WORKING ON AN INTEGRATED CARE COMMUNITY SPECIALIST TEAM FOR THE OLDER PERSON

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STEP
South Tipperary Enablement Programme for the Older Person

nICPOP
National Integrated Care Programme for Older Persons

HSE our health service

OVERVIEW

01. FRAILTY AN INTEGRATED CARE APPROACH

02. COMPREHENSIVE GERIATRIC ASSESSMENT
CGA

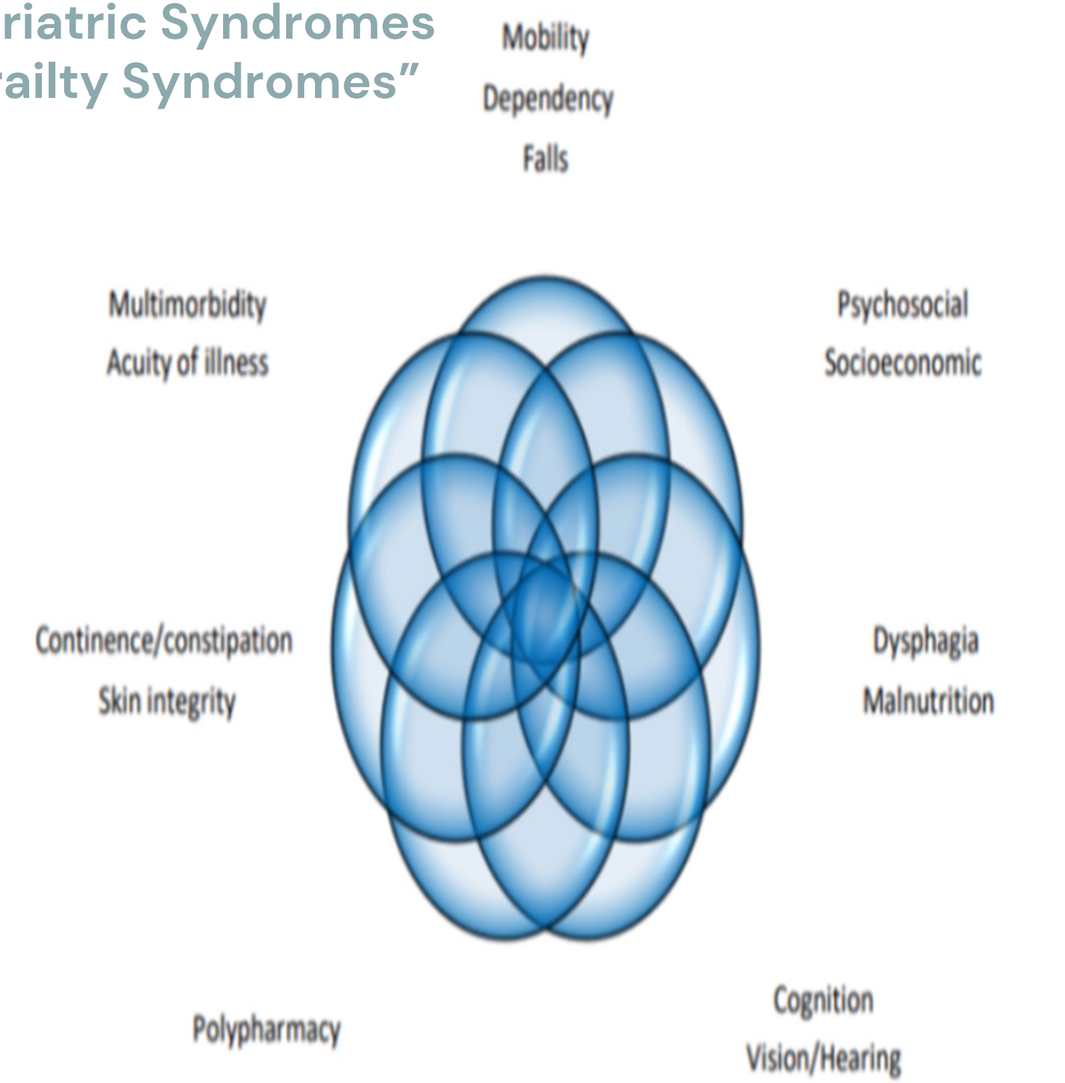
03. INTERDISCIPLINARY WORKING

04. MY EXPERIENCE OF WORKING WITH PHARMACY

Introduction

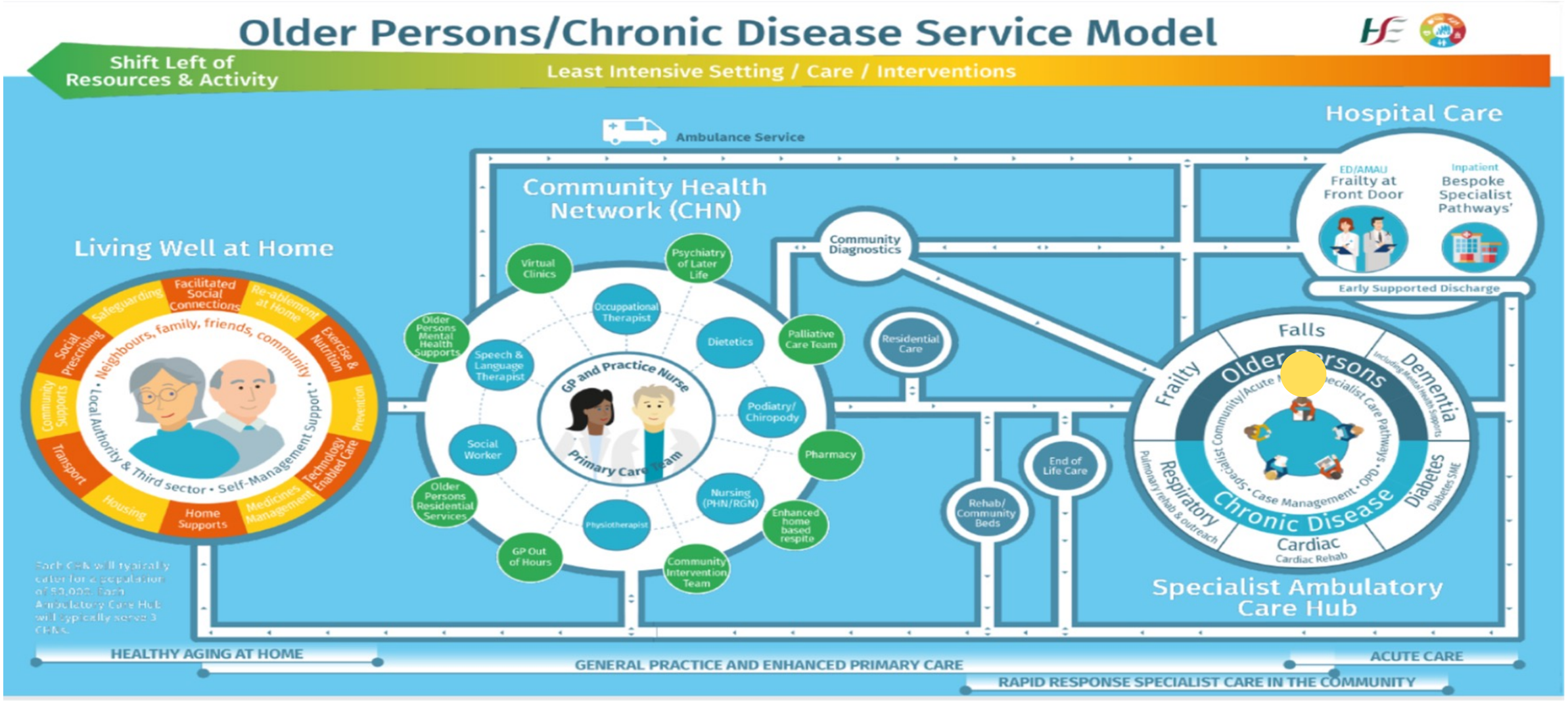
- Ageing Population
- With increasing life expectancy comes increasing age related disease morbidity & age related syndromes
- Geriatric Syndromes :Term to describe a group of common health conditions in older person that do not fall into discreet disease categories
- National Integrated Care Programme for Older Persons

Geriatric Syndromes "Frailty Syndromes"



O'Hallorna et al 2021

National Older Persons Service Model



FRAILTY

“A condition or syndrome which results from a multi-system reduction in reserve capacity to the extent that a number of physiological systems are close to, or past, the threshold of symptomatic clinical failure.

