage their condition.

The Framework supports the following questions:

How do we identify frailty as a trigger to ensure people are supported appropriately within the health and social care system?

How do we recognise that frailty is a long term condition – living WITH frailty rather than BEING frail?

How do we do this in a way that is acceptable for older people and enables them to work in partnership?

Key Actions for the Recognition and Management of Frailty in Primary Care

- **Assess older people for frailty during all healthcare encounters**
- **Provide clear links to the voluntary sector and early help**
- **Identify the needs of carers/families and signpost to support as appropriate**
- **Encourage advance care planning discussions at the earliest opportunity, including conversations regarding potential “transitions” such as care at home or moving to a formal care setting**
- **Record frailty, and frailty severity, using Read codes**

- **Record known diagnosis of dementia using Read codes**
- In people with moderate or severe frailty, carry out a Comprehensive Geriatric Assessment (CGA) to:**
- **Diagnose medical illnesses and optimise treatment**
 - **Conduct a medication review**
 - **Generate the Dorset Anticipatory Care Plan in collaboration with the integrated community services team**
- **Refer for specialist assistance in complex or uncertain diagnoses**
- **Share Enhanced Summary Care Record between primary care, emergency services, secondary care and social services**
- **In people with very severe frailty, support with end of life planning**

Recognising & Identifying Frailty

ALL encounters between health and social care staff and older people should promote a discussion that includes an assessment of frailty

Frailty should be identified with a view to maintaining and restoring control, preserving dignity and facilitating person-centred care for the person and those close to them, improving outcomes and avoiding unnecessary harm. Many people with multiple long-term conditions will also be living with frailty which may be overlooked if the focus is on disease-based, long-term conditions such as diabetes or heart failure.

How to Case Find?

To provide the appropriate care and support, we need to engage proactively; the first step is to identify that a person is living with frailty. Primary Care and all services engaged with the care of older people need to be able to case find and identify those at risk and act upon that knowledge.

Identification that the person is experiencing any of the following problems may trigger recognition of frailty:

- Falls (e.g. collapse, legs gave way, 'found lying on floor')
- Immobility (e.g. sudden change in mobility, 'gone off legs', 'stuck in toilet')
- Delirium (e.g. acute confusion, sudden worsening of confusion in someone with dementia or known memory loss)

- Incontinence (e.g. change in continence – new onset or worsening of urine or faecal incontinence)
- Susceptibility to side effects of medication
- Those housebound or known to community nurses – this data could be obtained from those community nurses who visit for flu vaccines, if not Read coded
- Those with mild cognitive impairment
- Those on the dementia register
- Those on a LD register
- Those with serious mental illness
- Those on end of life care register or cancer care registers
- Those on community matron or district nursing caseload
- Those on >7 medications
- Those with neurological conditions, e.g. stroke, MS, Parkinson’s disease
- Those with rheumatological conditions
- Those with respiratory and cardiovascular conditions eg COPD, heart failure
- Those known to Adult Social Care and Support Services
- Social isolation (can be a cause and a result of frailty)

Key Actions Once Frailty Is Identified and Recognised

Assessing Frailty

There are a number of assessment tools currently available; these are outlined in detail in *Appendix 2* and include:

Electronic Frailty index

PRISMA 7

Gait Speed Test

Rockwood Frailty Scale

Groningen Frailty Indicator Questionnaire

ISAR Screening tool

Once recognized as a syndrome and a long term condition frailty can be classified as a continuum from mild frailty to severe frailty and should be coded as shown in the table below:

Frailty Read Codes

CTV3	
X76Ao	Frailty
XabdY	Mild frailty
Xabdb	Moderate frailty
Xabdd	Severe frailty

Read V2	
2Jd.	Frailty
2Jd0.	Mild frailty
2Jd1.	Moderate frailty
2Jd2.	Severe frailty

