Fit for Frailty
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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.

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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*

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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.

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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

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THE CASE FOR CHANGE

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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.

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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.






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Our ageing population is growing 3-4 times faster than the general population

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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%**

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Source: DPE Population Projections 2016

What we know

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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.

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Average Length of Stay

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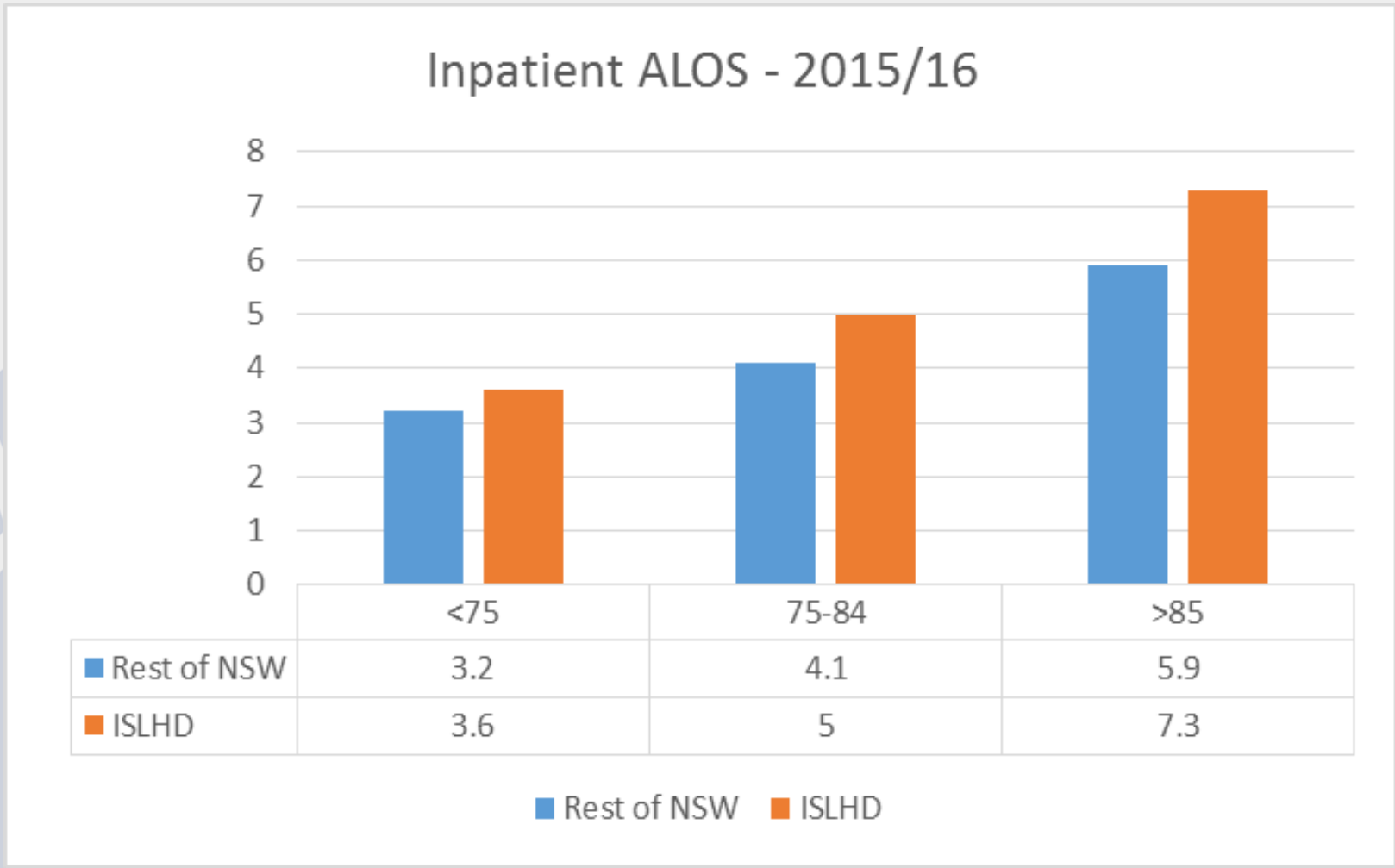
- >85 year olds had double the ALOS of <75 year olds.



