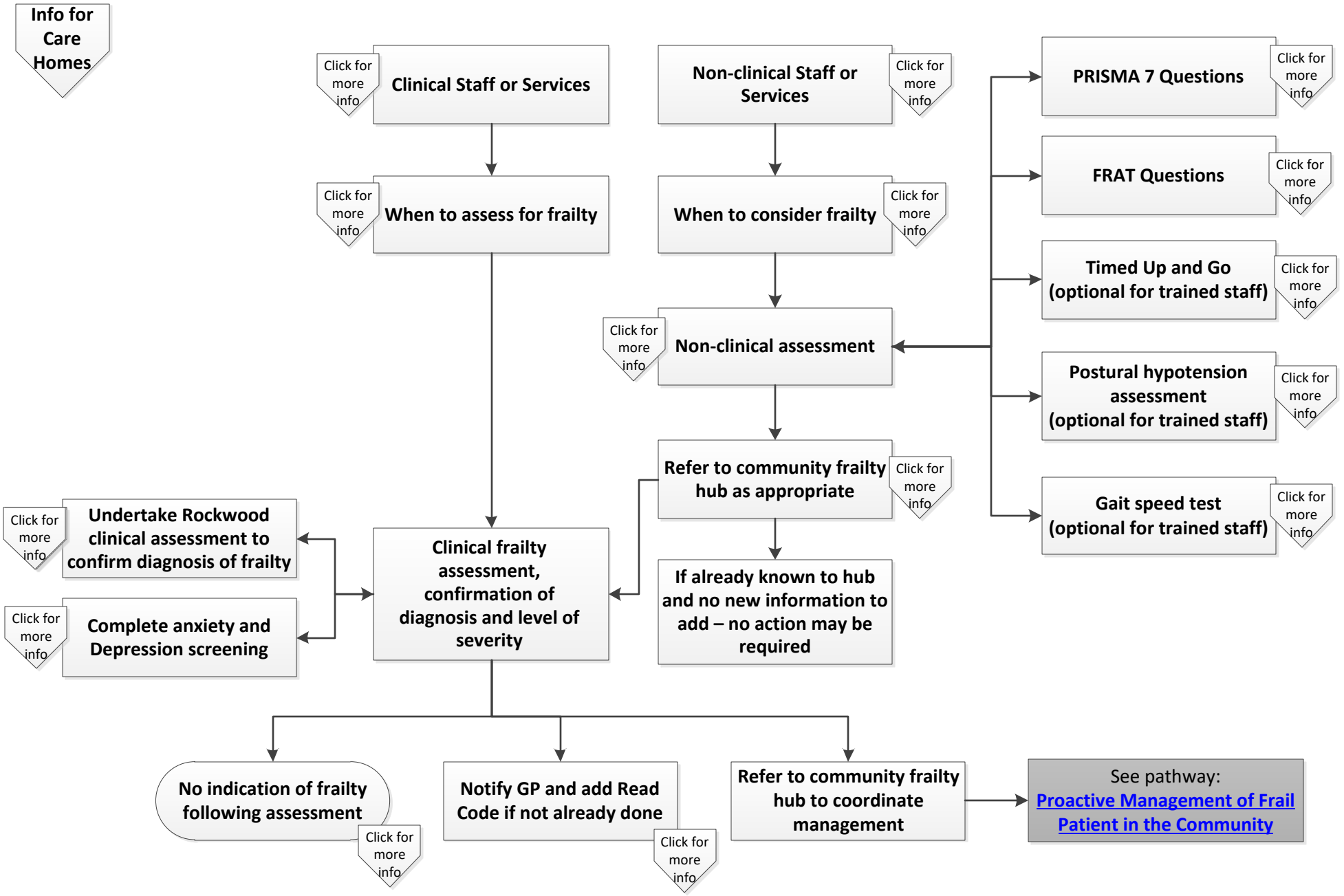
Identification of Frailty

A clinically recognised long term condition of increased vulnerability that results from aging, associated with a decline in the body's physical and psychological reserves



