USING OUR STRENGTHS TO SUPPORT THE

Fit for Frailty
PROGRAM

Friday 24th August 2018
ISLHD Falls Prevention Network Rural Forum

Padmini Pai and Megan Foye
Co-Project Leads: Fit for Frailty Program
Office of the Chief Executive.
Introductions to who we are and why are we here

Padmini
most recently worked as
• Leadership Development Manager
• Network Service Manager of the Child and Adolescent Mental Health Unit
• Senior Social Worker of the Acute Geriatric Unit at Bulli Hospital.

Megan
most recently worked as
• Operations Manager SHH
• DDON/Site Manager at Kiama Hospital.
• Nurse Manager for Renal Services

Padmini will
• coordinating and evaluating implementation plans,
• liaising with stakeholders,
• foster and encourage an out-comes-focused workplace environment
• and instilling a culture of continuous improvement through effective change management, training and mentoring.

Megan will
• lead and manage clinical programs and complex service delivery
• model of care innovations to ensure effective and sustained change.
• oversee physical changes
• engagement with clinicians engagement with key stakeholders
Fit For Frailty

THE CASE FOR CHANGE
What do we mean by frail?

In simple words:

A person with frailty has increased vulnerability and decline in physical and cognitive ability.

Frailty also directly impacts a person’s ability to function and maintain independence on a daily basis.
Why is this important?

- "Frail" older people are at **greatest risk of adverse outcomes** (worsening disability, institutionalisation and death) and are more likely to present with a geriatric syndrome (particularly delirium and falls).

- **Falling is strongly linked to frailty.** The frail older person can present with falls in the face of seemingly minor stressors. Comprehensive and multifaceted assessment and management programs are needed to reduce falls in person with frailty.

- Person with frailty **have multiple chronic diseases** and are prescribed long lists of medications increasing their risk of adverse drug reactions.
Our ageing population is growing 3-4 times faster than the general population

Within five years, our population will grow by 7.6%:
- 75-84 age group by 16.8%
- 85+ age group by 20.8%

Within 10 years, our population will grow by 12.10%:
- 75-84 age group by 40.3%
- 85+ age group by 39.4%

Source: DPE Population Projections 2016
What we know

Over 75 year olds are only 9% of the Illawarra Shoalhaven population, but make up:

- 30.5% of inpatient separations
- 16% of ED presentations
- 60% of falls*
- 34% of SAC 1 and 2 incidents^*
- 43% of medication errors/issues

* This figure includes all falls across ISLHD facilities, including outpatient and community settings. It does not include falls that occur outside of an ISLHD care setting.

^ Clinical SAC incidents only.
Average Length of Stay

- >85 year olds had double the ALOS of <75 year olds.

Inpatient ALOS - 2015/16

<table>
<thead>
<tr>
<th></th>
<th>Rest of NSW</th>
<th>ISLHD</th>
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<tbody>
<tr>
<td>&lt;75</td>
<td>3.2</td>
<td>3.6</td>
</tr>
<tr>
<td>75-84</td>
<td>4.1</td>
<td>5</td>
</tr>
<tr>
<td>&gt;85</td>
<td>5.9</td>
<td>7.3</td>
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Average Length of Stay in ED

In 2017, there was a clear increase in the ALOS (hrs) based on the person's age, with over 85s triple the ALOS than those aged 0-16 years.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Average LOS (hrs)</th>
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<tbody>
<tr>
<td>0-16</td>
<td>2.8</td>
</tr>
<tr>
<td>17-35</td>
<td>3.5</td>
</tr>
<tr>
<td>36-55</td>
<td>4.1</td>
</tr>
<tr>
<td>56-74</td>
<td>5.2</td>
</tr>
<tr>
<td>75-84</td>
<td>6.7</td>
</tr>
<tr>
<td>85+</td>
<td>7.4</td>
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</tbody>
</table>
### ED Presentations by Age and Outcome

