



# Fit for Frailty

Consensus Best Practice Guidance for the care of older people living with frailty in community and outpatient settings

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*in association with the Royal College of General Practitioners and Age UK*

## Part 1: Recognition and management of frailty in individuals in community and outpatient settings

### How to use this guide

This summary guide is for anyone who may be called on to provide support to older people living with frailty, including GPs, district nurses, social workers, care staff, paramedics and informal carers. It explains how to recognise frailty and offers guidance on how best to manage the condition.

A fuller and more detailed edition of the guide including case examples is available as a free download on our website ([http://www.bgs.org.uk/campaigns/fff/fff\\_full.pdf](http://www.bgs.org.uk/campaigns/fff/fff_full.pdf)).

Part 2 of the guide entitled, “Designing, Managing and Commissioning services for Older People with Frailty” will be published in December 2014.

### What is frailty?

Frailty is a clinically recognised state of increased vulnerability. It results from ageing associated with a decline in the body’s physical and psychological reserves.

Frailty varies in its severity and individuals should not be labelled as being *frail* or *not frail* but simply that they have frailty. The degree of frailty of an individual is not static; it naturally varies over time and can be made better and worse.

Frailty is not an inevitable part of ageing; it is a long-term condition like diabetes or Alzheimer’s disease.

### Why is frailty important?

Older people living with frailty are at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event which challenges their health (e.g. infection, new medication, fall, constipation or urine retention).

Frailty might not be apparent unless actively sought.

Many people with multiple long-term conditions will also have frailty which may be overlooked if the focus is on disease-based long-term conditions such as diabetes or heart failure.

Other people whose only long term condition is frailty, may not be known to primary care or the local authority until they become immobile, bed bound, or delirious as a result of an apparently minor illness.

There is evidence that in individuals with frailty, a person-centred, goal-orientated comprehensive approach reduces poor outcomes and may reduce hospital admission.

### When and how should frailty be recognised?

Any interaction between an older person and a health or social care professional should include an assessment which helps to identify if the individual has frailty.

The type of assessment will differ depending on circumstances. But planning any intervention, such as new medication, emergency admission or elective joint surgery, in an individual who has frailty without recognising it, risks significant harm to the patient as the presence of frailty may change the balance of benefit and risk.

### Frailty syndromes

The presence of one or more of these 5 syndromes should raise suspicions that the individual has frailty and that the apparently simple presentation may mask more serious underlying disease:

- Falls (e.g. ‘collapse’, ‘legs gave way’, ‘found lying on floor’)
- Immobility (e.g. sudden change in mobility, ‘gone off legs’ ‘stuck on toilet’)
- Delirium (e.g. acute confusion, worsening of pre-existing confusion/short term memory loss)
- Incontinence (e.g. new onset or worsening of urinary or faecal incontinence)
- Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants).

### Simple assessments for identifying frailty

A range of simple tests for identifying frailty is available:

- Gait speed: taking more than 5 seconds to cover 4 metres
- ‘Timed up-and-go test’ (TUGT): a cut off score of 10 seconds to get up from a chair, walk 3 meters, turn round and sit down.

A brief clinical assessment would help exclude some false positives (e.g. fit older people with isolated knee arthritis causing slow gait speed).

- **PRISMA 7 Questionnaire** which is an alternative for self-completion, including use as a postal questionnaire. A cut off score of 3 or more suggests the need for further clinical review. (see Box 1).

There is currently no evidence that routine population screening for frailty improves health outcomes.

### How Should Frailty Be Managed?

The gold standard for the management of frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA). CGA involves a holistic, interdisciplinary assessment of an individual and has been demonstrated to improve outcomes. It can be time consuming so it is not feasible for everyone with frailty in community settings to undergo a full multidisciplinary review with geriatrician/old age psychiatry involvement.

However **all** patients with frailty should have a holistic medical review by their GP based on the principles of CGA. This must include a review of current symptoms and signs and consideration of underlying medical conditions. Some people will need referral to a geriatrician or old age psychiatrist for support with diagnosis, intervention or care planning, and others will need to be referred to other specialists in the community such as therapists, specialist nurses, dieticians and podiatrists (*figure 1*).

The result of this holistic review (CGA) should be a personalised Care and Support Plan (CSP) (<http://tinyurl.com/qezrllt>) focusing on the individual’s needs and goals. The CSP documents a plan to optimise and maintain health and function, an escalation plan advising when the patient/carer might need to seek further advice, an urgent care plan and, when appropriate, an end of life care plan.

In an emergency situation, the presentation of an older person with frailty is not always straightforward. Frailty syndromes such as falls, delirium and reduced mobility, can mask serious underlying illness.

Prior knowledge that the patient has frailty and that they have a CSP in place will help decision making.

#### Box 1

##### Prisma 7 Questions

- 1] Are you more than 85 years?
- 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?

1. Assess clinical condition - measure vital signs and consider if any 'red flags' are present which suggest the patient needs acute hospital care - such as hypoxia, significant tachycardia or hypotension (if possible compare readings with what is usual for that patient as recorded in their CSP).

2. Assess current function - can they get out of bed, can they walk, are they able to use the toilet?

3. Are they confused? - is this usual (may need input from carers to determine this) or worse than usual? Patients with dementia are at higher risk of delirium. Is there evidence of head injury?

If the patient is stable, i.e. demonstrates usual level of function, but has a temperature or evidence of delirium, they will need timely medical review, but not necessarily immediate conveyance to hospital.

If a patient is not severely unwell but is unable to maintain their usual *status quo* in the community due to a change in their care needs, it is good practice to transfer care to a responsive community service rather than arranging admission to hospital, as long as a diagnosis has been made.

## Summary of BGS Recommendations

- ▶ Older people should be assessed for the presence of frailty during all encounters with health and social care professionals. Gait speed, the timed-up-and-go test and the PRISMA questionnaire are recommended assessments.
- ▶ Provide training in frailty recognition to all health and social care staff.
- ▶ Do not offer routine population screening for frailty.
- ▶ Look for a cause if an older person with frailty shows decline in their function.
- ▶ Carry out a comprehensive review of medical, functional, psychological and social needs based on the principles of comprehensive geriatric assessment.
- ▶ Ensure that reversible medical conditions are considered and addressed.
- ▶ Consider referral to geriatric medicine where frailty is associated with significant complexity, diagnostic uncertainty or challenging symptom control.
- ▶ Consider referral to old age psychiatry for those people with frailty and complex co-existing psychiatric problems, including challenging behaviour in dementia.
- ▶ Conduct evidence-based medication reviews for older people with frailty (e.g. STOPP START criteria).
- ▶ Use clinical judgment and personalised goals when deciding how to apply disease-based clinical guidelines to the management of older people with frailty.
- ▶ Generate a personalised shared care and support plan (CSP) outlining treatment goals, management plans and plans for urgent care. In some cases it may be appropriate to include an end of life care plan.
- ▶ Where an older person has been identified as having frailty, establish systems to share health record information (including the CSP) between primary care, emergency services, secondary care and social services.
- ▶ Develop local protocols and pathways of care for older people with frailty, taking into account the common acute presentations of falls, delirium and sudden immobility. Wherever the patient is managed, there must be adequate diagnostic facilities to determine the cause of the change in function. Ensure that the pathways build in a timely response to urgent need.
- ▶ Recognise that many older people with frailty in crisis will manage better in the home environment but only with appropriate support systems.