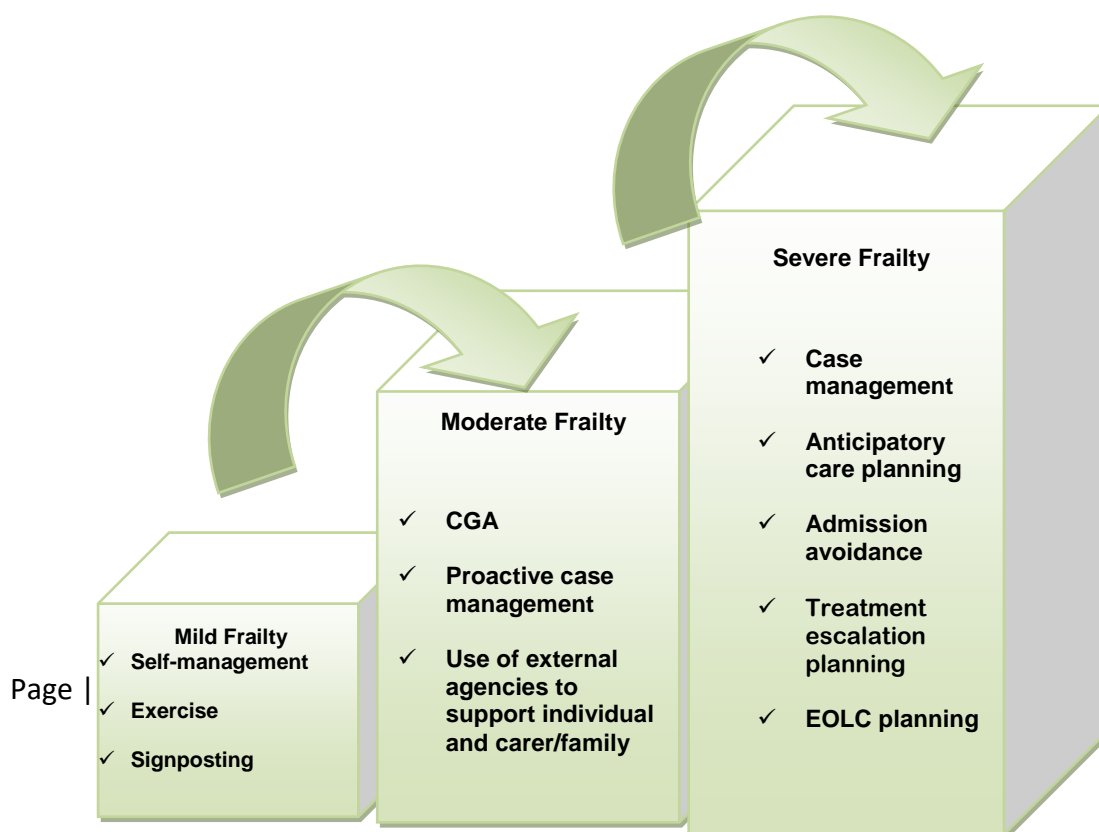
Frailty as a Long Term Condition

Mild frailty: Self-management advice, signpost to external agencies, exercise

Moderate frailty: Assessment and development of a care plan in which Comprehensive Geriatric Assessment (CGA) becomes an integral part of the plan, Dorset Anticipatory Care Plan completed

Severe frailty: Anticipatory care planning and end of life care planning is undertaken with the person and carer. If it has not occurred before CGA is offered.

End of Life Recognition and Care: Recognise the end of life and support the person with end of life issues [The blocks below represent amount of need/work. Numbers will be inversely proportional]



Key Features and Priorities

The assessment will define the level of frailty experienced; ensuring that the appropriate care, support & proactive management can be planned, agreed and shared.

- Every area will follow the framework as a system to identify people at risk of frailty
- Once frailty is identified as moderate a Comprehensive Geriatric assessment (CGA) will be undertaken by the multidisciplinary team (MDT) in collaboration with Primary Care and community services (including older people's mental health services) and a Dorset Anticipatory Care Plan completed with the individual and their family, carers or advocate
- Every person living with severe frailty will have an agreed and shared Dorset Anticipatory Care Plan and appropriate Treatment Escalation Plan (TEP) in place.

Comprehensive Geriatric Assessment (CGA)

This is a multidimensional assessment, treatment plan and regular review delivered by a multidisciplinary team (MDT).