#### ISLHD Presentations to ED 2015-17 by age group and outcome

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Departed: Treatment completed</th>
<th>Departed: Other Hosp/Died/Did not wait</th>
<th>Admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-16</td>
<td>85431</td>
<td>9024</td>
<td>8724</td>
</tr>
<tr>
<td>17-35</td>
<td>81732</td>
<td>13804</td>
<td>14581</td>
</tr>
<tr>
<td>36-55</td>
<td>66009</td>
<td>9829</td>
<td>18133</td>
</tr>
<tr>
<td>56-74</td>
<td>51509</td>
<td>5743</td>
<td>27627</td>
</tr>
<tr>
<td>75-84</td>
<td>19725</td>
<td>1990</td>
<td>21558</td>
</tr>
<tr>
<td>85+</td>
<td>10195</td>
<td>970</td>
<td>17092</td>
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</tbody>
</table>
The compelling story

If you had 1000 days left to live, how many would you choose to spend in hospital?

- 48% of people over 85 die within one year of hospital admission\(^1\)
- 10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80\(^2\)

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1. Imminence of death among hospital inpatients: Prevalent cohort study
   David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, published online 17 March 2014 Palliat Med

2. Gill et al (2004). studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.
A short video

“Your Last 1000 days”

https://www.youtube.com/watch?v=kbdjhN2471c
How do we address this?

Frail Older Person Project

Fit for Frailty
Today not Tomorrow

NSW Health
Illawarra Shoalhaven Local Health District
Priority Focus Areas

1. **Access and Flow**: through *Fit for Frailty* frail older persons project
2. **Service Redesign**: focus on Maternity 2020 to improve Maternity Services
3. **Integrated Care**: through Community Health Review to enhance service delivery with partners and in community
4. **Aboriginal Health Care** (Closing the Gap): Aboriginal Partnership Committee to address areas of inequality
5. **Workforce Safety and Engagement**: focus on Safety Transformation Program and Strategic Capability Development Program
7. **Value for Money**: focus on financial sustainability

NSW Government
Health
Illawarra Shoalhaven Local Health District
Frail Older Persons Project

Aim: LHD-wide view of improvement initiatives and to ensure that all risks, issues and dependencies are visible and managed appropriately.

Clinical Leads:
- Professor Jan Potter
- Dr Spiros Miyakakis

Program Leads:
- Megan Foye
- Padmini Pai
Fit For Frailty Project

- Governance group, chaired by CE
- Will meet fortnightly to provide rhythm and momentum
- Will report through to Strategic Executive Committee

- Executive Director Clinical Operations
- Executive Director Nursing & Midwifery
- Executive Director Medical Services & Clinical Governance
- Executive Director Allied Health
- Executive Director Integrated Care, Mental Health, Planning Information & Performance
- Project Manager
- Co-Directors Aged Care, Rehabilitation & Palliative Care
- Director Ambulatory and Primary Health Care
- A General Manager
- Director Mental Health
- Co-Directors Medicine
- Co-Directors Cancer Care
- Co-Directors Surgery
- Co-Director Critical Care
- Primary Health Network, COORDINARE
- Illawarra Retirement Trust

NSW Government
Illawarra Shoalhaven Local Health District
In very simple words this program is about:

- Acknowledging what we are already doing for our patients and their families i.e. best practice
- Empowers and promotes confidence among all staff
- Focus on patient/family/carer are heard and have control
- Enhances MDT working
- Should give staff no extra work, if anything it should save staff time

And by doing all the above we want to collectively make ISLHD ‘FIT’ to meet the needs for Frail Older Persons
What have we achieved so far?

- Identified use of Rockwood Frailty Scale for use across the District.
- Started working on a frailty treatment plan that will be commenced in ED and accompany patient throughout their admission.
- eMR- working on CFS and treatment plan in firstnet.
- Work commenced on Frailty dashboard
- eMR- working on CFS and treatment plan in firstnet.
- SDMH – CPI project re preoperative screening
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, mildly frail 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 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.

