GUIDELINES & PROTOCOLS
ADVISORY COMMITTEE

Frailty in Older Adults – Early Identification and Management

Effective Date: October 1, 2008

Scope

This guideline addresses the early identification of patients who are at risk for frailty and the management of patients aged 65 years or older who are identified as frail. Over a series of planned office visits, this guideline will facilitate enhanced individualized planning for patients who are frail or at risk for frailty, and implementation of patient-centred strategies to prevent further functional decline, particularly during transitions in care.

Elements of Care

- In people over 65, those at risk of frailty will be identified proactively (see Frailty Scale, pg.2)
- Significant issues, including safety risks, will be noted through targeted assessment
- Patient goals will be identified and recorded in a Care Plan that includes a medication review, advance care planning and scheduled follow-up
- Appropriate community referrals will be made and monitored
- The Care Plan will accompany the patient to consultations or admissions
- Key management information will be available to other health care providers after regular business hours as required
- Care contact names and phone numbers will be recorded and updated regularly

Care Summary

This guideline focuses on the development of a Care Plan. The Care Plan is individually developed and addresses modifiable biological and psychosocial factors while integrating individual disease factors that impede the health goals of patients. The recommended approach to care incorporates patient-centred preferences and tolerance for intervention and support. The approach is grounded in the philosophy that frailty may be prevented or delayed and that patients can improve their function and quality of life through rehabilitation.[1]

Identification of Frail Patients and Patients at Risk for Frailty

Each visit provides an opportunity to engage the patient in individualized care planning, and to identify any follow-up needs.[2]

Older adults may share a number of non-specific concerns that could lead the physician to think about their older patients as frail or at risk for frailty, such as:[3-6]

- difficulty managing daily activities at home
- unintentional weight loss
- fatigue or loss of energy (often occurs over a period of time)
- recent fall(s), fear of falling
- memory loss
- concerns about the patient, expressed by the family/caregiver(s)

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Once a patient is identified as frail, or at risk for frailty, it is recommended that the *Canadian Study on Health and Aging (CSHA) Clinical Frailty Scale*[7] be used to categorize the needs of the patient. The scale is based largely on a person's function for Basic and Instrumental Activities of Daily Living (ADL and IADL).

The CSHA Clinical Frailty Scale

1 **Very fit** – Robust, active, energetic, well motivated and fit; these people commonly exercise regularly and are in the most fit group for their age

2 **Well** – Without active disease, but less fit than people in category 1

3 **Well, with treated comorbid disease** – Disease symptoms are well controlled compared with those in category 4

4 **Apparently vulnerable** – Although not frankly dependent, these people commonly complain of being "slowed up" or have disease symptoms

5 **Mildly frail** – With limited dependence on others for instrumental activities of daily living

6 **Moderately frail** – Help is needed with both instrumental and non-instrumental activities of daily living

7 **Severely frail** – Completely dependent on others for the activities of daily living, or terminally ill

IADL

Activities required to live in the community

- Meal preparation
- Ordinary housework
- Managing finances
- Managing medications
- Phone use
- Shopping
- Transportation

ADL

Non-instrumental activities of daily living; related to personal care

- Mobility in bed
- Transfers
- Locomotion inside and outside the home
- Dressing upper and lower body
- Eating
- Toilet use
- Personal hygiene
- Bathing

Further Assessment

Patients with identified frailty (CSHA Scale, Level 4 and above) require additional assessment in order to support the development or refinement of a Care Plan (see Appendix A for a sample Seniors Assessment Tool).

Ideally, the physician and other health professionals will work collaboratively to complete assessments, in order to create one comprehensive Care Plan that is used by the patient and all health professionals involved in the patient's care. For example, if community case managers have completed their comprehensive initial assessment using the Minimal Data Set-Home Care[8], a list of identified problem areas generated by that assessment could help to further inform the physician assessment and Care Plan.

In addition to the collection of information on underlying chronic conditions, some practical areas to pursue in assessing older adult patients are noted below. [9-12] Observed changes in these areas constitute early warning signs of frailty (CSHA Frailty Scale Level 4), while a combination of impairments may signal progression toward frailty (CSHA Frailty Scale Levels 5-7):

- weight change
- reduced physical activity levels and endurance
- impaired balance and mobility
- increased number and frequency of falls or first fall if not with cause
- declining functional status
- difficulties due to polypharmacy and psychoactive medications
- impaired vision/hearing
- increased alcohol consumption
- driving competency
- difficulty maintaining continence
- irregular patterns of sleep
- frequent/increased pain
- inappropriate behaviour
- social isolation
- transition in living circumstances
- change in family/caregiver support
- advanced caregiver stress
- irrational fears/concerns
- altered mental health status, including presentation of delirium, depression and/or dementia

