SeeMe™
Understanding frailty together.

Introduction to Frailty-Informed Care

What is Frailty?

> Frailty is a state of increased vulnerability, with reduced physical reserve and loss of function across multiple body systems. This reduces ability to cope with normal or minor stresses, which can cause rapid and dramatic changes in health.
>
> **– Canadian Frailty Network**

The prevalence of frailty is greatest in older adults, but frailty may impact people of any age. Over time, stressors have a compounding effect on a person's body and limit the ability to respond to health events. Increased vulnerability and reduced reserve mean that a seemingly minor health event (e.g. infection, fall, visit to ER) can result in significant changes to a person's health status. While a fit person may overcome a minor health event relatively easily, the same condition may cause a person with frailty to experience a delayed or incomplete recovery. The individual with frailty may never completely "bounce back" to their baseline ability to move, think, and complete daily activities following the health event. Similarly, receiving intensive medical treatments for a given condition may increase the risk of delayed or incomplete recovery for a person with frailty. This is why it's important to ensure that frailty is well understood, particularly in the context of health care decision-making.

The Clinical Frailty Scale[1] was developed to provide a standard clinical definition of different degrees of frailty, based on activity level, medical status, and independence with daily activities.

Frailty-Informed Care

Frailty is now recognized as a strong predictor of health outcomes.[2] At Perley Rideau, we believe that understanding and recognizing frailty is crucial to providing good care. That's why we've developed **SeeMe: Understanding *frailty* together™**.

SeeMe™ is a program that recognizes and assesses frailty as part of a person's overall health and supports residents and their families to make informed decisions around treatment that may be helpful or harmful within the context of frailty. The program involves a true partnership between the healthcare team and the resident/family in terms of considering the whole person and what matters most to them as an individual. SeeMe™ aims to align care with quality of life goals, with a true understanding of what a quality life means to individuals. ***"See me"*** is the heart's cry of our residents: a call to be seen and known during a period of life when they may not have a voice. With SeeMe™, we strive to see residents for who they are, the unique strengths they bring, and the rich life experience they have.

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

[2] Rockwood, Rockwood & Mitnitski. Physiological redundancy in older adults in relation to the change with age in the slope of the frailty index. J Am Geriatrics Soc. 2010;58:318-323.

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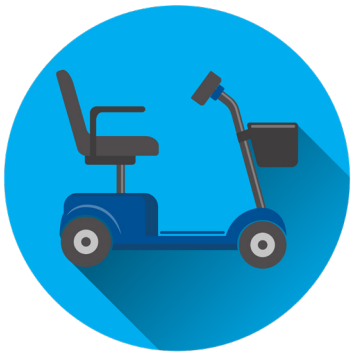
Introduction to Frailty-Informed Care

The first step of SeeMe™ is to understand the person's degree of frailty by completing a Comprehensive Frailty Informed Assessment. This assessment provides a detailed overview of different drivers of frailty, including the major drivers of cognition, function, and mobility, and assigns an overall Clinical Frailty Scale score. Following the assessment, a care conference is held with the person and/or family to discuss the overall health picture and considerations for future decision-making. During this meeting, potential treatment risks are considered in the context of frailty and individuals are invited to discuss their goals, values, and preferences with the care team. There is also ongoing dialogue outside of care conferences, particularly when there are significant changes in the resident's condition. These discussions help the care team support the person and/or family in making informed decisions about the next steps of care when acute health events arise.

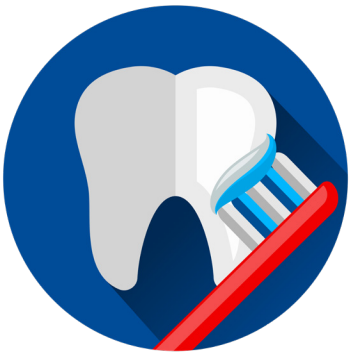
For more information on SeeMe: Understanding *frailty* together™ please contact:
Melissa Norman (mnorman@prvhc.com, x2448)
or visit - www.PerleyRideau.ca/seeme

Major Drivers of Frailty

Cognition
Thinking or mental abilities



Mobility
Ability to move in different ways



Function
Participation in daily activities

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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.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY
Inspiring Minds

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Comprehensive Frailty-Informed Assessment

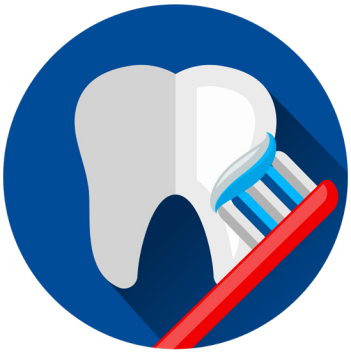
What is it?