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Date of Birth</th>
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<tbody>
<tr>
<td>Bradmar</td>
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<tr>
<td>CFS</td>
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**Diagnosis List**

**Medical and Surgical Escalation Plan OR Limitations**
- ARP

**Cognitive Assessment**
- MMSE
- RUDAS

**Intercurrent Delirium**

**Baseline Mobility and ADL Status**

**Current Mobility and ADL Status**

**Nutritional Status and Treatment Plan**

**Medications**
*attach information if required*

**Social Supports**

**Function Required for Discharge**

**MAC Approvals**

**Follow up plan**

<table>
<thead>
<tr>
<th>Date Plan Completed</th>
<th>Review Date?</th>
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<tr>
<th>Completing Officer</th>
<th>Signature</th>
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Where to from here

INCREASE FRAILTY AWARENESS ACROSS ISLHD

• Meeting with ward staff across the district

• Master classes and presentations district wide

• Flyers “What is Fit for Frailty”

• Work on FFF Newsletter

• Pilot projects to commence on wards across the district.
Initial Pilot Project Proposal

- #last1000days
- #endPJparalysis
- #red2greenDays
The cycle of deconditioning

1. Prolonged bed rest
2. Increased risk of falls due to muscle weakness
3. Increased confusion or disorientation
4. Constipation and incontinence
5. Decreased appetite, poor digestion
6. Increased risk of swallowing problems
7. Further immobility
8. Increased risk of infection and further decline

- So...if this is the case......what can we do about it?
END PJ PARALYSIS

“The premise of #endPJparalysis is simple -

Hospitalised patients get up, dressed and moving in order to prevent deconditioning.

End PJ paralysis should not be a ‘project’ with strict KPIs, most of all, #endPJparalysis is about trusting clinicians to do the right thing and not underestimating the power of permission giving. (Brian Dolan)

In other words – JUST DO IT!

This is not a new idea. We’ve long known about the risks of immobility. What’s great about the #EndPJParalysis movement is it didn’t originate from a central mandate or a meeting room. It’s simply the right thing to do and the message is simple. For those patients that can get up, dressed and moving they should be given the opportunity to do so which will in many cases help them to return HOME sooner.”

Professor Brian Dolan, the leading figure behind #EndPJParalysis.
Why wear day clothes?

By getting up, getting dressed and getting mobile patients can:

• Maintain their normal routine
• Keep their independence
• Prevent loss of muscle strength and aerobic function
• Lower the risk of infection
• Prevent pressure injuries and falls
• Reduce the length of time they have to spend in hospital
**RED DAYS**

- A Red day is when a patient receives little or no value adding acute care. The following questions should be considered:
  - Could the care or interventions the patient is receiving today be delivered in a non-acute setting?
  - If I saw this patient in out-patients, would their current ‘physiological status’ require emergency admission?
  - Could the care or interventions the patient is receiving today be delivered in a non-acute setting?
  - A RED day is a day of no value for a patient

**GREEN DAYS**

- A Green day is when a patient receives value adding acute care that progresses their progress towards discharge.
  - A Green day is a day when everything planned or requested gets done.
  - A Green day is a day when the patient receives care that can only be in an acute hospital bed.
  - A GREEN day is a day of value for a patient

Essentially red2green days operationalises the last 1000 days
Let’s empower patients

● What is wrong with me?
● What is going to happen this morning, this afternoon, tomorrow morning?
● What needs to happen for me to go home?
● If all goes to plan, when will I go home?
District Fit for Frailty Road trip

- Master Class
- PJ Paralysis
- Red2Green to commence
- Teach back

- Physio rehab project
- Master class
- Community stocktake

- PJ paralysis planned September followed by Red2Green
- ED CFS data collection and planned implementation of FTP.
- Master classes x3

- Governance committee
- Support and research continues
- SW student support – risk perception coordination

- Master class
- Pre-op screening
- PJ Paralysis and Red2Green
- Exec and staff meets at SDMH and DBH
- Milton tba

- Master Class, meet with exec.
- DC card project
- Planned PJ Paralysis project
- Red2Green interest – focus rehab

- RAS and Stocktake
- Cognitive frailty directly related to MH
“When deciding to admit a patient we routinely analyse the risk of discharging a patient home but fail to analyse the risk of them being in hospital. This lop-sided equation results in many decisions to admit.”

Christopher Tuckett
If you change the way you look at things, the things you look at change

- Wayne Dyer
Small is All (commitment to join the dots)
THANK YOU FOR YOUR ATTENTION! ANY QUESTIONS?

Fit for Frailty
Today not Tomorrow

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