Evidence from cases where a comprehensive assessment has been useful suggests that the team should consist of:

- A competent specialist physician in medical care of frail and older people
- A coordinating specialist nurse with experience of frail and older people
- A social worker or a specialist nurse who is also a care manager with direct access to care services
- Dedicated appropriate therapists
- Access to mental health team
- The patient, and their family, carers, friends or advocates

Although CGA is commonly conducted in hospital settings, there is evidence that provision of CGA to older people with frailty in community settings could reduce hospital admissions, admissions to nursing homes and increase the chance of continuing to live at home (Berwick et al. 2010).

Other circumstances which warrant a comprehensive assessment include:

- Acute illness associated with significant change in functional ability
- Transfers of care for rehabilitation/reablement or continuing care
- A person prior to surgery or experiencing two or more "geriatric syndromes" or falls, delirium, incontinence or immobility

Care & Support Planning

The CGA and Dorset Anticipatory Care Plan should be created in collaboration with the person, their carers or advocates and the MDT to outline goals, roles and responsibilities for the proactive management of the condition. This will be agreed and made accessible to those involved in that individual's care. This will ensure the person living with frailty defines what is important to them, their family, carers and advocates, in terms of their future care.

The Dorset Anticipatory Care Plan includes a Self-Care Management plan, an Advance Care Plan and a Treatment Escalation Plan (TEP).

Managing Specific Frailty Syndromes across the Primary/Community/ Acute Care Divide

Specific Symptoms:

Delirium

Falls

Dementia with Frailty

Incontinence

Immobility

Polypharmacy

Delirium

“Delirium (sometimes called an acute confusional state) is a common clinical condition characterized by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course. It usually lasts 1-2 days” (NICE, 2010). As we age, the risk of Delirium increases and 15-26% of these persons will die (Fox et al., 2012). The older person who presents with delirium offers a challenge to the practitioner that will often lead to the person being admitted. Frail older persons are at higher risk of Delirium and subsequent admission than those who are not frail (Verloo et al., 2016). Up to 31% of all admissions are due to delirium (Siddiqi et al., 2006) and many who are frail will die. In 90% of all cases causes can be determined and treated within a few hours therefore avoiding admission.

Falls

Frailty has been identified as an independent factor for falls (Rockwood, 2005) and falling should be recognised as a ‘macro-state’ indicator of complex system failure rather than a specific disorder of particular organs (such as the brain or heart). *“Existing clinical guidelines and risk assessments agree that falls require multifaceted assessment and holistic management” (Nowak and Hubbard, 2009)* Less than one in four people over 75 report receiving any support or advice in preventing further falls or progression of osteoarthritis (Melzer et al 2012 as cited in Oliver et al., 2014)

Every person who has been seen to require a falls risk assessment should be considered as potentially having frailty and equally every person identified as having frailty should be considered to be at risk of falls. Falls prevention is an important consideration in this group of persons.

Dementia

Although it is possible to have dementia in the absence of frailty and frailty in the absence of dementia, there is a large area of overlap between the two conditions. Dementia contributes to frailty and physical frailty contributes to cognitive impairment and dementia. It is important to identify cognitive frailty since there may be a component of reversibility within the multi-dimensional approach. Joint working is particularly important for those with frailty and dementia and their carers. Improved information, advocacy and training will be required for all involved. It should also be recognised that a person with frailty is associated with risk of mild cognitive impairment.

Continence Issues

Urinary incontinence and lower urinary tract symptoms are highly prevalent in older adults, and are strongly associated with frailty. Despite this, frail older persons are under-represented in the research evidence and much of the management of lower urinary tract symptoms. (*Gibson, W. and Wagg, A., 2014*) As in other frailty syndromes the causes are seldom one factor. There are often complex inter-related issues that lead to incontinence and these issues need to be taken into account when considering management options. It is advised a continence assessment be conducted once a person is identified as living with frailty as many will not voluntarily admit to continence problems.

Immobility

Frailty can present in crisis as a sudden loss of mobility and functional independence. The common presentation of immobility should prompt the possible presence of frailty.

