British Geriatrics Society
Improving healthcare
for older people

Living and dying well with frailty

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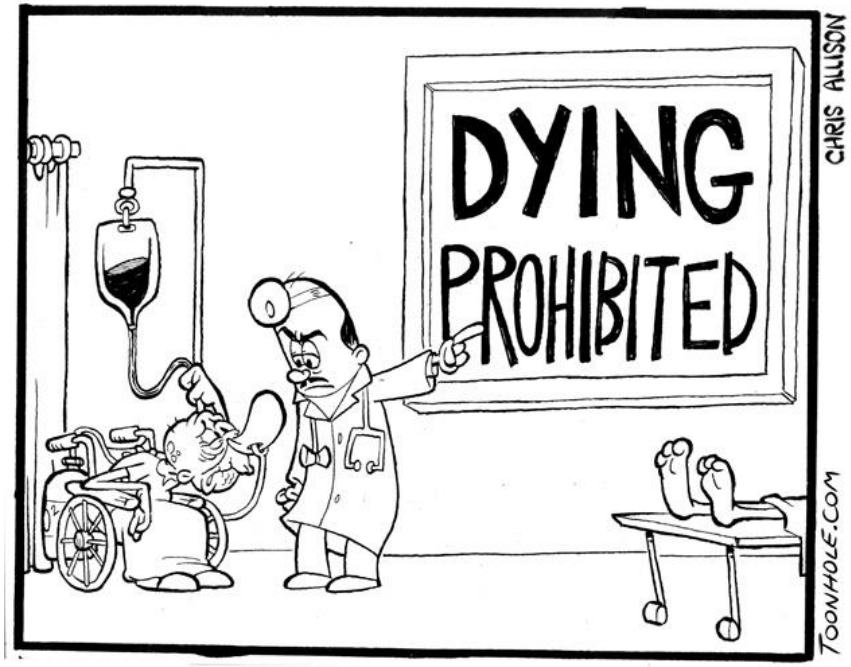
- What is frailty and why does it matter?
- Reframing the context – The last 1000 days
- Comprehensive geriatric assessment

Modern Medicine

- Life saving
- Heroic
- Scientific
- Evidence based

Modern Medicine

- Episodic
- Fragmented
- Expensive
- Burdensome
- Undignified
- Pathways of care developed to meet the needs of patients with one problem



The burden of multi-morbidity

Applying NICE guidelines to a 78 year old woman with previous myocardial infarction, type-2 diabetes, osteoarthritis, COPD, and depression…

- 11 drugs (and possibly another 10)
- 9 lifestyle modifications
- 8-10 routine primary care appointments
- 8-30 psycho-social interventions
- Smoking cessation appointments
- Pulmonary rehabilitation

Hughes et al Age & Ageing 2013

Hospitals- a place of safety?

- Delirium
- Falls & Immobility
- Incontinence
- Pressure sores
- Anorexia and weight loss
- Iatrogenic harm

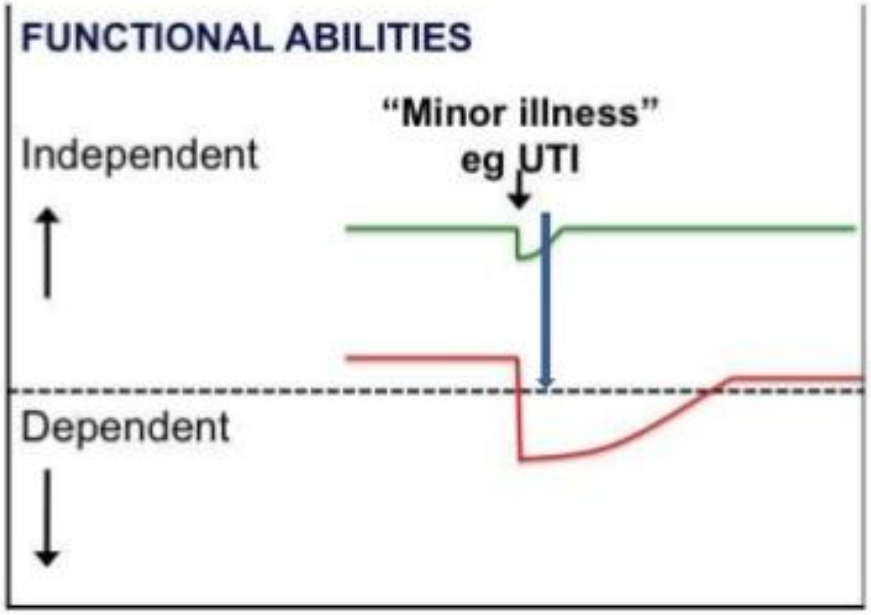
What is frailty?