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Clinical Staff or Services

This may include but is not limited to:

- Doctors
- Nurses – acute, community, care homes and social care
- Allied health professionals
- Paramedics

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When to assess for frailty

Patients with multi-morbidities and have presented with one or more of the following should be considered for an assessment:

- Proactive identification/risk stratification i.e. eFI (electronic Frailty Index)
- Predisposition to falls
- Immobility
- Delirium / acute confusional state / cognitive impairment
- Change in continence
- High susceptibility to medication side effects, and/or withdrawal from medication
- Poly-pharmacy (4+ medications)
- Deteriorating functional score e.g. performance status - Barthel/ECOG/Karnofsky
- Anyone in a care home (including residential and nursing homes) or in receipt of a package of care

Anyone aged >75

A person presenting with a wound that is not responding to 6 weeks of treatment and is either: aged over 75 or has one of the other points outlined in the list above.

This list is not exhaustive and a holistic view of the patient should be considered.

NB: Although frailty is more common in people aged >75, people aged <75 should not be excluded from assessment if they are presenting with one or more of the above risk factors. In addition, patients who have a learning disability and/or severe mental health issues may have an increased risk of developing frailty.

For people who have additional needs (e.g. deafness, learning disability or dementia) or in whom English is not their first language, reasonable adjustments should be made to the delivery of the assessments. For example, this may include having an interpreter or carer present. Presence of additional needs should not be a barrier to assessing a person for frailty or falls.

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Rockwood clinical assessment

Use code = Use of Rockwood tool

CTV3 = XaQik

V2 Read Code = 38DW.

SNOMED = 445414007

Ensure consent is obtained from patient to conduct the assessment and share the results with relevant organisations/staff.

Frailty Screening tools:

Do initial assessment to confirm if frail and if so the level of frailty by using Rockwood assessment tool. Use in combination with electronic frailty index if available.

NB: patients frailty can fluctuate particularly during episodes of ill health.

NB: do not use electronic frailty index on its own without clinical assessment to diagnose frailty.

NB: presence of dementia may mean people can appear more or less frail than they actually are. Consider cognitive assessments e.g. MOCA

Use Rockwood assessment tool. Use standardised templates
Suitable for use by clinicians only

<u>Making an Assessment using the Rockwood Scale: Quick Guide</u>

The Rockwood Scale is intended to be used by clinicians.

Below is a quick guide to help you think about where someone is on the scale. The tool can be used as a prediction or a patient's risk of a category of frailty. Ultimately the decision will be based on the entire clinical and social picture and the judgement of the clinician.

Very Fit to Vulnerable	Mildly Frail	Moderately Frail	Severely Frail
 **1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age. • Exercise at least 5 times a week • Feel energetic • < 5 chronic conditions from - Dementia - Heart disease - Depression - Arthritis - Asthma - Bronchitis/ Emphysema - Diabetes - Hypertension - Osteoporosis - Stroke • May complain of some memory symptoms but they do not cause any deficits.  **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. • Similar to Very Fit group but less activity / exercise  **3 Managing Well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking. • May have multiple chronic conditions but these are well controlled. • Less active than Well group  **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. • Still able to manage ADLS • May have mild cognitive impairment which will begin to impact on function • Reduced activities due to fatigue • Typically multiple co-morbidities with varied control • Families often report some degree of withdrawal • Collateral histories are valuable to make this diagnosis • Decline in motivation	 **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. • Need good social support for ADLs • At risk of social withdrawal due to difficulties managing outside the house independently • May have mild dementia • Typically multiple co-morbidities with varied control • Frequently use mobility aids • Collateral histories are valuable to make this diagnosis • Decline in motivation	 **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. • Reliant on the help of others for ADLs • High risk of social withdrawal • May have moderate dementia • Very limited activity • Poorly controlled chronic illnesses • Need help with all outside activities • Collateral histories are valuable to make this diagnosis • Little motivation	 **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). • Need good social support for ADLs • Severe risk of social withdrawal • Unable to manage alone • Likely to have several poorly managed chronic conditions but are likely to be stable • May have severe dementia • Likely to have unintended weight loss • Very little motivation  **8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness. • May be bedbound or limited time out of bed • Will need full time care support • Likely to have untended weight loss • Likely no motivation • May be approaching terminally ill  **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. • Not just for frailty patients • May appear moribund