Polypharmacy

Older people have a higher risk of multiple diseases and illnesses and the physiological changes of ageing can masquerade as illness. They are more likely to be prescribed medication by their doctors and to take multiple medications. The risk of adverse drug reactions and adherence is high in this group of individuals particularly in those who are identified as living with frailty and people in this group are also likely to be receiving several medicines. Anticholinergics have long been linked to impaired cognition and falls risk, but (more recently) have also been linked to increased morbidity and mortality. Anticholinergics may also be a cause of constipation and urinary retention.

Many symptoms can be caused by medication which may include:

- Falls
- Confusion or altered cognition
- Decrease in functional ability
- Dizziness
- Constipation
- Incontinence
- Fatigue
- Depression
- Tremor

Monitoring for Polypharmacy

“Monitoring for problems requires consideration of the increased risk of doing harm in elderly people from altered pharmacokinetics, comorbidity and polypharmacy. Some drugs, when used in elderly people, are more likely to be associated with an increased risk of adverse events. Assessing each individual person for problems will generally mean knowing age, weight, general well-being, cognitive function, use of over-the-counter and complementary medications, specific renal and hepatic function, likely compliance, and an accurate understanding of the person’s other conditions and medications” (Best Practice Journal, 2013)

The key principle when prescribing for older people (*Best Practice Journal, 2013*) is to consider quality of life as the most relevant outcome and:

- Treat the disease process rather than symptoms, be cautious about adding new medication
- ‘Start low, go slow’
- Monitor closely for adverse effects
- Manage the whole of the persons treatment regimen, including medication used for the treatment of dementia and other mental health conditions

Medication reviews are therefore recommended with a pharmacist:

- Annually for persons who are taking a large number of medications (polypharmacy) – this may include over-the-counter remedies
- with new medication
- after discharge from hospital
- after any change in condition of the person (both exacerbations and improvements)

Acute and Emergency Care Management

Using the principles set out by the Acute Frailty Network and Silver Book, ensure there is a Frailty Pathway from emergency care across the hospital with a view to preventing deconditioning by adhering to principles of facilitated early discharge to the usual place of residence as soon as possible.

Key principles must include the following:

- All persons to be recognised as having frailty within all front door areas (e.g. ED, AMU, etc.)

- Start a Comprehensive Geriatric Assessment (CGA) within 2 hours of attendance/admission.
- Complete the CGA and have had a plan documented with an expected date of discharge within 24 hours of admission.
- Plan for the Expected Date of Discharge and undertake an MDT review of the person daily.
- Consider whether all the tests have to be in hospital – can the person be discharged and return rather than stay in hospital to decondition:
Discharge to Assess - Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. (NHS England Publications Gateway Reference 05871)
- Every day in hospital will have a meaningful active task completed to return the person home in as short a time as possible. There will be no wasted time for the person waiting unnecessarily due to delays e.g. Consider the use of Red/Green days as shown in the table below.

Red and Green Days



A **Red** day is when a patient is waiting for an action to progress their care and/or this action could take place out of the current setting.

- Could the current interventions be feasibly (not constrained by current service provision) delivered at home?
- If I saw this patient in out-patients, would their current 'physiological status' require immediate emergency admission?

If the answers are 1. Yes and 2. No, then this is a 'Red bed day'.

Examples of what constitutes a **Red** Day:

- Medical management plans do not include the expected date of discharge, the clinical criteria for discharge and the 'inputs' necessary to progress recovery
- A planned diagnostic/referral is not undertaken the day it is requested
- A planned therapy intervention does not occur
- The patient is in receipt of care that does not require a hospital bed.

A RED day is a day of no value for a patient

A **Green** day is when a patient receives an intervention that supports their pathway of care through to discharge

A **Green** day is a day when all that is planned or requested happened on the day it is requested, equalling a positive experience for the patient

A **Green** day is a day when the patient receives care that can only be delivered in a hospital bed

A GREEN day is a day of value for a patient

Integrated Community Services

Many of the acute crises affecting people with frailty might be more safely managed in ways other than admission to an acute hospital, whilst remembering that a clinical assessment to identify the cause or combination of causes that precipitated the acute decline is of core importance.

