Safer Care Victoria

Care of Older People Clinical Network

# Expression of interest | Frailty recognition and response in the community

The Care of Older People Clinical Network is seeking expressions of interest from clinicians to join our quality improvement initiative aimed at improving our recognition and response to frailty. This collaborative project involves teams working together to achieve targeted improvement.

## BACKGROUND

Globally, up to 27 per cent of older adults are frail and up to 50 per cent pre-frail.

While there is no internationally recognised definition of frailty, it is generally considered to be a geriatric condition characterised by an increased vulnerability to external stressors.

When exposed to a stressor, people who are frail are more likely to experience negative health outcomes, including falls, disability, hospitalisation, institutionalisation, and death.

The network is focusing on frailty as a priority improvement area, identified by the sector. Timely recognition and response to frailty can improve health outcomes and encourage older people to stay active for longer, also known as active ageing.

## WHY PARTICIPATE?

- Gain knowledge and skills in improvement science
- Contribute to your organisation's accreditation
- Opportunities for networking between participating teams
- May contribute to your continuing professional development points

## WHAT IS INVOLVED?

- Commit to the six-month project duration
- Form a project team
- Participate in three interactive learning sessions and three online meetings
- Apply improvement science to plan, test, refine and implement sustainable changes
- Collaborate with other teams
- Develop a project plan with the support of Safer Care Victoria
- Collect data pre, during and post project
- Submit a monthly one-page report (template provided by SCV)
- Submit and presentat an end of project report.

## WHAT SUPPORT DOES NETWORK PROVIDE?

- A dedicated project officer to support your project team
- Coaching on improvement science and project management for your team
- Quality improvement tools for your project plan, data collection, interpretation and reporting
- Support with project implementation through regular communication and site visits
- A final summary report with data analysis for each participating team

## PROJECT TIMELINE

- **1 November 2019**: Introduction to improvement science and the frailty project online meeting (one hour)
- **8 November 2019**: Initial collaborative workshop (full day)
- **6 December 2019**: Collaborative online meeting (one hour)
- **31 January 2019**: Second collaborative workshop (half day)
- **Mid-February 2020:** Collaborative online meeting (one hour)
- **Early March 2020**: Third collaborative workshop (half day)
- **Late April 2020**: Collaborative forum, including presentations (half day)

## WHAT DATA DO WE NEED TO COLLECT?

**Completed by team member**:

- Percentage of people aged 65 years and older (or 50 years and older for Aboriginal and Torres Strait Islanders) accessing your service who have been screened for frailty
- Percentage of people who have an intervention initiated as a result of being screened as frail or pre-frail
- Type and frequency of intervention received
- Percentage of drop-outs (patients who cease the recommended intervention prematurely)

**Completed by or with consumer and recorded by team member**:

- Change in frailty status between baseline and three-month follow-up measured by a validated frailty screening tool
- Consumer reported benefits at three-month follow-up
- Change in carer burden between baseline and three-month follow-up measured by the Zarit 4 Item Burden Interview

## SELECTION CRITERA

We are looking for clinicians who provide services to older adults in the community setting.

Selection criteria includes the ability to:

- Complete a frailty screening tool on a minimum of six consumers aged 65 years and older (or 50 years and older for Aboriginal and Torres Strait Islanders) per week and review these consumers three months later (see Appendix 1 for screening tools)
- Implement the minimum requirements of the bundle of care either at your site or by referring to other services, including:
  - exercise including resistance training
  - nutrition intervention, ideally involving a dietitian
  - a medication review
- Provide consumer centred individualised care with health professional oversight
- Educate staff and consumers about frailty and the collaborative project

Teams able to provide these additional interventions either at your service or by referring to other services will be considered favourably:

- group based multi-modal exercise training including resistance, aerobic, balance and flexibility exercises
- exercise frequency of two to three times per week for up to 60 minutes depending on degree of frailty
- exercise and nutrition interventions that the consumer can continue in an ongoing capacity
- cognitive training
- a comprehensive geriatric or gerontic assessment.

