phn
HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

PRIMARY HEALTH NETWORK

FRAILTY FUNDAMENTALS

IDENTIFYING AND MANAGING FRAILTY IN OLDER AUSTRALIANS

A Guide for General Practitioners, Nurses and aged care professionals

10 May 2024

THEPHN.COM.AU

CONTENTS

An introduction to frailty 3

What is frailty? 3
Identifying frailty 3
The FRAIL Scale 4
The FRAIL Scale flowchart 5
Implementing frailty screening 7
Developing a frailty management - or "healthy muscle health" - plan 7

75+ Health Assessments 8

Improving the 75+ Health Assessment 9
Medicare Benefits Scheme (MBS) item numbers 10

Movement and exercise 11

Exercise handouts for patients 12

Diet and nutrition 15

Malnutrition among older and overweight people 15
Barriers to better nutrition 16
How to assess risk of malnutrition 16
The link between nutrition and better care of older people 16
Treating undernutrition or malnutrition 17
How to recommend protein 17
Fortifying food for people living with frailty 17
Diet and nutrition resources 18
Protein handout for patients 19

Polypharmacy and deprescribing 20

Patient engagement 20
Medication review and the importance of accurate medication lists 20
Weight measurement and medication management 21
Relationship between polypharmacy and frailty 21
Deprescribing and Home Medicines Reviews 21
Medication review and deprescribing resources 23

Grief, loss and bereavement 24

What is grief? 24
The stages of grief 24
Loss accumulates as people age 24
Grief impacts healthy ageing and the ability to self-manage 25
Grief does not need more medication 25
Grief, loss and bereavement resources 27

Specialist and Allied Health referral options 28

Other useful frailty resources 28

Appendix 1 - FRAIL Scale templates for clinical software 29

Appendix 2 - Updating immunisation records in Best practice 30

Appendix 3 - Comprehensive Medical Assessment for people in RACF 32

Appendix 4 - Adding an autofill in Best Practice 36

Produced by the Hunter New England Central Coast Primary Health Network (PHN) with content contributed by Bollen Health and Ruralfit.

AN INTRODUCTION TO FRAILTY

What is frailty?

Frailty is a multi-system, multi-dimensional deterioration of function in cognitive, physical, and social domains, and may have one or more of the following features:

- cognitive decline,
- balance issues with falls and low trauma fractures,
- deteriorating gait,
- chronic urinary incontinence,
- multiple medical problems (especially for people aged 85+), and/or
- polypharmacy and medication side effects.

Frailty is a common syndrome which occurs due to a combination of de-conditioning and acute illness, on a background of existing functional decline that is often under recognised.

Frailty affects up to 25% of people aged 70 and above. It is more common in females than males, and the risk of frailty increases with age. It increases the risk of falls, prolongs hospital stays, and causes decline in function.

People with frailty have 2-3 times the health care utilisation of non-frail people and experience higher morbidity and lower quality of life. They are less able to perform the usual activities of daily living, due to weakness, reduced muscle strength, and reduced exercise.

Frailty and functional decline are core factors for attendance at Emergency Departments, admission to hospital and premature entry to residential aged care facilities after an acute illness. Frailty also increases the likelihood of institutionalisation and death.

However, while frailty is linked with getting older, the two do not have to go hand-in-hand. Effective early intervention can help people stay healthy and active for longer.

Many causes of frailty can be managed and - in some cases - reversed, to create better health outcomes and quality of life. See the PHN Healthy Ageing and Frailty web page for more information.

Identifying frailty

Not all older people are frail, and not all people living with frailty are old.

However, it is important to identify frailty early, in order to combat the condition and it effects. Current health guidelines[1] suggest that people over the age of 70 should be screened routinely.

Use of a validated frailty screening tool will help ensure that identification of frailty is accurate, reliable and consistent. The PHN recommends use of “The FRAIL Scale” to identify a level of frailty.

In addition to assessment via the FRAIL Scale, clinicians can consider using the 4m walk (gait speed) test, testing grip strength and measuring the number of sit-to-stands in a set period (see Hunter New England HealthPathways[2] and Central Coast HealthPathways[3] for more information).

Best practice care for older people is well described in Fit For Frailty, a joint collaboration between the British Geriatric Society and the UK Royal College of General Practitioners.

---

[1] Dent E., Lien C., Lim W.S., Wong W.C., Wong C.H., Ng T.P., Woo J., Dong B., de la Vega S., Poi P.J.H., et al. *The Asia-Pacific clinical practice guidelines for the management of frailty*. J. Am. Med. Dir. Assoc. 2017;18:564–575. doi: 10.1016/j.jamda.2017.04.018
[2] Username: hnehealth/ Password: p1thw1ys
[3] Username: centralcoast / Password: 1connect

The FRAIL Scale

The FRAIL Scale[4], developed by Geriatrician and Professor John Morley (St Louis, Missouri)http://www.frailty.net/) asks simple questions which require only a "yes/no" response:

F	**Fatigue** - Are you feeling tired or fatigued?	Yes = 1
R	**Resistance** - Do you have difficulty[a] walking a flight of stairs? (overcoming the resistance of body weight against gravity)	Yes = 1
A	**Ambulation** - Do you have difficulty[a] walking around the block?	Yes = 1
I	**Illnesses** - Do you have 5 or more chronic conditions[b]?	Yes = 1
L	Has there been **Loss of weight**[c] of 5% or more over the past 12 months?	Yes = 1

[a] Ask "Do you have difficulty…., not "Can you or can't you do…". This is important with being consistent with assessments, as the importance of screening is to intervene before a person cannot do an activity.
[b] Only count chronic conditions which will impact risk of shortening lifespan.
[c] Only score loss of weight if it is not intentional.

A score of 1 to 2 indicates pre-frailty, and a score of 3+ indicates that the patient is living with frailty and would benefit from a discussion about:

- their goals in life, and the barrier(s) to achieving them,
- their mood, assessing for any medical cause of fatigue (e.g. anaemia, heart failure, or chronic kidney disease[5] and - in younger people - sleep apnoea),
- exercising at home or in the community,
- diet and nutrition, and
- the appropriateness of their medications.

Evidence shows that frailty can be improved, resulting in reduced functional decline, reduced cognitive decline, reduced hospital admissions, lower residential aged care facility admissions and better quality of life for older people.

The rate of functional decline can be slowed - and frequently reversed - if people are detected at the early frail stage, and:

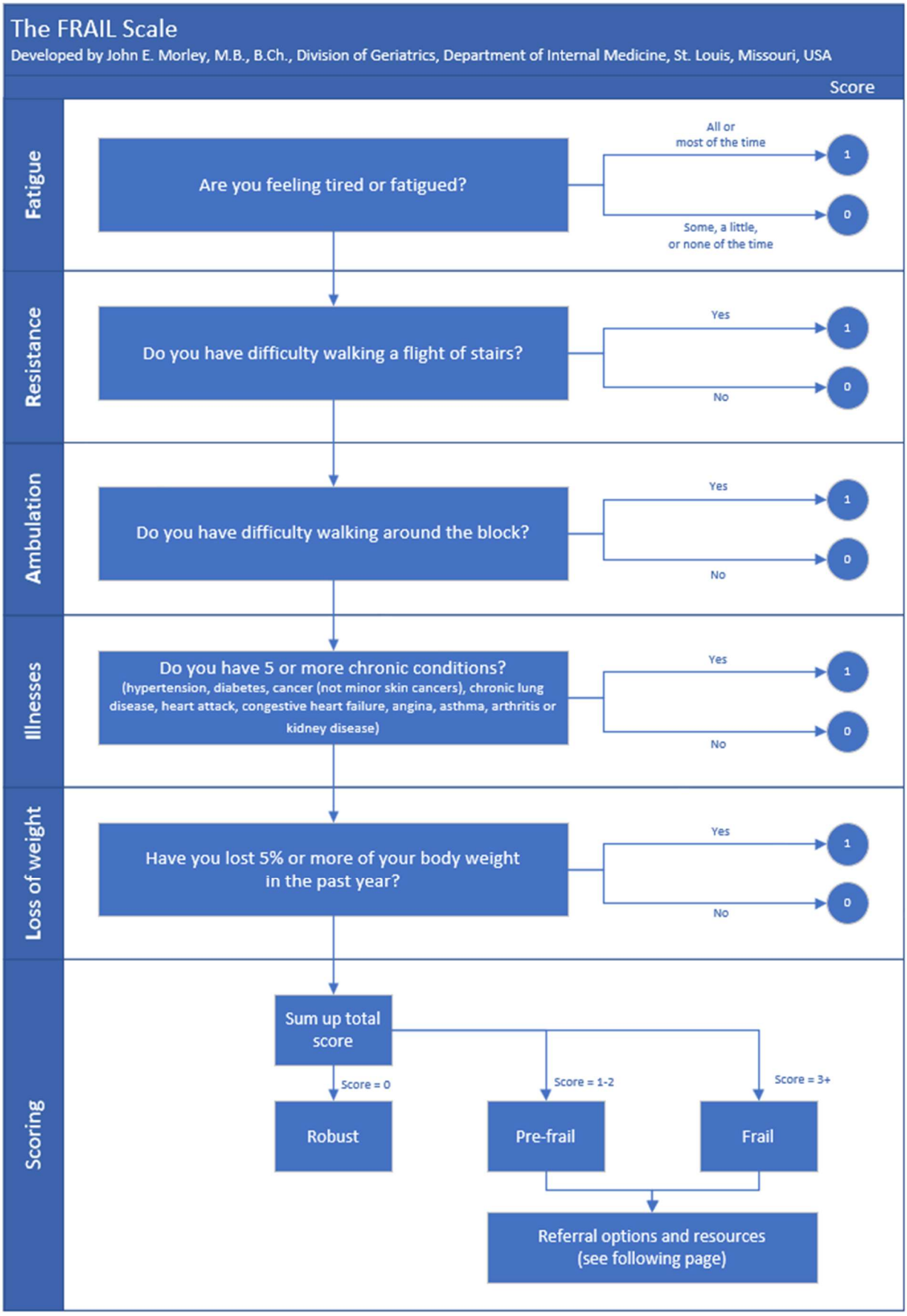
- participate in resistance exercise (muscle building) programs,
- have their medication regime reviewed and the appropriateness of prescribing assessed,
- supplement their diet (with vitamin D and [whey] protein enrichment), and
- receive social and cognitive stimulation and support.

