Frailty in LTC

Benoit Robert, MD, MBA
Daniela Acosta, RN, GNC(C), BScN, BSc,

Perley Health

Perley Health is a unique community that empowers Seniors and Veterans to live life to the fullest. One of the largest and most progressive long-term care homes in Ontario, Perley Health is home to more than 600 Seniors and Veterans in long-term care and in independent apartments.

Perley Health provides a growing number of clinical, therapeutic, and recreational services; and is also home to the Centre of Excellence In Frailty-Informed Care, leading research, education, and clinical innovation.

Objectives

1. To understand frailty as a medical condition, including its assessment and management, in the context of a Long-Term care environment.

2. To be able to describe a frailty-informed care approach (SeeMe™) in the context of health care decision-making and future goals of care.

3. Participate in a simulated learning activity where participants will be able to apply a frailty-informed care approach using the SeeMe™ framework

Perley Health

Points to Remember

1 %

50%

OLTCC – 2017 report

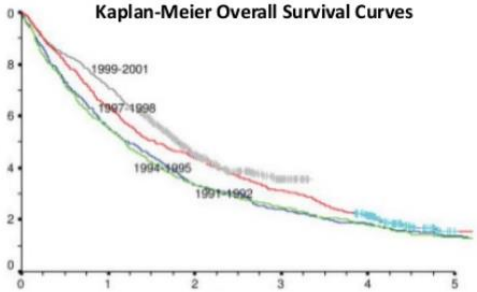
Perley Health

More points…

50 %
Average LOS = 2.5 years

Do Patients with Stage IV Breast Cancer Live Longer with Their Disease?

- British Columbia Registry*
- N=2150 patients with stage IV breast cancer
- Diagnosis years – 1991-2001



*Chia et al, Cancer 2007

Conference Board of Canada, 2012

Perley Health

TLC in LTC

Perley Health

Is admission to long term care

“life threatening”?

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.

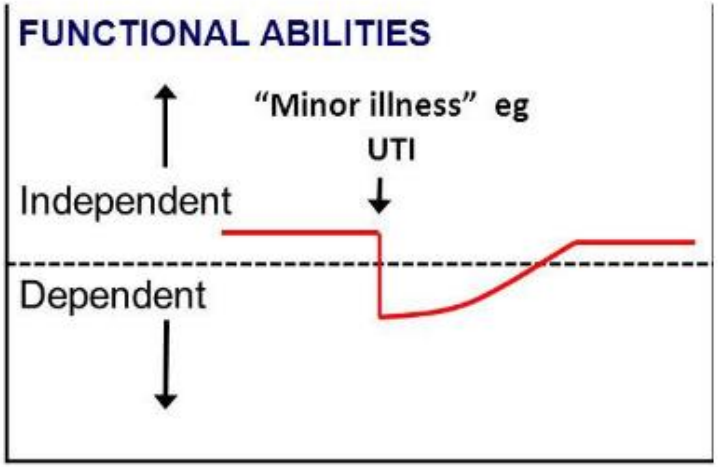
* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY
Inspiring Minds

Perley Health

Frailty is loss of physiological reserve

Frailty syndromes present in crisis



Hyper-acute Frailty syndromes:

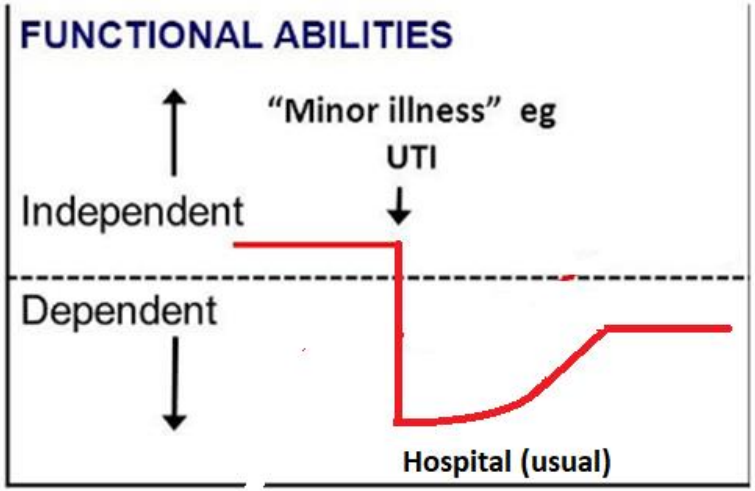
- Immobility
- Falls
- Delirium
- Fluctuating disability
- Incontinence

(Clegg, Young, Rockwood Lancet 2013)

Perley Health

Frailty is loss of physiological reserve

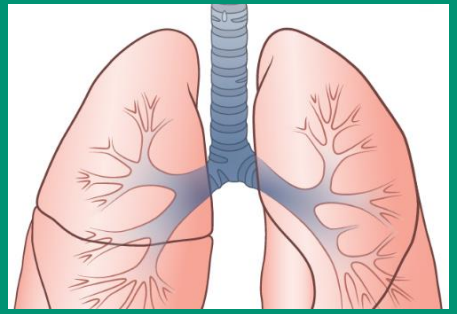
Frailty syndromes present in crisis

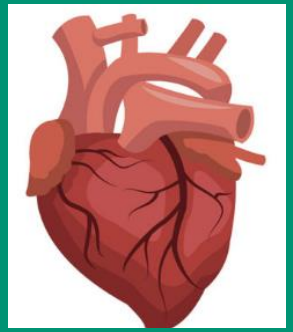


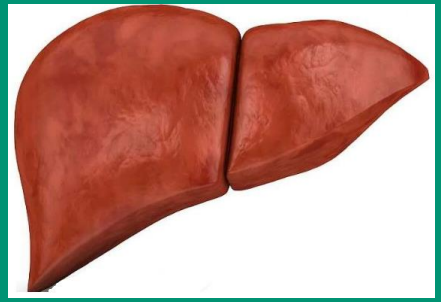
(Clegg, Young, Rockwood Lancet 2013)

