GEDC | THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

Frailty in the Geriatric ED

Expert Panel Webinar

Monday, January 23, 2023

3:00–4:00PM EST

Moderated by:

Don Melady, MD, MSc(Ed)
Emergency Physician
Mount Sinai Hospital, Toronto, Canada
GEDC Faculty

Sharing best practices and promising interventions in Geriatric Emergency Care

EXPERT PANEL

Kenneth Rockwood, MD, MPA, FRCPC, FRCP
Professor of Medicine (Geriatric Medicine & Neurology)
Dalhousie University, Halifax, Canada

Simon Conroy, MB ChB, FRCP, PhD
Professor of Geriatric Medicine
University College London
Lead, Acute Frailty Network, England

Aaron Malsch, RN, MS, GCNS-BC
Senior Service Program Manager
Advocate Aurora Health

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How does frailty change the ED management of older patients?

300 Registrants from 14 countries

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We are currently working on processes to identify it early, at triage.

It helps to commence CGA on acute floor.

How can we build a frailty Patient Pathway after the ED ?

People with frailty stay longer and suffer more

It leads to patient being roomed more quickly.

Symptoms can be evaluated appropriately.

Delirium prevention and care bundle orders can be implemented.

Minimally at present

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Our Vision

A world where all emergency departments provide the highest quality of care for older patients

Our Mission

We bring best practice into action.

We transform and evaluate interdisciplinary best practice in geriatric emergency medicine, and then build and distribute practical, evidence-based clinical curriculum and quality improvement tools that support sustainable, quality care for older adults.

GEDC Members

gedcollaborative.com

Membership

GEDC Members work together to transform ED care of older adults; catalyze action at local and national levels to support these care transformations; and evaluate the impact of these new models of care for older people.

Join the GEDC

- Access to GEDC community
- Share best Geri ED practices
- Access to education tools
- Implementation tools and training
- Evaluation resources

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The Geriatric Emergency Department Collaborative
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What question do you have for our panelists?

@theGEDC

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Meet Your Expert Panel

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CLINICAL FRAILTY SCALE

1 **VERY FIT** — People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.

2 **FIT** — 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**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.

4 **LIVING WITH VERY MILD FRAILTY** — Previously "vulnerable," this category marks early transition from complete independence. 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 **LIVING WITH MILD FRAILTY** — People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

6 **LIVING WITH MODERATE FRAILTY** — People who 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 **LIVING WITH SEVERE FRAILTY** — **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 **LIVING WITH VERY SEVERE FRAILTY** — Completely dependent for personal care and approaching 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 living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally 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.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY

Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html

Identifying Seniors At Risk (ISAR)

ISAR	Yes	No
1) Before the illness or injury that brought you to the Emergency, did you need someone to help you on a regular basis?	1	0
2) Since the illness or injury that brought you to the Emergency, have you needed more help than usual to take care of yourself?	1	0
3) Have you been hospitalized for one or more nights during the past six months (excluding a stay in the Emergency Department)?	1	0
4) In general, is your sight good?	0	1
5) In general, do you have serious problems with your memory?	1	0
6) Do you take more than three different medications every day?	1	0

If two or more of the 6 questions are positive responses, it suggests a need for further attention to the person's ability to function in the home environment now when faced with a new medical or surgical condition.

McCusker, Jane et al., Detection of older people at increased risk of adverse health outcomes after an emergency visit: the ISAR screening tool. J Am Geriatr Soc. 1999;47:1229-1237. 69

https://gedcollaborative.com/article/screening-tools-for-delirium-dementia-and-functional-decline/

Take away points.

Ken:

1. Frailty is constituently linked to aging: whenever age is important, frailty will be too.

2. To develop sensible care plan, it is important to know not just *whether* a person is frail, but to know *how frail* they are.

3. We must avoid all-or-none, dichotomous decisions in the ED, e.g., “do you want us to do everything for your father? Or nothing?” Instead, we need to set up for trials of treatment and dynamic decision-making that include a consideration of frailty.

Take away points.

Simon's:

1. Frailty is fundamental to understanding where someone is on their life trajectory: you need to understand it to design a treatment plan.

2. Frailty scoring can be quick simple and easy to implement even at large scale. It provides a common currency in the care of older people.

3. The CFS is to geriatric emergency care what the ECG is to the cardiology.

Take away points.

Aaron's:

1. If you don’t have Frailty scoring, engage with it “by proxy” using other tools.

2. Build the concepts of frailty into your protocols: Falls, Mobility, Physical Therapy Assessment; Discharge Planning; Rehab referral; Abuse and Neglect.