This has led to a need to ensure appropriate staff skills and competency in the care of older people, specifically in appreciating the complexity of care, when older people have multiple long term conditions, including dementia.

Integrated Community Services Teams (ICST's) are developing methods to monitor and maintain a knowledge and intelligence around understanding who in their communities are at risk of frailty. MDTs (within Primary Care and integrated locality hubs) are utilised to discuss the management for these people and individual case managers are assigned to support those with moderate to severe frailty.

In some cases, when integrated care cannot be carried out in the person's home, a short-term step-up/step-down bed may be required for the purpose of providing rehabilitation, reablement or end of life care.

Education and Training

Every integrated community services team should have an identified Frailty Champion/Lead trained in how best to facilitate support for people identified as living with frailty.

Training in the recognition and response to frailty will be offered to staff engaged with people who are at risk of frailty. These skills and knowledge will include the ability to:

- Define frailty
- Recognise and respond to frailty conditions
- Develop an understanding of when to manage the acutely frail person within their setting and when to seek specialist advice and support
- Recognise and respond to early signs of deterioration in acutely frail adults
- Have a knowledge and understanding of the pathophysiology of ageing
- Recognise deteriorating memory and dementia presentation
- Differentiate and respond swiftly to delirium and other frailty syndromes aiming for a reduction in acute hospital admission or where admission is required to have a minimum number of bed days as a result
- Understand mental capacity and safeguarding guidelines

Principles of Care in Nursing and Residential Homes

Prior to a person becoming a resident in a care home (with nursing or residential) the home manager, senior staff member or a trusted assessor is required to carry out a pre-admission assessment to identify and agree that this person's needs can be met. Once in the home a number of assessments are carried out, including (but not exclusively) MUST, Waterlow, falls

risk, continence, medication review, etc., to generate a care or support plan, that includes input from the people involved in that person's care: including the integrated community services team, the home staff, the resident, their family, carers or advocate if that person lacks mental capacity.

Through the development of Frailty Champions and the involvement of the multi-disciplinary team the anticipated benefits would be improved health outcomes, enhanced satisfaction for residents and a more efficient use of resources (NHS Confederation, 2016).

Early Help and Third Sector Support

Prevention at scale, including self-management, early help and third sector support is key to delivering the sustainability and transformation plan for local health and social care.

Supported self-management considers the needs and personal goals of the person then considers what support is required and how this can best be achieved, empowering individuals, their family, carers or advocates, to promote proactive care, meaningful activity and actively manage their condition/s.

There are various early help schemes within Dorset at present, many of which support those individuals who are frail.

- Services responding to the holistic needs of people to include consideration of social and psychological needs as well as physical needs e.g. isolation
- A significant focus on prevention through delivery of education, screening and the promotion of self-care and self-help activities
- Safe and well home visits – Dorset Fire and Rescue
- Education and group classes delivered through community based facilities such as community health centres
- Clear and accessible sign posting of services, prevention activities, lunch opportunities, education and group classes available through digital technology

Conclusion

The development of the Dorset Framework for Frailty is a response to the request for a common approach to case finding, assessment, care planning and case management for those who are frail. It enables a move away from disease-based systems of care towards a more appropriate integrated, person-centred approach to supporting those living with frailty. It has been shaped by local clinicians and supports the Sustainability and Transformation Plan for local health and care – focusing on prevention and early help, integrated community services working in collaboration with acute services. Respect for the autonomy and dignity of the older or frail person must underpin our approach and practice at all times.

As Dorset's vision develops and new ways of working emerge it is likely that innovative ways of addressing the needs of those who are frail will evolve. A whole systems approach with integrated health and social care services, providing a person centred approach provides the only means to achieve the best outcomes for older or frail individuals.

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Appendix 1: Features of Frailty

There are two models proposed for frailty by the British Geriatric Society.

1. The **Phenotype model**

This describes a group of person characteristics (unintentional weight loss, reduced muscle strength, reduced gait speed, self-reported exhaustion and low energy expenditure) which, if present, can predict poorer outcomes.