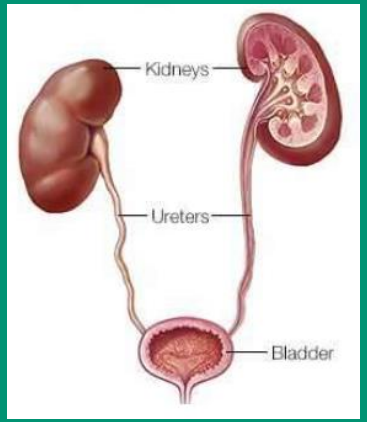
Perley Health

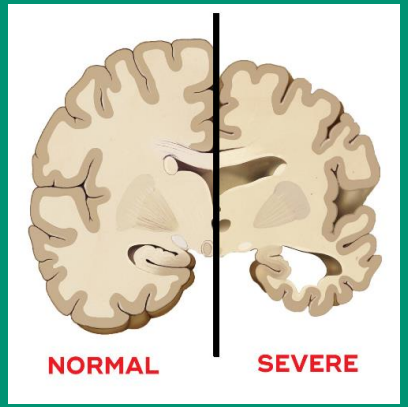
Perley Health

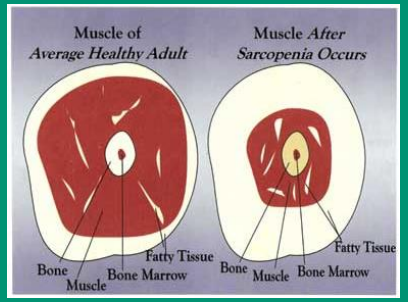




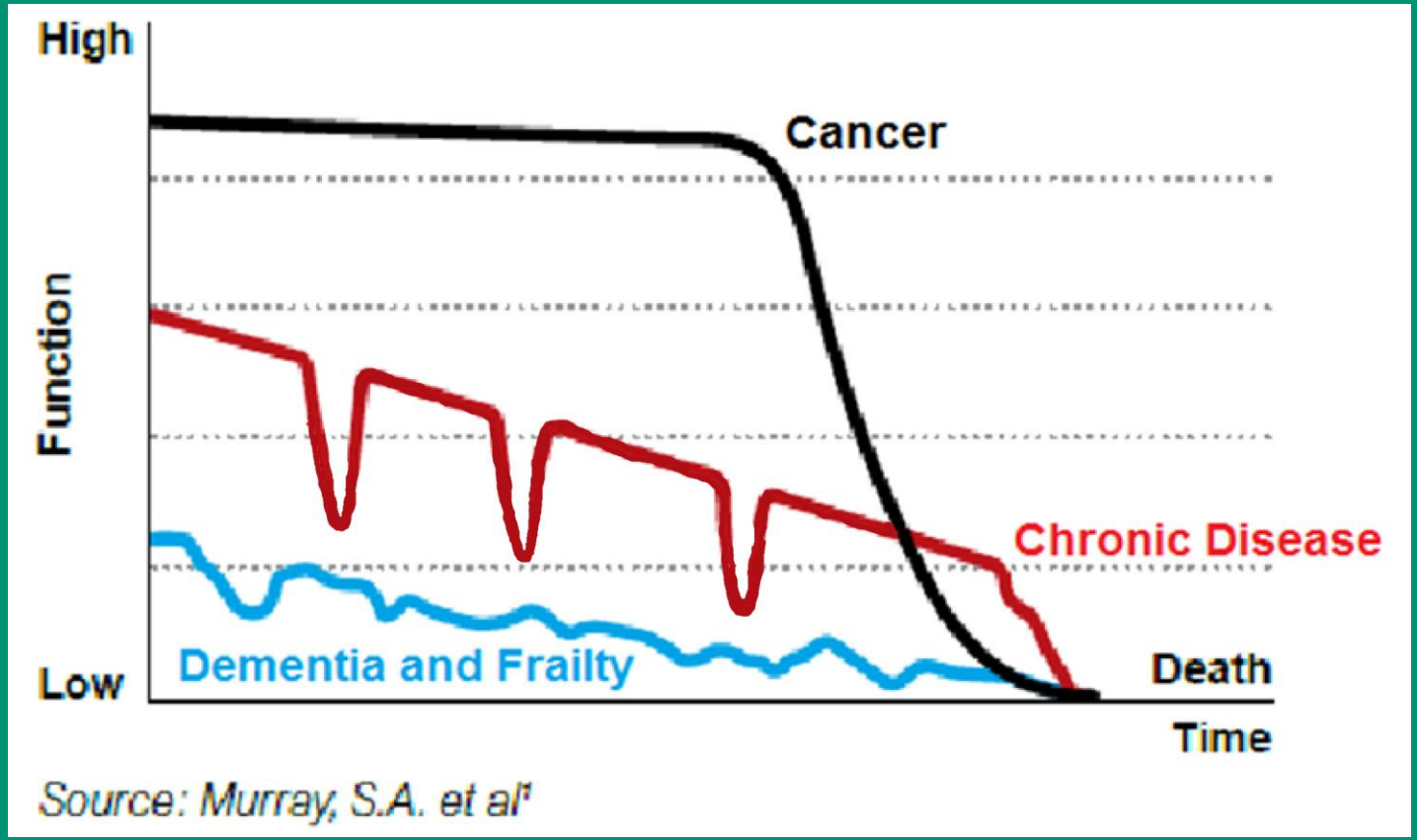






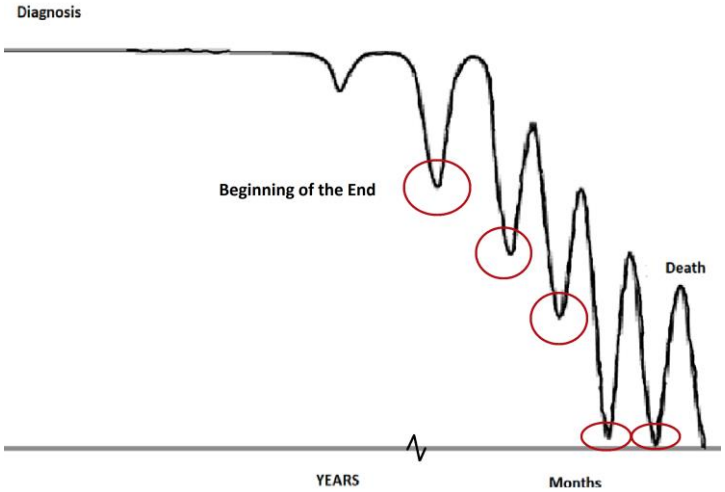


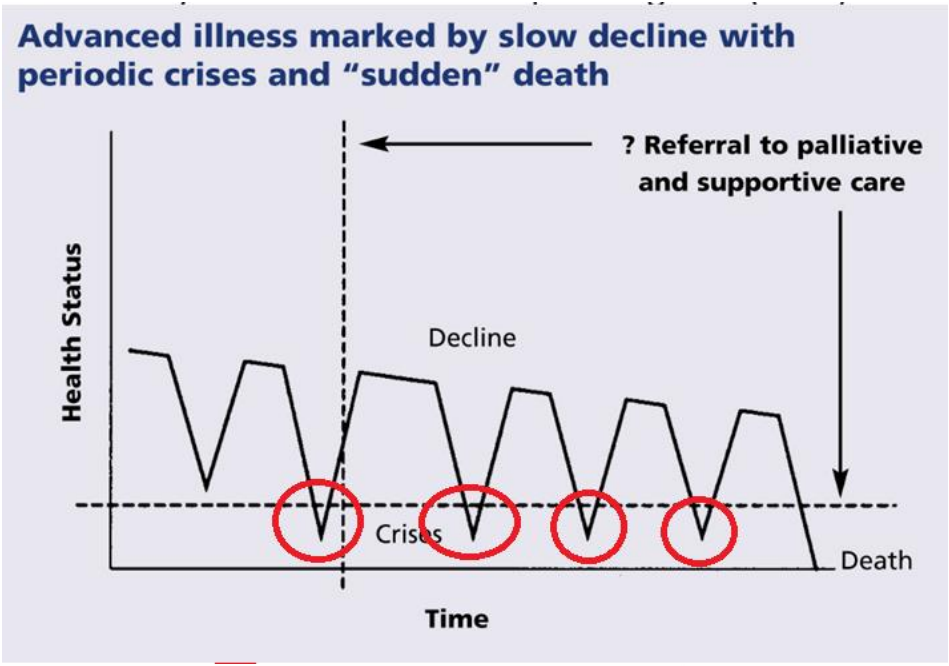
Perley Health



Perley Health

Health Crises





GOLD STANDARDS FRAMEWORK

P roactive

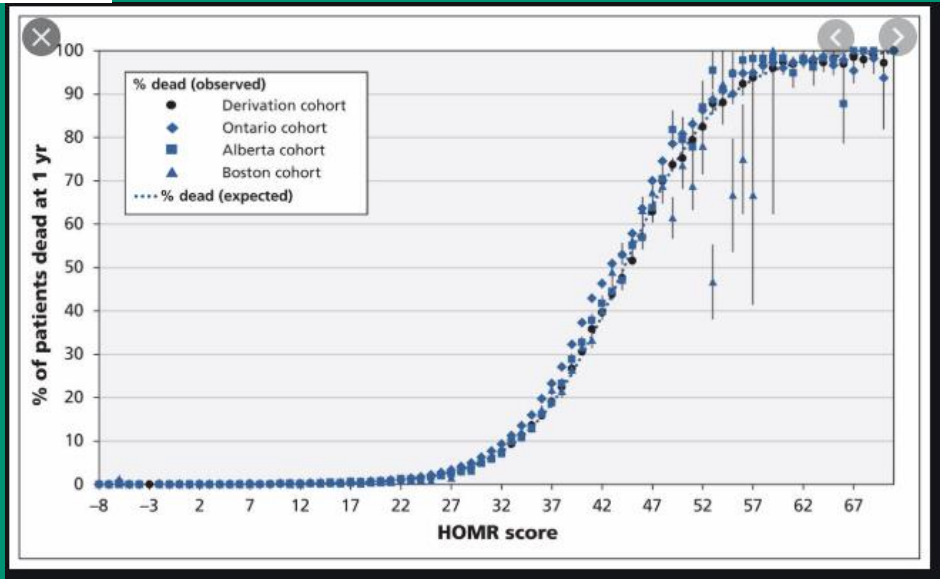
I dentification

G uide

http://www.goldstandardsframework.org.uk/

Perley Health

The RESPECT predictive algorithm



Story with a beginning - CANCER

- acute disease trajectory
- Concern re prognosis at time of diagnosis
- “How long have I got?”
- Treatment calendar dominates life, many services, many providers

Story with no beginning – Congestive Heart Failure

- Progressive disability trajectory
- Little understanding of prognosis at time of diagnosis
- “I hope it won’t get worse”
- Other illnesses to cope with
- Shrinking social world dominates life, may not have any human company