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Anxiety and Depression screening

PHQ-2 and GAD-2 screening

PHQ-2 GAD-2	Over the **last 2 weeks** (or other agreed time period) how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Feeling nervous, anxious or on edge	0	1	2	3
4.	Not being able to stop or control worrying	0	1	2	3

Questions 1 & 2 screen for depression, with a total score of 3 or more for these two items suggesting the strong possibility of clinical depression.

Questions 3 & 4 screen for anxiety (GAD, panic, PTSD & social anxiety), with a total score of 3 or more for these two items suggesting the strong possibility of clinical anxiety.

Refer to IAPT if screening is positive

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No indication of frailty following assessment

Self-management information

The following actions can be completed by any professionals involved in the person's care:

Signpost to:

- Regular sight and hearing checks
- Health promotion advice
- STP Healthy Aging resource pack

Raise awareness of:

- Eating well and staying hydrated - https://www.nhs.uk/conditions/dehydration/
- Home hazards and wearing the correct footwear
- Skin health – recommend regular moisturising
- Local and National campaigns that occur at different times of the year e.g. Slipper's Swap campaign
- Appropriate foot care
- Staying active

Further assessment (as appropriate):

- Recommend an annual medication review. For clinicians, this may include a polypharmacy review – use STOPP START methodology (ideally in clinical system)
- Carers assessment as appropriate – refer to appropriate service
- Postural hypotension assessment

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Notify GP – GP to Read Code if not already done

CTV3

X76Ao: Frailty

XabdY: Mild Frailty

Xabdb: Moderate Frailty

Xabdd: Severe Frailty

Read V2

2Jd: Frailty

2Jd0: Mild Frailty

2Jd1: Moderate Frailty

2Jd2: Severe Frailty

SNOMED CT concepts for frailty

All linked to the concept 248279007: Frailty (finding)

925791000000100: Mild frailty (finding)

925831000000107: Moderate frailty (finding)

925861000000102: Severe frailty (finding)

Coding

XaZP6 - FRAT assessment has been completed

XaIuJ - TUG assessment has been completed

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Non-clinical Staff or Services

This may include but is not limited to:

- Fire service
- Police service
- Voluntary/third sector
- Social care (including social workers, domiciliary carers and care homes)
- Assistive services e.g. meals on wheels
- Community groups

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Refer to falls and frailty hub

If assessments indicate patient is at risk of frailty and /or falls, refer into the falls and frailty hub (Single Point of Access).

NB: information should also be passed to GP practice if known, or community health services if not

Notify hub of result of assessment

Patient name ……

Address of patient ……

Name and contact at GP surgery if known ……..

Dear Falls and Frailty hub,

The patient by the name of (patient name here)…….was seen/ interviewed for a consideration of frailty / falls risk.

by (your name here) ……..

at (your organisation name here, e.g. Age UK) ……

we completed a (circle tests completed): PRISMA-7; FRAT; Timed up and Go test; Gait speed test.

The results are as follows:

PRISMA-7 …….. *(score of 3 or more is risk of frailty)*

FRAT score …….. *(score 3-5 is high risk of falls)*

Timed up and Go test Average Speed……. metres per second
<10 seconds = Normal; > 10 seconds = Risk of frailty; > 30 seconds = Risk of frailty and falls.

