Using the e-Frailty Index to Improve Patient Care

A story from Living Well in Communities

Snapshot 1: Mild frailty

Jean is a widow who lives alone and is independent.

She plays bowls regularly and likes to get the bus to the shops with her friends.

Her other medical conditions include high blood pressure, hypothyroidism, pernicious anaemia and osteoarthritis. She uses a stick to mobilise outside only.

She has seen the practice nurse for a routine blood pressure check and the nurse notices her eFI frailty score suggests she has mild frailty and gives her an exercise prescription. She has had a conversation about her assets and agrees that returning to the bowling club would allow her to keep fit and catch up with old friends. She also decides to get her flu jag regularly.

Snapshot 2: Mild frailty

Jean had a fall outside in the street (tripped over a paving slab). She is not badly hurt. After consulting her GP, she is reviewed by the falls team who make some changes to her medication. She has an eyesight check by her optician and after advice from the physiotherapist starts using her stick regularly. Her diagnosis list at the surgery is updated but her frailty score has not changed.

She gets some exercises to try but despite this has lost some confidence and her exercise tolerance is reduced.

Snapshot 3: Moderate frailty

One night while going to the bathroom Jean falls inside the house and bangs her head. She has to stay in hospital overnight for observation in the frailty unit but is seen by the geriatrician and the multidisciplinary team the following morning. They assess her gait, blood pressure, medication and cognition, ECG and medical assessment. They discuss with Jean their conclusions and that they are keen to provide care out of hospital.

They are happy for her to go home that day with assessment in the community by the community rehabilitation team. The team agree to refer her for a falls alarm and she is assessed for her care needs. Jean agrees to a carer for housework and her daughter offers to help with shopping and evening meals.

Her primary and community care team review her case. They notice with the recent events that her eFI frailty score has changed to moderate and look at her medication list, agreeing to stop some medication. The district nurse who is due to visit her the following week for her B12 injection agrees to explore an anticipatory care plan with her. She phones ahead and at Jeans request they discuss it with her daughter present. Her daughter agrees to explore a power of attorney with her.

Snapshot 4: Moderate frailty

Jean has an episode of delirium caused by a chest infection and has difficulty walking. She is unable to self-care and is admitted to hospital. The team in A&E screen her for frailty and recognising that she is becoming frail, fast-track her for a Comprehensive Geriatric Assessment.

She is seen by the frailty nurse and consultant geriatrician and after assessment and discussion with the MDT is admitted to an older people's ward. She is discussed daily at the team huddles and is actively encouraged to keep active and stay out of bed. After 6 days in hospital she is able to go home with the community rehabilitation team. The team have explained to Jeans daughter that prolonged admissions may result in loss of independence and when she is medically stable she will be transferred back to community services.

They organise an increased package of care after assessment in her own home as well as the delivery of some equipment to allow her to maintain some independence at home.

Snapshot 5: Severe frailty

Jean's daughter has organised power of attorney but as Jean returns to normal routines at home much of her delirium seems to lift and she is able to discuss more of her care wishes.

Jean revisits the discussion about her anticipatory care plan and expresses the wish to avoid hospital admission if at all possible.

The primary care team discuss Jean at the next meeting. They have noticed that in addition to their clinical interactions and concerns that her eFI is now flagging her as severely frail. It is also identified that Jean will need her cognition re-assessed once she has had time to recover. They discuss her daughters caring needs as they recognise that despite increasing her care support she is under pressure.

Snapshot 6: End of life

Some time passes and Jean becomes frailer at home. Her daughter notices that she is losing weight and is often sleeping or lacking in energy. Her walking pace has slowed.

Her memory has worsened dramatically over recent months and these features cause the daughter to seek medical attention.

Her District Nurse visits and runs through some memory questions and is alarmed by how fast she has deteriorated. She explores Jeans daughter's expectations who is realistic that some significant change has arisen.

The primary care team discuss her case and they agree that her condition has changed dramatically. They stop some of her tablets and refer her to the Hospital at Home service. They review her and recognise that she is approaching an end of life phase. Discussing their concerns with her daughter the team organise an ultrasound of abdomen after finding an enlarged liver. This shows secondary cancer spread and they agree with the daughter that a cure is not possible for Jean. Jean isn't able now to express her own opinions but her daughter is keen to respect the wishes she expressed in her anticipatory care plan to stay at home and avoid hospitals or care if at all possible. A hospital bed is ordered along with medication. The carers are increased and her care is transferred to the district nurses who visit daily to support Jean and provide emotional support to her daughter.

After a short illness Jean dies peacefully at home with her family present.