Improving frailty identification and management

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Within NHS Lothian, the North East Leith GP Cluster has successfully implemented a consistent method of identifying and coding frailty and frailty severity in primary care using the Rockwood Clinical Frailty Scale and a quick frailty identification guide. This case study summarises this work.

Nine practices within the NHS Lothian North East Leith Cluster opted to work together to improve frailty identification and management using QI methodology.

The total population across the nine practices is 72,600 people, of whom 6,426 are aged 65 years and over.

The initial pilot project took place in Leith Mount Surgery.

> "Recognising and coding these patients and having a structured proactive approach to their care seems to improve their quality of life, patients seem to really appreciate it"
>
> GP Practice staff member

Why?

Prior to 2018, Leith Mount Surgery did not actively identify, record or code frailty. There was no care pathway in place, there was no process to capture important information on patients presenting with frailty or frailty syndromes and there was no polypharmacy review process in place.

Aim

By completing a fishbone diagram, the practice was able to identify the reasons that they did not have a frailty register. From this, the initial aims of the project were developed:

- To set up a Clinical Frailty register
- Increase awareness and knowledge of frailty and frailty syndromes
- Use the Rockwood Clinical Frailty Scale (CFS) as a structured method to identify clinical frailty
- To promote safer prescribing and improve polypharmacy medication reviews
- To reduce falls
- To prevent unnecessary hospital admissions.

First steps

Patients were identified initially from the District Nurse caseload. Using the Rockwood CFS, Malnutrition Universal Screening Tool (MUST) and Waterlow (pressure ulcer risk assessment) scores along with clinical judgement, patients were identified as frail and had their frailty severity read coded in the GP clinical system.
Interventions were then considered such as polypharmacy medication reviews, referral for multidisciplinary Comprehensive Geriatric Assessment and completion of Key Information Summaries on SPIRE.

Frailty identification – a quick guide

People living with frailty usually experience three or more of the following five symptoms, that often co-exist. These symptoms are:

- muscle loss and weakness
- fatigue
- unintentional weight loss (10 or more pounds within the past year),
- low levels of physical activity
- slow walking speed.

You should also consider the following as possible indicators of frailty:

- falls
- immobility (e.g. sudden change in mobility)
- delirium
- incontinence (new onset or worsening urine or faecal incontinence)
- susceptibility to side effects of medications (especially confusion and hypotension)
- visual impairment
- cognitive impairment Mini Mental State Examination (MMSE with a score of < 25)
- increasing need for support.

Rockwood Clinical Frailty Scale

The Rockwood Clinical Frailty Scale is administered in around five minutes by a GP or nurse and can stratify patients according to their frailty severity.

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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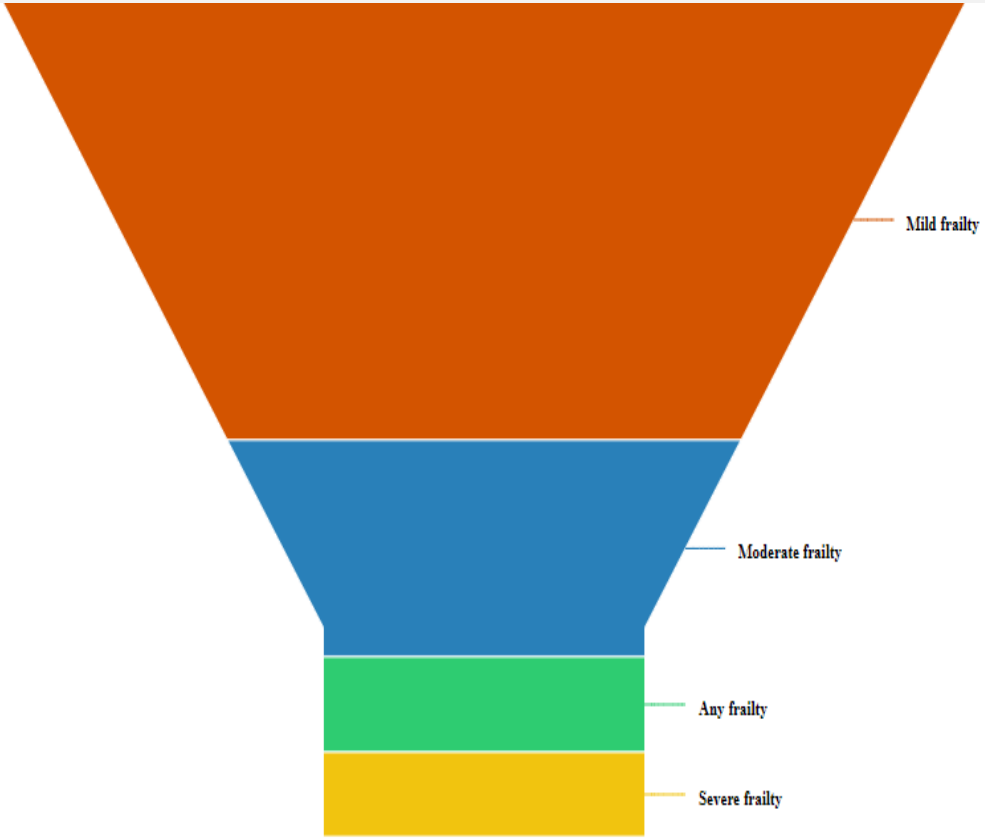
Evaluation