As a consequence the frail person is at risk of disability and death from minor external stresses.” (Campbell & Buchner, 1997) .

FRAILTY

- **Vulnerability** due to a reduced or adversely altered biological state

- Challenge by a **Stressor** if even minor can result in an adverse outcome

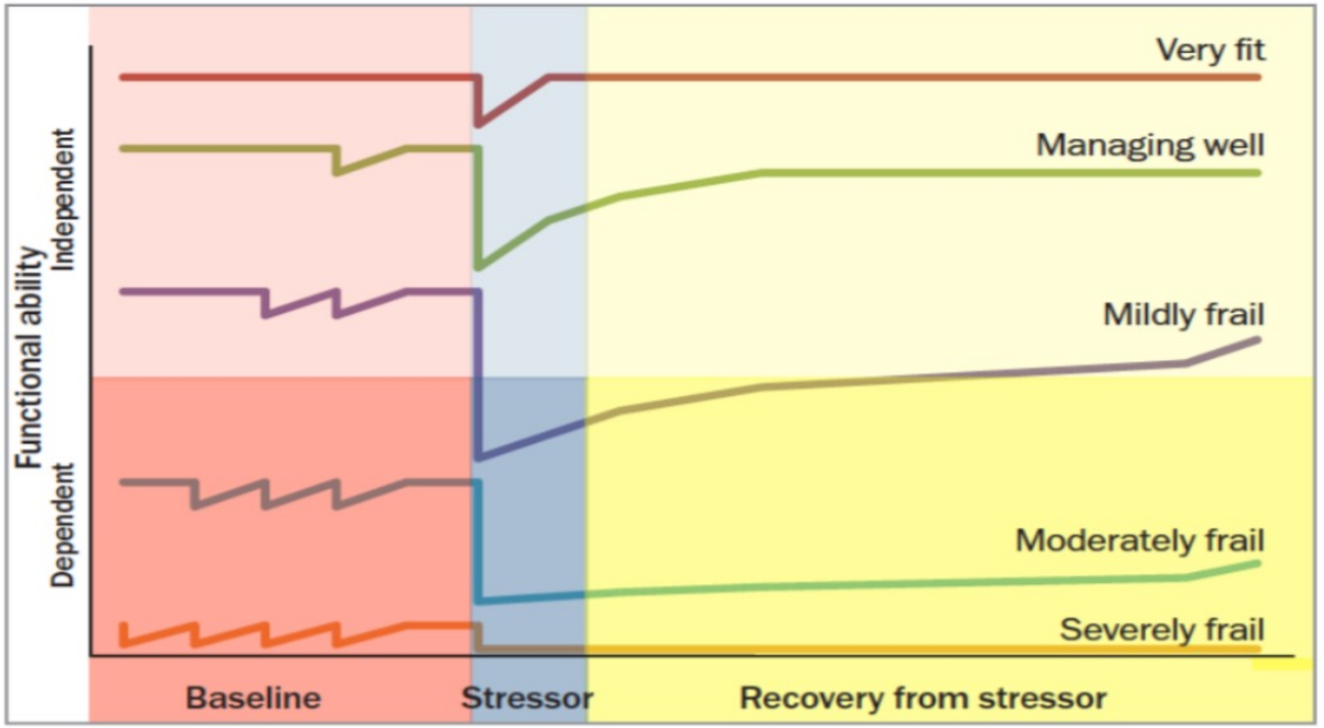


Figure 1. Effect of level of frailty on experience of a stressor (e.g. a fall) and recovery in five people of the same age and social environment.

