

Rapid Improvement Guide to:

Identifying and managing frailty at the front door

Why is it important to identify frailty at the front door?

Hospitalisation can be the initial event that heralds an intensive period of health and social care use, especially for 'older people with frailty', a distinctive late-life health state in which apparently minor stressor events are associated with adverse health outcomes.

About 5-10% of all emergency department (ED) attendees and 30% of patients in Acute Medical Units are older people with frailty. Focusing on frailty is an exercise in risk stratification - identifying a cohort at especially high risk of adverse outcomes.

Once identified, the Acute Frailty Network (AFN) principles two and three apply: 'put in place a multi-disciplinary response that initiates Comprehensive Geriatric Assessment (CGA) within the first hour' and 'set up a rapid response system for frail older people in urgent care settings.'

There is concern in clinical teams that there will be too many patients to manage if we measure accurately. However unless the demand is identified (i.e. the number of older people with frailty and urgent care needs) and gaps exposed, we won't understand the true need. Do not be scared about the size of the problem. It exists already, and it is better to know about it and start plans to address it, than to deny it.

Which frailty tool should I use?

There is limited evidence for the discriminant ability of frailty scales in the urgent care context. Until more accurate tools become available, simple, clinically acceptable criteria can be used to identify a large proportion of older people who are frail (sensitivity). Some patients will be incorrectly scored as not frail (specificity), this can be sorted by sensible discussion between clinical teams. Examples include:

- Age 65+ AND presenting with one or more frailty syndromes (confusion, Parkinson's disease, presenting with fragility fractures and/or falls, care home residents) OR people aged 85+ unless their need is best met by a single organ team
- AND/OR
- Moderate or severe frailty (grade 6-9) using the Canadian Frailty Scale

At the moment there is almost a different tool used in every hospital. However no one tool is better than any other, and moreover, it is confusing for clinicians, managers, and patients. It is critical that geriatricians as service leads for frailty adopt some consistency across the country (AFN principle 5: 'adopt clinical professional standards to reduce unnecessary variation') – variation harms patients.

Stratified problem lists

The idea is to reflect all the problems identified in a given patient, from any or even all of the domains of the CGA. Or they might be a summary of the multi-disciplinary team (MDT) discussion. The stratification should be in terms of urgency and importance, and associated with a list of actions, allowing all members of the MDT and other clinicians to clearly see the plan for the patient.

Example problem list	Example management plan
<p>Multifactorial fall, due to:</p> <ul style="list-style-type: none"> ■ Delirium/dementia ■ Bradycardia (medications: atenolol/donepezil) ■ Neurological deficit (previous stroke) ■ Hypotension - medications and fluid depletion due to reduced oral intake 	<ul style="list-style-type: none"> ▶ Reduce/stop beta-blocker as BP low and likely to be contributing to falls risk; will require on-going monitoring (POLYPHARMACY) ▶ Stop and review later the Bendroflumethazide (or Furosemide) given dehydration and low BP (also limited evidence of benefit from tight BP control in established dementia) (POLYPHARMACY) ▶ Do not stop donepezil (likely to help with delirium recovery), but monitor ECG response to withdrawal of beta-blocker (POLYPHARMACY) ▶ Nurse in an environment less likely to aggravate delirium (reduced noise, low lighting, and orientation cues) ▶ Later, arrange a home hazards review, consider assistive technology such as pressure sensors as several fixed irreversible drivers of falls risks – stroke, dementia (ENVIRONMENTAL factors)
<p>Reduced oral intake due to:</p> <ul style="list-style-type: none"> ■ Delirium ■ Reduced appetite during illness ■ Constipation ■ Inaccessible drinks 	<ul style="list-style-type: none"> ▶ Start off with iv fluids ▶ As recovery kicks in ensure cups in reach ▶ Ensure food appetising and accessible ▶ Monitor fluid balance
<p>Constipation due to:</p> <ul style="list-style-type: none"> ■ Opioids ■ Reduced mobility etc. 	<ul style="list-style-type: none"> ▶ Treat bowels – enema for impaction, add in laxatives as likely to need to restart opioids for shoulder pain (POLYPHARMACY)
<p>Urinary retention due to:</p> <ul style="list-style-type: none"> ■ constipation/faecal impaction +/- donepezil causing: <ul style="list-style-type: none"> • UTI (drug resistant) • Acute (mixed pre and post-renal) kidney injury 	<ul style="list-style-type: none"> ▶ Treat bowels ▶ Treat UTI ▶ Hydrate ▶ No catheter! If in pain consider in-out catheter ▶ Repeat UE tomorrow at 7am
<p>Polypharmacy</p> <ul style="list-style-type: none"> ■ (opiates/beta blockade/thiazide) 	<ul style="list-style-type: none"> ▶ Medication review as described above and below
<p>Hypoactive delirium secondary to issues above</p>	<p>Delirium - (NON-SPECIFIC PRESENTATION)</p> <ul style="list-style-type: none"> ▶ Address hydration (consider parenteral fluids given drowsiness and likely lower oral intake), hypoxia, hypothermia, hypotension and hypoglycaemia ▶ Treat infections – consider broad spectrum antibiotics given established resistance to many antibiotics (including Trimethoprim), pending CSU obtained from in-out catheter to drain bladder ▶ Consider urinary retention: plan for follow up bladder scans rather than insert a catheter ▶ Hold opioids temporarily to facilitate recovery from delirium, but continue paracetamol (NSAIDs contraindicated due to acute kidney injury) (review POLYPHARMACY)

Useful resources

Clinical guidance

<http://www.bgs.org.uk/index.php/cga-managing>

<http://www.bgs.org.uk/index.php/topresources/publicationfind/goodpractice/195-gpgcgassessment>

<https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-3-acute-medical-care-frail-older-people>

Evidence base

<http://www.bmj.com/content/343/bmj.d6553>

http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf

In the pipeline...

<http://www.bgs.org.uk/index.php/how-cga>