Managing patients with frailty:

A guide for non-Geriatricians

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Frailty is everywhere!

Aside from Paediatrics, whichever speciality you work in - from cardiology to ophthalmology and beyond you will encounter patients living with frailty.

This guide aims to help non-specialists look after patients living with this condition.

We are happy for this guide to be distributed freely.

We welcome feedback - we will publish v3 in due time with updates

You can contact us via Twitter @WrexhamCOTE or via email cameron.abbott@wales.nhs.uk

https://coterota.wixsite.com/Wrexham

#hello my name is…

It should always start with an introduction!

The Campaign was founded by Dr Kate Granger and her husband Chris Pointon based on their own encounters with healthcare services. Kate died in 2016 but her legacy lives on in many ways.

It started with an observation that a lot of healthcare professionals did not routinely introduce themselves, and it has grown into an international movement.

For more information visit
https://hellomynameis.org.uk/

Patients have names!

There is always a risk of dehumanising patients by referring to them in different ways:

"The lady in room 2"
"The man with delirium"

This is easy to do especially in pressured environments, however it dehumanises patients and allows us to see them as summations of their medical conditions rather than individuals.

Ask your patient what they would like to be called- “Doris” may prefer to be called “Mrs Jones” or “Brenda!”

Caring for older patients

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DO:

- **Offer drinks** regularly e.g. on ward round
- **Ensure patients have their dentures, hearing aids and glasses** (this can prevent delirium)
- **Beware of atypical presentations**- 1/3 older patients with MI don't describe chest pain
- **Think before you request a test**- scientific curiosity has no place in medicine.

Don't:

- **Automatically give IV fluids if a patient has reduced oral intake.** This can be one of the later signs of dementia and if dehydration is the only pathology, then careful thought should be given to the appropriateness artificial hydration
- **Prescribe sedation to older people just because they are confused**
- **Diagnose "Acopia"**- it is not a diagnosis and those labelled with "Acopia" have a higher mortality than those with MI. It is usually a marker of acute deterioration.
- **Routinely repeat blood tests in well inpatients**- 30-50% inpatient lab testing is unnecessary