  (see GPAC Cognitive Impairment in the Elderly Guideline to access the Geriatric Depression Scale [GDS] and the Standardized Mini Mental State Exam [SMMSE]: http://www.BCGuidelines.ca)

Collaborative Goal Setting

It is important to have a shared understanding of desired care with the patient and family/caregiver.[1] One approach is to combine the physician's problem list with the patient and family/caregiver concerns and preferences for care:

- What are the patient's or family/caregiver's concerns?
- What are the physician's concerns?
- What are the patient's priorities for their care when considering both the physician's concerns and their own concerns?
- What does the patient or family/caregiver hope to achieve from medical treatment?
- Incorporate and document discussion of advance care planning (see Appendix D).

Collaborative goal setting will inform the development and implementation of a functional Care Plan.

Development and Implementation of a Care Plan

The Care Plan (see sample, Appendix B) is generated from these collaborative goals. Develop a Care Plan by first noting the most bothersome complaint, as voiced by the patient, and proceed with consideration for:

- Patient rehabilitation potential
- Appropriate prevention activities for the patient[13]
- Self-management support for the patient and family/caregiver(s)

In this complex population of older adults, it is recommended that the Care Plan also include:

1. A Medication Review [10,14-16] (see Appendix C)
2. Advance care planning[17] (see Appendix D)
3. Goals associated with significant health and safety risks (e.g. falls, living alone)[18]
4. Plans to manage significant co-morbidities in relation to patient goals[19]
5. Expected outcomes
6. Names and contact information of other providers involved in the care of the patient (i.e. for case conferencing as required)
7. Plans for follow-up

Sharing Care Plan Documents with Patients

Communication for coordination and continuity of care is particularly important with older adult patients.[20] Key management information should be made available at transitions of care to other providers including medical specialists, as well as emergency room staff and acute care practitioners. The Care Plan, including advance care planning documentation, could be given to the patient (and/or family/caregivers) to carry as they become involved with other care providers and as they transition across care settings. The patient could also carry a copy of the Medication Review (includes medication list paired with medical problem list).

Monitoring, Follow-up and Re-evaluation

A scheduled Care Plan review should include input from the patient, family/caregiver(s), and other involved health care providers. The review should be undertaken as scheduled, at the request of the patient, or when there is a transition (planned or unplanned), such as:

- significant change in a patient's health status;
- transition across care locations (e.g. into and out of the emergency room and/or hospital, into assisted living or a care facility, etc.); and
- change in patient's caregiver support.

Rationale

While many older adults living in British Columbia are robust and active, some older adults who are frail, or at risk for frailty, have a limited capacity to respond to stresses and are at significant risk of morbidity or death. A prudent response is to identify older adults in our population who are frail, or at risk for frailty, and take steps to reduce or manage the risks associated with frailty.[1,5, 21-23]

A common approach to assessment is needed that would enable physicians:

- to evaluate older adults based upon level of risk and prioritize unmet needs in collaboration with the patient;
- to efficiently determine whether older adult patients require additional care and support interventions in their current environment (particularly with respect to risk factors associated with the social determinants of health); and
- to identify patients who are frail or at risk for frailty and refer those patients for further comprehensive assessment as needed.

Information collected during assessment visits will inform the development of a Care Plan – an essential tool for capturing key medication information, patient/provider goals and patient preferences for care. To help facilitate shared understanding within a multi-disciplinary approach, the Care Plan

could be given to the patient (and/or family/caregivers) to carry as they become involved with other care providers and as they transition across care settings.

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Provincial Resources

- B.C. Nurse Line 1-866-215-4700
- B.C. Seniors Line 1-800-465-4911
- B.C. QuitNow 1-877-455-2233
- Dial-a-Dietician 1-800-667-3438
- Federal Information 1-800-OCANADA
- Provincial Toll-Free Health Information Lines (On-line Listing) http://www.healthservices.gov.bc.ca/cpa/1-800.html
- B.C. Health Guide http://www.bchealthguide.org

- Family Caregivers Network Society http://www.fcns-caregiving.org
- Alzheimer Society of B.C. http://www.alzheimerbc.org/
- Vancouver Coastal Health Authority Dementia Journey http://www.vch.ca/dementia/
- Interior Health Authority Phased Dementia Pathway www.interiorhealth.ca
- B.C. Injury Research and Prevention Unit
- Falls Prevention http://www.injuryresearch.bc.ca
- British Columbia Association of Lifeline Programs http://www.bclifeline.com/index.htm

Office Practice and Redesign Resources

- Sinsky, CA. Improving office practice: Working smarter, not Harder. Family Practice Management-American Academy of Family Physicians. 2006; 28-34. http://www.aafp.org/fpm
- How's Your Health? www.HowsYourHealth.com
- Impact BC & Practice Support Program http://www.impactbc.ca/programs/practicesupport/

This guideline is based on scientific evidence current as of the Effective Date.