The Comprehensive Frailty-Informed Assessment (CFA) is a comprehensive overview of multiple systems that helps create a holistic understanding of drivers that contribute to a resident's level of frailty. The CFA includes an analysis section where the major frailty drivers of cognition, mobility, and function are analyzed to assign a frailty score based on the Clinical Frailty Scale. The CFA was designed for a long-term care context and can be built into the PointClickCare electronic health record. The assessment takes select information relevant to frailty from assessments already completed over the course of normal care at Perley Rideau and pieces them together into logical categories to understand the person's overall frailty. The CFA helps assembles the pieces of a person's frailty story.

Major Drivers of Frailty

Cognition
Thinking or mental abilities

Mobility
Ability to move in different ways



Function
Participation in daily activities

Why is it important?

Understanding a resident's level of frailty is important for providing person-centred care that takes into account quality of life goals. The resident's frailty level also informs goals of care discussions, in which an understanding of how the degree of frailty affects outcomes of certain medical interventions is crucial for making informed decisions. Residents and their families may choose to avoid certain assessments or interventions if the outcomes are likely to involve several complications with minimal effectiveness for older adults who are highly frail.

Because the CFA is completed at minimum once per year, or more often when necessary, there is an opportunity to see the trajectory of frailty over time. The frailty trajectory can assist with a timely recognition of a resident approaching end of life.

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Comprehensive Frailty-Informed Assessment

Sections of the CFA

Section	Items in Section	Data Source
Psychosocial Review/ Cognitive Review	Review of Psychosocial history Delirium history; Dementia history: Prior cognitive testing; Mini Mental State Exam (MMSE) score, Montreal Cognitive Assessment (MOCA) score	Psychosocial Assessment Past medical history, MMSE, MOCA
Functional Review	Level of independence with dressing, eating, toilet use, and personal hygiene	RAI-MDS
Mobility Review	Level of independence with bed mobility, transfer, ambulation for short distances, and ambulation for prolonged distances; Falls history	RAI-MDS
Medical Review	Medical diagnoses; Changes in Health, End-Stage Disease, Signs and Symptoms Scale (CHESS) Score; Palliative Performance Scale (PPS) score; Number of hospital transfers in past year	RAI-MDS, PPS, progress notes
Physical Review	Orthostatic hypotension assessment; Vitals; Pressure Ulcer Risk Score (PURS); Number of pressure ulcers by stage; Bowel and bladder continence; Bowel patterns; Significant weight loss	Assessment, RAI-MDS, progress notes
Frailty Analysis	Frailty subscale rating for cognition, mobility and function; Overall Clinical Frailty Scale score rating; Other contributing factors to frailty	N/A

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Care Conference Agenda

Items For Discussion	Objectives	Action Items (If Identified)
1. Welcome and Introductions	Set the tone for the meeting and plan for attendees that will be leaving before the end. Resident/family highlights most important issue(s) they would like to address during the meeting.	
2. Interdisciplinary Care Overview **Quality of Life Discussion**	Understand how the resident is doing from a holistic perspective, including challenges and risks. Discuss changes observed since admission, last care conference. Discuss 3 most important issues impacting quality of life.	
Goals Of Care And Future Health Preferences Discussion		
3. Medical Overview	Understand illness/frailty and decline. Discuss most likely future trajectory/prognosis.	*[Information from these sections to be recorded in the **Goals of Care/Future Health Preferences** assessment in PCC]*
4. Resident Values, Beliefs	Understand the resident's story, and what is most important to the resident and family.	
5. Goals of Care/Future Health and Personal Care Preferences	Discuss goals of care in light of current condition, beliefs, and values. Discuss impact of treatment/care decisions on goals.	
6. Review of Emergency Contacts	Update PCC profile with any changes in emergency contacts. Refer to RCL for changes in contact type or ordering of contacts.	
7. Follow-Up, Most Responsible Person(s) and Timelines	Summarize actions arising from the care conference and identify timelines for follow-up.	