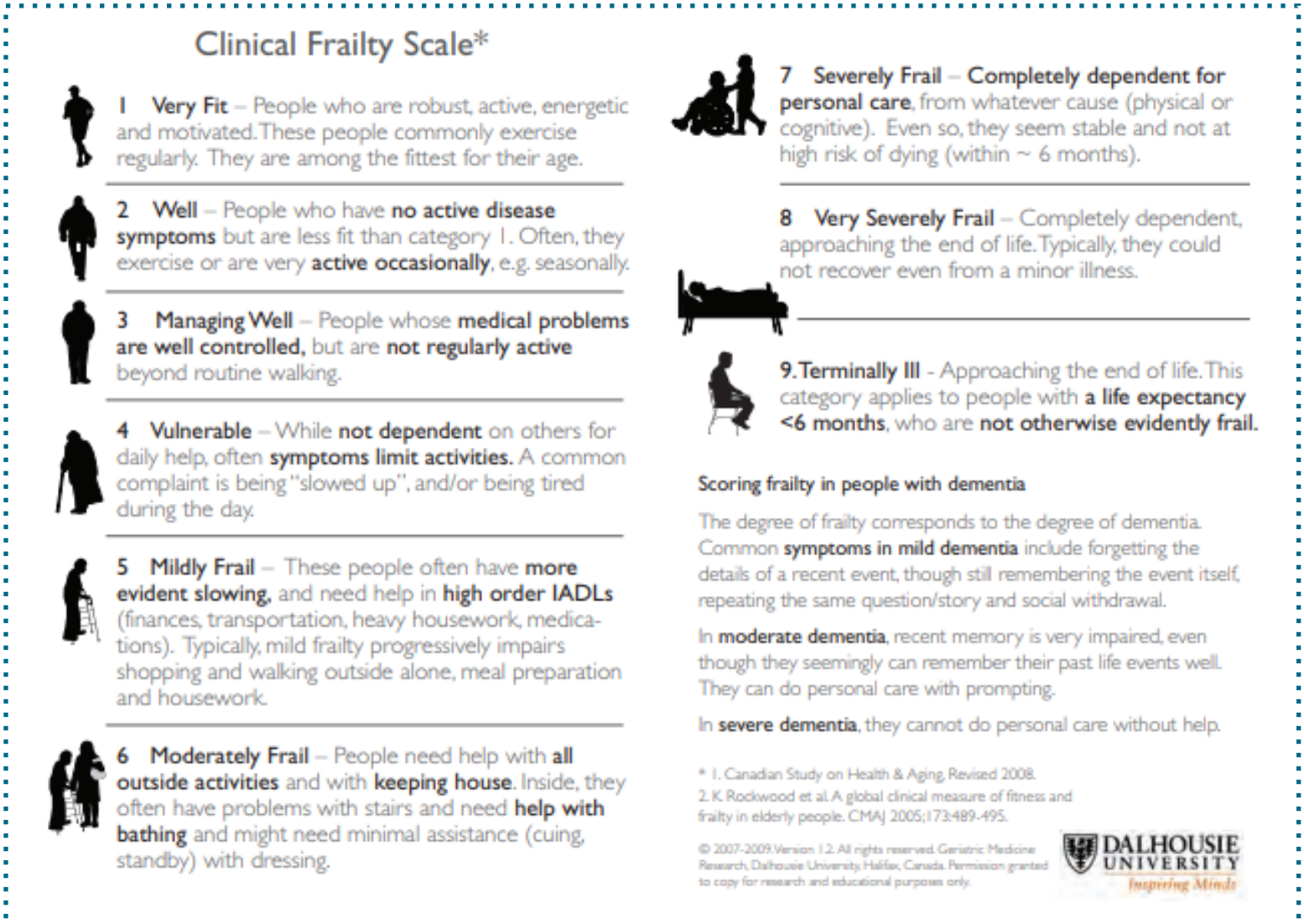
The F word

So what is Frailty?

"A clinically recognisable state of increased vulnerability resulting from ageing associated decline in reserve and function across multiple physiologic systems such that the ability to cope with everyday or acute stressors is compromised"[1]

Roughly translated when something happens to patients that have frailty they will be worse than non-frail patients and it will take them longer to recover.

Geriatricians can argue for hours about the best frailty assessment - The Clinical Frailty Scale is probably the one used most often in practice pioneered by K. Rockwood.[2]



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.

DALHOUSIE UNIVERSITY *Inspiring Minds*

1. https://www.geriatric.theclinics.com/article/S0749-0690(10)00083-2/fulltext

2. https://www.ncbi.nlm.nih.gov/pubmed/16129869

Why should you care about Frailty?

- 30-40% of the acute medical take are frail
- Increasing frailty is linked with an increase in adverse events including **death, falls, delirium, deconditioning, poor outcomes from surgery, and needing 24 hour care.** [3]
- The presence of frailty should change your targets of treatment - and should trigger the question:

"I know I can request this test/procedure/treatment for my patient but should I?"

- Patients with frailty should trigger a more detailed review of different aspects of a patient's care including a medication and falls review.

Beyond Scales - the TUG test

The timed up and go test can be used to detect frailty with a high sensitivity. (but low specificity - think of it as a screening/rule out tool)[4]

It can be easily done in outpatient and even ward & admissions settings to give you a quick idea if a patient could be frail.

How to guide:

- Start with the patient seated in a chair
- Ask them to stand up, walk 3 metres, turn around, walk back and sit down
- If this takes them longer than 10 seconds think of frailty!

3. http://www.clinmed.rcpjournal.org/content/15/4/377.full

4. http://www.bgs.org.uk/campaigns/fff/fff_full.pdf

Immobility is a huge problem for our patients and should be discouraged at every opportunity.

