BCGuidelines.ca

# 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)

BRITISH COLUMBIA | Ministry of Health

doctors of bc

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).

## Further Assessment

**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

"A global clinical measure of fitness and frailty in elderly people" – Reprinted from, CMAJ 30-Aug-05; 173(5), Page(s) 489-495 by permission of the publisher. © 2005 Canadian

Medical Association

**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

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.

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]
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.

## References


1. Tinetti ME, Fried T. The end of the disease era. American Journal of Medicine. 2004;116:179-185.
2. Hebert R, Durand PJ. Frail elderly patients: New model for integrated service delivery. Canadian Family Physician. 2003;49:992-997.
3. Fried LP, Tangen JW, Walston J, et al. Frailty in older adults: Evidence for a phenotype. Journal of Gerentology. 2001;56(3):M146-M156.
4. Bergman H, Beland F, Karunananthan S, et al. Developing a working framework for understanding frailty. Gérentologie et Societé. 2004;109:15-29.
5. Fried LP, Ferrucci L, Darer J, et al. Untangling the concepts of disability, frailty, and comorbidity: Implications for improved targeting and care. Journal of Gerontology Medical Sciences. 2004;59A(3):255-263.
6. Gill TM, Gahbauer EA, Allore HG, et al. Transitions between frailty states among community-living older persons. Archives of Internal Medicine. 2006;166:418-423.
7. Rockwood K, Song X, MacKnight C, et al. A global clinical measure of fitness and frailty in elderly people. Canadian Medical Association Journal. 2005;173(5):489-495.
8. interRAI Minimum Data Set - Home Care (MDS-HC). Details of MDS-HC tool available online at: http://www.interrai.org/section/view/?fnode=15
9. Pereles LR, Boyle NG. Comprehensive geriatric assessment in the office. Canadian Family Physician. 1991;37:2187-2194.
10. Fick DM, Cooper JW, Wade WE, et al. Updating the Beers criteria for potentially inappropriate medication use in older adults. Archives of Internal Medicine. 2003;163:2715-2724.
11. Ensberg M, Gerstenlauer C. Incremental geriatric assessment. Primary Care: Clinics in Office Practice. 2005;32:619-643.
12. Examples of available tools for screening and evaluation (Appendices). Primary Care: Clinics in Office Practice. 2005;32:829-853.
13. Gill TM, Baker DI, Gottschalk M, et al. A program to prevent functional decline in physically frail elderly persons who live at home. New England Journal of Medicine. 2002;347(14):1068-1074.
14. Petrone K, Katz P. Approaches to appropriate drug prescribing for the older adult. Primary Care: Clinics in Office Practice. 2005;32:755-775.
15. LeCouteur DG, Hilmer SN, Glasgow N, et al. Prescribing in older people. Australian Family Physician. 2004;33(10):777-781.
16. Holmes HM, Hayley DC, Alexander GC, et al. Reconsidering medication appropriateness for patients late in life. Archives of Internal Medicine. 2006;166:605-609.
17. Temkin-Greener H, Gross DL. Advance care planning in a frail older population. Research on Aging. 2005;27(6):659-691
18. Sloan J. Keeping Frailty out of the hospital. BC Association of Geriatric Care Physicians. Spring News. 2004:4.
19. Durso SC. Using clinical guidelines designed for older adults with diabetes mellitus and complex health status. Journal of the American Medical Association. 2006;295(16):1935-1940.
20. Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: Implications for patient safety and continuity of care. Journal of the American Medical Association. 2007;297(8):831-841.
21. Beland F, Bergman H, Lebel P, et al. Integrated services for frail elders (SIPA): A trial of a model for Canada. Canadian Journal on Aging. 2006;25(1):25-42.
22. Kramer BJ, Auer C. Challenges to providing end-of-life care to low-income elders with advanced chronic disease: Lessons learned from a model program. The Gerentologist. 2005;45(5):651-660.
23. Stock RD, Reece D, Cesario L. Developing a comprehensive interdisciplinary senior healthcare practice. Journal of the American Geriatrics Society. 2004;52:2128-2133.


## 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

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.

## Contact Information

Guidelines and Protocols Advisory Committee
P.O. Box 9642 STN PROV GOVT
Victoria BC V8W 9P1

Phone: 250 952-1347
Fax: 250 952-1417
E-mail: HLTH.Guidelines@gov.bc.ca
Web site: www.BCGuidelines.ca

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

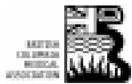
- encourage appropriate responses to common medical situations
- recommend actions that are sufficient and efficient, neither excessive nor deficient
- permit exceptions when justified by clinical circumstances.

## 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

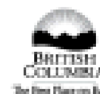
Disclaimer

The Clinical Practice Guidelines (the "Guidelines") have been developed by the Guidelines and Protocols Advisory Committee on behalf of the Medical Services Commission. The Guidelines are intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. The Guidelines are not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of clinical problems.




# SENIORS ASSESSMENT TOOL

This Assessment Tool pertains to the Guideline:
Frailty in Older Adults – Early Identification and Management
www.BCGuidelines.ca




| 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)



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

British Columbia – The Best Place on Earth | Ministry of Health Services

Guidelines & Protocols Advisory Committee | British Columbia Medical Association

# SAMPLE CARE PLAN TEMPLATE

## This Care Plan pertains to the Guideline: Frailty in Older Adults – Early Identification and Management

www.BCGuidelines.ca

| PATIENT PERSONAL HEALTH NUMBER | | |
|---|---|---|
| NAME OF PATIENT | TELEPHONE NUMBER | DATE |
| NAME OF CAREGIVER | TELEPHONE NUMBER(S)<br>DAY: EVENING: | |
| NAME OF ALTERNATE DECISION MAKER | ROLE OR RESPONSIBILITY | TELEPHONE 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<br>Prioritized based on patient preferences | STRATEGIES<br>Include rererrals made | CAREGIVER RESPONSIBILE | EXPECTED OUTCOMES | STATUS |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

NEXT CARE PLAN REVIEW DATE YY MM DD

Guidelines & Protocols Advisory Committee

# MEDICATION REVIEW

This Medication Review pertains to the Guideline:
Frailty in Older Adults – Early Identification and Management
www.BCGuidelines.ca

Ministry of Health Services

| 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<br>☐ VIALS<br>☐ DOSETTE<br>☐ 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 Bipo-
- ☐ lar

Endocrine
- ☐ Diabetes
- ☐ Hypothyroid

Other: ____________________

## VISITS (EVERY 6 MONTHS)

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

HLTH/BCMA 6013 (06/08)

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:
Frailty in Older Adults – Early Identification and Management

www.BCGuidelines.ca

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?

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

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

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

---

1 Petrone K, Katz P. Approaches to appropriate drug prescribing for the older adult. Primary Care: Clinics in Office Practice 2005; 32:755-775.
2 LeCouteur DG, Hilmer SN, Glastgow N, Naganathan V, Cumming RG. Prescribing in older people. Australian Family Physician 2004;33(10): 777-781.
3 Fick DM, Cooper JW, Wade WE, Waller JL, Maclean JR, Beers MH. Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Arch Intern Med 2003;163:2716-2724.
4 Samoy LJ, Zed PJ, Wilbur K, Belen RM, Abu-Laban RB, Roberts M. Pharmacotherapy 2006;26(11)1587-1586
5 Strand LM, Morley PC, et al. Drug-related problems: their structure and function. DICP ANN Pharmacother 1990;24:1093-7