## HOW DO I APPLY?

**Step 1:** Gather your project team with a minimum of three multidisciplinary members, including:

- Project lead
- Clinicians who can complete the frailty screening tool, make referrals for interventions and provide follow up at three months
- Clinicians who can oversee the interventions

**Step 2:** Complete the application form (page 4-6) and submit to:

Jackie O'Connor

Clinical Fellow

Care of Older People Clinical Network

Older.People.clinicalnetwork@safercare.vic.gov.au

**Applications close:** 27 September 2019

Successful applicants will be notified by 4 October 2019

## FOR MORE INFORMATION

Jackie O'Connor

Clinical Fellow

Care of Older People Clinical Network

(03) 9096 8238

Older.People.clinicalnetwork@safercare.vic.gov.au

# Application form

**Please print or type**

| **Project lead** (needs to attend learning sessions and online meetings, submit data and complete monthly reports) |
|---|
| **Contact name** |
| **Clinical role** |
| **Postal address** |
| **Email** |
| **Work phone** |
| **Mobile phone** |

**Proposed team** (preferable for these team members to attend learning sessions and online meetings)

| Name | Discipline | Organisation | Email |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please provide a brief statement in the box below about why your team is interested in participating.

Please tick one box below.

| Criteria | |
|---|---|
| Number of consumers aged 65 years and older (50 years and older for Aboriginal and Torres Strait Islanders) who can be screened for frailty each week and reviewed three months later | ☐ 0-5<br>☐ 6-15<br>☐ >15 |

Please indicate the interventions your consumers will receive and explain how you will provide this intervention.

| Intervention | What clinician and/or centre will provide this service? |
|---|---|
| ☐ Resistance training | |
| ☐ Home medication review | |
| ☐ Nutrition intervention | |
| ☐ Group based multi-modal exercise | |
| ☐ Exercise frequency of two to three times per week for up to 60 minutes | |
| ☐ Cognitive training | |
| ☐ Comprehensive geriatric or gerontic assessment | |

**Please complete one table for each team member**

This registration form must be signed by a senior delegate at your health site who can approve your ability to participate in the collaborative and release data to share with the collaborative to facilitate learning.

We will endeavour to publish de-identified learnings and results of the collaborative. Please contact us if you do not wish for your results to be published.

| Participating clinician name |
| --- |
| Senior delegate name |
| Title |
| Organisation |
| Signature |
| Date |

| Participating clinician name |
| --- |
| Senior delegate name |
| Title |
| Organisation |
| Signature |
| Date |

| Participating clinician name |
| --- |
| Senior delegate name |
| Title |
| Organisation |
| Signature |
| Date |

| Participating clinician name |
| --- |
| Senior delegate name |
| Title |
| Organisation |
| Signature |
| Date |

# Frequently asked questions

## WHO IS SAFER CARE VICTORIA?

Established in January 2017, Safer Care Victoria is the state's lead agency for improving quality and safety in Victorian healthcare. We support health services to monitor performance, guide best practice, and help them identify and respond to areas where they can improve.

### Relevant publications

- Safer Care Victoria Clinical Networks
- Framework for Clinical Networks
- Clinicians as Partners: A framework for clinician engagement
- Safer Care Victoria Corporate Plan
- Safer Care Victoria Annual Report
- Safer Care Victoria Strategic Plan

## WHAT IS SAFER CARE VICTORIA'S RELATIONSHIP WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES?

SCV is an administrative office of the Department of Health and Human Services.

At a functional level, Safer Care Victoria provides advice to the department on clinical quality and the safety implications of policy, planning and funding decisions. A memorandum of understanding is in place and sets out principles to underpin the relationship between the department and Safer Care Victoria and outlines the shared services arrangements.

## WHAT ARE THE CLINICAL NETWORKS?

Clinical networks work collaboratively across Safer Care Victoria drawing on expertise in leadership development, innovation, systems improvement, and consumer experience to achieve their improvement objectives.

Clinical networks are tasked with:

- identifying and implementing care that is supported by the best available research
- improving the quality and safety of care delivered to patients
- monitoring the performance of health services over time
- providing advice to Safer Care Victoria and the Department of Health and Human Services.
- reducing clinical practice variation by promoting the development and implementation of evidence-based guidelines and clinical protocols.