Average Length of Stay in ED

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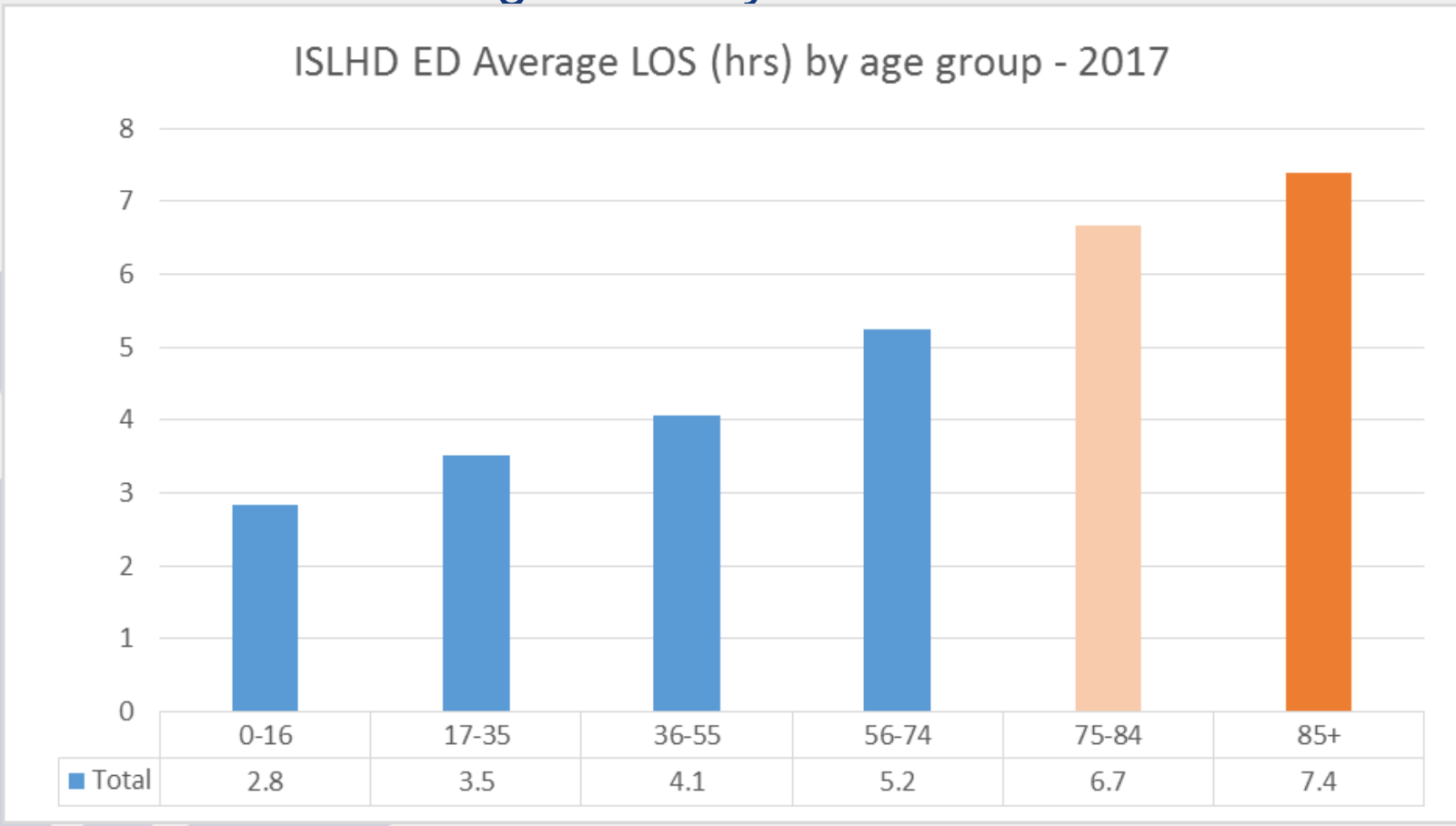
In 2017, there was a clear increase in the ALOS (hrs) based on the persons age, with over 85s triple the ALOS than those aged 0-16 years