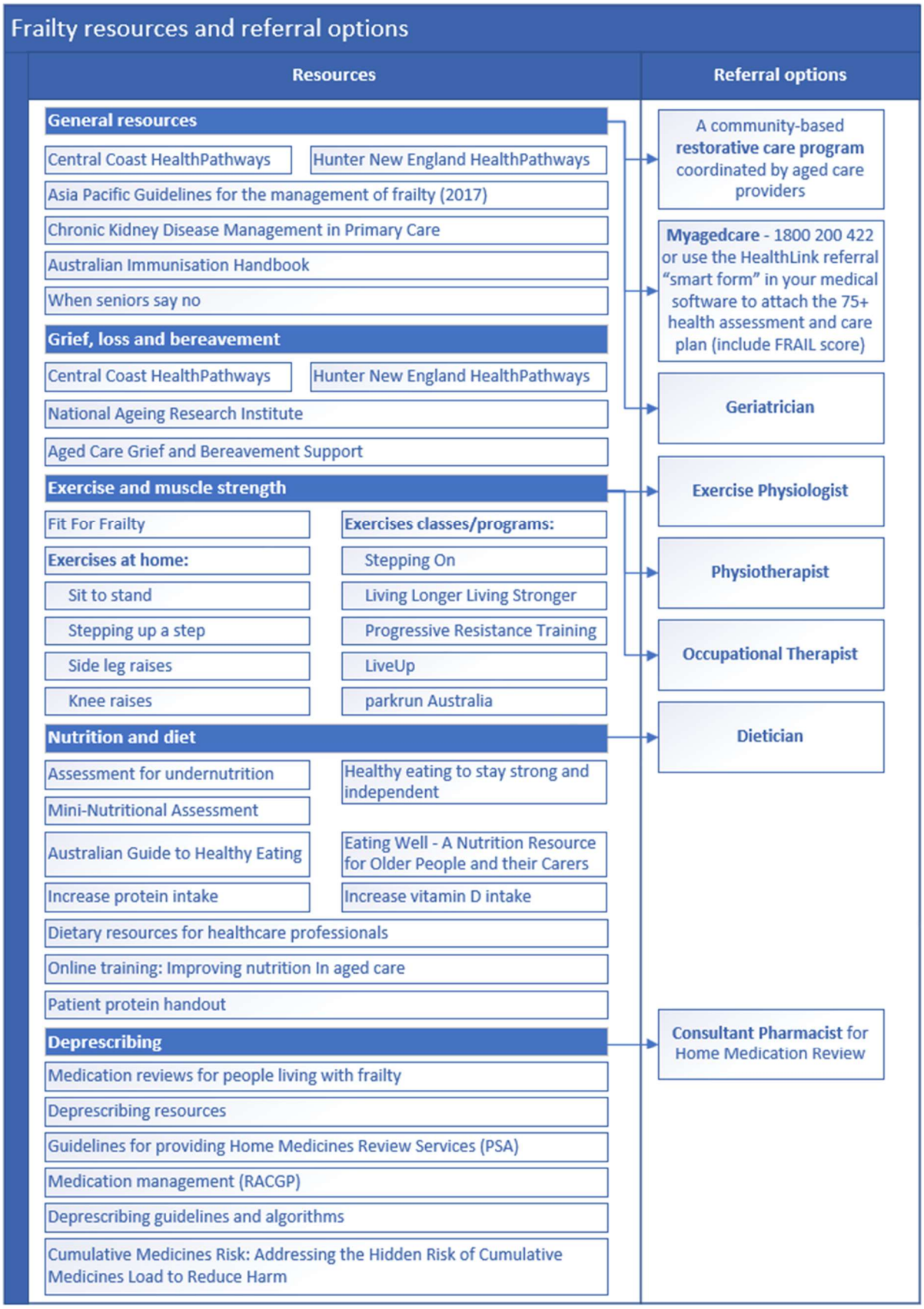
[4] Use of the FRAIL Scale is supported by many articles, studies, reviews and guidelines, including the Asia Pacific Clinical Practice Guidelines for the Management of Frailty, Nutritional Interventions in Sarcopenia, Effects of physical exercise interventions in frail older adults, The Effectiveness of Exercise Interventions for the Management of Frailty, Interventions for Treating Sarcopenia: A Systematic Review and Meta-Analysis of Randomized Controlled Studies, Inappropriateness of Medication Prescriptions to Elderly Patients in the Primary Care Setting, and Beliefs and attitudes of older adults and carers about deprescribing of medications.
[5] Open the attachments for information on how to search for Chronic Kidney Disease using PENCAT.

How To Search for CKD with PENCAT - ı

How To Search for CKD with PENCAT - ı

The FRAIL Scale flowchart





Download a PDF of this resource (with relevant links) from the PHN Healthy Ageing and Frailty web page, and see Appendix 1 - FRAIL Scale templates for clinical software for templates that can be imported into Best Practice, Medical Director and ZedMed as .rtf files.

Implementing frailty screening

When consulting with patients, be careful to:

- Observe patients with frailty in mind - Pay attention to how patients walk to the consultation room or move during your consultation, as it can tell you a lot about how unsteady patients are on their feet,
- Think outside the box of disease and injury (e.g. If a patient with a cold mentions that they have unintentionally lost quite a bit of weight, don't assume they will improve when the cold is gone, but consider the FRAIL scale, whether they may be pre-frail or frail, and the options available),
- Be proactive in talking about frailty and falls prevention, especially with at-risk patients (e.g. during immunisation, wound care, 75+ health assessment, GP management plan, etc.),
- Involve Practice Nurses, who have an important role in frailty screening and management,
- Ask patients aged 75+ years about healthy aging and staying active,
- Provide advice and support (e.g. referrals, contact numbers or brochures) and go through frailty prevention resources with patients so they can learn and be more proactive,
- Use your practice database to identify people at risk of frailty and send them recall letters (be mindful of language - suggest they attend for a "muscle health" or "healthy ageing" check, rather than a "frailty check"),
- Schedule follow up appointments to discuss risk factors and make a frailty management plan if you cannot complete all frailty management activities in one appointment, and
- Consider affordability and provide options that are suitable for the patient:
    - If the patient has private health insurance, some prevention activities will be subsidized, which helps them get good value out of their insurance.
    - Medicare funds Enhanced Primary Care (EPC) group allied health sessions for people with diabetes (T1DM or T2DM) as a comorbidity with their pre-frailty/frailty.
    - Some patients might prefer to pay to attend group classes which are also social.
    - Others might prefer or require one-on-one consultation with a physiotherapist or exercise physiologist.
    - Some patients might prefer to do their own exercises at home (e.g. following exercises in information leaflets) to save service and transport costs as well as to develop confidence before attending a group.

Developing a frailty management - or "healthy muscle health" - plan

Managing frailty well can significantly improve a person's function and quality of life. It can provide a better chance of recovery from acute illness, as it reduces susceptibility to negative health outcomes.

Early intervention for frailty can allow people to stay active and healthy longer, keeping them in their homes and out of hospital.

Once a person has been assessed as pre-frail or frail, a management plan should be developed (see Frailty in Older Adults). This targeted approach may include guidance and advice on diet and nutrition, referral to appropriate allied health professional, and medication review.

The decision support tool provides more detail and guidance about the best course of action.

Encourage patients to use resources like the Positive Ageing Tool and NSW Active and Healthy to maintain and improve their health and strength as they age. A great free guide to responding to patients resisting assistance is When seniors say no.

75+ HEALTH ASSESSMENTS

General Practice has an important role in supporting relationships with older people who desire to remain well and independent at home.

GPs and practice nurses perform 75+ health assessments in the home and surgery, and together are involved in care planning and team care arrangements for access to appropriate services based on the person's needs. Nurses are increasingly involved in care coordination for older people with complex needs (e.g. DVA program).

However, many GPs and nurses receive no formal training to understand the current scientific evidence behind 75+ health assessments, and how to target such assessments for the most "at risk".

There is well-researched evidence that Comprehensive Geriatric Assessments - which review medical, functional, psychological and social needs - improve outcomes for older people.

However, although the term "Comprehensive Geriatric Assessment" is well known in geriatric medicine, it is lesser known in General Practice, where most older people are seen.

Over the last 24 years, considerable evidence has been published about how to support older people to be healthy and well. However, there are very few objective assessment tools provided in common General Practice clinical software, and the current 75+ health assessment templates do not include:

- Assessment for risk of undernutrition (see RACGP Silver Book 5th edition),
- Concepts of frailty and sarcopenia (measured by 4m walking speed tests and grip strength plus the benefits of resistance exercise - see Improving the 75+ Health Assessment),
- Osteoporosis risk assessment and screening,
- Reminders about Herpes Zoster/Shingles vaccinations for patients aged 65+,
- Single dose Pneumococcal 13 vaccinations at age 70, and
- Annual kidney health check reminders for all people aged 75+.

Having a good 75+ health assessment template, which includes objective assessment tools, enables optimal decision making about preventing or reducing the impact of common issues[6] such as:

- Falls (see Central Coast HealthPathways and Hunter New England HealthPathways),
- Osteoporosis,
- Cognitive impairment,
- Incontinence,
- Mobility difficulties,
- Weight loss/poor nutrition,
- Polypharmacy,
- Physical inactivity (see Movement and exercise),
- Low mood,
- Visual problems, and
- Social isolation/loneliness.

[6] Evidence can be found in the RACGP Red Book, RACGP Silver Book, Chronic Kidney Disease Management Handbook, Australian Immunisation Handbook and Asia Pacific Guidelines for the Management of Frailty (2017).

Improving the 75+ Health Assessment

The 75+ health assessment can be improved by reviewing the practice software template and considering whether it is worthwhile to add the following questions, which capture greater detail than a “Yes”/“No” response:

- What are the patient’s goals?
- Which nutrition screen has been used? Ensure a validated tool to assess nutrition, such as the Mini-Nutritional Assessment® is used.
- How many times has their weight been recorded in the last 12 months? What was the trend? If weight loss was noted, what action has occurred?
- How was mobility assessed? What objective assessment occurred (e.g. 4m walk test)?
- How was muscle health assessed? What objective assessment occurred (e.g. grip strength and five timed sit-to-stands)?
- What mobility or strength deficit was noted? What recommendations were made?
- How many medicines is the older person taking?
- What is the person’s eGFR?
- Has an annual kidney health check been recommended (creatinine, eGFR, Blood pressure and urinary ACR)?
- Is the person taking any renally cleared medications?
- Is a Home Medicines Review required? (See Deprescribing and Home Medicines Reviews)
- Does the health assessment review osteoporosis risk?
- Does the health assessment check for immunisations relevant to the age group (e.g. shingles, pneumococcal 13 and COVID)? (See Appendix 2 - Updating immunisation records in Best practice)
- What is documented in the social history of the person? Does this information transfer to all referral letters and care plans?
- What legal documents have been documented to support the person’s choices if a loss of capacity occurs (e.g. Advance Directive, Enduring Power of Guardianship, Enduring Power of Attorney)?

Identifying opportunities to improve the 75+ health assessment is a useful quality improvement activity for GPs and the practice team.

Consider using a frailty screening autofill/autotext in Best Practice or Medical Director to add the following tests:

Test	Performance
Timed Up and Go (TUG) test	≥ 12 secs is a high risk of fall
4m walk test	< 5 secs is normal; 5+ secs requires further investigation
Grip strength	>30 kg for males; >25kg for females in dominant hand

See Appendix 4 - Adding an autofill in Best Practice for instructions on how to create an autofill.

The health assessment should be used to develop a personal shared care and support plan outlining treatment goals to optimise medical conditions, management plans to optimise wellness and plans for urgent care. This should always include discussions around advance care directives and, potentially, an end-of-life care plan.

Visit the My Aged Care portal (call 1800 200 422, fax 1800 728 174 or use the HealthLink referral smart form in medical software which allows the 75+ Health Assessment and care plan to be attached, noting the FRAIL Scale score in the referral).

Medicare Benefits Scheme (MBS) item numbers

To avoid duplication and provide maximum value for patient and practice, the same nurse or GP should complete the health assessment (707), care plan (721) and team care arrangement (723).

Complex patients will need a three-monthly review of their care plan and team care arrangement (732s), which is often underutilised.

To monitor progress, nurses can use item number 93203 for phone calls to patients with an existing care plan (phone version of item number 10997).

Health assessment MBS item numbers 705 and 707 (depending upon time for the assessment) can be used for any aged person living permanently in a Residential Aged Care Facility (RACF).