### Our 11 clinical networks

- Cardiac Clinical Network
- Care of Older People Clinical Network
- Critical Care Clinical Network
- Emergency Care Clinical Network
- Infection Clinical Network
- Maternity and Newborn Clinical Network
- Mental Health Clinical Network
- Paediatric Clinical Network
- Palliative Care Clinical Network
- Renal Clinical Network
- Stroke Clinical Network

The clinical networks link Safer Care Victoria with clinicians in health and community services, drawing on their expertise to drive improvements.

Each clinical network has a Governance committee, an Insight (data and evidence) subcommittee and various other working groups that provide clinical leadership, expertise and advice to Safer Care Victoria, with the ultimate aim of improving consumer outcomes and experiences.

### What is the Care of Older People Clinical Network?

The network brings together expert clinicians, healthcare leaders, consumers and academics working in direct care of older people or research, to identify opportunities to improve the quality of care provided to people aged over 65 across Victoria.

## WHAT IS CONSUMER ENGAGEMENT?

Consumers are at the centre of Safer Care Victoria's work. That means a core principle for clinical networks is to always act in the best interests of consumers and the wider Victorian community.

As part of our commitment to consumer representation, we include consumers and/or carers on each of our clinical network's Governance, Insight committees and expert working groups. We need consumer representatives from throughout regional, rural and metropolitan Victoria. Teleconferencing options are supported.

# Appendix 1: Frailty screening tools

You may choose one of the following three tools. Training is required for the Clinical Frailty Scale.

### Edmonton Frail Scale (EFS)

| Frailty domain | Item | 0 point | 1 point | 2 points |
|---|---|---|---|---|
| Cognition | Please imagine that this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions then place the hands to indicate a time of 'ten after eleven' | No errors | Minor spacing errors | Other errors |
| General health status | In the past year, how many times have you been admitted to a hospital? | 0 | 1–2 | ≥2 |
| | In general, how would you describe your health? | 'Excellent', 'Very good', 'Good' | 'Fair' | 'Poor' |
| Functional independence | With how many of the following activities do you require help? (meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications) | 0–1 | 2–4 | 5–8 |
| Social support | When you need help, can you count on someone who is willing and able to meet your needs? | Always | Sometimes | Never |
| Medication use | Do you use five or more different prescription medications on a regular basis? | No | Yes | |
| | At times, do you forget to take your prescription medications? | No | Yes | |
| Nutrition | Have you recently lost weight such that your clothing has become looser? | No | Yes | |
| Mood | Do you often feel sad or depressed? | No | Yes | |
| Continence | Do you have a problem with losing control of urine when you don't want to? | No | Yes | |
| Functional performance | I would like you to sit in this chair with your back and arms resting. Then, when I say 'GO', please stand up and walk at a safe and comfortable pace to the mark on the floor (approximately 3 m away), return to the chair and sit down' | 0–10 s | 11–20 s | One of : >20 s , or patient unwilling , or requires assistance |
| Totals | Final score is the sum of column totals | | | |

**Scoring :**
0 - 5 = Not Frail
6 - 7 = Vulnerable
8 - 9 = Mild Frailty
10-11 = Moderate Frailty
12-17 = Severe Frailty

**TOTAL** /17

## Clinical Frailty Scale (CFS)

### 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.

## Fatigue, Resistance, Ambulation, Illness, Loss of weight (FRAIL) scale

| Component | Question |
|---|---|
| **Fatigue** | How much time during the previous 4 weeks did you feel tired? (all of the time, most of the time = 1 points) |
| **Resistance** | Do you have any difficulty walking up 10 steps alone without resting and without aids? (yes = 1 point) |
| **Ambulation** | Do you have any difficulty walking several hundred years alone with without aids? (yes = 1 point) |
| **Illness** | How many illnesses do you have out of a list of 11 total? (5 or more = 1 point) |
| **Loss of Weight** | Have you had weight loss of 5% or more? ( yes = 1 point) |

**Frail Scale scores range from 0-5, one point for each component, 0=best to 5=worst**
Robust = 0 points
Pre-Frail = 0-1 points
Frail = 3-5 points