Focus on frailty
Essential as the population ages

MedicineToday | AUGUST 2015, VOLUME 16, NUMBER 8

OPERATIONALISING FRAILTY

Understanding the frailty models helps to translate the definition into something more tangible

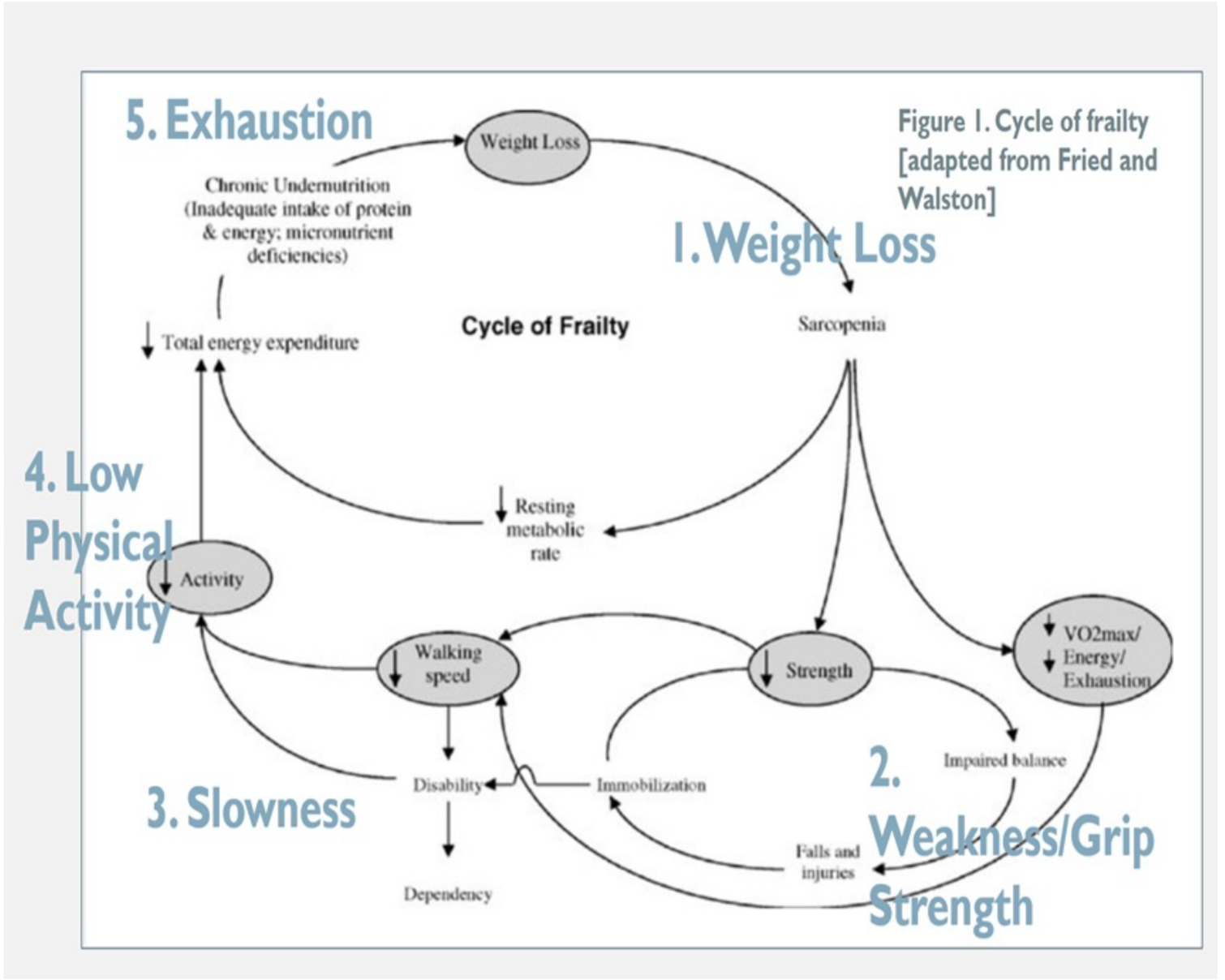
Frailty Models

Frailty Phenotype : Physical Features

Frailty Index (FI): Accumulation of Health Deficits

Frailty Phenotype

5 Physical Features

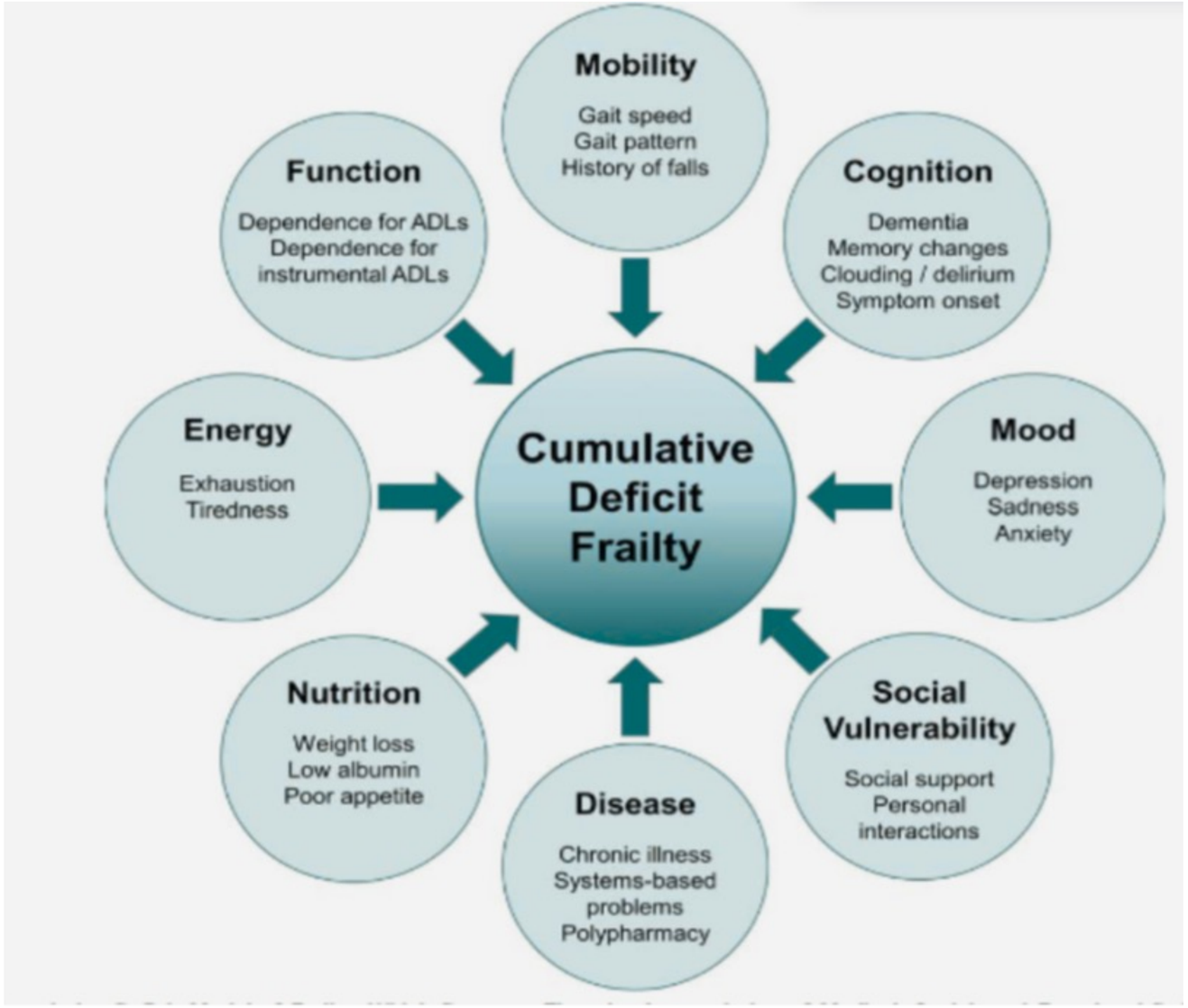


(Linda P.Fried, et al., 2001)

Frailty Index

Accumulation of Health Deficits

Health deficits that covers a more complete look at an individual than just physical , includes mental health , diseases, sleep , medication
(Jones, Song, & Rockwood, 2004)



COMPREHENSIVE GERIATRIC ASSESSMENT (CGA)

“Multidimensional interdisciplinary process , focused on determining an older person's medical, psychological and functional capability in order to develop a co-ordinated and integrated care plan.

CGA is not limited simply to assessment, but also directs a holistic management plan for older people, which leads to tangible interventions.