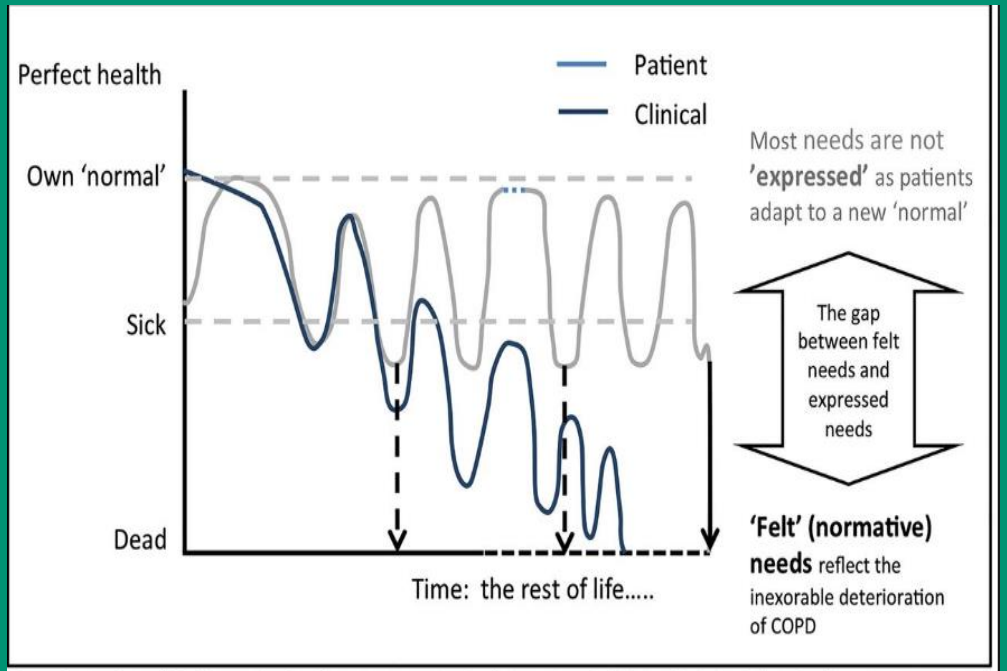
Perley Health

The Grey Line

patient's understanding

The Black Line

clinician's understanding



The professional story (black line on the chart) is a trajectory of gradually increasing disability in which the declining health status is punctuated at increasingly frequent intervals by exacerbations. Despite the certainty of deterioration, the timescale and the timing of the final event is unpredictable.

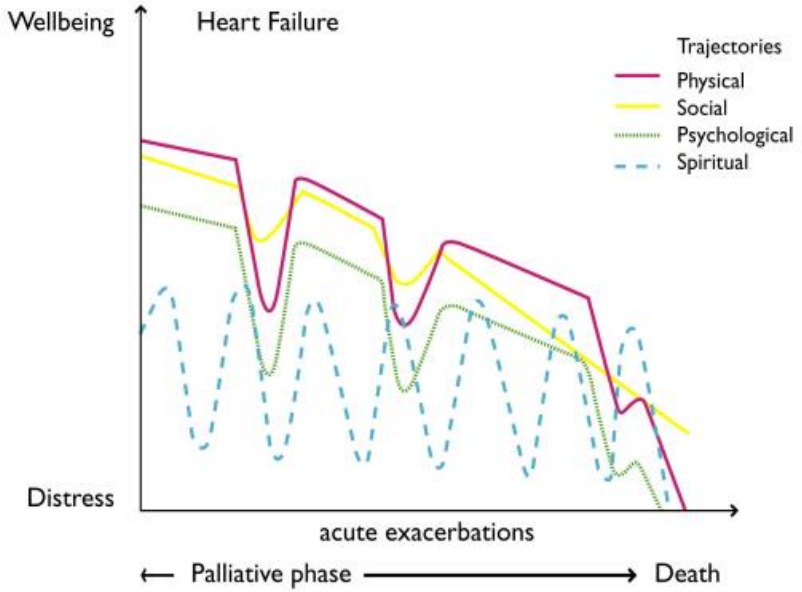
The patient story (grey line on the chart) describes the roller-coaster experience of good and bad days, exacerbations and stability which have evolved into a way of life. They are only 'ill' during exacerbations. Once recovered they return to their normal - the status to which they have adapted over a lifetime of developing COPD.

'Felt' needs reflect the inexorable deterioration of clinical COPD, but they are not 'expressed' because for much of the time the patient perceives themselves as normal.

Exploring the concept of need in people with very severe chronic obstructive pulmonary disease: a qualitative study: Marilyn Kendall, Susan Buckingham, Susie Ferguson, William MacNee, Aziz Sheikh, Patrick White, Allison Worth, Kirsty Boyd, Scott A Murray and Hilary Pinnock

Psychosocial and spiritual decline towards the end of life in heart failure

Murray SA, Kendall M, Grant E, Boyd K, Barclay S, Sheikh A. Patterns of social psychological and spiritual decline towards the end of life in heart failure. J Pain Sympt Man 2007; 34: 393-402



Perley Health

If changes are occurring **month to month**

- Prognosis is (many) months

If changes are occurring **week to week**

- Prognosis is (many) weeks

If changes are occurring **day to day**

- Prognosis is days

If changes are occurring **hour to hour**

- Prognosis is hours

Perley Health

Framework for Decisions

- What is easily treated? What is not?
- How will the treatment improve or maintain good quality of life?
- How will frailty make treatment risky? What function (e.g. mobility or memory) will be put at risk?
- What can be done to promote comfort and dignity – in the time left?
- What matters most?

Perley Health

Focusing on Care that is Consistent with Goals

Understand the story

- Put the Pieces together

Communicate and Educate

- Frailty Framework to present prognosis

Empower

- Build skills for future decisions

Perley Health

Family and Patient Issues

- Health literacy
- Elderly SDM
- Stressed
- Has chronic condition or disability

Perley Health

Address Emotions
Discussing lag time to benefit
Make a recommendation, ask permission
Address uncertainty
Align care with goals
Discuss next steps
Discuss trade-offs
Individualize prognosis

http://eprognosis.ucsf.edu/communication/index.php Accessed Aug 2017

https://academic.oup.com/annonc/article/16/7/1005/166970/Communicating-prognosis-in-cancer-care-a

http://ascopubs.org/doi/full/10.1200/jco.2006.06.007

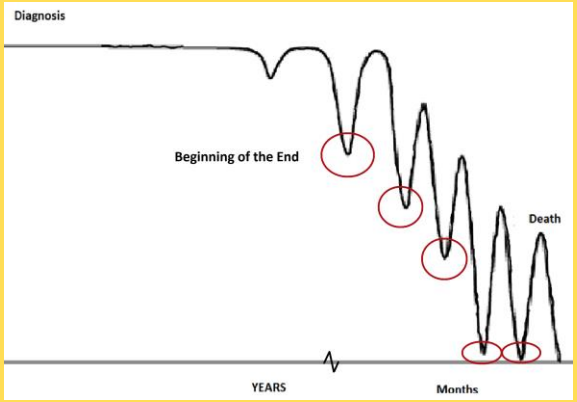
Perley Health

- Physician and Care Team - error in prognostication
  - Experience of the clinician
  - Inversely proportional to the duration of the patient-physician relationship
  - Chagrin factor (being wrong and underestimating)
  - Reliance on tests
  - Most want to learn to discuss EOL care

Palliat Med 2015 Mar;29(3):260-7. doi: 10.1177/0269216314556565. Epub 2014 Dec 8.

