Appendix A: Frailty Assessment and Management Pathway

A) USE A CASE FINDING APPROACH TO IDENTIFY WARNING SIGNS OF FRAILTY (SCREENING NOT RECOMMENDED)

Particularly among older adults who regularly or increasingly require health and social services (e.g. emergency room visits, ambulance crew attendance, adult day clinics, home support, etc.).

See Table 1: Possible early warning signs of frailty

FRAILTY SUSPECTED

B) CONFIRM CLINICAL SUSPICION OF FRAILTY WITH A SCORING TOOL

**Tools not appropriate for all patients*

	Tool	Frailty suggested by:
General	PRISMA-7 Questionnaire	Score ≥ 3
Mobility*	Gait Speed Test	Time > 5 seconds over 4m
	Timed Up and Go Test	Time > 10 seconds
Cognitive Impairment	Standardized Mini Mental State Exam Montreal Cognitive Assessment	See BCGuidelines.ca: *Cognitive Impairment*

FRAILTY IDENTIFIED

C) CONDUCT COMPREHENSIVE ASSESSMENT OF PATIENT WITH FRAILTY

May be conducted as a rolling assessment over multiple office visits.

See Table 3: Areas of geriatric assessment

D) USE CLINICAL FRAILTY SCALE TO GRADE SEVERITY OF FRAILTY

See Figure 3: Clinical Frailty Scale

KEY ASSESSMENT AREAS

Medical: immunization, habits, nutrition, pain, bowel/bladder, vision/hearing/speech

Psychological: cognition, mood

Functional: mobility, fall risk, physical activity, basic and instrumental ADLs

Social/environmental: social/spiritual needs, need for care support/help at home

FRAILTY ASSESSED

E) DEVELOP OR REFINE THE CARE PLAN – see *Appendix B: Sample Care Plan Template*

Care plan may be developed during a complex care planning visit, or over a series of planned office visits with one or more areas of concern addressed at each appointment.

1. **Inquire about the patient's primary concerns**
   Consider concerns of family/caregivers/representatives, as appropriate.
2. **Review patient goals of care, values and preferences**
   Care plan should be developed jointly with the patient and/or representative.
3. **Review history, current medical conditions, and interventions**
   Review signs and symptoms and conduct investigations, as appropriate.
   Consider adherence and comfort with past or current treatment plans.
4. **Consider a medication review – see *Appendix C: Medication Review***
   Consider requesting a medication review by a pharmacist.
   Compile a complete record of drugs the patient is currently taking and give a dated copy to the patient/caregiver/representative – see *Best Possible Medication History*
5. **Initiate advance care planning discussions**
   See *Advance Care Planning: Resource Guide for Patients and Caregivers*
6. **Communicate the care plan**
   Share with patient and family/caregiver/representative and key care providers.
7. **Reassess the care plan at selected intervals**
   Identify an appropriate timeframe to re-evaluate the care plan.

SUPPORT AND REFERRAL

HOME AND COMMUNITY CARE
For patients who require additional support at home or in the community.

COMPREHENSIVE GERIATRIC ASSESSMENT
For patients with multiple complex needs, diagnostic uncertainty or challenging symptom control.

PALLIATIVE CARE
For patients who would benefit from a palliative approach to care. See BCGuidelines.ca: *Palliative Care Part 1: Approach to Care*

See *Resource Guide for Older Adults and Caregivers*