ED Presentations by Age and Outcome

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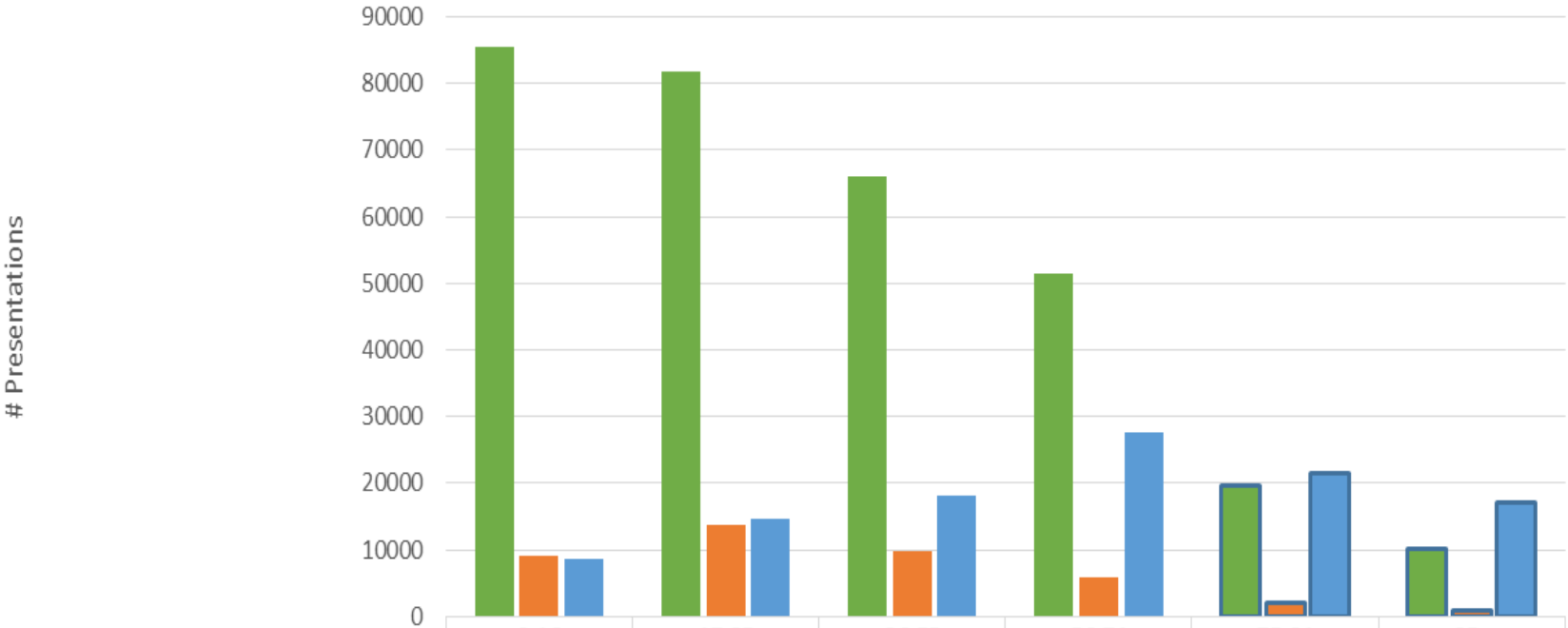

	0-16	17-35	36-55	56-74	75-84	85+
Departed: Treatment completed	85431	81732	66009	51509	19725	10195
Departed: Other Hosp/Died/Did not wait	9024	13804	9829	5743	1990	970
Admitted	8724	14581	18133	27627	21558	17092

The compelling story

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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]

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.
Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2008;63:1076–1081.

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A short video

“Your Last 1000 days”

https://www.youtube.com/watch?v=kbdjhN2471c

How do we address this?

Frail Older Person Project

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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
6. **Research:** through Research and Innovation Strategy 2018-2020
7. **Value for Money:** focus on financial sustainability

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Frail Older Persons Project

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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 Miyakis

Program Leads:

- Megan Foye

- Padmini Pai

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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

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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

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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

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Clinical Frailty Scale

Very Fit

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

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.

Managing Well

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

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.

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.

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.

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).