Perley Health

Key Points



- TIMELY IDENTIFICATION
- FRAILTY
- GOLD STANDARDS FRAMEWORK
- TRAJECTORIES can be UNPREDICTABLE
- GOALS OF CARE are NOT MEDICAL most of the time

Perley Health

Pitfalls

- Starting too late
- Starting too early
- Expecting too much too soon
- Trying to do too much – giving prognosis and goals of care in one setting
- Bias in the conversation

UpToDate – Discussing Goals of Care, Accessed Aug 2017

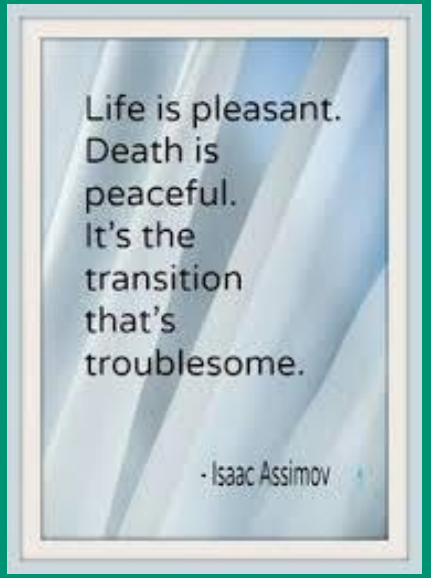
Perley Health

Framework for Decisions

- What is easily treated? What is not?
- How will the treatment improve or maintain good quality of life?
- How will frailty make treatment risky? What function (e.g. mobility or memory) will be put at risk?
- What can be done to promote comfort and dignity – in the time left?
- **What matters most?**

PATH Presentation, Moorhouse and Mallery

Perley Health



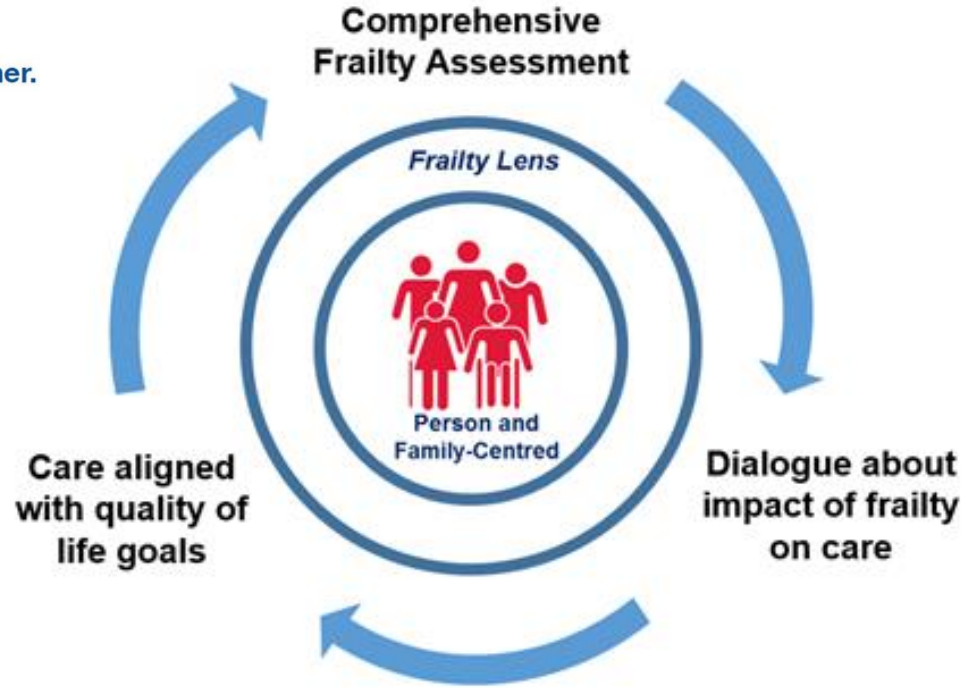
Perley Health

Putting it All Together

- How do we ensure a more consistent, effective and easier approach to discussing frailty and prognosis with residents and families?
- How do we align the plan of care with resident/family goals?

Frailty-Informed Care Program

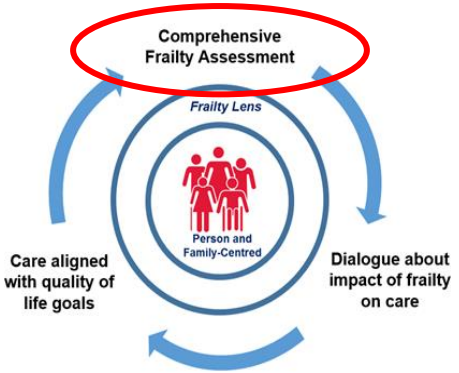
SeeMe™
Understanding frailty together.