See Appendix 3 - Comprehensive Medical Assessment for people in RACF.

MOVEMENT AND EXERCISE

Research has found that exercise of any type has been shown to reduce the risk of falling by 23%. For optimal physical and mental health, it is recommended that all adults (regardless of age, health, or ability) do 30-60 min of physical activity most days.

- Search for frailty prevention exercise program options at NSW Active and Healthy
- ViviFrail provides materials for people responsible for physical exercise programs
- Watch the Falls Prevention and Awareness webinar from the NSW Council on the Ageing
- Visit the NSW Falls Prevention and Healthy Ageing Network website

Patients requiring an individual exercise prescription may need to consult a physiotherapist or exercise physiologist who will assess gait and balance, design an individually tailored program, provide one-on-one progressive exercises and recommend correct use of assistive devices.

See Specialist and Allied Health referral options for further information.

Exercise opportunities	- Stepping On program - Living Longer Living Stronger - Progressive Resistance Training - LiveUp - parkrun Australia
Handouts	- Exercise handout for patients (two A4 pages, following) - Sit to stand patient handout (one A4 page, following) - How to keep your bones healthy and avoid fractures (Osteoporotic Refracture Prevention Services)
Videos of exercises for patients to do at home	- Resistance muscle exercises (e.g. sit-to-stands) - Sit to stand - Stepping up a step - Side leg raises - Knee raises

1. Sit to Stand

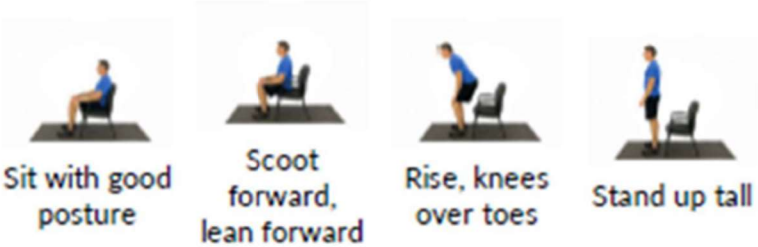
Sets: 3 | **Reps:** 10 | **Rest:** 60s

Preparation:

- Sit with good posture

Execution:

- Scoot forward on chair
- Incline trunk slightly forwards
- Knees over toes
- Rise up to standing



2. Step Up

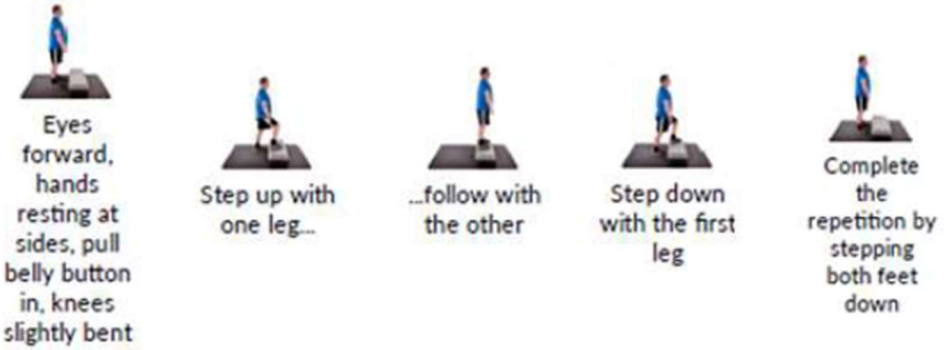
Sets: 3 | **Reps:** 10 | **Rest:** 60s

Preparation:

- Stand in front of a box or step
- Hands resting at sides, pull belly button in

Execution:

- Step up with one leg, follow with the other
- Step down with the first leg
- Complete the repetition by stepping both feet down



Exercises from Simple Set, courtesy of

Rural*fit*

3. Hip Abduction (Countertop)

Sets: 3 | **Reps:** 10 | **Rest:** 60s

Preparation:

- Stand with good posture in front of a counter or table

Execution:

- Lift leg straight out to the side
- Keep toes facing forward
- Avoid hiking your pelvis as you left your leg

Stand in front of counter

Lift leg straight out to the side, toes facing forward

4. Hip Flexion

Sets: 3 | **Reps:** 10 | **Rest:** 60s

Preparation:

- Start in a plank position with arms straight on a box/ countertop/table

Execution:

- March your knee towards your chest
- Return to start position
- Repeat keeping your pelvis stable throughout the movement

Start in a plank position

March knee forward

Return to start position

Exercises from Simple Set, courtesy of

Rural fit

Simple home exercise program to improve leg strength

To start these exercises, try just five per day, twice daily, using a chair in front of you for support, if necessary. Each week, work on doing an extra sit-to-stand morning and night, until you can do 20 at a time.

Week 1	5 sit-to-stands morning and night.
Week 2	6 sit-to-stands morning and night.
Week 3	7 sit-to-stands morning and night.
Week 4	8 sit-to-stands morning and night.
Week 5	9 sit-to-stands morning and night and keep increasing!

Adapted from How to keep your bones healthy and avoid fractures (Agency for Clinical Innovation).

DIET AND NUTRITION

Having a healthy diet and good nutrition are important parts of ageing well. When older people don't consume enough food or water, they lose muscle and strength, become unsteady on their feet and can feel weak and/or dizzy, which can lead to a fall.

Eating healthy food as part of a balanced diet with adequate energy and protein is important for maintaining muscle mass and muscle strength to reduce the risk of sarcopenia (muscle wasting), frailty and fall-related injury.

People may have poor nutritional intake or hydration for many reasons, including poor oral health and dentition problems, inability to shop, plan or prepare meals (e.g. socially isolated), lacking appetite, being unable to recognise or consume food/drink, forgetting to eat and/or drink, distraction at mealtimes, or difficulties with swallowing, chewing and/or using cutlery.

The information and resources below will help equip you and your patients to improve their diet, nutrition and - if applicable - supplement consumption.

Malnutrition among older and overweight people

Between 30-40% of older people living in the community with a home care package - and even more living in residential aged care - are experiencing malnutrition. Additionally, 60% of all community dwelling older people are at risk of malnutrition[7].

Malnutrition represents "a state of deficient energy or protein intake or absorption, characterized by weight loss and changes in body composition".

The recent Royal Commission into Aged Care Quality and Safety made many references to nutrition issues for all older people.

A common issue is only worrying about malnutrition in people who have a body mass index (BMI) of less than 20, but an increasing trend in Australia is for people over 65 to have obesity coexisting with malnutrition. One myth is that 'they can live off their fat for weeks', so if an overweight older person loses 5kg, no-one may worry about it.

However, excess body weight can place undue strain on the heart, joints and spine; increase the risk of high blood pressure, diabetes, respiratory diseases, osteoarthritis and other conditions, and exacerbate these conditions where they already exist.

Obese people can have a very poor micronutrient intake - they may consume sufficient energy, but the poor quality will be reflected in inadequate protein, low levels of many vitamins and minerals. This can lead to (or exacerbate) anaemia and other nutrient deficiencies, which will worsen their function and other long term health conditions.

Poor nutritional status often presents as unintentional weight loss. When an older person loses weight, they experience a doubling in their risk of death, even if they are overweight[8].

For people over 70, the focus should be on increasing the quality of the food being eaten and building muscle.

[7] Rattray M and Roberts S (2024) *Australian Journal of Primary Health* 30, PY22218. doi:10.1071/PY22218
[8] Morley JE. (2010). Nutrition and the aging male. *Clinics Geriatric Medicine*, 26(2):287-99.

Barriers to better nutrition

The risk of poor nutrition in a person is impacted by:

- Financial problems
- Poor budgeting skills
- Mobility issues
- Lack of cooking skills
- Inability to shop
- Access to appropriate foods
- Food hygiene issues
- Inability to feed oneself
- Mental health
- Communication issues with language and comprehension
- Social isolation - mealtimes are often a social outlet, and eating alone is rarely enjoyable

How to assess risk of malnutrition

The Mini-Nutritional Assessment (MNA®) is a validated nutrition screening and assessment tool that can identify people aged 65+ who are malnourished or at risk of malnutrition.

The MNA assesses a person against recognised risk factors for undernutrition, such as mobility issues, cognitive impairment, psychological distress and loneliness.

The link between nutrition and better care of older people

When working with a pre-frail or frail person, it is important to look at their goals and the 4 Ms for better care of older people[9]:

1. What **M**atters,
2. **M**obility,
3. **M**edicines, and
4. **M**entation.

As people age, they need adequate food with the right nutrition for energy, resistance to infection, improving wound healing, good bowel function and, importantly, to support any exercise program aiming to build muscle and improve mobility and independence.

Older people have a reduced ability to use protein, and need more protein, not less![10] Calculate 1 to 1.2g/kg/day - or more, if acute or chronic disease is present.

For example, if a patient is lying in bed due to an injury or an infection, the stress of the concurrent issue will cause the gut to reduce protein absorption. This in turn increases skeletal muscle protein catabolism, accelerating loss of muscle mass, strength and a decline in **M**obility.

All older people should aim for 25 to 30g of protein per meal. Supplementing with Vitamin D can also increase muscle strength.[11]

[9] John A. Hartford Foundation
[10] PROT-AGE study from 2013
[11] Vitamin D deficiency linked to loss of muscle strength, Harvard Health Publishing

Treating undernutrition or malnutrition

Ideally, refer the patient to a dietician to assist with improving the diet, and encourage them to adopt a high-protein, high-energy diet.

A high-protein, high-energy diet is used for a person who is otherwise eating minimal amounts. The aim is to meet normal protein requirements with a small amount of food.

This does not mean an excess of either protein or energy, but ensuring that all foods consumed provide valuable protein and energy, so that every mouthful counts.

Encourage small, frequent meals, a grazing approach, bread-and-butter plate sized meals, and saving dessert for later.

How to recommend protein

Recommending an increase in protein requires a basic understanding of what foods contain protein and how much protein per serve can be consumed. Some examples of a 10g protein serve can be found in the Patient protein handout.

Fortifying food for people living with frailty

Discuss options to fortify food before considering supplements. The following foods can be added to normal meals to increase:

- protein: grated cheese, milk powder and eggs (cheap and easy to add to meals and digest).
- energy: cream, butter, margarine, oils and sour cream.

Fortify milk by adding 1 cup milk powder (either skim, which is higher in protein, or full cream) into 1 litre full fat milk, and using wherever you would ordinarily use milk:

- In cereal
- In custard
- As a base for milk drinks
- In white sauces
- In mousse
- In soups and casseroles
- In mashed potato
- In tea and coffee

Flavoured milkshakes are an easy, enjoyable and nourishing, providing protein and energy.

If glycaemic control is poor (e.g. hba1c >9%), this may not be suitable for a person with diabetes, but the individual context should always be assessed before recommending. Improving quality of life, muscle strength and reducing frailty should take precedent over glycaemic control.[12]

The recipe below provides 9.4 g protein and 730 kJ energy for every 150 mls - comparable to commercial supplements - and most people say milkshakes taste better!

- 1 litre full cream milk,
- 1 cup milk powder,
- 350 mls ice cream (5-6 scoops), and
- 40 mls flavoured topping.