This guideline was developed by the Guidelines and Protocols Advisory Committee, approved by the British Columbia Medical Association and adopted by the Medical Services Commission.

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The principles of the Guidelines and Protocols Advisory Committee are to:

- encourage appropriate responses to common medical situations
- recommend actions that are sufficient and efficient, neither excessive nor deficient
- permit exceptions when justified by clinical circumstances.

Appendices

Appendix A - Seniors Assessment Tool (adapted from Seniors-At-Risk Initiative, Trail B.C.)
Appendix B - Sample Care Plan Template
Appendix C - Medication Review
Appendix D - Advance Care Planning

Disclaimer

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SENIORS ASSESSMENT TOOL

This Assessment Tool pertains to the Guideline:
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NAME OF SENIOR	PERSONAL HEALTH NUMBER	DATE

NAME OF PHARMACY	LOCATION

1. How has your health been since your last visit? ❑ better ❑ same ❑ worse: _____

2. Do you have concerns or problems with any of the following:

Medications	❑ No	❑ Yes: _____
Pain	❑ No	❑ Yes: _____
Falls	❑ No	❑ Yes: _____
Decreased energy	❑ No	❑ Yes: _____
Nutrition	❑ No	❑ Yes: _____
Memory	❑ No	❑ Yes: _____
Bladder/Bowels	❑ No	❑ Yes: _____
Hearing	❑ No	❑ Yes: _____
Vision	❑ No	❑ Yes: _____
Sleep	❑ No	❑ Yes: _____
Depression/Lonliness	❑ No	❑ Yes: _____
Looking after yourself	❑ No	❑ Yes: _____
Looking after your home	❑ No	❑ Yes: _____
Finances	❑ No	❑ Yes: _____
Transport	❑ No	❑ Yes: _____

3. Where do you live? ❑ own home ❑ with family ❑ facility
❑ other: _____
4. Do you live alone? ❑ No ❑ Yes
5. Do you have help in the home? ❑ No ❑ Yes:
6. Do you have a contact for emergencies? ❑ No ❑ Yes
If yes, who could you call? ❑ family friend ❑ neighbour ❑ Lifeline
❑ other: _____
7. Have you signed a Power of Attorney? ❑ No ❑ Yes
8. Have you made a Will? ❑ No ❑ Yes
9. Do you want to discuss end-of-life plans? ❑ No ❑ Yes
10. Have you signed a “No CPR” form? ❑ No ❑ Yes
11. Would you consider Lifeline quick response? ❑ No ❑ Yes ❑ I have Lifeline (or similar service)

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The Seniors Assessment Tool was developed as part of the Seniors-at-Risk Initiative (Trail, B.C.)

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SAMPLE CARE PLAN TEMPLATE

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NAME OF PATIENT	TELEPHONE NUMBER	DATE
NAME OF CAREGIVER	TELEPHONE NUMBER(S) DAY: EVENING:	
NAME OF ALTERNATE DECISION MAKER	ROLE OR RESPONSIBILITY	TELEPHONE NUMBER

PATIENT PERSONAL HEALTH NUMBER

NAME(S) OF SUPPORTING HEALTH CARE PROVIDER(S)	ROLE OR RESPONSIBILITY	TELEPHONE NUMBER
1.		
2.		
3.		

MEDICATION REVIEW COMPLETED? ☐ NO ☐ YES, DATE: YY MM DD

ADVANCE CARE PLANNING DISCUSSION HELD? ☐ NO ☐ YES. MOST RECENT DISCUSSION DATE: YY MM DD

"NO CPR" ORDER SIGNED? ☐ NO ☐ YES, DATE: YY MM DD

ADDITIONAL NOTES (IF ANY)

HEALTH CARE GOALS Prioritized based on patient preferences	**STRATEGIES** Include rererrals made	**CAREGIVER RESPONSIBILE**	**EXPECTED OUTCOMES**	**STATUS**

