Safer Care Victoria

Care of Older People Clinical Network

Frailty recognition and response in the community

In 2019-2020 the Care of Older People Clinical Network (COPCN) partnered with five health services to address frailty, a priority improvement area for the network. The project involved sites implementing routine frailty screening and providing those identified as frail or pre-frail with an evidence-based bundle of care.

BACKGROUND

Frailty is common in older people and characterised by vulnerability.[1] When people are frail, they are more likely to experience poor health outcomes including falls, hospitalisation, admission to long term care and death.[2] Timely identification and treatment, including protein supplementation, resistance training, deprescribing and cognitive training, can reduce frailty and improve health.[3-5]

Frailty screening and evidence-based interventions are recognised as best practice care for older people.[4] However, this does not routinely occur in Victorian health services. This project aimed to address the gap between current and best practice.

AIM

95% of people aged 65 years and older (50 years and older for Aboriginal and Torres Strait Islanders) at participating sites will be screened for frailty and provided with a bundle of care (if frail or pre-frail) by April 2020.

IMPROVEMENT APPROACH

The Institute for Healthcare Improvement's (IHI) Collaborative Model and the Model for Improvement were used as the quality improvement framework.

An expert working group of 15 clinicians, academics and consumers was formed via an expression of interest (EOI) process. This group defined the project scope, aim and measurement strategy, and selected the frailty screening tools and the interventions which formed the bundle of care. The bundle of care included resistance training, medication review and nutrition intervention. Cognitive training and a comprehensive geriatric assessment were also encouraged if feasible.

One rural, one outer regional, one regional and two metropolitan sites were selected to participate in the pilot project via another EOI process. These services attended two face to face learning sessions to collaborate and learn about improvement science. Teams developed change ideas to implement frailty screening and the bundle of care, tested these change ideas using Plan-Do-Study-Act (PDSA) cycles and determined their effectiveness by collecting data in real time. Teams maintained contact with each other and COPCN through Microsoft Teams® online communication platform, online meetings and site visits. Due to unforeseen circumstances, the project concluded one month before planned and a third learning session was cancelled.

RESULTS AT A GLANCE

Health services

Five health services providing care to older people living in the community completed the project

Duration

November 2019 to March 2020

Project measures

% screened for frailty
% referred to bundle of care
Change in frailty status
Consumer reported benefits

Results

The % screened for frailty increased from 70 to 88%

No significant improvement was observed in % referred to the bundle of care

There was a trend towards slight improvement in frailty status (note: limited data)

Consumer reported benefits including improvement in function, social interaction, increased independence, enjoyment and being pushed out of comfort zone

Other outcomes

Increased clinician knowledge and understanding of improvement science

KEY IMPROVEMENTS

Change ideas

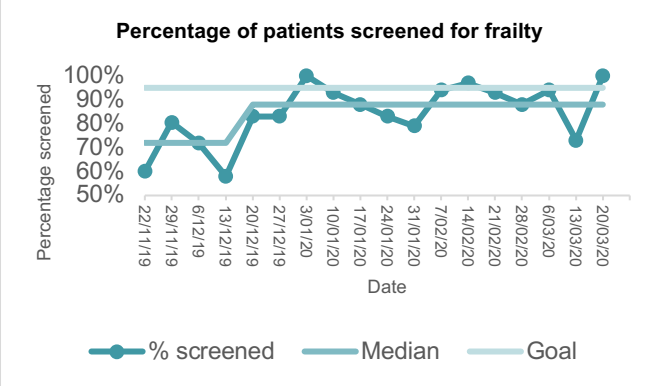
Each site tested various change ideas to implement frailty screening and the bundle of care. These included:

- Consumers, clinicians or intake staff completing the frailty screening tool
- Modification of screening tool format to make it easier for consumers to complete e.g. larger font, tick boxes
- Group resistance training and nutrition education
- Development of a medication review template
- Standardised GP letters to request medication review
- Consumer information brochures about frailty, the project, the bundle of care and the potential benefits
- Posters about frailty displayed in public areas
- Standard processes for bundle of care referrals e.g. booking slips for reception staff
- Specific allocation of appointment slots to provide the bundle of care

Results

No sites were screening for frailty prior to undertaking the project. Percentage of older people screened for frailty increased from a project baseline of 70% to 88% (Fig 1).

Figure 1: Percentage of older people screened for frailty (aggregate)



All sites made progress towards providing the bundle of care, however no significant improvement was identified beyond initial testing in the short project timeframe.

Most sites experienced challenges engaging consumers in the bundle of care. Reasons included consumers not identifying with the term frail, medical reasons, transport issues and appointment burden.

The small amount of outcome data available (n = 5) suggests that frailty status was slightly improved (median change on Edmonton Frailty Scale of -1). Additional data from one site indicated median improvement in Timed Get Up and Go score of -1 seconds and 10 Meter Walk Test score of -1.5 seconds and -1 step. There was no change in Hand Grip Strength, however upper limb strength was not a focus of the resistance exercise classes at this site.

Consumers who participated in the bundle of care reported multiple benefits, including improvement in function, social interaction, increased independence, enjoyment and being pushed out of comfort zone.

Change in carer burden could not be assessed as there was no follow-up data available.

Participating clinicians self-reported that improvement science knowledge and understanding increased.

KEY LEARNINGS

- It is feasible to provide routine frailty screening to older people living in the community
- Providing the bundle of care is resource intensive and group-based interventions are essential
- Further testing is required to determine the best setting to undertake frailty screening and intervention
- Face to face carer burden screening is not feasible as often carers do not attend appointments
- Strategies to engage consumers need to be tested
- The project timeframe was not sufficient to measure change in frailty status for consumers
- An alternative online sharing platform should be explored

NEXT STEPS

It is recommended that the project is repeated over a 9-12 month period to determine whether the bundle of care improves frailty status.

References:

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISBN/ISSN number (online/print)

Available at
www.safercare.vic.gov.au