[12] Abdelhafiz, A. H., Pennells, D., & Sinclair, A. J. (2022). A modern approach to glucose-lowering therapy in frail older people with type 2 diabetes mellitus. *Expert Review of Endocrinology & Metabolism*, *17*(2), 95–98. https://doi.org/10.1080/17446651.2022.2044304

Diet and nutrition resources

For clinicians	– Nutrition assessment tools and management information: – **Hunter New England HealthPathways** – Frailty in older adults – Mini-Nutritional Assessment (MNA) – Older people's weight management – Vitamin D supplementation – **Central Coast HealthPathways** – Older adults' weight and nutrition – Healthy eating services for older people – Standard oral nutrition supplements – Aged care nutrition resources – Nutrition referrals – Improving diet and nutrition in older people to change the trajectory of frailty (Dr Chris Bollen) – The Mini Nutritional Assessment (MNA®) (also available in Best Practice) – Protein Intake and Frailty: A Matter of Quantity, Quality, and Timing - an excellent summary of protein, sarcopenia, and frailty – A recording of the "What's All The Fuss About Protein?" webinar is available for $39 per person from Julie Dundon, Advanced Accredited Practising Dietitian, Nutrition Professionals Australia – Healthcare professional resources (Dietician Connection AU) – Consider Vitamin D to assist muscle strength – Improving Nutrition In Aged Care (Nutrition Professionals Australia) – Oral health care for older people in NSW (NSW Health) – Spotting the signs of poor nutrition (Clinical Excellence Commission) – Nutrition and falls prevention for patients with dementia - information for clinicians (Clinical Excellence Commission)
For Allied Health professionals	– Eating well to prevent falls - the role of Allied Health professionals (Clinical Excellence Commission)
For patients, families and carers	– The Australian Guide to Healthy Eating is an excellent dietary guide for well people, including older people who are living a healthy active life with no significant health problems, who are **not** living with or at risk of frailty. – One-page patient protein handout – Nutrition resources, including meal plans for older people (Nutrition Professionals Australia) – Eating Well - A Nutrition Resource for Older People and their Carers – Healthy eating to stay strong and independent – Increasing the intake of protein in the diet - aim for at least 1.2g/kg bodyweight – Eating Well to Prevent Falls (Clinical Excellence Commission) – Adding life to your years - the cookbook (Nutrition Australia) – Nutrition and falls prevention information for carers of people with Dementia (Clinical Excellence Commission) – Nutritional support for people living with frailty (from SA Postgraduate Medical Education Association) - Meeting 2, Tuesday 12 September

Protein handout for patients

Protein information for improving health for people aged over 65

How much protein do I need? Aim for 25 to 30g of protein per meal.

Current body weight = ... kg x 1.5 g protein per kg/day = ... g protein per day

What does this amount of protein look like?

Here are some examples of what makes a 10g protein serve... choose three per meal!

- 40 g cheese (2 big slices)
- 1 cup milk
- ¼ cup milk powder
- 1 tub yoghurt (170g size)
- 1.5 eggs
- 30 g steak
- 40 g chicken
- 50 g fish
- 2/3 cup baked beans
- 50 g nuts
- 2 large slices of grain bread
- 2.5 Weetbix... before milk is added!

What can be added to my usual food to increase protein?

Grated cheese, milk powder and eggs are inexpensive, and easy to add to other meals.

Make *fortified milk* by adding 1 cup milk powder (skim - which is higher in protein - or full cream) to 1 litre full fat milk and using it wherever you would use ordinary milk:

- On cereal
- In custard and mousse
- As a base for milk drinks
- In tea and coffee
- In white sauces, soups, casseroles
- In mashed potato

A very nourishing and enjoyable drink can be a real favourite that adds protein and energy... the flavoured milkshake!

- 1 litre full cream milk,
- 1 cup milk powder,
- 350 ml ice cream (5-6 scoops), and
- 40 ml flavoured topping.

This gives 9.4 g protein and 730 kJ energy for every 150 ml (just under a cup).

Milkshakes with extra milk powder are a great source of protein and energy.

POLYPHARMACY AND DEPRESCRIBING

People are living longer and the number of older people in practice populations is rapidly increasing[13].

Sixteen per cent of the NSW population is aged 65 or over - an increase of 25% in just five years.[14]

Care of community dwelling older patients comprises a large proportion of the workload for GPs, with patients aged 65+ accounting for over 30% of general practice encounters[15].

This group is also complex, with higher numbers of medications per person after the age of 75, with at least 50% taking 8 or more medications, and 40% having chronic kidney disease stage 3a or worse.

Patient engagement

Supporting patients to be active in their healthcare starts with preparing them to ask the right questions and have necessary information at their fingertips. Remind patients to bring both prescription and over the counter medications, lists of questions, etc. to appointments.

Encourage patients to ask questions, seek information on risks of treatment and consider options in care, prompting them with statements such as:

- Talk to your GP if you feel dizzy, unsteady on your feet or sleepy during the day.
- Ask your GP about the potential side effects of your medicines.
- Ask your GP about having a free Home Medicines Review. An accredited pharmacist will visit you at home to discuss your medicines and will work with your GP to determine whether medicine interactions can be improved and/or medicines (and side effects) can be reduced.

Medication review and the importance of accurate medication lists

Frailty is associated with increased vulnerability to stressors, including adding new medications.

Susceptibility to existing medications can also increase as an older person's overall function declines, particularly with reduced mobility and cognition, which are impacted by medication interactions.

Many medications cause fatigue, reduce physical activity and impact balance (which slows walking speed), and side effects - such as feeling dizzy or unsteady - can make an older person prone to a fall.

Taking several medicines, or certain types of medicines (e.g. sleeping tablets or opioids) can also increase the risk of falling.

Often the issue is not the individual medication, but the combination prescribed (e.g. a diuretic, anti-inflammatory medication and an ACE inhibitor, or a renally cleared medication in a patient with eGFR < 60mls/minute [CKD Stage 3a or worse]). If the combination of CKD and polypharmacy is not recognised, it is a patient safety issue.

Consider this group's multimorbidity:

- 50% of people aged 65+ have at least two long term health conditions,
- 40% of people aged 75+ have CKD (frequently unrecognised, not coded in the medical prescribing software, and not managed), and
- 50% of people aged 75+ are taking more than five medications per day.

The intersection of these groups suggests that 20+% of older patients will be impacted.

Consequently, having updated and correct medication lists is critical, especially for older patients.

---

[13] Intergenerational Report released in 2020
[14] Census data, 2016 and 2021
[15] BEACH study 2013

Many older patients, who are used to remembering medications by brand name, are confused by the introduction of ingredient prescribing. They may not recall every medication they take, or what has been altered by another prescriber, so it is important to review the patient's My Health Record to see what has been dispensed.

Over-the-counter medications also need to be listed and drug interactions need to be carefully monitored.

Weight measurement and medication management

Weight loss has many causes and many flow on effects. For example, it can impact medication metabolism, increasing its effect/risk as weight reduces and renal function deteriorates.

Consequently, older patients should be weighed at every GP visit, and medications should be reconciled after each hospitalisation or visit to another clinician. Medications should also be reviewed annually and the reason(s) for prescription should be clearly documented.

These simple steps reduce the potential for medication errors. They are particularly vital for medical practices where doctors regularly see each other's patients. Tenanted doctors working in general practices should also be aware of their duty of care to ensure these practices are occurring[16].

Relationship between polypharmacy and frailty

Polypharmacy increases the risk of frailty, and frailty increases the risks of adverse effects with polypharmacy - common examples include:

- reduced weight increases the efficacy of antihypertensives, reducing blood pressure to the point of hypotension and causing falls;
- reduced weight increases the therapeutic effect of anti-glycemic agents, resulting in higher risk of hypoglycaemia; and
- increased susceptibility to adverse effects of medications that cause falls, such as benzodiazepines, anticholinergics, CNS depressants (especially psychotropics), often seen with age-related renal decline.

Deprescribing and Home Medicines Reviews

Deprescribing is the "systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patient's care goals, current level of functioning, life expectancy, values, and preferences."[17]

Deprescribing medications (e.g. sedatives, cholinergic medications, opioids, renal toxic medications) can positively impact older people's frailty trajectory.

A Home Medicines Review (HMR) can help assess a patient's knowledge of their medications and how they are stored and obtain any feedback on medication interactions.

Home Medicines Reviews emphasise deprescribing existing medications based on actual adverse effects being experienced. Direct and open-ended questions are asked to monitor adverse effects of medications.

If adverse effects are detected, the most likely medications are outlined in a report sent to the GP, usually with a systematic plan to reduce the adverse effects.

Consultant Pharmacists can provide an HMR to patients who meet at least one of the criteria below:

- currently taking 5+ regular medications,
- taking more than 12 doses of medication per day,
- significant changes made to medication treatment regimen in the last 3 months,
- medications with a narrow therapeutic index or requiring therapeutic monitoring,

[16] "Good medical practice: a code of conduct for doctors in Australia", AHPRA October 2020, section 10.5.
[17] JAMA Internal Medicine (2015), Scott et al

- symptoms suggestive of an adverse drug reaction,
- sub-optimal response to treatment with medicines,
- suspected non-compliance or inability to manage medication related therapeutic devices,
- patients having difficulty managing their own medicines due to literacy/language difficulties, dexterity problems, impaired sight, confusion/dementia or other cognitive difficulties,
- patients attending several different doctors, both general practitioners and specialists, and
- recent discharge from a facility/hospital (in the last 4 weeks).

Patients who have had evidence of improvement include:

- heart failure patients, particularly those recently diagnosed,
- patients with chronic pain,
- patients with diabetes (type I and II), and
- patients taking antipsychotic medications (antidepressants, anti-epileptics, insomnia, etc).

Find a pharmacist who is accredited to provide HMR by visiting www.findapharmacy.com.au/, entering the relevant location and selecting “Home Medicines Review” in the drop-down menu.

A deprescribing protocol may follow the steps below:

1. Ascertain all drugs that the patient is currently taking and the reasons for taking each one,
2. Consider the overall risk of drug-induced harm in patients in determining the required intensity of deprescribing intervention,
3. Assess each drug for its eligibility to be discontinued,
4. Ask the patient their concerns about potential medication changes,
5. Prioritise drugs for discontinuation, then
6. Implement and monitor drug discontinuation regimen:

    a. Inform patient, family and other clinicians,
    b. Set expectations (timing, effects to observe),
    c. Determine discontinuation regimen (gradual reduction, cessation),
    d. Monitor for discontinuation symptoms/ return of symptoms of disease,
    e. Manage adverse effects by pharmacological/non-pharmacological strategies, and
    f. Document and communicate success/failure of regimen.

Pharmacists use several strategies with every HMR to get a clear picture of actual medication usage and whether patients with sub-optimal responses to treatment - despite increasing dosages and introducing new medications - have compliance issues.

They can also determine causes and recommend strategies for improvement. For example, the patient may:

- have misunderstood the directions or medicine indication (in which case counselling can be a quick fix);
- have brand confusion, resulting in accidental under- and over-dosing (in which case clearer labelling of medicines may help);
- have experienced an adverse effect, such as taking all medications together, which can induce nausea and result in patients selectively take medicines that make them feel better (in which case dividing daily doses, slower up-titrating or trialling an alternative may help).

A slow reduction - to gain both the patient and their family’s confidence of the process - is a useful deprescribing approach. General Practice is well suited to manage this, given the continuity of the relationship between older patients and their usual GP.

Additionally, rather than the older person attending the practice for every visit, a video or phone consultation can now be booked to follow up the impact of medication changes.

For example, the GP may give a patient written instructions to take ½ a tablet daily (instead of a whole tablet) for the next 2 -4 weeks, then call to review the outcome of the medication change.