Briggs et al 2022

Comprehensive Geriatric Assessment

Who should have a CGA ? CGA is fundamental to the assessment, planning and intervention required to meet the health and social care needs of the older person that is living with frailty or at risk of frailty

How to Refer : STEP Team : GP/Consultant or Recommendation by Other HCP (but comes through GP/Consultant) - this varies for different ICPOP teams

Who does the CGA: Assessment completed by Team Member - all CGA's are discussed at MDM

Where : Outpatients , Home, where is suitable for patient

Comprehensive Geriatric Assessment

Domains

- Medic
- Medic
- Cognit
- Comm
- Nutriti
- Falls &
- Mobili
- Living
  Engage
- Social

Discussion

ic & Services

ervices

Protection

y

ackage Assessment

E/Family Carers

Homes

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, mild frailty 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 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 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.

Date of Assessment

Patient Details

Hospital no:
Name /Address of Patient/DOB

Preferred Name
Contact Number:
Ethnicity/language details:
GP:

Preferred/Nominated Contact:
Contact Number
Relationship:

Date of Referral & Referrer:
Date of Assessment:

Reason for referral

_____ yr old M F

Main goals/Concerns of patient/

Medications

Pharmacy Name, Address and Contact Details:

Blister Pack : Yes No **Separate Meds :** Yes No **Medication Looked After By :**

Allergies :

Medication List Source : Pharmacy over Phone Ph

Adherence:

NOT TO BE USED FOR PRESCRIBING/ADMIN PURPOS

Medication List:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Prioritisation Toolkit for Pharmacy Referrals (Ti	
1)	Regular use of greater than 10 medications (excl
2)	High risk medications (see list)
3)	Anti-Cholinergic Drugs (see list)
4)	Specific Pharmaceutical concerns (e.g. Crushing
5)	Renal Impairment
6)	Falls review of medication

Nutrition & Sarcopenia Screening

Current Weight (kg): **Previous Weight (kg & Date):** **Height:** **BMI : kg/m^2**

Malnutrition MST:

A. Has the patient lost weight recently?

(emphasize "without trying", have you or your family/carers notice weight loss)

Yes –go to B☐ No –go to C☐ Unsure – Go to C + score 2 ☐

B. Weight Loss Score (Past 6 Months)

1-5kg = 1 ☐ , 6-10kg = 2☐, 11-15kg = 3☐

> 15kg = 4 ☐ Unsure = 2 ☐

C. Lack of appetite/ Eating poorly (<¾ of usual amount, decrease in portions, decrease noted by self or carers/family) :Yes= 1☐ No= 0 ☐

MST Score : **Score ≥2 indicates Risk of Malnutrition:**

On ONS : Y N **Good Compliance ONS:** Y N N/A **Pressure Sore :** Y N **Constipation:** Y N **Regular Fluids Daily:** Y N

Do you consume dairy foods (milk, cheese, yogurts) on a daily bases/fortified dairy alternative? Y N **Dysphagia :** Y N

Sarcopenia Screen: **Grip strength (kg) Right**

Left

Grip: 3 Readings on each hand, highest reading used, record all readings. <27kg Men, <16kg Women

STEP
South Tipperary Enablement Programme for the Older Person

CGA CASE STUDY

Referral

79yr old Lady, GP Requested Comprehensive Geriatric Assessment
Recent fall , increasing dependency on daughter for activities of daily living
CGA Assessment Completed by Member of ICPOP Team & Discussed at MDM

CGA Outcome

P2
Meds Anticholinergic Burden
Pharmacy

Falls Risk
Environmental
OT

Positive Swallow Screen
SLT

Malnutrition Risk/ Constipation
Dietitian

Positive AD8
Memory Clinic

Barthel 12/20 /Lawton Brody 2/8
PHN/Home Help

Dementia Advisor

High Frax
Bone Health Pathway

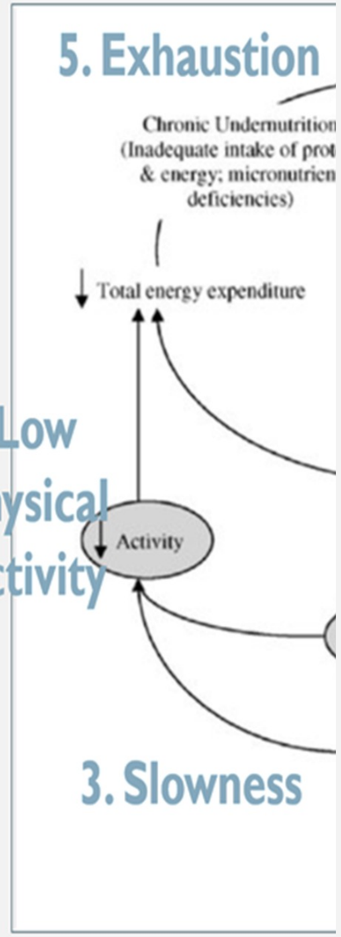
INTERDISCIPLINARY WORKING

Interdisciplinary teams are organised to work on a common set of **complex problems.**

Each person's contributes their skill set in order to augment and support others in the team whilst taking account of that person's contribution.