Population by frailty level

The funnel chart and table below shows the number of patients from the nine surgeries that fall within each level of frailty



Read Code	Level	No. Patients	% of Frail Patients	No. Patients Aged 65+	% Frail Patients Aged 65+
2Jd0.	Mild frailty	573	53	547	54
2Jd1.	Moderate frailty	282	26	262	26
2Jd..	Any frailty	124	11	110	11
2Jd2.	Severe frailty	110	10	95	9

The Dataloch team developed a practice frailty report which provides monthly data at an individual practice and cluster level. It extracts data on frailty coding, medication and polypharmacy review activity as well as the recording of falls. In time, these reports will be linked with additional data sets including prescribing data and secondary care activity such as falls with fractures and unscheduled care.

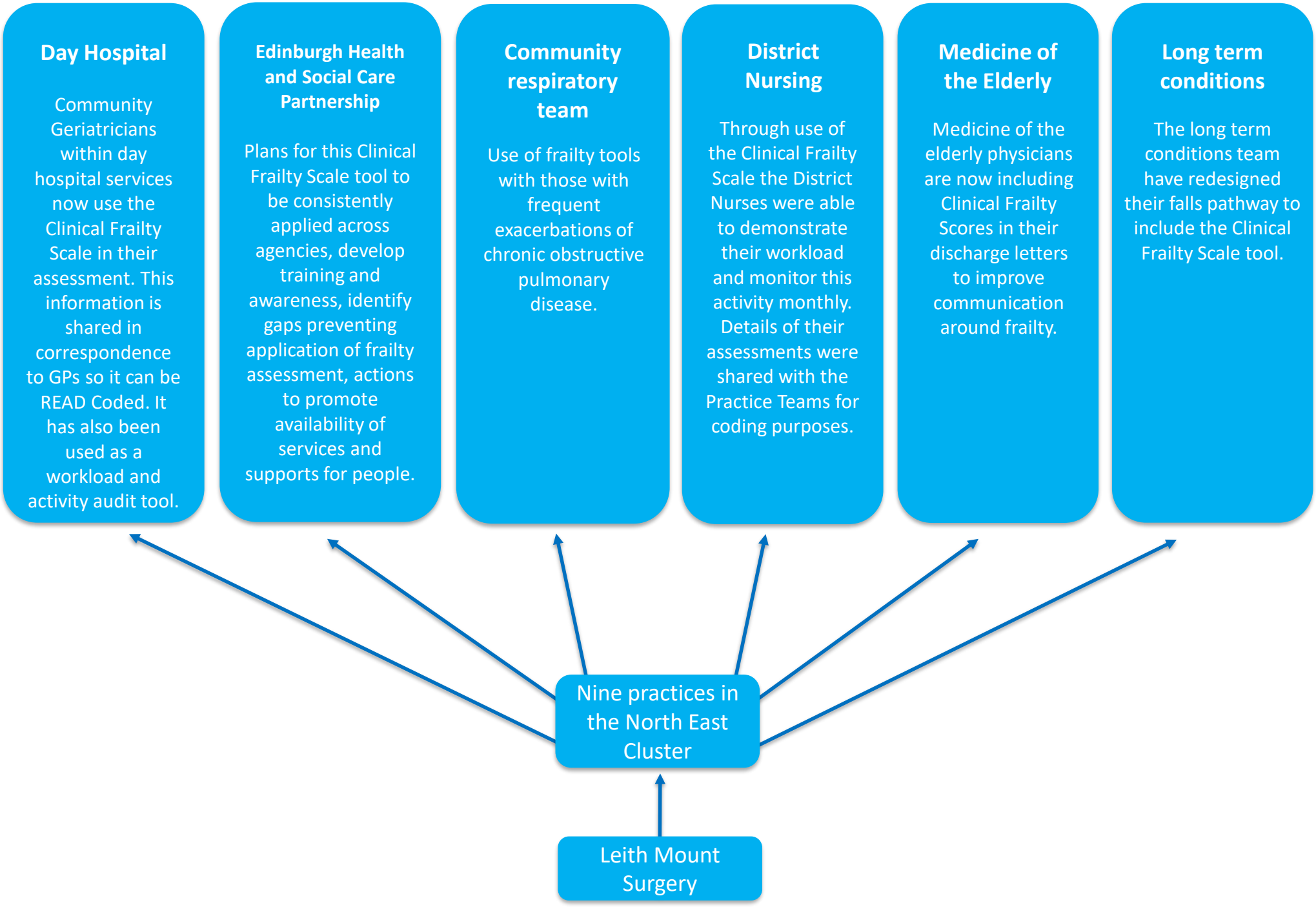
READ codes

- The number of patients with any frailty READ code in the nine surgeries has increased from 250 to 1,042 in the year from June 2020 to June 2021.
- The percentage of 65+ patients READ coded as frail has risen from 3% to 16%

Medication and polypharmacy reviews

- From a baseline of almost zero, over the 12 months to 1 April 2022, 26.4% of patients who are both frail and aged over 65 have had a documented medication review.
- Over the same period to 1 April 2022, 257 polypharmacy reviews have been performed for 210 patients across the 9 surgeries. 183 of these patients who received a polypharmacy review are aged 65 and over, and 178 of these patients have a frailty READ code recorded.
- There is now a reporting tool which can measure this activity and assist practices with safer prescribing.

Scale and spread



Staff reflections

- "I think about frailty more often and I'm sure I'm making safer prescribing decisions because of it"