Medication review and deprescribing resources

- Frailty and Polypharmacy are linked! (Dr Chris Bollen)
- Prescribing for frail older people explains the need for frailty monitoring and how to prescribe new medications cautiously and effectively (Australian Prescriber)
- Taking more than 5 pills a day? 'Deprescribing' can prevent harm – especially for older people (Medicine Today)
- Read Medication Management Review and Polypharmacy information at:
  - Hunter New England HealthPathways
  - Central Coast HealthPathways
- Frailty - getting to grips with polypharmacy webinar (Dr Chris Bollen, start at 6:00)
- Reviewing medications
- Medication review for people living with frailty
- Medication management - deprescribing resources
- PSA Guidelines for providing Home Medicines Review Services
- RACGP Medication management
- Anticholinergic Cognitive Burden (ACB) calculator
- Deprescribing Guidelines and Algorithms
- Cumulative Medicines Risk: Addressing the Hidden Risk of Cumulative Medicines Load to Reduce Harm
- Patients, carer and families handout: Falls prevention - medications (Clinical Excellence Commission)

GRIEF, LOSS AND BEREAVEMENT

Fatigue is a very common complaint during both the acute and long-term phases of grief, which - with it's consequences - increase a patient's FRAIL Scale score.

What is grief?

Grief is a reaction to loss of any type. Common types of grief include:

- Loss of sense of purpose or identity upon or after retirement,
- Loss of partner through death or divorce,
- Loss of children by death or leaving the local region for work or marriage,
- Loss of a pet,
- Loss of friends, either through death or changes in their function or family, which impacts the person's ability to meet and socialise meaningfully,
- Loss of independence (which often coincides with loss of driver's license),
- Loss of function, which impacts ability to mobilise, and everything associated with this - hobbies, friendships, activities, social functions and much more…
- Loss of sight and/or hearing, and
- Loss of the long-term family home and a move into smaller retirement home.

Grief may also be anticipatory, after a major operation (e.g. heart disease or cancer). This occurs when previously well-functioning adults confront their mortality and experience a major change in their self-perception, and it takes place despite the positive benefits of surgery for treatment of the underlying disease.

The stages of grief

The classical stages of bereavement-related grief described by Elizabeth Kubler-Ross will apply to older people and can be exacerbated by non-bereavement related loss.

Initial shock, numbness, denial and disbelief is followed by anger, bargaining ("If only I had…"), guilt and depression, then finally acceptance. These should be recognised by all clinicians.

It is helpful for clinicians to briefly describe the stages of grief, and to listen to how the patient has experienced these stages. Explain that there is no fixed timeframe for each stage, and that progress is not always linear - in fact, significant dates can trigger earlier feelings of grief again. These are acute, painful and are real.

Listening and being supportive is essential. Recognising the anger stage is helpful, and how it has impacted behaviour is an important clinical action.

Loss accumulates as people age

Grief (and its short- and long-term effects) have a major impact on older people. Any change - major or minor - can trigger a reaction of grief, regardless of the magnitude of change.

After age 65, people may experience an accumulation of losses which may or may not have been appropriately dealt with during their life. Any accumulation of loss or unresolved earlier losses - plus the acute reaction of grief to a new loss - can trigger a downhill slide.

These losses are often not discussed (apart from the obvious major loss of a partner), and the inability to articulate feelings and their impacts can impact the normal resolution of grief.

Grief impacts healthy ageing and the ability to self-manage

When people experience the various stage of grief and are angry or depressed, self-care suffers. The impacts of grief upon older people with multiple long-term health conditions can include:

- Poor sleep, which causes fatigue,
- Increased use of analgesia to address physical pain from osteoarthritis or other issues - and increased use of opioids or tricyclics increases tiredness and fatigue,
- Raised or markedly reduced blood glucose in diabetics, as meal planning and usual eating habits are challenged (which can result in fatigue),
- Reduced appetite, which is why psychological distress is a risk factor for undernutrition,
- Forgetting to take medications, causing deterioration of underlying health conditions,
- Reduced activity due to social withdrawal (e.g. not attending exercise-based activities, and so sitting or lying more at home), triggering deconditioning and subsequent loss of muscle mass, walking speed and grip strength, and
- Increased self-medicating with alcohol, smoking, opioids and/or other drugs, which can cause deterioration in mental and physical health, aggravate other health conditions, trigger fatigue and result in loss of physical strength.

Grief does not need more medication

Underlying losses, resultant grief reactions and a depressed mood may have triggered more isolation, leading to a downward trajectory rather than a health ageing experience.

Both grief and frailty can be aided by supportive counselling, sleep supports (e.g. reading, podcasts, relaxing music), aerobic and/or resistance exercise (alone or with a friend or group), eating protein (good quality cheese and dark chocolate) and releasing endorphins (through crying and/or laughter).

A depressed mood does not always require treatment with an antidepressant, and sleep disorders should not be addressed with benzodiazepines such as oxazepam or diazepam (which can further sedate older people, cause drug interactions and aggravate underlying health conditions, resulting in less activity and less appetite, both of which can spiral the trajectory of ageing further downwards).

Finally, additional medication adds to the burden of polypharmacy for older people, which itself has been recognised as a risk factor for unhealthy ageing. There are many non-drug options for managing grief and a depressed mood which should be discussed and trialled well before any medications. See

Protein information for improving health for people aged over 65

How much protein do I need? Aim for 25 to 30g of protein per meal.

Current body weight = ... kg x 1.5 g protein per kg/day = ... g protein per day

What does this amount of protein look like?

Here are some examples of what makes a 10g protein serve... choose three per meal!

- 40 g cheese (2 big slices)
- 1 cup milk
- ¼ cup milk powder
- 1 tub yoghurt (170g size)
- 1.5 eggs
- 30 g steak
- 40 g chicken
- 50 g fish
- 2/3 cup baked beans
- 50 g nuts
- 2 large slices of grain bread
- 2.5 Weetbix... before milk is added!

What can be added to my usual food to increase protein?

Grated cheese, milk powder and eggs are inexpensive, and easy to add to other meals.

Make *fortified milk* by adding 1 cup milk powder (skim - which is higher in protein - or full cream) to 1 litre full fat milk and using it wherever you would use ordinary milk:

- On cereal
- In custard and mousse
- As a base for milk drinks
- In tea and coffee
- In white sauces, soups, casseroles
- In mashed potato

A very nourishing and enjoyable drink can be a real favourite that adds protein and energy... the flavoured milkshake!

- 1 litre full cream milk,
- 1 cup milk powder,
- 350 ml ice cream (5-6 scoops), and
- 40 ml flavoured topping.

This gives 9.4 g protein and 730 kJ energy for every 150 ml (just under a cup).

Milkshakes with extra milk powder are a great source of protein and energy.

Polypharmacy and deprescribing for more information.

Grief, loss and bereavement resources

- Grief - a big issue for older people and the trajectory of healthy ageing
- National Ageing Research Institute
- Aged Care Grief and Bereavement Support
- National Association for Loss and Grief (NSW)
- Hunter New England HealthPathways
  - Bereavement
  - Bereavement Support Services
  - Patient Mental Health Hotlines and Telephone Counselling
  - Adult Psychology, Social Work and Counselling Referrals
- Central Coast HealthPathways
  - Bereavement, Loss, and Grief Counselling
  - Adult Psychology and Counselling
  - Older Peoples' Mental Health Assessment

SPECIALIST AND ALLIED HEALTH REFERRAL OPTIONS

Patients with scores of two (pre-frailty) and scores of three or more (frailty) may benefit from referral to a Specialist or Allied Health professional.

Ensure that reversible medical conditions are addressed and consider referral to a geriatric medicine specialist where frailty is associated with significant complexity, diagnostic uncertainty or challenging symptom control.

Search options are below:

1. Exercise Physiologists (search by location),
2. Physiotherapists (search by location),
3. Occupational Therapists (search by online/face-to-face consultation, practice area, funding scheme or name),
4. Dieticians (search by location),
5. Geriatricians (search by location) for overall review and possible deprescribing, and
6. Consultant Pharmacists for Home Medication Review (HMR, item 900, search within NSW) to support optimum medication regimes and possible deprescribing.

OTHER USEFUL FRAILTY RESOURCES

- Central Coast HealthPathways
  - Frailty in Older People
  - Falls Pathway

- Hunter New England Central Coast HealthPathways
  - Falls Prevention and Assessment pathway
  - Frail but stable older persons pathway

- Agency for Clinical Innovation resources:
  - Assess function in patients using the PROMIS29 questions,
  - Leverage Frailty Taskforce resources,
  - Refer to the Frailty Toolkit, which includes conversation and patient guides, and supports shared decision-making between health professionals and pre-frail or frail older people who are considering surgery, and
  - Use Finding your way, an Aboriginal-specific shared decision-making model.

- Doing what matters: Keeping older people well at home (Dr Chris Bollen)
- Frail patients fall between software cracks discusses the need for frailty to be incorporated into clinical software templates
- Geriatric Care Australia promotes quality of life, health, and wellbeing with geriatricians, specialist doctors for older people, and a health team that provide access to medical care to all Australians aged 65+ (or 55+ for Aboriginal and Torres Strait Islander people, with bulk-billing options available), irrespective of location.

APPENDIX 1 - FRAIL SCALE TEMPLATES FOR CLINICAL SOFTWARE

FRAIL Scale templates can be imported into Best Practice, Medical Director and ZedMed as .rtf files.

These templates should not be opened and viewed before importing them. Do not click directly on the links or the files will load within the web browser instead of download.

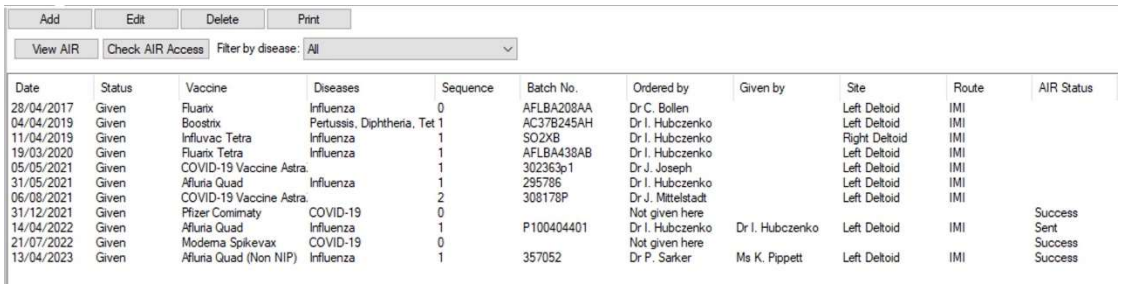
Instead, right click, copy and save the file, or drag the .rtf file onto your desktop.

See instructions below:

Medical Director	– Read instructions on how to upload templates. – Frail Scale for Medical Director - Right click and save link. – 75+ assessment that includes Frail Scale - Right click and save link.
Best Practice	– Read instructions on how to upload templates. – Frail Scale for Best Practice - Right click and save link. – 75+ assessment that includes Frail Scale - Right click and save link.
ZedMed	– Read instructions on how to upload templates – Frail Scale for ZedMed - Right click and save link. – 75+ assessment that includes Frail Scale - Right click and save link.