3. Remember the interprofessional role in addressing frailty: interventions by MD, RN, PT, SW Pharm, Case Manager differ. Each team member needs to under the others’ strengths.

Frailty in the Older Ed Patient

A Geri-EM.com E-learning Module

You have completed this module.

Download Certificate

Review

Share on

Course Summary

When we meet an “old” patient in the ED, we don’t really ask ourselves how old they are, but how frail they are. When we are thinking about the clinical and physiological changes of aging, we are talking about frailty. Frailty is a relatively new concept in geriatric medicine and one of the geriatric syndromes. It has been described as a state of reduced physiologic reserve, causing an increased vulnerability to acute and chronic stressors. Frailty has been correlated with functional decline, institutionalization, and increased mortality.

https://gedcollaborative.com/course/frailty/

Q & A

Ask your questions

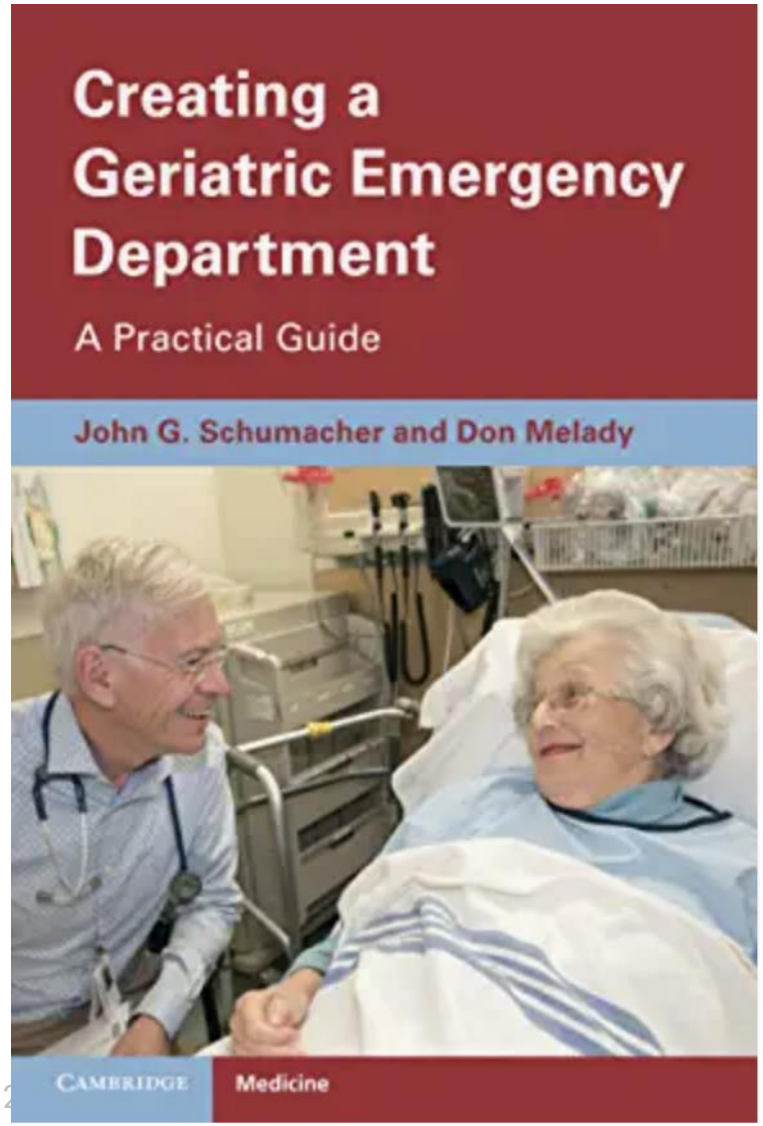
in the chat!

We will try to get to everyone

Resources

1. Clinical Frailty Scale
2. Top Tips When Using Clinical Frailty Scale
3. Hierarchical Assessment of Balance and Mobility
4. Silver Book
5. The Frailty Index
6. How older people move in bed when they are ill Blog
7. GEDC Frailty in the Older Ed Patient E-Learning Module
8. Frailty affects the initial treatment response and time to recovery of mobility in acutely ill older adults admitted to hospital
9. Impact of frailty on persistent critical illness: a population-based cohort study
10. The role of illness acuity on the association between frailty and mortality in emergency department patients referred to internal medicine
11. Using the Clinical Frailty Scale in Allocating Scarce Health Care Resources
12. Association of Geriatric Emergency Department post-discharge referral order and follow-up with healthcare utilization

Creating a Geri ED: A Practical Guide



A practical guide to getting started with lots of personal stories and resources from around the world