- A clinically recognised state of increased vulnerability.
- Age and morbidity related decline in the body's physical and psychological reserves.
- At risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event which challenges their health.
- The degree of frailty of an individual is not static; it naturally varies over time and can be made better and worse.

Frailty as a LTC

NHS England

(Global loss of physiological reserve)



Clegg, Young, Iliffe, Olde-Rikkert, Rockwood. Frailty in elderly people. Lancet 2013; 381: 752-762

Fried's frailty phenotype

- Unintentional weight loss
- Reduced muscle strength
- Reduced gait speed
- Self-reported exhaustion
- Low energy expenditure.
- Individuals with three or more are said to have frailty

Not everyone over 65 years will be frail, so who is at greater risk of frailty?

Gender

Compared with male, females are **2.5** times more likely to be frail

Ethnicity

Compared with White ethnicity, South Asians are **3** times more likely to be frail

Age

Compared with under 65 years

65-69 years are **3** times more likely to be frail

70-74 years are **4** times more likely to be frail

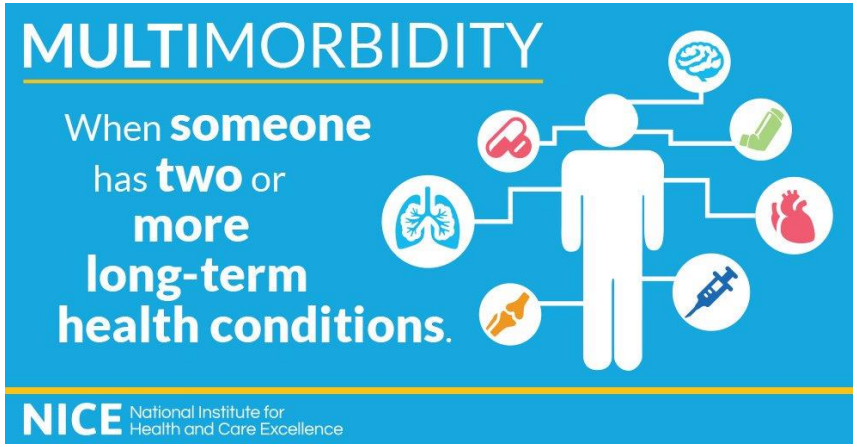
75 + years are **8** times more likely to be frail

Deprivation

Compared with people living in least deprived quintile

People living in most deprived quintile are 3 times more likely to be frail

Single, widowed or divorced and living alone are more likely to be frail



- Many people with long term conditions also have frailty which may be masked when the focus is on the long term conditions.
- Some people are frail but do not suffer from any chronic diseases and may not be known to their GP.
- There is overlap between the management approaches for people with multi-morbidity and those with frailty but these conditions are not identical.
- There is an overlap between frailty and physical disability – many people with frailty also have disability, however many people with a long term disability do not have frailty.

Why is frailty important?

- Simple interventions e.g. a short term residential placement for respite, a trip to the local emergency department after a fall or the trial of a new analgesic can have unforeseen and adverse outcomes
- Higher risk of complications from hospitalisation – pressure sores, delirium, loss of weight, immobility
- Longer length of stay in hospital
- Worse outcome – death and disability
- Less benefit and more side effects from medication

Why is it important to identify frailty?

- To understand why deterioration may appear sudden and catastrophic
- To understand why recovery from illness is prolonged and uncertain
- To recognise burdens as well as benefits of hospitalisation and medication.
- To understand the risk factors for delirium and impact on recovery
- **To ensure appropriate specialist referral to provide comprehensive, multi-faceted multidisciplinary care to improve outcomes**
- To enable people to plan for their future

Identifying frailty

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.