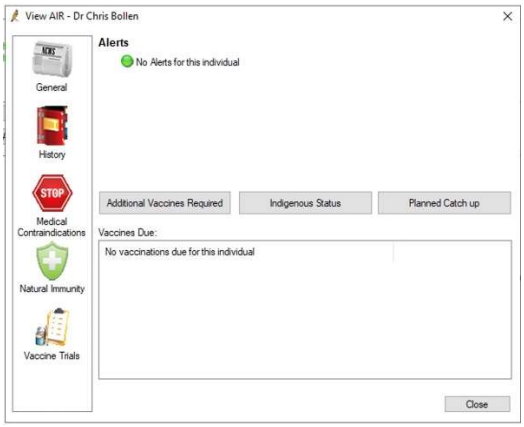
APPENDIX 2 - UPDATING IMMUNISATION RECORDS IN BEST PRACTICE

1. Review the patient's current immunisation list in Best Practice.

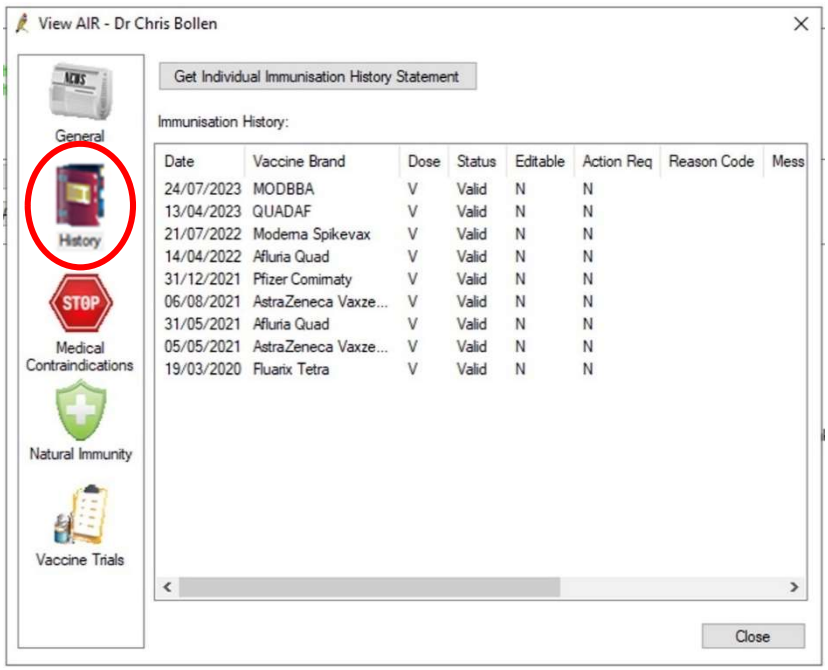


Date	Status	Vaccine	Diseases	Sequence	Batch No.	Ordered by	Given by	Site	Route	AIR Status
28/04/2017	Given	Fluarix	Influenza	0	AFLBA208AA	Dr C. Bollen		Left Deltoid	IMI	
04/04/2019	Given	Boostrix	Pertussis, Diphtheria, Tet	1	AC37B245AH	Dr I. Hubczenko		Left Deltoid	IMI	
11/04/2019	Given	Influvac Tetra	Influenza	1	SO2XB	Dr I. Hubczenko		Right Deltoid	IMI	
19/03/2020	Given	Fluarix Tetra	Influenza	1	AFLBA438AB	Dr I. Hubczenko		Left Deltoid	IMI	
05/05/2021	Given	COVID-19 Vaccine Astra.		1	302363p1	Dr J. Joseph		Left Deltoid	IMI	
31/05/2021	Given	Afluria Quad	Influenza	1	295786	Dr I. Hubczenko		Left Deltoid	IMI	
06/08/2021	Given	COVID-19 Vaccine Astra.		2	308178P	Dr J. Mittelstadt		Left Deltoid	IMI	
31/12/2021	Given	Pfizer Comimaty	COVID-19	0		Not given here				Success
14/04/2022	Given	Afluria Quad	Influenza	1	P100404401	Dr I. Hubczenko	Dr I. Hubczenko	Left Deltoid	IMI	Sent
21/07/2022	Given	Moderna Spikevax	COVID-19	0		Not given here				Success
13/04/2023	Given	Afluria Quad (Non NIP)	Influenza	1	357052	Dr P. Sarker	Ms K. Pippett	Left Deltoid	IMI	Success

2. Open the Australian Immunisation Register (AIR).

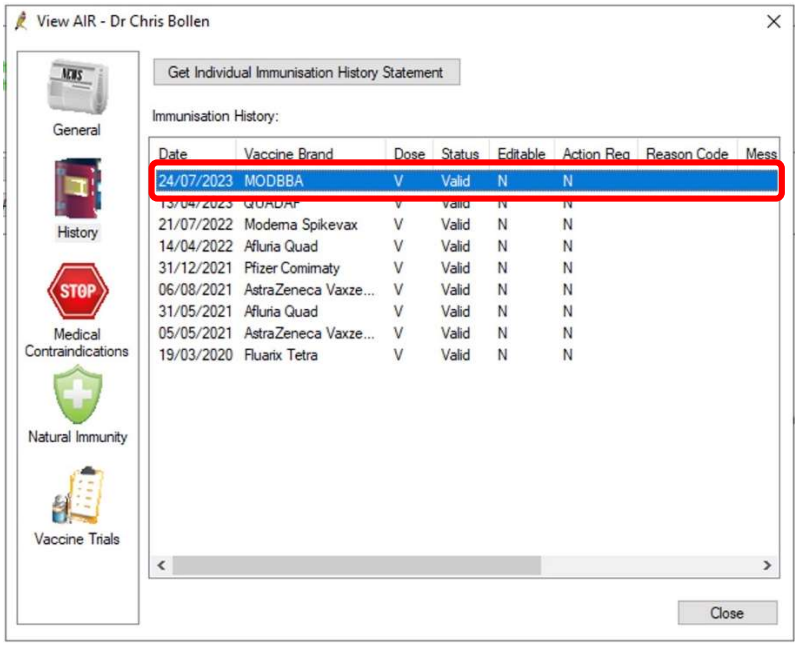


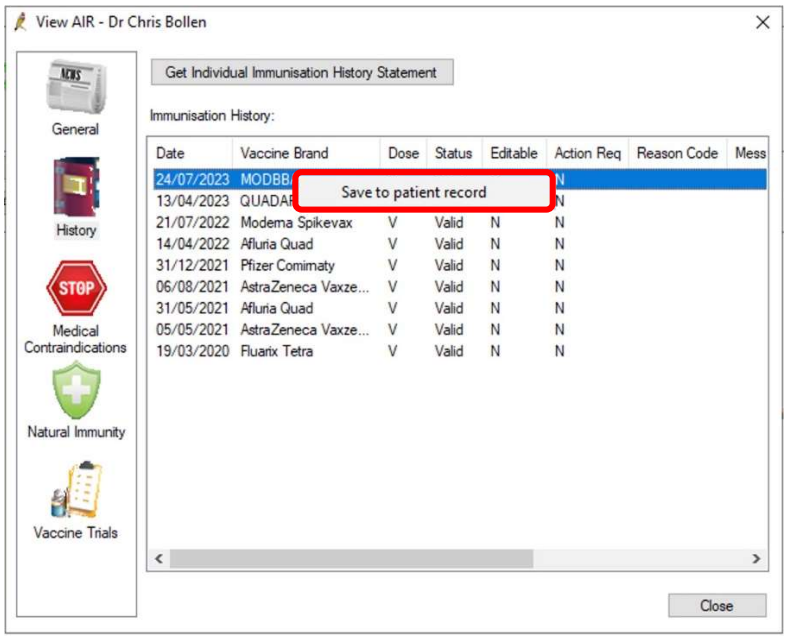
3. Click on the red "History" icon.



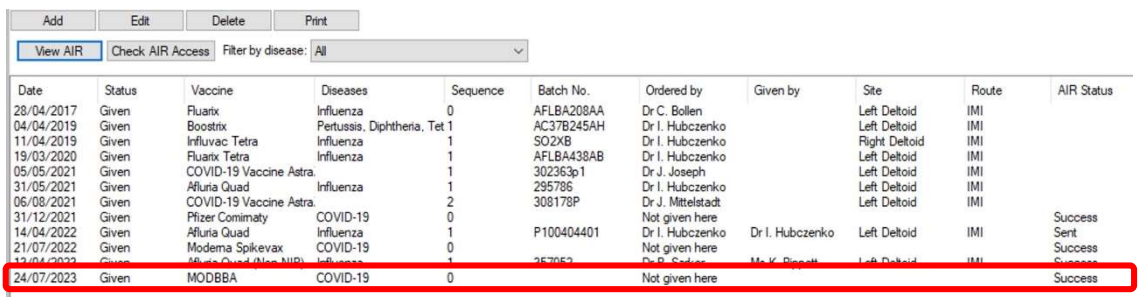
Date	Vaccine Brand	Dose	Status	Editable	Action Req	Reason Code	Mess
24/07/2023	MODBBA	V	Valid	N	N		
13/04/2023	QUADAF	V	Valid	N	N		
21/07/2022	Moderna Spikevax	V	Valid	N	N		
14/04/2022	Afluria Quad	V	Valid	N	N		
31/12/2021	Pfizer Comimaty	V	Valid	N	N		
06/08/2021	AstraZeneca Vaxze...	V	Valid	N	N		
31/05/2021	Afluria Quad	V	Valid	N	N		
05/05/2021	AstraZeneca Vaxze...	V	Valid	N	N		
19/03/2020	Fluarix Tetra	V	Valid	N	N		

4. Click on each immunisation which is missing from the practice list (one at a time) and click “Save to patient record”.





The missing immunisation now appears in the practice list.

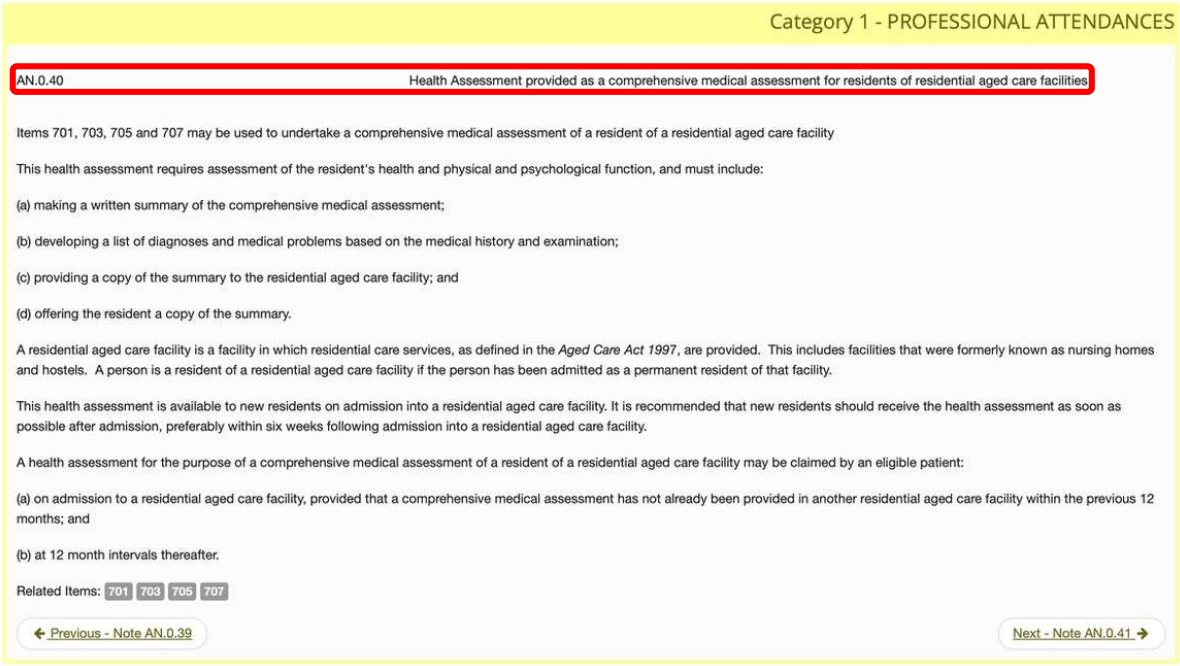


APPENDIX 3 - COMPREHENSIVE MEDICAL ASSESSMENT FOR PEOPLE IN RACF

Health assessment MBS item numbers 705 and 707 (depending upon time for the assessment) can be used for any aged person living **permanently** in a RACF.