- "The introduction of frailty screening using the Clinical Frailty Scale has enabled the District Nursing team to offer an enhanced holistic assessment of the patient. In conjunction with the person-centred risk bundle, this tool allows the team to make a more comprehensive assessment of the patient's needs. It allows us to identify those at risk of frailty. It encourages the team to question why a patient might re-present to the service, for example with repeated falls, readmissions on to the caseload or poor compliance with medication. It also allows us to work more collaboratively with our GP colleagues and the multidisciplinary team."

Our learning

We have successfully tested and demonstrated a change idea that the use of the Rockwood Clinical Frailty Scale and a quick frailty identification guide can improve the identification and coding of frailty in primary care. A brief educational intervention and some simple tools are all that is required. It is easily adopted and widely accepted and it is entirely feasible that this could be adopted across the entire health and social care community.*

** The findings are consistent with the ihub frailty change package which recommends the standardised use of reliable tools in the identification and assessment of frailty.*

The future

An Edinburgh Clinical Frailty Network has been set up to raise awareness about frailty and the importance of early identification.

An Operational Group has been set up with the following aims:

- To ensure the Clinical Frailty Scale is consistently applied across all agencies in Edinburgh
- To promote and support training and awareness for multidisciplinary teams to apply the agreed frailty tool
- To promote public awareness of frailty
- To encourage self management and highlight available information and resources.

With thanks to Dr Stephen Carty, Clinical Frailty Primary Care Lead, Edinburgh Health and Social Care Partnership, and his team for sharing this case study with the ihub.