NEXT CARE PLAN REVIEW DATE → YY MM DD

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MEDICATION REVIEW

This Medication Review pertains to the Guideline:
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NAME OF PATIENT	SEX ☐ M ☐ F	AGE AT DIAGNOSIS	DATE OF BIRTH

NAME OF PHARMACY	PHN

CARE OBJECTIVES

DATE OF REVIEW	NAME OF REVIEWER

ALLERGIES OR INTOLERANCES (STATE DRUG AND INTERACTION)	COMPLIANCE ISSUES	SYSTEM
		☐ VIALS ☐ DOSETTE ☐ BLISTER PACKS

RISK FACTORS AND CO-MORBID CONDITIONS

Neurological
- ☐ Stroke

Musculoskeletal
- ☐ Arthritis
- ☐ Osteoporosis

Renal
- ☐ CKD GFR: _____

Cardiovascular
- ☐ HTN
- ☐ CAD
- ☐ PVD
- ☐ Hypercholesterolemia
- ☐ MI
- ☐ CHF Echo: _____
- ☐ Arrhythmia

Gastrointestinal
- ☐ GERD
- ☐ Ulcer
- ☐ IBS/IBD
- ☐ Constipation

Respiratory
- ☐ Asthma
- ☐ COPD

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar

Endocrine
- ☐ Diabetes
- ☐ Hypothyroid

Other:
_____

VISITS (EVERY 6 MONTHS)

DRUG SCHEDULE (Rx, OTC, HERBS, REMEDIES, PRN)	MEDICAL PROBLEM	PLAN (CHANGE/NO CHANGE)

CONTINUED ON REVERSE

DRUG SCHEDULE (Rx, OTC, HERBS, REMEDIES, PRN)	MEDICAL PROBLEM	PLAN (CHANGE/NO CHANGE)

Medication Review Process

This Medication Review Process pertains to the Guideline:
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Why is it important for me to complete a Medication Review with my patients?

When considered as a disease, medication-related adverse outcomes are the 5th leading cause of death in the United States.[1] People over 65 years represent the largest consumers of medications and subsequently experience the highest rate of adverse drug events. Yet, the evidence base for older patients is small and disproportionate to the level of prescribing.[2] (Generally speaking, older adults are systematically excluded from many trials - only 3% of randomized control trials and systematic reviews include patients greater than 75 years.)[1,2]

Medication-related morbidity and mortality has been recognized as adverse events, mimicking the disease and a safety concern in older adults.[3] A prospective observational study done in a Vancouver hospital found approximately one quarter of admissions to the emergency department were medication-related with 70% of those being preventable.[4]

A regular medication review is an effective way of addressing these concerns. The process helps you prioritize the patient's health goals, eliminate unnecessary drugs, review monitoring requirements for existing or on-going therapies and reduce the risk of adverse reactions.

What steps could I follow to facilitate the Medication Review process?

Common Drug-Related Problems[5]

1. Untreated indications
2. Improper drug selection
3. Subtherapeutic dosage
4. Failure to receive drugs
5. Overdosage
6. Adverse drug reaction
7. Drug interactions
8. Drug use without an indication

1. Establish the best possible medication list (including OTC, herbals, etc.)
   - ✔ Have the patient bring all his/her medications into the appointment
   - ✔ Get a list from the patient's pharmacy or *PharmaNet.*
   - ✔ See Medication Review Template
2. Reconcile with the medical problem list
   - ✔ Engage the patient into the discussion/decision-making clarifying the patient's health care goals and willingness to carry out the therapeutic plan
   - ✔ Match each medication with an established medical problem/need/issue/symptom
   - ✔ Question the need for any medications that do not have an obvious purpose
   - ✔ Consider if any medications are contributing to the patient's medical problems
   - ✔ Consider benefits/risks if starting new therapies & consider time-limited trials
   - ✔ Consider monitoring requirements for existing or on-going therapies
3. Assess compliance/adherence
   - ✔ Patient-specific factors - cognition, beliefs, vision, swallowing, manual dexterity
   - ✔ Compliance – prescribed versus actual use

Consider Medical Practice Access to *PharmaNet* (MPAP)-a secure computer network that links community and hospital pharmacies throughout B.C. www.health.gov.bc.ca/das/medpract.html

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Advance Care Planning

What is advance care planning?

Advance care planning (ACP) is a process of communication between patients, their families, and health care providers regarding the care that will be appropriate when a patient is no longer able to make decisions themselves. It is based on patient preferences and wishes. In British Columbia, every capable adult (19 years-of-age and older) has the right to consent or withhold consent to health care. B.C. law supports adults in planning for a time when they are not able to make health care decisions by allowing them to legally appoint a health care representative. The person can also write down, or otherwise communicate instructions.