Good information about this is found in the RACGP Silver Book.

The MBS descriptor for “AN.0.40 - Health Assessment provided as a comprehensive medical assessment (CMA) for residents of residential aged care facilities” is shown below.



Category 1 - PROFESSIONAL ATTENDANCES

AN.0.40 Health Assessment provided as a comprehensive medical assessment for residents of residential aged care facilities

Items 701, 703, 705 and 707 may be used to undertake a comprehensive medical assessment of a resident of a residential aged care facility

This health assessment requires assessment of the resident's health and physical and psychological function, and must include:

(a) making a written summary of the comprehensive medical assessment;

(b) developing a list of diagnoses and medical problems based on the medical history and examination;

(c) providing a copy of the summary to the residential aged care facility; and

(d) offering the resident a copy of the summary.

A residential aged care facility is a facility in which residential care services, as defined in the *Aged Care Act 1997*, are provided. This includes facilities that were formerly known as nursing homes and hostels. A person is a resident of a residential aged care facility if the person has been admitted as a permanent resident of that facility.

This health assessment is available to new residents on admission into a residential aged care facility. It is recommended that new residents should receive the health assessment as soon as possible after admission, preferably within six weeks following admission into a residential aged care facility.

A health assessment for the purpose of a comprehensive medical assessment of a resident of a residential aged care facility may be claimed by an eligible patient:

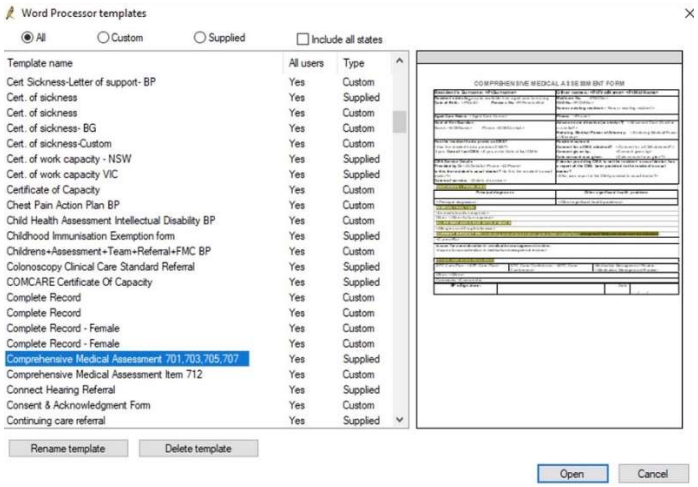
(a) on admission to a residential aged care facility, provided that a comprehensive medical assessment has not already been provided in another residential aged care facility within the previous 12 months; and

(b) at 12 month intervals thereafter.

Related Items: 701 703 705 707

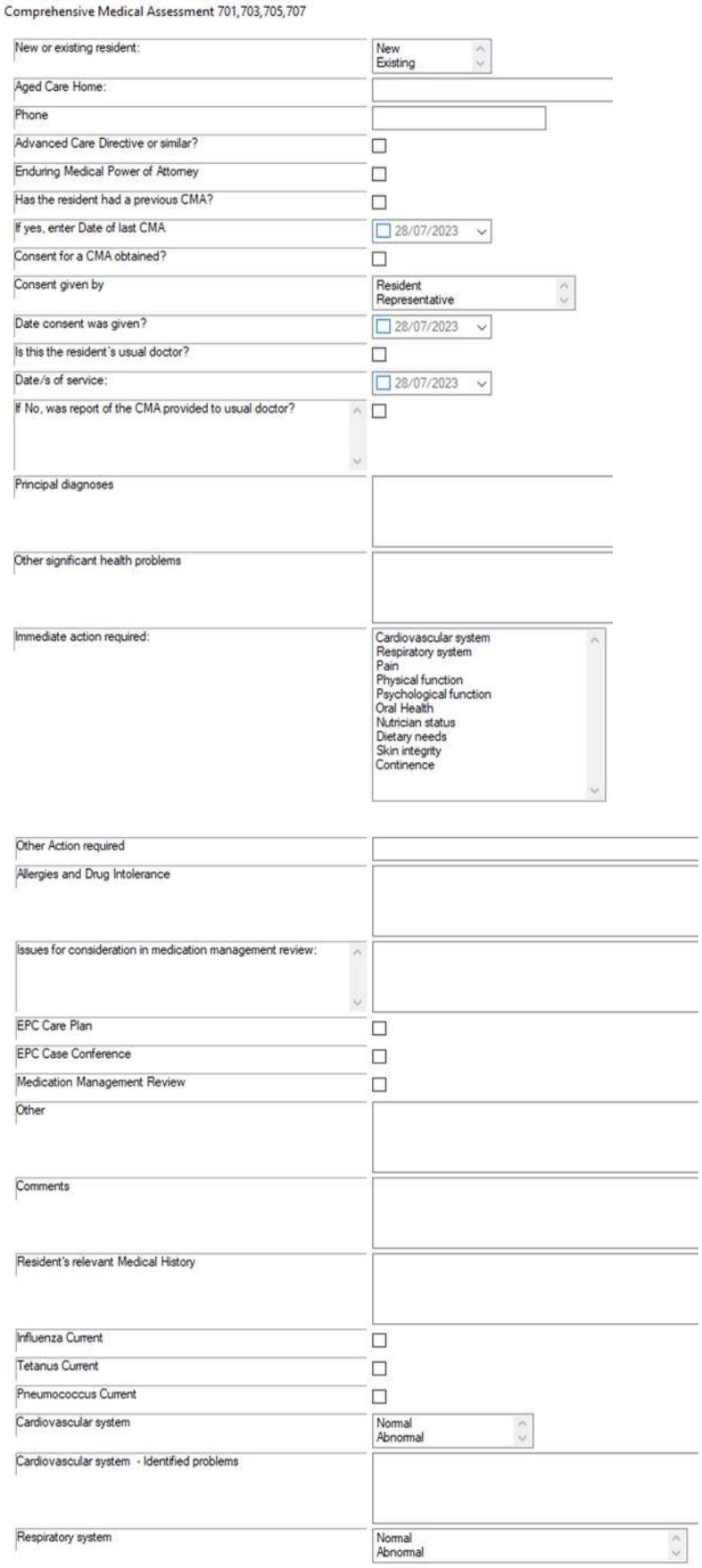
← Previous - Note AN.0.39 Next - Note AN.0.41 →

The screen shots below show where the CMA template is found in Best Practice.



Click “Open” to access a template with drop-down responses, completed in the software.

The following screen shots show the full template.



Comprehensive Medical Assessment 701,703,705,707

New or existing resident:	New Existing
Aged Care Home:	
Phone	
Advanced Care Directive or similar?	☐
Enduring Medical Power of Attorney	☐
Has the resident had a previous CMA?	☐
If yes, enter Date of last CMA	☐ 28/07/2023
Consent for a CMA obtained?	☐
Consent given by	Resident Representative
Date consent was given?	☐ 28/07/2023
Is this the resident's usual doctor?	☐
Date/s of service:	☐ 28/07/2023
If No, was report of the CMA provided to usual doctor?	☐
Principal diagnoses	
Other significant health problems	
Immediate action required:	Cardiovascular system Respiratory system Pain Physical function Psychological function Oral Health Nutrician status Dietary needs Skin integrity Continence
Other Action required	
Allergies and Drug Intolerance	
Issues for consideration in medication management review:	
EPC Care Plan	☐
EPC Case Conference	☐
Medication Management Review	☐
Other	
Comments	
Resident's relevant Medical History	
Influenza Current	☐
Tetanus Current	☐
Pneumococcus Current	☐
Cardiovascular system	Normal Abnormal
Cardiovascular system - Identified problems	
Respiratory system	Normal Abnormal

Respiratory system - Identified problems.	
Pain: Acute	Yes No
Pain: Chronic	Yes No
If yes, cause of pain	
Physical Function (daily living): Identified problems	
Mood	Normal Depressed Other
Cognition	Normal Impaired
Test or screening tool used (eg MMSE)	
Psychological Function: Identified problems	
Oral Health	Teeth Dentures Gums
Oral Health: Identified problems	
Weight	
Height	
BMI	

Nutrition Status: Identified problems	
Dietary Needs: Identified problems	
Skin Integrity	Normal Abnormal (sores/lesions) Other
Skins Integrity: Identified problems	
Urinary	Normal Abnormal
Urine Test	Normal Abnormal
Faecal	Normal Abnormal
Continence: Identified problems	
Other Medical examinations as relevant	Fitness to drive Hearing Vision Smoking Foot care Sleep Cardiovascular risk factors Alcohol use Other
Other Medical examination: Identified problems:	

The following screen shot shows what the document looks like when completed and ready to print for the RACF and any family members.

COMPREHENSIVE MEDICAL ASSESSMENT FORM

Resident's Surname: Test	**Other names: Robot Tester**
Resident's details (may be available from aged care home) eg **Date of Birth:** 01/01/1947 **Pension No.**	**Medicare No.** **DVA No.** **New or existing resident:**
Aged Care Home:	**Phone:**
Next of Kin/Guardian Name: Phone:	**Advance care directive (or similar?)** No **Enduring Medical Power of Attorney:** No
Has the resident had a previous CMA? No if yes: **Date of last CMA**:	**Resident consent** **Consent for a CMA obtained?** No **Consent given by:** **Date consent was given:**
CMA Service Details **Provided by Dr** Dr Chris Bollen 132 - 134 Fosters Road HILLCREST 5086 Phone: 8266 7788 **Is this the resident's usual doctor?** No **Date/s of service:**	**If doctor providing CMA is not the resident's usual doctor, has a report of the CMA been provided to the resident's usual doctor?** No

DIAGNOSES / PROBLEMS

Principal diagnoses	*Other significant health problems*

IMMEDIATE ACTION

Other:

ALLERGIES AND DRUG INTOLERANCE

CURRENT MEDICATION (including prescribed and non-prescribed medication) *(drug chart/ Webster sheet can be attached)*

No long term medications.