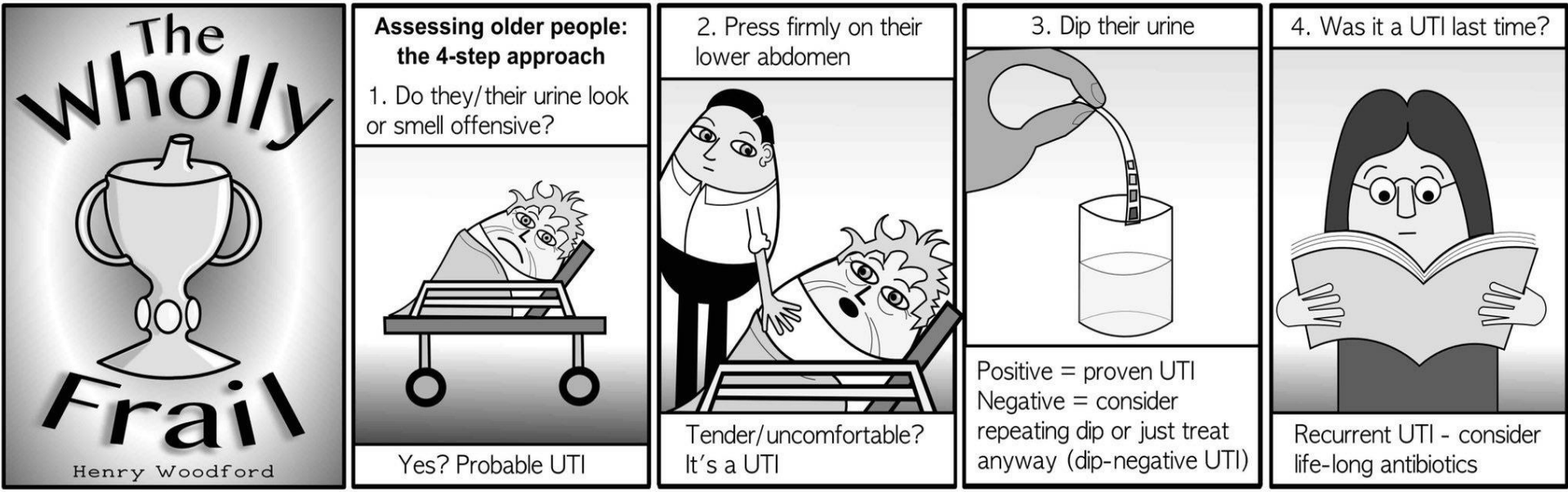
DALHOUSIE UNIVERSITY
Inspiring Minds

The narrative of aging and frailty

- Loss of reserve / resilience
- Continually adapting to loss
- Loss of the future – inhabiting the space between living and dying
- Living with fear and loneliness
- Worry about being a burden

- Maintaining personhood through routines, rituals and relationships
- Care and support to maintain independence more important than prevention and cure
- Preserving dignity and relationships more important than risks

What can we do about frailty?



Off Legs

Acopia

Social admission

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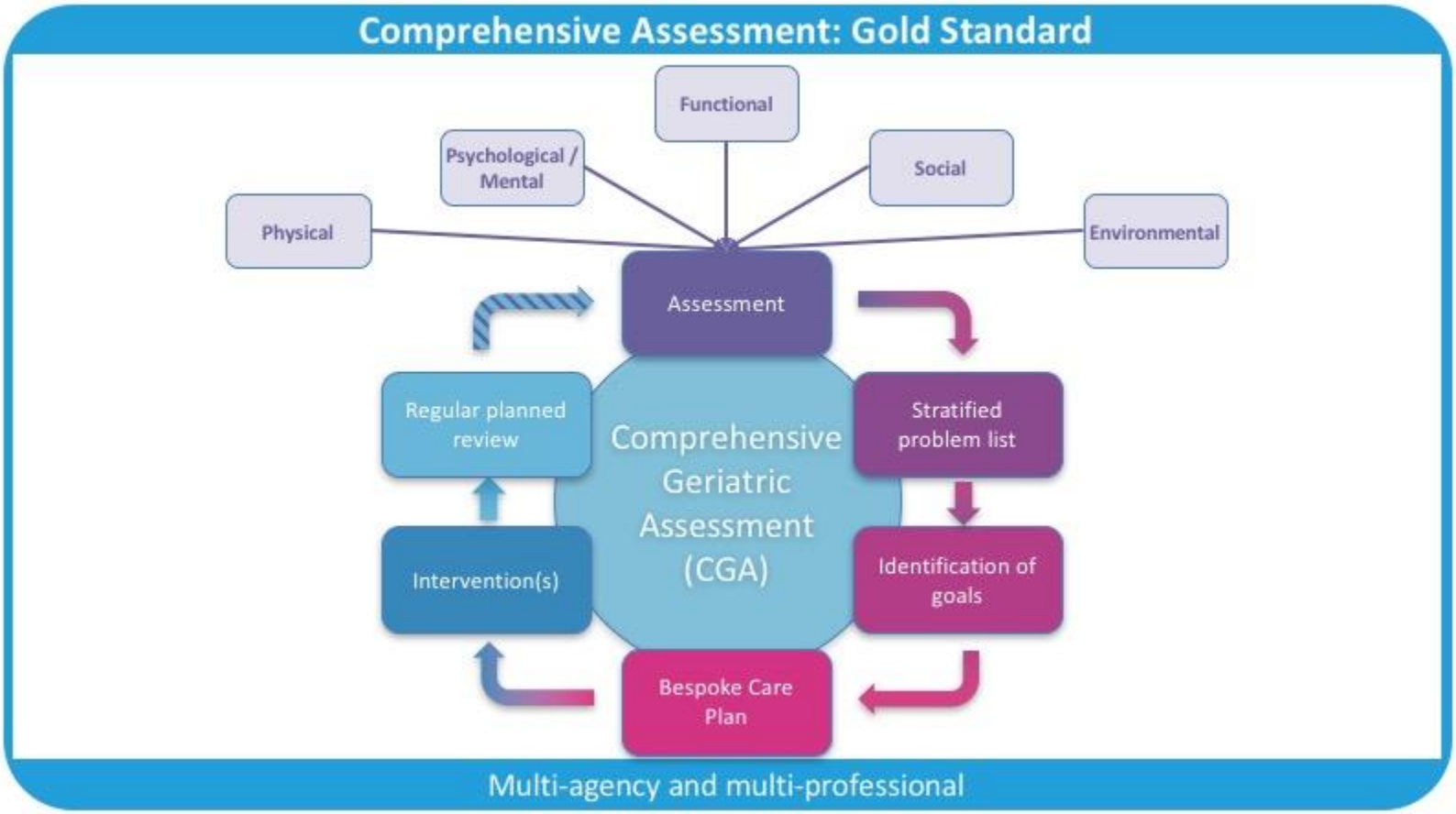
What can we do about frailty