Very Severely Frail

Completely dependent, approaching the end of life. Typically, they could not recover from a minor illness.

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.

K. Rookwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005:173:489-495. **Courtesy of Geriatric Medicine Research, Dalhouse University.**

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FIT FOR FRAILTY
TREATMENT PLAN

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Patient's Name		**Date of Birth**	
MRN			

Bradmar	
CFS	
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	

Date Plan Completed		**Review Date?**	
Completing Officer			
Signature			

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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.

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Initial Pilot Project Proposal

- #last1000days
- #endPJparalysis
- #red2greenDays

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The cycle of deconditioning

- So…if this is the case……what can we do about it?

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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.

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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

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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

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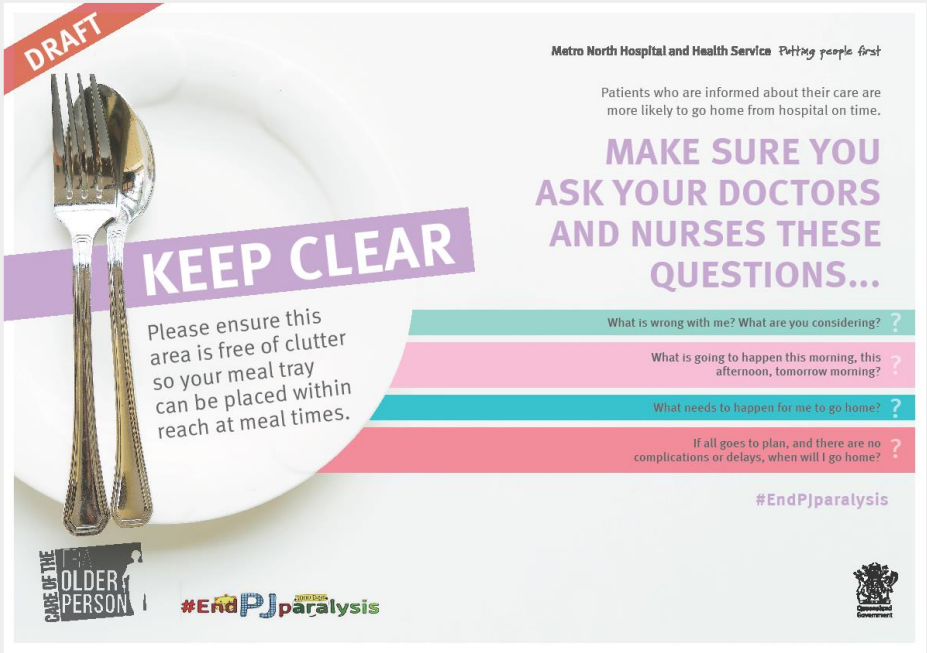
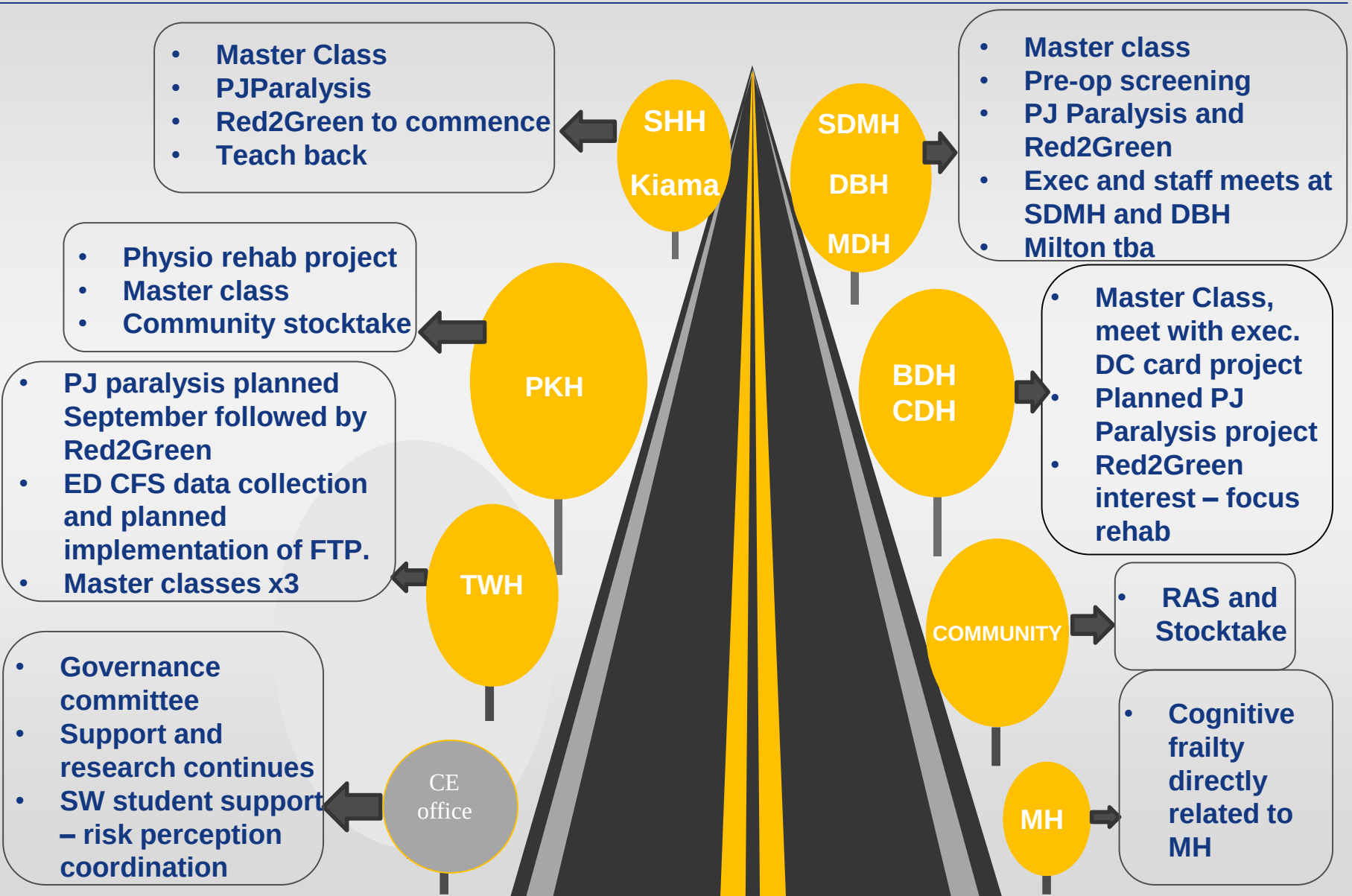
Let's empower patients