Gait Speed Test Average Speed…….
This is normal/ slower than normal for their age *(please delete as appropriate).*

Postural hypotension assessment:
Lying …….. or Sitting…….
Standing- First minute result ……
Standing – 3 minutes ……..
Reported symptoms when doing test: yes/no *(please delete as appropriate)*
Detail below any dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations:

……..
……
NB: a positive screening result is:

a. A drop in systolic BP of 20mmHg or more (with or without symptoms)
b. A drop to below 90mmHg on standing even if the drop is less than 20mmHg. (with or without symptoms)
c. A drop in diastolic BP of 10mmHg with symptoms (although clinically much less significant than a drop in systolic BP)

Thank you for reviewing the results of this patient.

I (patient name here)……. Consent to this information to be sent to the GP

(signature here)……

Date ……..

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When to consider frailty

Consider frailty in the following patients:

- >75 years
- Living in a care home
- Repeated falls (e.g. collapse, legs gave way, 'found lying on floor')
- Immobility (e.g. feeling dizzy on standing, sudden change in mobility, 'gone off legs', 'stuck in toilet')
- Delirium (e.g. acute confusion, 'muddledness', sudden worsening of confusion in someone with previous dementia or known memory loss)
- Dementia
- Change in continence (new onset or worsening continence problems, including being unable to control opening of bowels or urination)
- In receipt of social/package of care (including homecare package)

This list is not exhaustive and a holistic view of the patients should be considered.

NB: Although frailty is more common in people aged >75, people aged <75 should not be excluded from assessment if they are presenting with one or more of the above risk factors. In addition, patients who have a learning disability and/or severe mental health issues may have an increased risk of developing frailty.

For people who have additional needs (e.g. deafness, learning disability or dementia) or in whom English is not their first language, reasonable adjustments should be made to the delivery of the assessments. For example, this may include having an interpreter or carer present. Presence of additional needs should not be a barrier to assessing a person for frailty or falls.

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Non-clinical assessment

NB: patients frailty can fluctuate particularly during episodes of ill health.

Consent

Obtain consent to share findings of assessment with GP and care professionals as relevant before starting assessment.

Capacity

The requirement to assess the individual's capacity to undertake frailty assessments and subsequent interventions should be considered.

Question based assessment

If interviews by telephone use PRISMA 7 and FRAT

If interviews in person use PRISMA 7 and FRAT and TUGT or gait speed test

Mobility tests (Timed Up and Go (TUGT)) and Gait Speed Test

- Use timed up and go test as first preference unless patient needs assistance to stand from sit
- Use of walking aids allowed in all mobility tests
- Wheelchair-bound patients are not suitable for these mobility tests

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PRISMA 7 – instructions

Equipment:

- Pen
- Copy of questions

Instructions to the person taking the test:
Please answer yes or no to each of the questions.

Instructions the assessor:
This is a self-completion questionnaire; however you will need to assist patients for who English is not a first language and those who may not be able to read the questions or write answers. Please do not answer questions on a patient's behalf or influence their answers, but allow them to answer themselves.

1. Are you more than 85 years?
2. Are you Male?
3. In general do you have any health problems that require you to limit your activities?
4. Do you need someone to help you on a regular basis?
5. In general do you have any health problems that require you to stay at home?
6. In case of need, can you count on someone close to you?
7. Do you regularly use a stick, walker or wheelchair to get about?

1 point is scored for each question that is answered as yes. If there are 3 or more yes answers then the patient has a risk of frailty.

Codes (clinicians only)

PRISMA 7 Questionnaire

CTV3 (SystmOne)	Xacme
V2 (EMIS)	38VL.
SNOMED Concept ID	973221000000109

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FRAT Questions

- Ask the following 5 questions.
- Each answer should be 'Yes' or 'No'
- Score 1 for every answer of 'Yes'

Falls Risk Assessment Tool (FRAT)

1. **Have you had a fall in the previous year?** Yes □ No □

2. **Are you taking four or more medications per day?** Yes □ No □

3. **Have you had a stroke? Have you been diagnosed with Parkinson's disease?** Yes □ No □

4. **Do you have any problems with your balance?** Yes □ No □

5. **Are you able to stand up from a chair of knee height without using your arms?** Yes □ No □

TOTAL SCORE (Score 1 for each 'Yes') ……

How to interpret the FRAT score

Score 0 = You have a lower risk of falls. To help you maintain independence, stay steady and reduce your future risk of falls, we have simple self-help advice.