Reappraising 'the good death' for populations in the age of aging

Pollock &Seymour Age and Aging 2018; **0:** 1-3

- National strategy for end of life care – emphasis on choice and ACP
- "*principles are challenging to apply to uncertain illness trajectories where there is often not clear cut point at which the end of life phase begins*"
- Many older people do not prioritise choice or autonomy
- More concerned about relationships and worried about being a burden.
- *"older people towards the end of life are intensely vulnerable and profoundly dependent on those around them"*

Reframing the context
1000 days of life

Brian Dolan

- If you're an 80 year-old woman or a 76 year-old man, what have you got left?
- **What you have left is 1,000 days.**
- Every 10 days of bed-rest in hospital = 10 years of aging.
- One week of bedrest = 10% loss of strength which can be the difference between dependence and independence.

Different paradigms

- Medical model
- Disease orientated
- Diagnosis
- Treatment
- Cure
- Autonomy
- Episodic
- Guidelines
- Safety focus

- Person centred
- Well-being
- Goal orientated
- Reablement
- Palliation
- Family
- Continuity
- Integrated care
- Risk enablement

The last phase of life

- To encourage healthcare staff, families and patients to talk more openly about the last phase of life
- Opens up discussion to be more than end of life and DNACPR
- **“Adding life to years not just years to life”**
- What are the goals of treatment?
- Re-adjusting perspective when managing chronic disease e.g. diabetes
- Re- considering preventative medication vis symptom control e.g. Heart failure
- Personalising evidence based medicine
- Reducing the burden of medication

Rationalising medication

- > 4 meds = increased risk of falls
- Low BP – falls, cognitive decline
- Low BMs – confusion
- Sedatives – confusion
- Anticholinergic side effects- dry mouth, constipation, confusion
- Diuretics and incontinence
- Secondary prevention- statins, ACEIs, bisphosphonates less benefit as life expectancy gets shorter.
- **No drug is life long**

End of life care and frailty- what do we need to do differently?

- Talking about a different phase of life where healthcare goals may change, balancing quality against quantity of life
- Dual approach- affirming life and preparing for death
- Talking about benefits and burdens of healthcare – understanding the impact of frailty on response to illness and recovery
- Understanding that just **because we can does not mean we should** e.g.
  - Treating LRTI in a person with severe dementia
  - Investigating for a PE in a bed bound NH resident

Changing the response to crisis

- Advance/anticipatory care planning
- Sharing information across services
- 24/7 options for accessing help in the community

Your last 1000 days; living and dying well with frailty

- Patient centred
- Optimising function- multi-dimensional
- Continuity
- Involving family and carers
- Integrating health and social care
- Multidisciplinary and multiagency
- Responsive in a crisis