Perley Health

Comprehensive Frailty Assessment

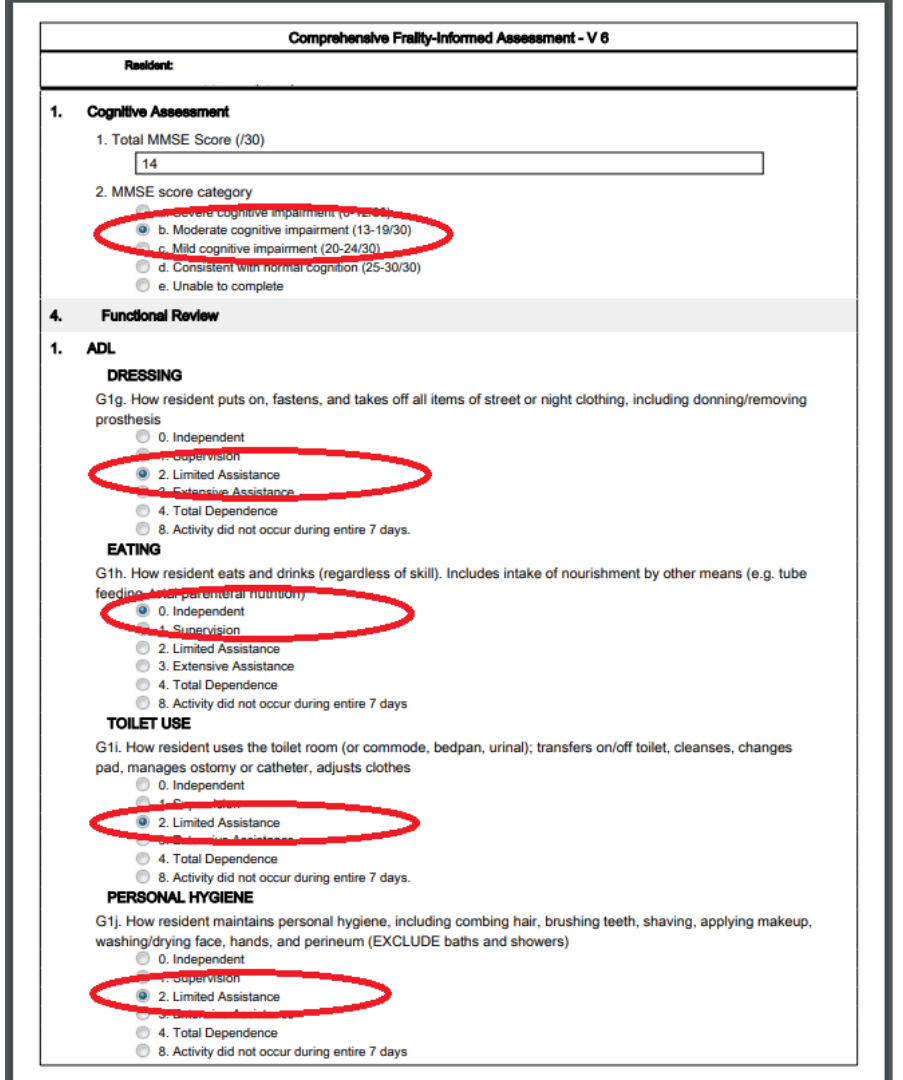
- Psychosocial Review/Cognitive Review
- Functional Review
- Mobility Review
- Medical Review
- Physical Review
- Frailty Analysis



Perley Health

Using Information That We Already Have

- Integrated into Point-Click-Care
- RAI-MDS
- MDS Scores
- Diagnosis
- Vital Signs
- MMSE/MOCA
- Etc.



Comprehensive Frailty-Informed Assessment - V 6

Resident:

1. Cognitive Assessment

1. Total MMSE Score (/30)

14

2. MMSE score category

a. Severe cognitive impairment (0-12/30)
b. Moderate cognitive impairment (13-19/30)
c. Mild cognitive impairment (20-24/30)
d. Consistent with normal cognition (25-30/30)
e. Unable to complete

4. Functional Review

1. ADL

DRESSING

G1g. How resident puts on, fastens, and takes off all items of street or night clothing, including donning/removing prosthesis

0. Independent
1. Supervision
2. Limited Assistance
3. Extensive Assistance
4. Total Dependence
8. Activity did not occur during entire 7 days.

EATING

G1h. How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)

0. Independent
1. Supervision
2. Limited Assistance
3. Extensive Assistance
4. Total Dependence
8. Activity did not occur during entire 7 days

TOILET USE

G1i. How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes

0. Independent
1. Supervision
2. Limited Assistance
3. Extensive Assistance
4. Total Dependence
8. Activity did not occur during entire 7 days.

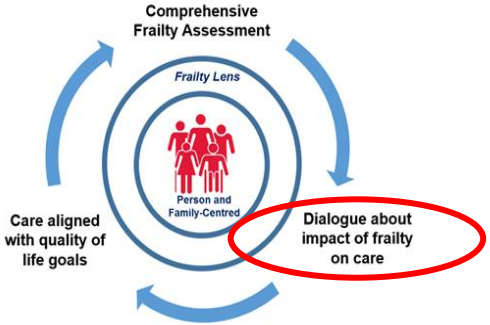
PERSONAL HYGIENE

G1j. How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)

0. Independent
1. Supervision
2. Limited Assistance
3. Extensive Assistance
4. Total Dependence
8. Activity did not occur during entire 7 days

Speaking to Frailty

- A structured discussion
  - Care conference schedule
  - Goals of Care
  - Future Health and Personal Care preferences
- A standardized approach to frailty and prognosis and treatment planning discussions
- Formally embeds a frailty lens into the conversation
- Aligns with Advanced Care Planning principles



Perley Health

SeeMe™
Understanding frailty together.

Care Conference Agenda

Date	Resident Sticker
Time	
Location	
Attendees	

Items For Discussion	Objectives	Action Items (If Identified)
1. **Welcome And Introductions**	Set the tone for the meeting and plan for attendees that will be leaving before the end. Resident/family highlights most important issue(s) they would like to address during the meeting.	
2. **Interdisciplinary Care Overview** **Quality Of Life Discussion**	Understand how the resident is doing from a holistic perspective, including challenges and risks. Discuss changes observed since admission, last care conference. Discuss 3 most important issues impacting quality of life.	
Goals Of Care And Future Health Preferences Discussion		
3. **Medical Overview**	Understand illness/frailty and decline. Discuss most likely future trajectory/prognosis.	*[Information from these sections to be recorded in the **Goals of Care/Future Health Preferences** assessment in PCC]*
4. **Resident Values, Beliefs**	Understand the resident's story, and what is most important to the resident and family.	
5. **Goals Of Care/ Future Health And Personal Care Preferences**	Discuss goals of care in light of current condition, beliefs, and values. Discuss impact of treatment/care decisions on goals.	
6. **Follow-Up, Most Responsible Person(S) And Timelines**	Summarize actions arising from the care conference and identify timelines for follow-up.	

[1]Plan of care: All resident information provided by the interdisciplinary team in both paper and electronic format formulates the plan of care.

[2]Care plan: A document outlining the plan of care – to be followed by the interprofessional team. Provides direction for the individualized care of the resident. Provides a road map to guide all who are involved with the resident's care. Flows from the resident's unique attributes. Organized by the resident's specific needs.

Perley Health

SeeMe™
Understanding frailty together.