[1]Plan of care: All resident information provided by the interdisciplinary team in both paper and electronic format formulates the plan of care.

[2]Care plan: A document outlining the plan of care – to be followed by the interprofessional team. Provides direction for the individualized care of the resident. Provides a road map to guide all who are involved with the resident's care. Flows from the resident's unique attributes. Organized by the resident's specific needs.

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Goals of Care & Future Health and Personal Care Preferences

Current Understanding of Illness, Frailty, Decline and Prognosis

Resident Values, Beliefs - *What is important for maintaining the resident's quality of life and personal identity?*

Goal(s) of Care

- ☐ Focus on comfort/symptom management, quality of life (comfort)
- ☐ Focus on managing illness while maintaining current function/independence (less invasive tests and interventions)
- ☐ Focus on treatment of illness (more invasive tests and interventions, hospitalization)
- ☐ Focus on extending life (resuscitative)

Comments:

End of Life Wishes - *What is important to the resident when they are at end-of-life?*

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Goals of Care & Future Health and Personal Care Preferences

Future health and personal care preferences				
Transfer to ED for **urgent** diagnostics and treatment	☐ Yes	☐ No		
CPR *(WITNESSED cardiac events only – if resident is found without a pulse following an unwitnessed event, CPR will not be initiated)*	☐ Yes	☐ No		
Stay at Perley Rideau for diagnostics and treatment	☐ Yes	☐ No		
Stay at Perley Rideau for palliative/comfort care	☐ Yes	☐ No		
Advanced Interventions not available at Perley Rideau *(only discussed if resident wants to be admitted to hospital for treatment)*				
Chemotherapy	☐ Yes	☐ No	☐ Unsure	☐ N/A
Surgery (e.g. cardiac, hip)	☐ Yes	☐ No	☐ Unsure	☐ N/A
Dialysis	☐ Yes	☐ No	☐ Unsure	☐ N/A
Tube Feeding	☐ Yes	☐ No	☐ Unsure	☐ N/A
Ventilator	☐ Yes	☐ No	☐ Unsure	☐ N/A
Comments:				

Resident Name:

Substitute Decision Maker Name:

Information and preferences recorded above reflect discussion held with:

☐ The Resident ☐ Substitute Decision Maker

Date:

Physician:

DISCLAIMER: Information and preferences recorded on this form reflect the discussion held on this day and are NOT legally binding. These can be changed at any time. Preferences are based on the resident's current health condition and prognosis. Following all future health events, the resident/SDM(s) will be contacted to discuss the proposed plan of care and obtain informed consent.

If staff are unable to obtain informed consent from the resident/reach any of the resident's SDM(s) following an ACUTE health event, these preferences will be used to help guide care.

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Understanding CPR

What is Cardiopulmonary Resuscitation (CPR)?

CPR is a type of medical treatment used to restart a person's heart after it has stopped beating.

Cardio = Heart

Pulmonary = Lungs

Resuscitation = Attempting to restart a person's heart and breathing when they have stopped

How well does CPR work?