Some headline stats about deconditioning:

- 10 days of bed rest is equivalent to ageing 10 years in the muscles of patients over 80 years old
- Hospitalised patients spend 83% of their time in bed!
- 60% of immobile older patients have no medical reason for bed rest

Immobility puts patients at risk of pneumonia, pressure sores, deconditioning (and hospital acquired disability)

Programmes looking at routine mobilisation of hospital patients have shown a decrease in average length of stay by more than 3 days!

It doesn't have to be a physiotherapist to mobilise patients, any member of staff can do it - even the patient's visitors can help.

Hospitals around the country have taken part in the #EndPJparalysis campaign in an effort to try to end immobility for inpatients.[5]

5. http://www.endpjparalysis.com/

Discharge planning

10 Tips for Successful Discharge Planning:

1. Begin discharge planning at admission
2. Ensure a detailed history of home circumstances e.g. Role of carers/family and mobility
3. Determine patient and family expectations
4. Work closely with other members of MDT
5. Determine whether the patient has any barriers to discharge e.g. No available package of care
6. Involve patients, families and carers at an early stage
7. Transfer to Community Hospital or Rehab unit is NOT a discharge plan and social work referrals should take place prior to rehab
8. Plan for discharge alongside other transfers of care e.g. Think about where the patient will go after rehab/community hospital
9. Consider whether the patient has capacity to make decisions regarding their treatment and discharge
10. Assess the need for inpatient treatment- can the patient be treated in the community?

Medication Reviews

Medication reviews should be carried out on frail patients whenever they encounter healthcare professionals. The way that patients in this group process medications is different from the average patient and they are more at risk of side effects.

Medication reviews and rationalisation can be intimidating for non-geriatricians but there are some simple rules of thumb to follow.

Talk to your patient! What are their aims when it comes to their health? Do they want to live for longer or are they more looking for quality of life.

A starting point to any change in a patient's care should be a discussion with the patient about what their goals are.

Many guidelines are on the basis of life preservation.

Best tools for medication reviews:

- START/STOPP[6]
- IMPE[7]
- Polypharmacy app
- STOPPFrail[8]

70% of patients leave hospital on more medications than they were admitted with.

"But we can't do that it will make people ill stopping all of their medications?!"

In one study looking at the feasibility of stopping multiple medications;

- >50% of medications were stopped
- 4/5 didn't have to be restarted
- 80% reported an improvement in general health

6. https://academic.oup.com/ageing/article/44/2/213/2812233#99983201
7. http://patientsafety.health.org.uk/sites/default/files/resources/the_improving_prescribing_for_the_elderly_project.pdf
8. https://watermark.silverchair.com/afx005.pdf?

The "Frailty Syndromes"

Specific presentations should prompt a wholistic patient review including medications:

- Falls
- Immobility
- Delirium
- Incontinence
- Susceptibility to side effects of medications.

Numerous articles could (and have) be written about the intricacies of a medication review for frail patients. We have prepared some key pointers, this is not exhaustive but a good jumping off point.

NNT

We often prescribe following guidelines without thinking of our individual patient and informing them of why we are doing it. NNT for alendronate as primary prevention for osteoporotic spinal fractures is 148!

The polypharmacy app made by NHS Scotland contains many helpful hints re NNT amongst other things - take a look, it's free.

Think before you sedate!

Don't routinely prescribe anti-psychotics or sedatives to patients with dementia or delirium - it leads to an increased mortality and few benefit.

Medication should only be used in this way if the patient is physically aggressive and a risk to themselves or others. **It should not be used for patients shouting out or wandering** (it will increase falls risk, not decrease it!)

Start low and go slow - consult your local guidelines

N.B. Never use Haloperidol in patients with Parkinson's disease or Lewy Body dementia

Beware automatic secondary prevention

Many elements of guidelines are based on studies in non-frail populations an individualised approach is needed - a couple of examples:

- Beta-blockers in care home residents following MI worsen functional decline and don't improve mortality unless in the presence of heart failure.
- Statins in patients aged >80 years have no significant effect on long term survival

Blood Pressure

Beware Controversy Ahead!