Generally, individuals with three or more of the characteristics are said to have frailty (although this model also allows for the possibility of fewer characteristics being present and thus pre-frailty is possible).

2. The **Cumulative Deficit model.**

Described by Rockwood in Canada, it assumes an accumulation of deficits (ranging from symptoms e.g. loss of hearing or low mood, through signs such as tremor, through to various diseases such as dementia) which can occur with ageing and which combine to increase the 'frailty index' which in turn will increase the risk of an adverse outcome. Rockwood also proposed a clinical frailty scale for use after a comprehensive assessment of an older person; this implies an increasing level of frailty which is more in keeping with experience of clinical practice.

The British Geriatric Society states that:

"A central feature of physical frailty, as defined by the phenotype model is loss of skeletal muscle function (sarcopenia) and there is a growing body of evidence documenting the major causes of this process. The strongest risk factor is age and prevalence clearly rises with age. There is also an effect of gender where the prevalence in community dwelling older people is usually higher in women".

Appendix 2: Recommended Identification Tools

Primary care

Electronic Frailty Index:

The EFI uses a 'cumulative deficit' model, which measures frailty on the basis of the accumulation of a range of deficits, which can be clinical signs (e.g. tremor), symptoms (e.g. vision problems), diseases, disabilities and abnormal test values. It is made up of 36 deficits comprising around 2,000 Read codes. The score is strongly predictive of adverse outcomes and has been validated in large international studies. The score can be used to define frailty categories.

The Electronic Frailty Index Guidance Notes

The electronic frailty index (eFI) helps identify and predict adverse outcomes for older patients in primary care. It is therefore useful to plan at an individual and whole systems level.

- Information for the eFI is collected using existing electronic health record information at no extra cost
- The eFI uses a 'cumulative deficit' model, which measures frailty on the basis of the accumulation of a range of deficits, which can be clinical signs (e.g. tremor), symptoms (e.g. vision problems), diseases, disabilities and abnormal test values
- The eFI is made up of 36 deficits comprising around 2,000 Read codes (follow link for map and table 1 in appendix for list of 36 deficits¹).
- The score is strongly predictive of adverse outcomes and has been validated in large international studies
- The eFI is presented as a score (e.g. if 9 deficits are present out of a possible total of 36 the FI score = 0.25) - higher scores indicate increasing frailty
- Higher scores indicate increasing frailty and greater risk of adverse outcomes (e.g. on average, those with an eFI > 0.36 have a six-fold increased risk of admission to a care home in the next 12 months and a five-fold increased mortality risk, compared to fit older people).
- The eFI can be used to score to define frailty categories:
 1. **Fit (eFI score 0 - 0.12)** – People who have no or few long-term conditions that are usually well controlled. This group would mainly be independent in day to day living activities.
 2. **Mild frailty (eFI score 0.13 – 0.24)** – People who are slowing up in older age and may need help with personal activities of daily living such as finances, shopping, transportation.
 1. **Moderate Frailty (eFI score 0.25 – 0.36)** – People who have difficulties with outdoor activities and may have mobility problems or require help with activities such as washing and dressing.
 3. **Severe Frailty (eFI score > 0.36)** – People who are often dependent for personal cares and have a range of long-term conditions/multi-morbidity. Some of this group may be medically stable but others can be unstable and at risk of dying within 6 - 12 months.²

¹http://www.improvementacademy.org/documents/Projects/healthy_ageing/eFI%20Guidance%20SystemOne%20Notes%20for%20HAC%20Partners.pdf

² Authored by: Sarah De Biase, Improvement Programme Manager, Healthy Ageing Collaborative Improvement Academy part of the AHSN Yorkshire and Humber

Tools to Identify Frailty in Community & Hospital Settings

PRISMA 7

A score of three or more indicates frailty

- 1. Are you more than 85 years old?**
- 2. Male?**
- 3. In general, do you have any health problems that require you to limit your activities?**
- 4. Do you need someone to help you on a regular basis?**
- 5. In general do you have any health problems that require you to stay at home?**
- 6. In case of need, can you count on someone close to you?**
- 7. Do you regularly use a stick, walker or wheelchair to get about?**

PRISMA 7 has been used as an annual postal questionnaire to people aged over 75.