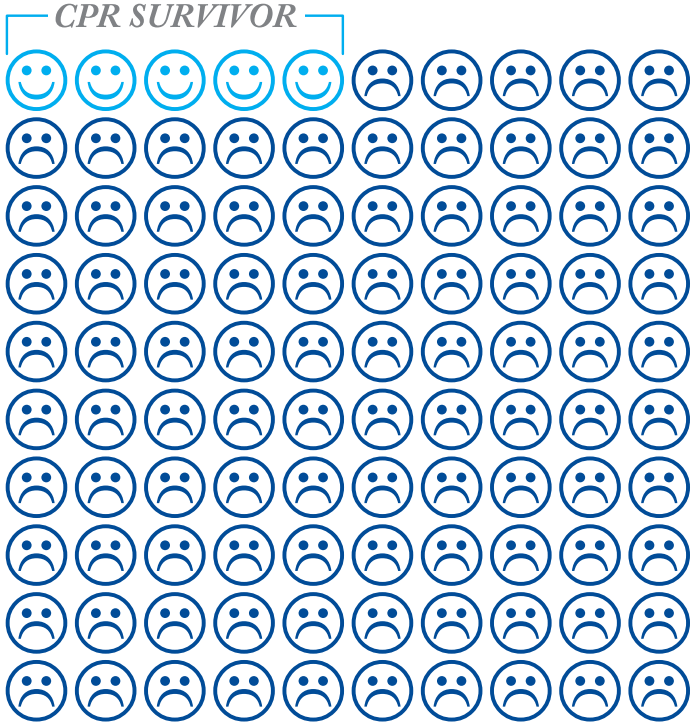
The effectiveness of CPR depends on the physical and medical condition of the person. For older adults with higher levels of frailty and multiple medical conditions, the survival rate is approximately 5%. For individuals with severe dementia, CPR is unlikely to be successful. CPR has a higher rate of survival for unexpected heart attacks or when the heart stops functioning in an otherwise healthy person.

What happens during CPR?

At Perley Rideau, if CPR is chosen as a desired intervention, CPR will only be administered for witnessed cardiac events. If the resident is found without a pulse following an unwitnessed event, CPR will not be initiated, as there is an extremely low chance of success due to the elapsed time. If CPR occurs at Perley Rideau, a staff member or team trained in CPR may:

- Press down hard on the chest (breastbone) to keep blood flowing around the body
- Use electric shocks (defibrillator) to restart the heart

For a resident whose heart has successfully re-started, hospitalization is likely required, and life-support may be needed. CPR in a hospital setting may also include the insertion of a breathing tube through the mouth to the lungs to help the resident breathe, or powerful medications to restart the heart.



5 out of 100

older adults with medical conditions will survive CPR

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Understanding CPR

Are there side effects of CPR?

Possible side effects of CPR include:

- Rib and breastbone fractures
- Damaged airways
- Bruised or punctured lungs
- Internal bleeding
- Pain
- Brain damage from extended oxygen deprivation (e.g., memory loss, paralysis, speech problems)

What happens if I don't choose CPR?

If a resident chooses not to have CPR and his/her heart stops beating, he/she will become unconscious within a few seconds due to a lack of blood going to the brain. During this time, the resident will typically not be aware of what is happening and would not experience any pain. If the heart is not restarted within a few minutes, the natural process of death will occur.

How can I let my CPR decision be known?

The decision about whether to have CPR or not will be discussed further in depth during the initial or annual care conference, using the Goals of Care & Future Health and Personal Care Preferences tool. This tool can be found as an assessment in the electronic health record. The CPR decision status is also displayed on the main page of the electronic health record, the care plan, the resident's arm band, and the name plate outside the resident's room and above the resident's bed. For new residents, the admissions team will ask about CPR preferences prior to admission to document in the electronic health record, in the case that any acute events occur prior to the initial care conference.

For more information on SeeMe visit - www.PerleyRideau.ca/seeme

Resources

Arcand, M. (2015). End-of-life issues in advanced dementia. Canadian Family Physician, 61(4), 330-334.

Canadian Researchers at the End of Life Network. (2020). Cardio-Pulmonary Resuscitation (CPR): A Decision Aid for Patients and Their Families. Retrieved from: https://www.advancecareplanning.ca/resource/cpr-decision-aids/

East Toronto Health Link Advance Care Planning Working Group. (2016). Cardiopulmonary Resuscitation (CPR): A healthcare decision aid for patients and their substitute decision-makers. Retrieved from: https://setfht.on.ca/files/CPR%20ETHeL%20Feb%202016.pdf

Ehlenbach, W.J. et al. (2009). Epidemiologic Study of In-Hospital Cardiopulmonary Resuscitation in the Elderly. The New England Journal of Medicine, 361, 22-31.

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