- 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



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"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

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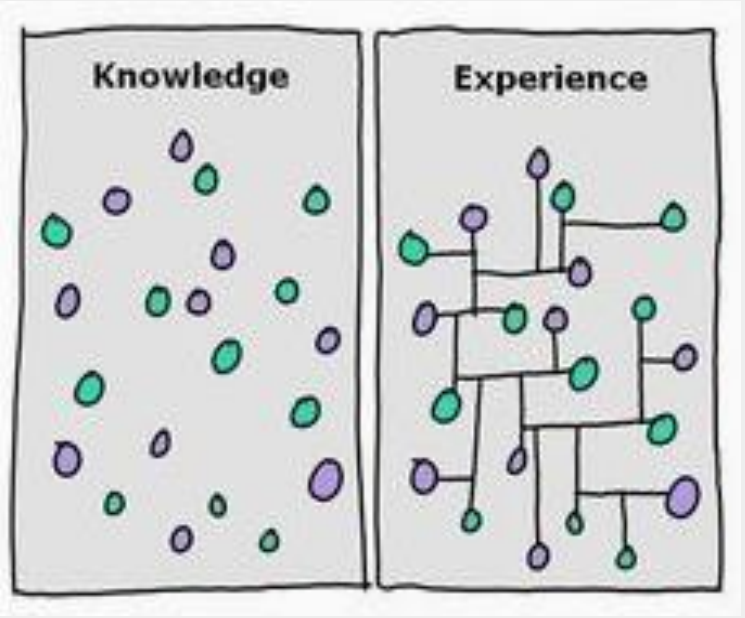

If you change the way you look at things, the things you look at change

- Wayne Dyer

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Small is All (commitment to join the dots)

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