Available online through:
Amazon and
Cambridge University Press

20% Discount Code for GEDC users
if you purchase on the Cambridge site:

CGED2021
https://www.cambridge.org/core/books/creating-a-geriatric-emergency-department/8A860CD9BADB4E1C1509BDB49B814159

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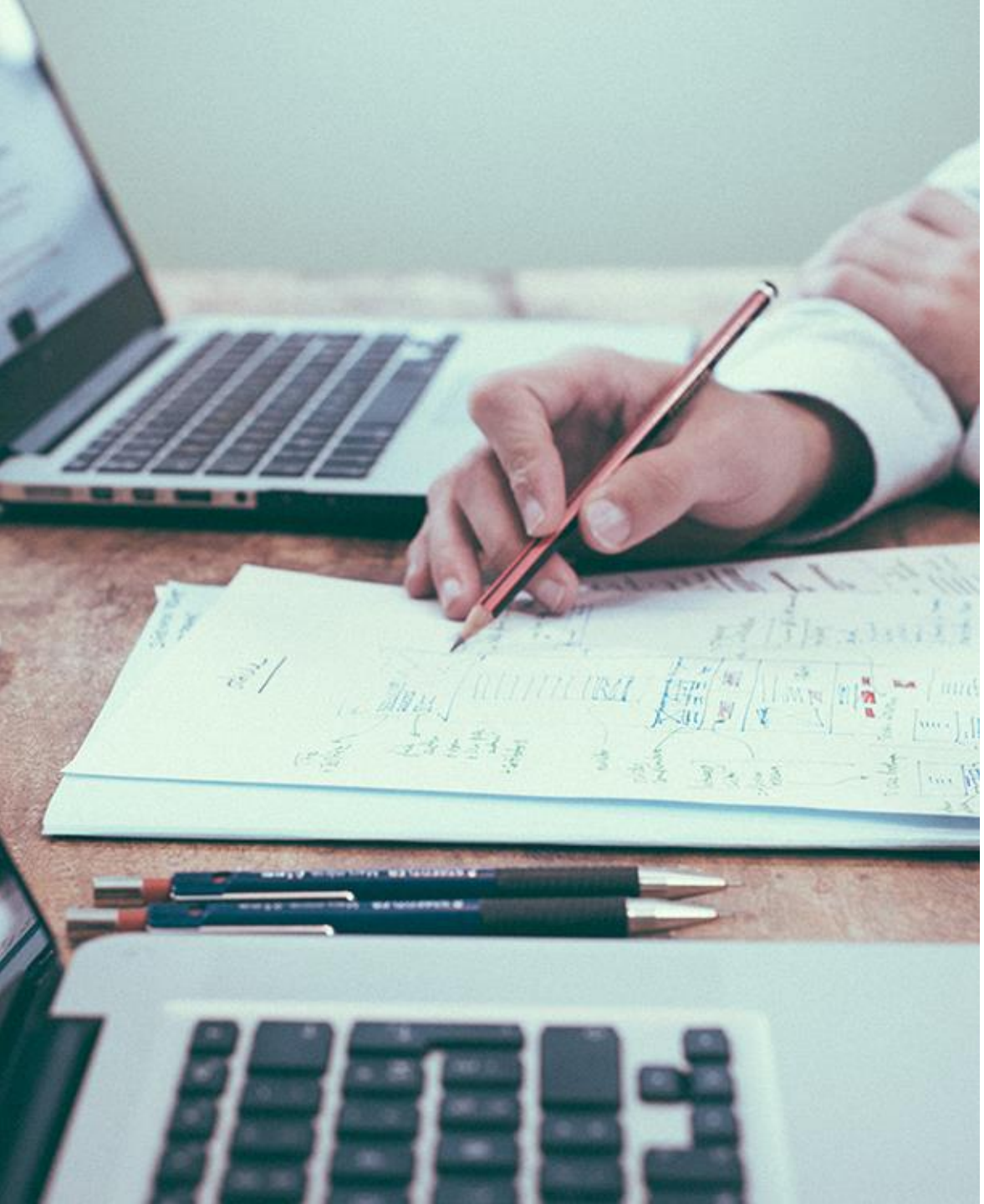
Brain Health in the ER

New Videos Address Brain Health Issues in Hospitals, Emergency Rooms

Dementia in the ED: Providing Better Care for Older ED Patients

Delirium in the Emergency Department: Serious, costly, and potentially deadly



OUR NEXT GEDC
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Poll slide

How do you identify frailty in your ED

- **CFS;**
- **ISAR;**
- **Something else;**
- **GEM Nurse Assessment;**
- **Gestalt**
- I don't know