Goals of Care & Future Health and Personal Care Preferences

Current Understanding of Illness, Frailty, Decline and Prognosis

Resident Values, Beliefs - *What is important for maintaining the resident's quality of life and personal identity?*

Goal(s) of Care

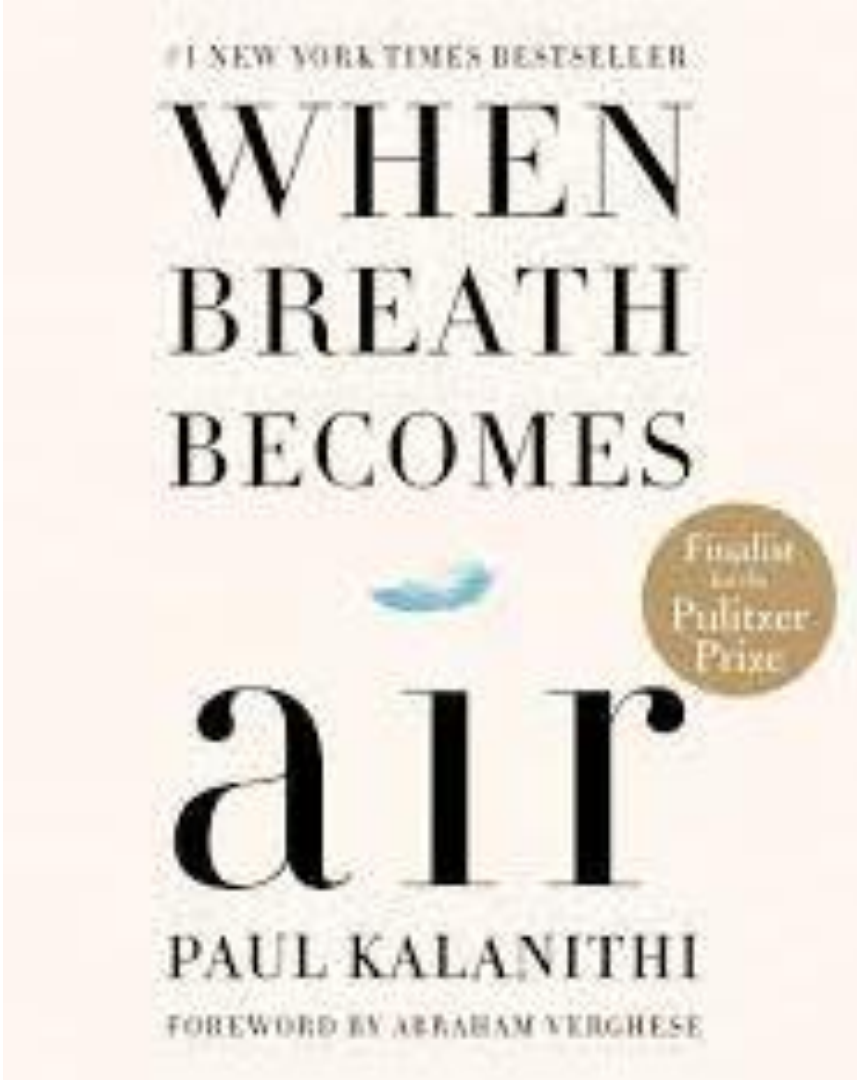
- ☐ Focus on comfort/symptom management, quality of life (comfort)
- ☐ Focus on managing illness while maintaining current function/independence (less invasive tests and interventions)
- ☐ Focus on treatment of illness (more invasive tests and interventions, hospitalization)
- ☐ Focus on extending life (resuscitative)

Comments:

End of Life Wishes - *What is important to the resident when they are at end-of-life?*

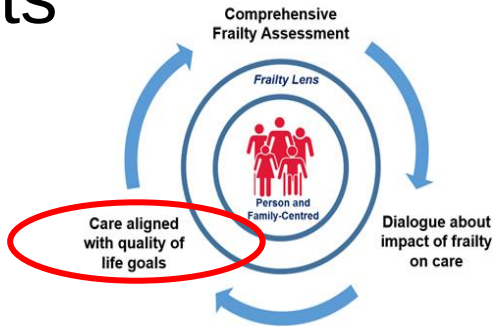
Goals of Care & Future Health and Personal Care Preferences

- Current understanding of illness, frailty, decline and prognosis
- Resident's values and beliefs (what is important for maintaining a resident's quality of life and personal identity)
- Goals of Care
- End of life wishes
- Future Health and Personal Care preferences
  - DNR
  - Transfer to ER
  - Invasive interventons ..etc.



Aligning Care With Goals

- Collaboratively choosing treatments and care interventions that align with what the resident and family have said is important to them.
- Supporting informed decisions to acute health events and changes of condition.



Perley Health

SeeMe™
Understanding frailty together.

Acute Health Event Management

Acute Health Event Management

Step 1
- Complete a comprehensive nursing assessment

Step 2
- Review the Goals of Care and Future Health and Personal Care Preferences (GOC) assessment in PCC

Step 3
- Notify physician & discuss treatment options (aligned with Goals of Care and health preferences)

Step 4
- Engage with resident and/or SDM to discuss treatment options and decide on next steps

Step 5
- Document in PCC
- Notify interprofessional team

An **acute health event** is defined as a significant change in the resident's condition such that a decision is posed as to whether to send the resident to the hospital or not. Choosing to treat for comfort over curing the acute health condition with invasive medical intervention may result in the provision of end of life care to the resident. An acute health event could be caused by a new medical illness, an exacerbation of a current condition, or an incident involving physical trauma.