There is a lot of controversy regarding BP control in older patients. An abridged summary of the evidence:

Both SPRINT and HYVET showed benefits from reducing BP in older adults but excluded more frail patients from inclusion

Several observational trials looking at frailer populations showed a lower mortality in patients with higher blood pressure **(160-180 systolic)**[9,10 & 11]

But how can we apply this?!

The lower mortality does not make this a target for treatment, it does however mean that patients do not come to more harm for having higher blood pressure.

It's good to talk

Regardless of what intervention you are making in an older patient's care, it is vital to communicate this to the relevant parties.

This always includes the patient's GP, but also needs to include the patient and their next of kin. This is especially important where the patient has any form of cognitive problems, whether they are acute or chronic (See delirium vs dementia a diagnostic conundrum).

Top tips for new Doctors

A GP on an average will receive 30-40 letters - keep any discharge summaries succinct and only containing relevant information

9. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3537835/

10. https://academic.oup.com/ageing/advance-article/doi/10.1093/ageing/afy072/4993723#.WvSPn3xsOQg.twitter

11. https://www.ncbi.nlm.nih.gov/pubmed/26504116

Don't be a Dipstick!
UTI diagnosis

UTIs are notoriously badly diagnosed- a problem perpetuated from university training onward. Bearing in mind 50% of female residents in care homes have asymptomatic bacturia there is a high possibility of misdiagnosis.[12]

Some common pitfalls:

Character

Change in colour & smell of urine only has a positive predictive value of 47% for bacturia & pyuria.

Other causes for these changes include dehydration, renal stones, and certain dietary intake (think ausparagus)

UTIs can be confidently diagnosed when 3 of the following are present:

- Dysuria
- Frequency
- Suprapubic tenderness
- Urgency
- Polyuria
- Haematuiria

Urine dipstick - the D. dimers of the UTI world

For patients with a urine dipstick for leucocytes or nitrites only 45% had bacturia.

That being said a negative urine dipstick has a negative predictive value of 100%

We need to talk about catheters...

A few key points:

- Where possible catheters should be minimised in frail patients. If a new catheter is needed set a review date.
- **Where a patient is confused and catheterised use a leg bag to reduce the risk of self TWOC!**
- Patients with CAUTI need a catheter change after starting antibiotics, otherwise it will not improve
- Constipation is a common cause of retention - get patient's bowels moving pre-TWOC
- **Never** use a urine dipstick to diagnose CAUTI - it will be positive

12. https://www.bmj.com/content/349/bmj.g4070

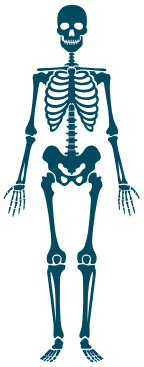
Falls

A diagnosis of "fall ? cause" isn't a diagnosis and means more work needs to be done!

A detailed history of the falls are vital. Important aspects to focus on:

- A clear history of the fall
  - Any cause they can identify
  - What were they doing immediately before the fall
  - Any history of presyncope/syncope/vertigo (important to delineate between the three)
  - Any history of cognitive impairment/delirium
- A medication review (antidepressants are more strongly linked to falls than benzodiazepines)

Osteoporosis



Whenever you are reviewing patients that have fallen it is important to think about their osteoporosis risk.

This can be easily assessed using the FRAX score available from:

https://www.sheffield.ac.uk/FRAX/tool.aspx

"Silver Trauma"

A fall from a standing height in a frail patient can cause equivalent injuries to being hit by a car in a non-frail individual.

It is vital when reviewing patients with falls that you consider injuries and have a low threshold for imaging.

Pimp my Zimmer

A quality improvement project based in care homes in Essex (the PROSPER project) came up with an inovative way of reducing falls in care home residents.

They had the zimmer frames "pimped" so that they were more noticeable, and individualised for the residents.