How could I incorporate ACP conversations into patient visits?

The best way to start ACP in your office is to build it into your regular process of care. If you meet a healthy patient for the first time, or are seeing a patient for a yearly check up, you can remind them of the benefits of ACP. For example, you might say: *"I like to remind my patients that you cannot always predict what happens in the future. Have you ever thought about your wishes should you have an accident or become seriously ill? You can save your family a lot of distress by expressing your thoughts about being on life support, feeding tubes or being resuscitated."*

All patients with chronic illness and those who are in the age range where they are more likely to have incapacitating illnesses (e.g. over 70 years) should be asked to visit to discuss ACP. ACP should be revisited both regularly (e.g. once yearly), and following major changes in health status as preferences for care tend to evolve after people experience a significant change in overall health status[1].

How might I initiate an ACP conversation with my patients?

You can start with an open-ended question such as *"What do you understand about your illness at this time?", or, "How are you feeling about your illness?"* Let the patient express concerns or ask questions about their illness then focus on important values/beliefs of the patient.

To follow-up and to share additional background information, you might say: *"I am now setting aside time to talk with all my patients with chronic illnesses about their choices for treatment so I would like to do this at our next visit. I want to respect your choices about health care treatment and should you become unable to make your own decisions, I need to know how you feel about things. Perhaps you already have a living will or have discussed this with your family? If so I would like to talk with you about it. Next visit, can you bring a family member or someone who would be making decisions for you?"*

What if my patient is from a culture where ACP decisions may be made as a family and/or it may be considered rude to be too forward in speaking of illness?

In this case, you could ask: *"[Mr. Smith], if you ever had a serious illness, would you make your own decisions about your treatment or would it be a family decision?"* If the answer suggests that this person is not receptive to this you could say: *"If at any time you wish to ask me questions, I would be happy to answer them."* Be careful not to stereotype any culture by presuming that because of a certain ethnicity, the patient would never want to discuss ACP.

In general, what are some of the key points to remember when discussing ACP with my patients?

Asking three questions of your patients could elicit most of the important issues in end-of-life decision-making:

- What present/future experiences are most important for you to live well at this time in your life?
- What fears or worries do you have about your illness or medical care?
- What sustains you when you face serious challenges in life?

Resuscitation should always be discussed. A way of raising this issue is to state: *"Everything will be done to help you live as well as possible for as long as possible, but when your disease becomes very serious and you die of the illness, we will not try to resuscitate you. Resuscitation – that is, trying to restart your heart pumping and lungs breathing – would have almost zero chance of success. The most you could gain is to return to the state you were in just before death."* Focusing on what will be done for patients clears up the common misperception that "do not resuscitate" means "do not treat". Patients should understand also that they could still choose to receive disease-modifying therapy but that they will not be resuscitated when they die of the illness.

Make a record of the visit by documenting the date and who attended. You may also wish to document patient comments from the three questions listed above.

Be mindful of the legal requirements in B.C. with regards to health care consent and decision-making.

1. Requirement to obtain informed consent from capable adults
2. Requirement to obtain informed consent from legally-appropriate substitute decision maker (Representative, Temporary Substitute Decision Maker, or Committee of Person).
    * The *Representation Agreement Act* allows a capable adult to legally name a health care decision-maker. If this is not in place and the individual loses decision-making capacity, then a *Committee of Person* should be undertaken.
    * The term *Committee of Person* refers to a representative who has been appointed to make decisions related to the patient's physical well-being, including where the patient lives or whether medical treatment will be agreed to. *A Committee of Person* is granted by a Court Order, issued by the Supreme Court of B.C.
3. No requirement for health care provider to obtain informed consent in an emergency if none of the above is available
4. Requirement for all substitute decision makers (including health care providers) to make decisions based on the adult's wishes when capable

What tools are available to assist me with ACP discussion and documentation?

- *No Cardiopulmonary Resuscitation Form* – HLTH 302.1
  https://www.health.gov.bc.ca/exforms/bcas/302.1fil.pdf
  No CPR MedicAlert® bracelet
- Fraser Health Authority – *My Voice*© A workbook for Advance Care Planning
  http://www.fraserhealth.ca
- Public Guardian and Trustee of British Columbia - Financial and Personal Care Management Services http://www.trustee.bc.ca

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[1] An exception to this is dementing illness. Decisions about end-of-life care must be made before patients become cognitively impaired to the point where they can no longer make personal decisions.