Score 1-2 = You have a Lower risk of falls but do have some risk factors. Use our Step-by-step guide to staying independent and preventing future falls, which will give you further advice about reducing your risk factors. We also have simple self-help advice to help you.

Score 3 – 5 = Higher risk of falls. You have risk factors which could increase your risk of falls, so you will benefit from an assessment by a healthcare team to look at these factors in more detail (a multi-factorial risk assessment).

Your health, social or voluntary/third sector worker who completed this FRAT score can refer you for this assessment (via GP or Community Trust, or falls and frailty hub is available).

If you completed this score yourself, please inform your GP practice.

Codes (clinicians only)

FRAT questions asked:

CTV3 (SystmOne)	XaZP6
V2 (EMIS)	38GK.
SNOMED Concept ID	839781000000108

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Timed Up and Go Test – Instructions

Ensure the environment is suitable and safe to perform this test in, in particular look for any trip hazards (e.g. rugs, obstacles and wearing inappropriate foot wear)

Instructions for the assessor:
Make sure that the person taking the test is wearing their regular footwear and if they normally use a walking aid (stick, Zimmer frame etc.) make sure that they use this during the test. You should not assist the person during the test. They may stop to rest but they may not sit down during it.

If the person is very unsteady and likely to fall do not perform this test.
If the person becomes unwell or very unsteady during the test, stop the test and assist the person.

Equipment requirements:
Stopwatch/phone with stopwatch function
Chair with armrests
Measured distance of 3m (10ft)

Instructions to explain to the person taking the test:

I will count to three and then say 'go'.
When I say go, I will start the stopwatch, I would like you to stand up from the chair. You may use the arms of the chair to help you stand up.

I would then like you walk until you pass this piece of tape (marked end of the course). You may take any route that you would like, I would like you to move as quickly as you feel comfortable and safe walking at.

Once you have reached the end of the course, I would like you to turn around and walk back to the chair and sit back down on it.

I will stop the timer when your back touched the back of the chair.
You will complete one practice run and then two runs that are counted.

Instructions for the assessor:
Start timing on the word 'go', stop timing when the person taking the test has sat back on the chair.

Results:
Practice Test
Test 1 =
Test 2 =
Average time (add test 1 and test 2 times, divide the result by 2) =

Understanding the results
<10 seconds = Normal
> 10 seconds = Risk of frailty. Ensure that a PRISMA 7 is also completed
> 30 seconds = Risk of frailty and falls. Ensure that a PRISMA 7 is also completed.

Note: if >12 seconds, this indicates a high risk of falls
Codes (clinicians only)

Timed Up and Go completed:

CTV3 (SystmOne)	XaluJ
V2 (EMIS)	3986.
SNOMED Concept ID	401196007

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Assessment for postural hypotension risk

The following is a guide for identify a risk of having postural hypotension. This should only be performed by staff who have had appropriate approved training and with calibrated equipment:

Instructions to the assessor:
Do you sometimes or regularly feel unsteady, light-headed, dizzy or faint after getting up from lying or sitting?
Record the answer

Ideally, do a full assessment which includes a lying and a standing blood pressure as below:

Identify if you are going to need assistance to stand the patient and simultaneously record a BP. Use a manual sphygmomanometer if possible and definitely if the automatic machine fails to record.