Comfort, Symptom Management & Interventions Available at the Perley Rideau

	Diagnostics *(STAT not avail for X-ray & Bloodwork)*	Pain Management Options	Symptoms we can manage at the Perley Rideau	Plan of Care/Approaches to Care that can be considered *(with appropriate orders as needed)*	End-of-Life Options
Suspected Hip Fracture	• X-ray (usually within 48 hours)	• Straight order [PO or S/C, transdermal] • PRN for breakthrough (give as per MD orders)	• Dyspnea • Delirium • Restlessness/agitation • Nausea/vomiting	• Align care with pain medication and administer midazolam 30 min before moving resident • Keep head of bed at 30° or lower • Limit turning/repositioning • Limit/eliminate bowel interventions (especially if limited intake) • Insert catheter to minimize movement • Refer to OT for air mattress (if not already in place)	• Discuss with family re: end of life care • Refer to Spiritual Health • End-of-life order set • Refer to Regional Palliative consultation Team (if unable to manage pain adequately) – MD order required
Persistent Respiratory Infection	• Bloodwork (usually within 24 – 72 hours) • X-ray (usually within 48 hours)		• Dyspnea • Delirium • Fever • Secretions • Infection [PO/IM ATB only]	• Oxygen therapy (as needed) • Elevate head of bed • Shallow suctioning	
Severe Stroke	• Bloodwork (usually within 24 – 72 hours) • Neurological Assessment including Glasgow Coma Scale		• Dyspnea • Delirium • Acutely high Blood Pressure • Edema • Thrombosis	• Assess impact of stroke on ADLs and change in elimination patterns • Elevate head of bed to 30° or higher • Assistance with turning & repositioning (hemiplegia) • Refer to PT for transfer status assessment • Refer to OT for specialty mattress • Refer to Dietary or SLP for swallowing assessment	
MI	• Bloodwork (usually within 24 – 72 hours) • Mobile Cardiac Telemetry		• Dyspnea • Delirium • Restlessness/agitation • Edema • Thrombosis • Decreased heart perfusion	• Administer medications to relieve ischemia and decrease cardiac load (i.e. ASA, nitro spray) • Encourage rest to decrease oxygen demand on the heart • Oxygen therapy (as needed) • Refer to Dietary for modified diet	

Suspected Subdural Hematoma	• Neurological Assessment including Glasgow Coma Scale		• Dyspnea
			• Delirium
			• Restlessness/agitation
			• Nausea/vomiting
			• Seizures
				• Assess impact on ADLs
				• Reduce risk of increased Intracranial Pressure:
				  ◦ Keep head of bed at 30° or higher
				  ◦ Keep resident cool
				  ◦ Keep room quiet and reduce stimuli	

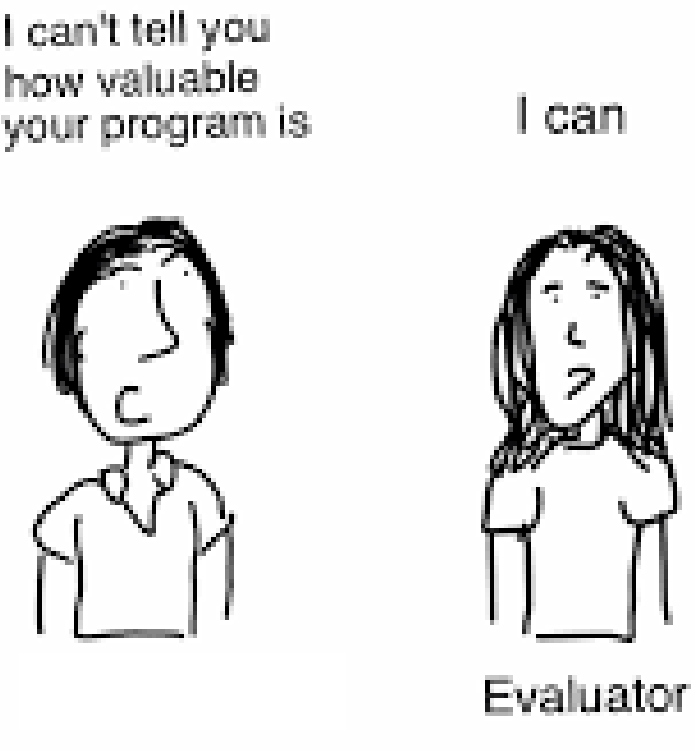
Perley Health

Formal Evaluation

Key Findings

- Average Clincial Frailty Score = 6.8 (moderately-severely frail)
- Families have a positive view of the SeeMe™ Program
- Care conferences viewed as an improvement compared to those conducted previously.
- 15% reduction in the number of residents who preferred to be transferred to hospital
- No significant decrease in hospital transfers during the first year.

Liu, A., et al. (2022). Program Evaluation of SeeMe™: Understanding Frailty Together. Canadian Geriatrics Journal. https://doi.org/10.5770/cgj.25.528



Perley Health

Let’s Practice!

- **Acute Health Event:** Your resident has had a change in their condition and a decision is required on whether, or not, to go to the hospital for more invasive treatment.
- **2 Scenarios:** How do you use the strategies discussed today to help the resident/family make an frailty-informed decision?

Perley Health

Scenario 1: Peggy (86) has a chronic diabetic wound with an infection that is unresponsive to oral and IM ATB. Peggy is showing signs of sepsis. She presents restless and anxious.

Code Status:

- Transfer to Hospital
- No CPR

Discussion of current understanding of illness, decline and prognosis:

- Frailty Level 7- Severely frail
- Mild Dementia
- Type II diabetes, wound to right ankle with recurrent infections over last few years
- Decline from walking to wheelchair over last year
- Daughter has noted seeing the decline as well

Discussion of resident's values, beliefs:

- values maintaining a close relationship with her daughter
- values engaging in life and her independence
- daughter values seeing her mom at peace

Discussion of end of life wishes:

- Resident believes comfort at EOL means passing away with only her daughter at her side, she doesn't want her friends to remember her like this. She wants to pass away with caregivers who know her well and whom she trusts.

Perley Health

Scenario 2: Casimir (93), WWII veteran with advanced dementia, has fallen with suspected hip fracture. Resident is presenting with 9/10 pain from the PAINAD. Resident is confused and resistive to intervention and care.

Code Status:

- Do not transfer to Hospital
- No CPR

Discussion of current understanding of illness, decline and prognosis:

- Frailty Level 8- Very Severely frail
- Advanced Dementia, Alzheimer's
- Increased incidences of delirium over last year.
- Increased confusion and responsive behaviors.
- Sharp decline in functional ability in last two months.
- Son and daughter fearful of resident's decline and making decisions

Discussion of resident's values, beliefs:

- Great pride in his presentation and sense of self
- Independent, has never accepted help from others easily
- Values regimen, routine and predictability.
- Devout Orthodox Christian

Discussion of end of life wishes:

- Never talked about end of life wishes with his family.
- Son and daughter unsure of his wishes, but feel that he would want to pass away quickly "without a fuss".

Perley Health

Questions

Perley Health