Falls reduced by 60%

Sometimes worth suggesting for patients, especially if they are leaving their walking aids behind - plus it's fun to do.

If you want to learn more: https://www.youtube.com/watch?

Delirium

Delirium is common!

It has had a prevalence of **up to 50%** of hospitalised patients in some studies.

Some important stats:

- Patients with delirium are 3 times more likely to develop dementia
- Patients with dementia are 5 times more likely to develop a delirium
- Only 20% of people will return to normal cognitive function at 6 months
- Hypoactive delirium 6 month mortality is 50%
- Higher mortality in less frail patients

Risk factors

- Dementia
- Severe illness
- #NOF
- Polypharmacy
- Visual impairment
- Age
- Previous delirium
- and about 500 others.....

Parkinson's Disease

- Medications should be prescribed by time e.g. 7am rather than 'morning'
- Avoid use of Haloperidol, Olanzapine, Metoclopramide, Prochlorperazine (Stemetil) as this can exacerbate symptoms.
- Use the OPTIMAL calculator if the patient cannot take oral medications e.g if the patient is drowsy. The calculator can be found at www.Parkinsonscalculator.com and there are versions for patients with and without NG tubes

The key to successful treatment and avoiding complications is to ensure patients receive their regular medications on time

- Ensure the local PD team are aware of the patient urgently within working hours. If advice is needed out of hours, consider contacting on call pharmacy or medical teams.

13. http://www.parkinsonscalculator.com/guideline.html

Capacity Assessment

- Capacity is decision and time specific and therefore a patient cannot be said to "lack capacity." A patient may lack capacity to make a particular decision e.g. place of care on discharge but may still retain capacity to make other decisions e.g. whether to eat breakfast.
- A patient should be assisted to maximise their capacity e.g by provision of hearing aids or interpreters
- If a patient is thought to lack capacity to make a particular decision but may regain the ability e.g. in delirium then the decision should be delayed if possible
- The capacity assessment and result should be recorded in patient notes and if available, on a Capacity Assessment form
- Consider DOLS for patients who do not have the capacity to self-discharge

Top tips for new Doctors

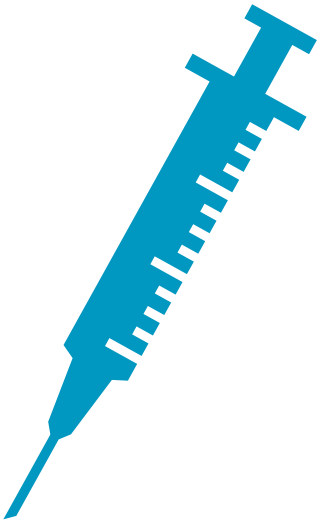
Consider covert medications if the patient lacks capacity to make decisions regarding their treatment and a best interests decision has been made

To determine that an individual has capacity to make a particular decision, they should be able to :

1. Understand the information
2. Retain the information
3. Weigh up the information to make a decision
4. Communicate the decision

#TalkCPR

Ceilings of treatment should be clarified for all frail patients admitted to hospital. This requires discussion with the patient or family if they lack capacity to discuss. All discussions and outcome of decisions should be clearly documented and communicated to other healthcare professionals



Key points to discuss include:

- CPR status
- HDU/ITU escalation
- IV and Oral antibiotics
- Invasive investigations e.g. blood tests
- Artificial feeding and fluids e.g. IV or subcut fluids
- Readmission or re-transfer on discharge/transfer to community hospital

Top tips for new Doctors

A good starting place is "Have you thought about what would happen if your heart were to stop beating..."

A DNACPR order remains a medical decision

Patients and families should not be asked to make a DNACPR decision.

This is a huge responsibility and burden for many.

Instead, they should be informed of CPR's futility in this situation. Natural vs traumatic death should also be explained

- 1/3 inpatients in their 70s will die within 1 year
- 1/2 inpatients over 85 will die within 1 year
- 30 day mortality of care home residents admitted to hospital is 30%