1. Explain procedure to the patient.
2. The first BP should be taken after lying for at **least five minutes.**
3. The second BP should be taken after standing in the first minute
4. A third BP should be taken after standing for three minutes
5. This recording can be repeated if the BP is still falling
6. Symptoms of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations should be documented.
7. A positive result is:
    a. A drop in systolic BP of 20mmHg or more (with or without symptoms)
    b. A drop to below 90mmHg on standing even if the drop is less than 20mmHg. (with or without symptoms)
    c. A drop in diastolic BP of 10mmHg with symptoms (although clinically much less significant than a drop in systolic BP)
8. Advise patient of results

If not possible to do lying and standing blood pressure do a sitting and standing blood pressure as below (this test is less sensitive than the lying and standing test):

1. Explain the procedure to the patient
2. The first BP should be taken after the patient has been sitting for at least 5 minutes
3. The second BP should be taken after standing in the first minute
4. A third BP should be taken after standing for three minutes
5. This recording can be repeated if the BP is still falling
6. Symptoms of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations should be documented.
7. A positive result is:
    a. A drop in systolic BP of 20mmHg or more (with or without symptoms)
    b. A drop to below 90mmHg on standing even if the drop is less than 20mmHg. (with or without symptoms)
    c. A drop in diastolic BP of 10mmHg with symptoms (although clinically much less significant than a drop in systolic BP)
8. Advise patient of results

If postural hypotension is present, risk of falls is increased.
Refer/advise person to have a clinical assessment (if non-clinical).

Codes (clinicians only)

Lying blood pressure reading

CTV3 (SystmOne)	246C.
V2 (EMIS)	246C.
SNOMED Concept ID	163033001

Standing blood pressure reading

CTV3 (SystmOne)	246D.
V2 (EMIS)	246D.
SNOMED Concept ID	163034007

Postural hypotension

CTV3 (SystmOne)	G971
V2 (EMIS)	G870.
SNOMED Concept ID	28651003

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Gait Speed Test

Ensure the environment is suitable and safe to perform this test in, in particular look for any trip hazards (e.g. rugs, obstacles and wearing inappropriate foot wear)

Equipment requirements

- Stopwatch or phone with stopwatch function
- Measured distance of 10m (with a marker e.g. tape on the floor)
- Measured distance of 5ft before the 10m starts
- Measured distance of 5ft after the 10m finishes

Instructions to the person taking the test:

1. start standing up
2. walk from this mark (point out starting position), at a pace that is comfortable for you with your normal walking aids. Start walking in your own time
3. Stop at the finishing mark (point out finishing position)
4. We will repeat this test three times

Instructions for assessor

The person will walk from the starting position to the end position. You should start recording the time when they past the 10m starting point mark and stop the timer when they reach the 10m finish point. To gain an accurate reading of test times, this must be performed 3 times and an average time calculated. (See instructions later). Anyone undertaking the test should wear their normal shoes and use any walking aids they require. Do not assist the person in any way during the test. If they appear too unsteady to complete the test then do not continue.

Results

Time test 1:
Time test 2:
Time test 3:

How to calculate gait speed:

First calculate Average Time – (Add all the test times together and divide by three)…….
Divide the distance (10m) by the result from the average time e.g. if the average time was 7secs this would be 10 divided by 7 = 1.4 metres per second. Therefore the gait speed is 1.4m per second.
Average time:
Gait speed: 10 divided by (enter the answer above) …….. = …… metres per second

Average Gait speeds by age (all metres per second)

- Age 60-70, Men: 1.26, Women: 1.24 metres per second
- Age 70-80, Men and Women: 1.25 metres per second
- Age 80-90, Men: 0.88, Women: 0.80 metres per second
- Age over 90, Men and Women 0.70 metres per second

If the person taking the test achieves the speed for their age or is faster than this (i.e. has a higher number), then their gait speed is normal. If their gait speed is slower than expected, ensure they have also completed the PRISMA-7. Please inform GP of gait speed and if normal or slower than normal.

Codes (clinicians only)

Gait Speed Test

CTV3 (SystmOne)	Xad51
V2 (EMIS)	398N.
SNOMED Concept ID	983281000000101

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Information for care homes

- Individuals living in care homes and other residential settings, should have equal access and opportunity to all risk tools and assessments (as appropriate for them).
- For people who have additional needs (e.g. deafness, learning disability or dementia) or in whom English is not their first language, reasonable adjustments should be made to the delivery of the assessments. For example, this may include having an interpreter or carer present.
- Presence of additional needs should not be a barrier to assessing a person for frailty or falls.