FOCUS ON FRAILTY

phn MURRAY
An Australian Government Initiative

As life expectancy is increasing, many more people are enjoying healthier and more active lives in their later years. However, some older people have reduced resilience and increased vulnerability to minor changes in their circumstances. This can lead to deterioration in their physical and mental health and impact on their ability to live independently.

Frailty is a condition that becomes more common as age increases but is not an inevitable consequence of getting older. Sarcopenia or normal muscle tissue begins to reduce from the age of 40 and vulnerable groups, such as people experiencing homelessness, are susceptible.

A quarter of all people aged 70 and older are said to have the condition, but often it's not diagnosed until after a health event occurs. Usually, this is a combination of deconditioning and acute illness, and with a background of existing functional decline.

Multimorbidity with frailty is common, and both have been associated with an increased risk of disability, hospitalisation and mortality, and do result in increased costs to the health system.

Increasing awareness and understanding of frailty among individuals, families and communities, as well as practitioners working with older people, is an important first step towards improving outcomes for people living with this condition.

Early identification and treatment is always best and identifying people who are living with frailty, will assist those at greatest risk of deterioration in their health, wellbeing to help them maintain their ability to live independently.

Approaches to management align with the 10 Year Primary Health Care Plan, especially Stream 2 goals of Person Centred Care of: boosting multidisciplinary team based care, improving access to appropriate care for people at risk of poorer outcomes, empowering people to stay healthy and manage their own healthcare.

The Asia-Pacific Clinical Practice Guidelines for the Management of Frailty recommends:

- A validated measurement tool to be used to identify frailty.
- Older adults with frailty be referred to a progressive, individualised physical activity program that contains a resistance training component.
- Polypharmacy be addressed by reducing or de-prescribing any inappropriate/superfluous medications.
- Persons with frailty are screened for reversible causes of fatigue.
- Persons with frailty who exhibit unintentional weight loss should be screened for reversible causes and considered for protein and caloric supplementation/food fortification.
- Vitamin D be prescribed for older adults found to be deficient in vitamin D.
- Provision of an individualised support and education plan for older adults with frailty.
- Screen all patients admitted to a residential aged care facility for risk of malnutrition.
- Early involvement of a physiotherapist can be helpful.
- Engagement of a dentist can be helpful.
- Engagement of a speech therapist can be helpful when necessary for swallowing difficulties.
- Consider comorbidities that may be contributing i.e. depression and cognitive impairment.

How general practices can help identify and treat frailty

- Use evidence based frameworks, such as RACGP's Silver Book, to guide assessment and treatment.
- Encourage patients to enrol in MyMedicare to ensure continuity of care and maximisation of MBS incentives.
- Know who in your practice is at risk of or could be living with a diagnosis of frailty (comorbidities).
- Pay attention to how your patients walk into the consultation room or move.
- Look for some of the key contributing factors, such as social isolation, poor nutrition.
- Discuss falls prevention with at risk patients e.g. during immunisation, wound care, 75+ Health Assessments, GPMPs etc.
- Enlist the patients support on how they might want to stay healthy and active (person centred, collaborative).
- Know the referrals that exist in your area: HealthPathways is a great starting point!
- Use practice nurses to identify, recruit, recall patients at risk of frailty.
- Consider frailty identification and management as a quality improvement activity

Resources

PDSAs – Quality improvement	Plan-Do-Study-Act cycles provide a framework to help develop, manage, and test quality improvement activities. Please contact your Quality Improvement Consultant for assistance with identifying change ideas for your practice.	• Frailty-QI-toolkit-May-2024.pdf (sydneynorthhealthnetwork.org.au) • PDF-Frail-scale.pdf (sydneynorthhealthnetwork.org.au) • Frail SNPHN DL Brochure_management 5-page-002 (sydneynorthhealthnetwork.org.au) • Aged Care - North Sydney Primary Health Network (sydneynorthhealthnetwork.org.au) (This includes instructions to upload templates for 75+HA for both BP and MD that include frailty questionnaires).
Murray HealthPathways	Murray HealthPathways aims to guide best-practice assessment and management of common medical conditions, including when and where to refer patients, with guidance on what information is needed	• Frailty in Older Adults - Community HealthPathways Murray
PENCS	TOPBAR	• FRAIL App - USER GUIDES TOPBAR - PenCS Help Frail Scale Questionnaire

Evidence-based guidelines

Guidelines	• RACGP - RACGP aged care clinical guide (Silver Book)Frailty | health.vic.gov.au • Health Ageing and Frailty - Hunter New England and Central Coast PHN • The Asia-Pacific Clinical Practice Guidelines for the Management of Frailty • Healthy ageing articles (liveup.org.au) • Ageing Well - Sydney North Health Network • Frailty: Every Step You Take Matters! • Australian Frailty Network (afn.org.au) • Frailty Hub | British Geriatrics Society (bgs.org.uk) • Frailty Hub: Education and training | British Geriatrics Society (bgs.org.uk) • Canada's Network for Older Canadians Living with Frailty - Canadian Frailty Network (cfn-nce.ca)

For further information or support please contact your local Quality Improvement Consultant, email: gpsupport@murrayphn.org.au or visit the general practice support page on our website.