Members retain specialised roles and functions whilst communicating actively with one another.

Practice Guidance for Older Person Multi-Disciplinary Teams National Integrated Care Programme, Older Persons, HSE 2021



Therapist

- CNM2

Mobility

Gait speed

Domains	Assessment Tool
• **Medical History/Investigations**	• Medical notes, Referral /DEXA, CT Brain /Biochemistry /Pain
• **Medications**	• Pharmacy Prioritisation Toolkit
• **Cognition**	• 4AT , AD8
• **Communication & Swallow**	• Swallow Screen , Comprehension , Expressive , Intelligibility
• **Falls & Bone Health**	• Falls Hx, FRAX , Bp
• **Mobility & Function**	• Independence , Barthel ,Lawton Brody
• **Living Environment & Engagement**	• Accommodation and how engages with environment
• **Social Assessment**	• Supports , mood , loneliness , social activities , Finance , EPA • What Matters to you • Clinical Frailty Score

MDT Engine Room of Geriatric Medicine

Interdisciplinary Working & Frailty

Frailty & Nutrition

Physical Features
Accumulation of Health Deficits

Factors which Effect Nutritional Status Older Person

Reduced Appetite

Low Physical Function - ADL , Mobility

Admission to Hospital

Oral Health/Vision

Mood/Loss of interest/Depression

Socioeconomic Factors - access to services

Medications

Swallowing Difficulties

Cognitive Decline

Constipation

Interdisciplinary Working & Frailty

How do we Identify the “drivers of Frailty ”? Comprehensive Geriatric Assessment (CGA)
CGA Steers us towards Interdisciplinary Working

Overview of Patient Profile Assessed by CGA:

Sample
- N=567 (325 Female, 242 Male)
- Mean Age :82yrs
- Median Clinical Frailty Score : 6

Identified
- 35% Positive Cognitive Screen
- 37% Positive Swallow Screen
- 31.6% Risk of Malnutrition

Identified
- 68% Fall Reported
- 14% Loneliness
- 44% Living Alone

Association with Risk of Malnutrition with Falls and Cognitive Impairment

L King, et al 2022

Introduction of Screening for Sarcopenia

Muscle Health Group

Joint Dietetic & Physiotherapy Project

Interdisciplinary Working & Frailty

- Calcium supplementation as part of bone protection management has become regular practice
- Concerns relating to compliance & increased risk of gastrointestinal disturbances, cardiovascular disease, malignancy and kidney stones with supplementation been reported
- Preference for optimising dietary calcium, supported by calcium supplementation only where required.
- Joint Dietetic & Pharmacy

My Experience of Working with a Pharmacist on a Community Specialist Team for Older Person

Interdisciplinary Working & Pharmacy

"Contributes their skill set in order to augment and support others"

"Retain specialised roles and functions whilst communicating actively with one another"

Pharmacist on Team
Presence & Active Communication

- CGA & Medication
- Correctly obtaining a patients list of medications
- Correctly finding out if the patient is taking medications
- PRN & OTC
- Properly documenting medication list
- Blister pack - pros/cons , who is suitable
- Contacting the Pharmacy
- Value in knowing when a patient was started , stopped or dose changed for a medication

Interdisciplinary Working & Pharmacy

Pharmacy Prioritisation Toolkit

- Simple to use
- Provides ability to Assess
- Targets Complex Multi-contributory factors

Pharmacy Prioritisation Toolkit & Frailty

Medications & Frailty

Reduction in appetite & weight loss

Swallow/Communication

Parkinsonism features

Multiple co-morbidities - polypharmacy

Adherence & Memory Concerns

Falls - Low blood pressure

Fatigue

Renal - Creatinine Clearance

Constipation

THANK YOU

Have any question?

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