



Appendix A: Frailty Assessment and Management Pathway

A) USE A CASE FINDING APPROACH TO IDENTIFY WARNING SIGNS OF FRAILITY (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

**Tools not appropriate for all patients*

B) CONFIRM CLINICAL SUSPICION OF FRAILITY WITH A SCORING TOOL

Tool	Frailty suggested by:
General PRISMA-7 Questionnaire	Score ≥ 3
Mobility* Gait Speed Test Timed Up and Go Test	Time > 5 seconds over 4m 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 FRAILITY
May be conducted as a [rolling assessment](#) over multiple office visits.

See [Table 3: Areas of geriatric assessment](#)

D) USE CLINICAL FRAILITY SCALE TO GRADE SEVERITY OF FRAILITY

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](#)