Gait Speed Test

Average gait speed of longer than 5 seconds to walk 4 meters is an indication of frailty. The test can be performed with any patient able to walk 4 meters using the guidelines below.

- 1. Accompany the patient to the designated area, which should be well-lit, unobstructed, and contain clearly indicated markings at 0 and 4 meters.**
- 2. Position the patient with his/her feet behind and just touching the 0-metre start line.**
Instruct the patient to “Walk at your comfortable pace” until a few steps past the 4-metre mark (the patient should not start to slow down before the 4-metre mark).
- 3. Begin each trial on the word “Go”.**
- 4. Start the timer with the first footfall after the 0-metre line.**
Stop the timer with the first footfall after the 4-metre line.
- 5. Repeat three times, allowing sufficient time for recuperation between trials.**

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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Groningen Frailty Indicator Questionnaire

For Patients to Use and Report

The GFI is a validated, 15-item questionnaire with a score range from zero to fifteen that assesses the physical, cognitive, social, and psychological domains. A GFI score of four or greater is considered the cut-off point for frailty. It is suitable for postal completion.

Circle the appropriate answer and add scores		
Mobility		
Can the patient perform the following tasks without assistance from another person (walking aids such as a cane or a wheelchair are allowed)		
	YES	NO
1. Grocery shopping	0	1
2. Walk outside house (around house or to neighbour)	0	1
3. Getting (un)dressed	0	1
4. Visiting restroom	0	1
Vision		
5. Does the patient encounter problems in daily life because of impaired vision?	1	0
Hearing		
6. Does the patient encounter problems in daily life because of impaired hearing?	1	0
Nutrition		
7. Has the patient unintentionally lost a lot of weight in the past 6 months (6kg in 6 months or 3kg in 3 months)?	1	0
Co-morbidity		
8. Does the patient use 4 or more different types of medication?	1	0
Cognition		

	YES	NO	SOMETIMES								
9. Does the patient have any complaints on his/her memory (or diagnosed with dementia)?	1	0	0								
Psychosocial											
10. Does the patient ever experience emptiness around him? <i>E.g. You feel so sad that you have no interest in your surroundings. Or if someone you love no longer loves you, how do you feel?</i>	1	0	1								
11. Does the patient ever miss the presence of other people around him? <i>Or do you miss anyone you love?</i>	1	0	1								
12. Does the patient ever feel left alone? <i>E.g. You wish there is someone to go with you for something important.</i>	1	0	1								
13. Has the patient been feeling down or depressed lately?	1	0	1								
14. Has the patient felt nervous or anxious lately?	1	0	1								
Physical Fitness											
15. How would the patient rate his/her own physical fitness? (0-10 ; 0 is very bad, 10 is very good) 0 – 6 = 1, 7 – 10 = 0	0	1	2	3	4	5	6	7	8	9	10
TOTAL SCORE GFI =											

ISAR Screening Tool

The ISAR Screening tool can be used with a person who attend the Emergency Department, and is a self-reporting tool to identify older people at risk who could benefit from early assessment and CGA.

ISAR screening tool (Identification of Seniors At Risk) ^[2] *Ask carer if patient unable to answer*

- | | | |
|--|-----------------------------|------------------------------|
| Before the illness or injury that brought you to the Emergency Department, did you need someone to help you on a regular basis? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Since the illness or injury that brought you to the Emergency Department, have you needed more help than usual to take care of yourself? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you been hospitalised for one or more nights during the past 6 months (excluding a stay in the Emergency Department)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| In general, do you have serious problems with your vision, that can't be corrected by glasses? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| In general, do you have serious problems with your memory? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you take more than three different medications every day? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

A score greater than 1 suggests increased risk of severe functional impairment, frequent hospitalisation and depression over the following six months; in this case please

- *Ask a Primary Care Coordinator to review (if one is available)*
- *Inform GP*

Number of questions answered with YES