Issues for consideration in medication management review:

OTHER SERVICES REQUIRED

EPC Care Plan: No	*EPC Case Conference : No*	*Medication Management Review : No*

Other:

Comments:

GP's Signature:		Date / /

RESIDENT'S RELEVANT MEDICAL HISTORY

(May refer to current information from nursing home; information from resident's records can be attached)

IMMUNISATION STATUS

Influenza Current No **Tetanus Current** No **Pneumococcus Current** No

COMPREHENSIVE MEDICAL EXAMINATION

Cardiovascular system
Identified problems:

Respiratory system
Identified problems:

Pain: Acute **Chronic**
If yes, cause of pain:

Physical Function including activities of daily living, eg walking, eating, dressing, personal care (bathing, toilet)
Identified problems:

Psychological Function
Mood
Cognition **Test or screening tool used (eg MMSE)**
Identified problems:

Oral Health:
Identified problems:

Nutrition Status: **Weight** **Height** **BMI**
Identified problems:

Dietary Needs:
Identified problems:

Skin Integrity:
Identified problems:

Continence: **Urinary** **Urine Test** **(if indicated)** **Faecal**
Identified problems:

APPENDIX 4 - ADDING AN AUTOFILL IN BEST PRACTICE

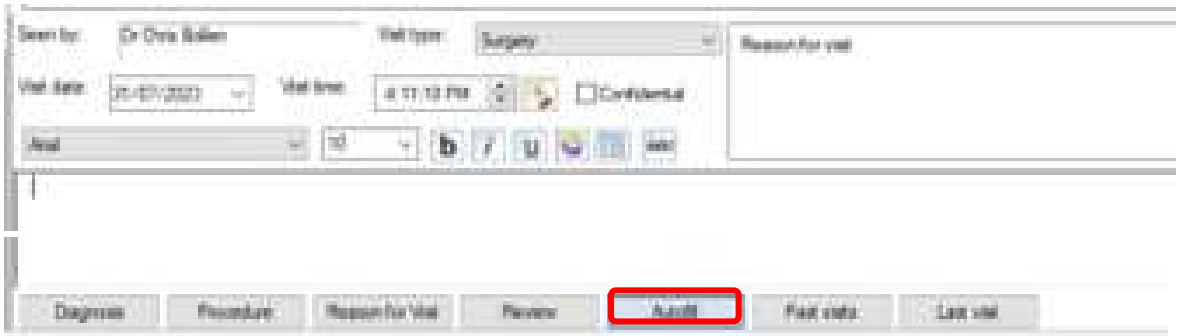
The 75+ health assessment can be improved by:

- adding a FRAIL screening tool,
- objectively assessing muscle strength (e.g. via 4m walking test, grip strength measured with a dynamometer) and leg strength (five timed sit-to-stands),
- assessing risk of malnutrition using the Mini Nutritional Assessment (MNA®),
- checking for shingles, COVID and pneumococcal vaccinations on AIR,
- adding a kidney health check (renal function, BP check and urine ACR) - last done and date due (40% of people aged 75+ have evidence of chronic kidney disease),
- adding an osteoporosis screening check, and
- checking blood pressure laying and standing to assess for postural hypotension.

Creating an autofill

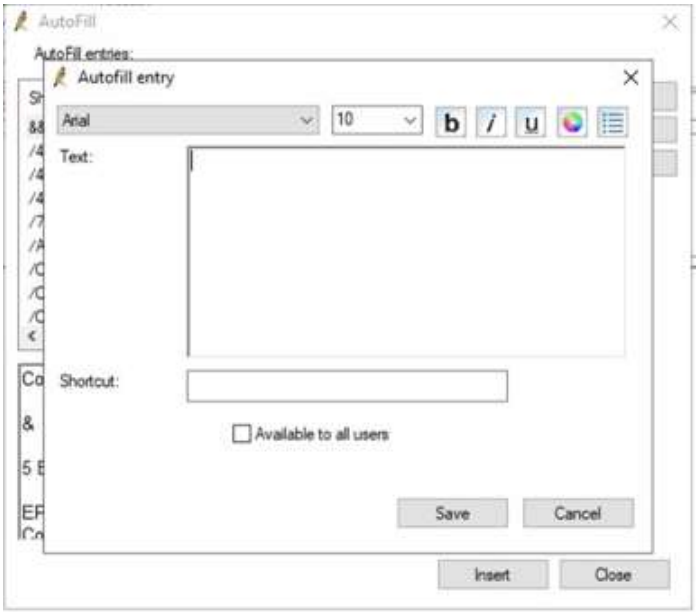
Create an “Autofill” known as “/Frail” by following these steps:

1. Find the “Autofill” button at bottom of the usual consult entry screen:



2. Click “Add” to add a new autofill.

3. A new window will open:

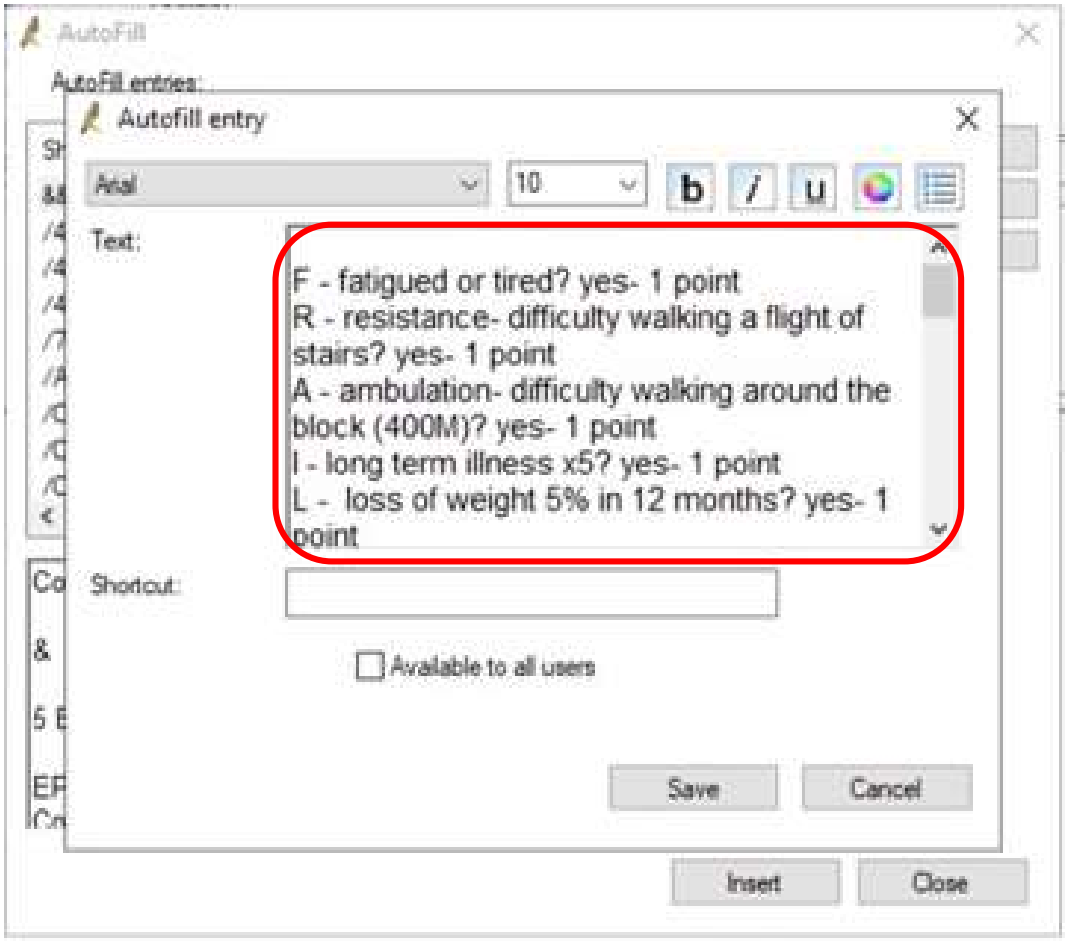


4. Copy and paste the text below (amend as required).

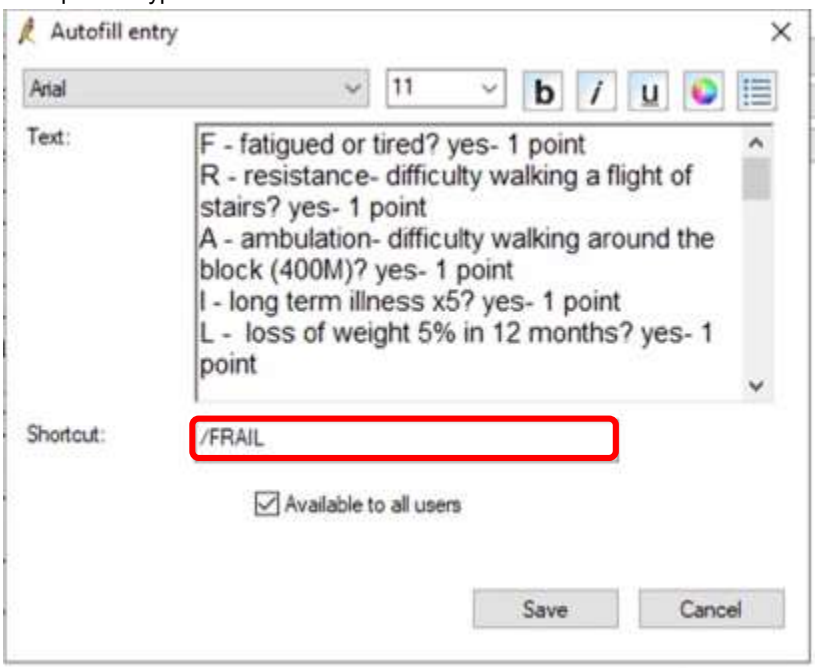
F - **Fatigued** or tired? Yes = 1 point
R - **Resistance** - difficulty walking a flight of stairs? Yes = 1 point
A - **Ambulation** - difficulty walking around the block (400m)? Yes = 1 point
I - long term **Illness** x 5? Yes = 1 point
L - **Loss of weight** of 5% in 12 months? Yes = 1 point

Sum up to obtain the frailty score (out of 5). Patients scoring 0 are robust. Patients scoring 1-2 are pre-frail and patients scoring 3+ are living with frailty. Both pre-frail and frail patients will benefit from:

- Being asked "What matters to you?" - List a person's goals, "bucket list"
- Being asked "How steady are you feeling" rather than “How many falls have you had?”
- Resistance exercises (home or supervised at least 2 x week to build muscle)
- **Nutrition**
  - Check for malnutrition using the Mini Nutritional Assessment (MNA®)
  - Increase protein in diet (aim for 25-30g of protein per meal)
  - Daily Vitamin D to improve muscle strength
- **Medication review**
  - Check for any over the counter medications
  - What can be deprescribed to improve fatigue and mobility?
  - Check blood pressure (lying and standing) to assess for postural hypotension, a common side effect of medications in older people
- **Osteoporosis screening**
  - Any minimal trauma fracture in past? Y/N
  - Last bone mineral density (BMD) date and date next due (5 yearly if no evidence of osteoporosis on previous BMD, and 2 yearly if the patient has established osteoporosis or had minimal trauma fracture)
- **Assess for sarcopenia**
  - Grip strength test using dynamometer
  - Mobility test - the 4M walk test - aim to do in less than 5 seconds
    0.6m/sec or less - Seriously Abnormal
    0.6m/sec - 1.0m/sec - Abnormal
    1.0m/sec - 1.4m/sec - Normal
    1.4m/sec or more - Superior
  - Sit to stand test - How long does it take to do 5 sit to stands? (if >17 seconds, the patient has an increased risk of hip fracture and hospitalisation)
- **Immunisations**
  - Are they up to date? Y/N
  - Check pneumococcal (Prevenar 13), shingles and COVID vaccination status (may need to view AIR) and include date next due.

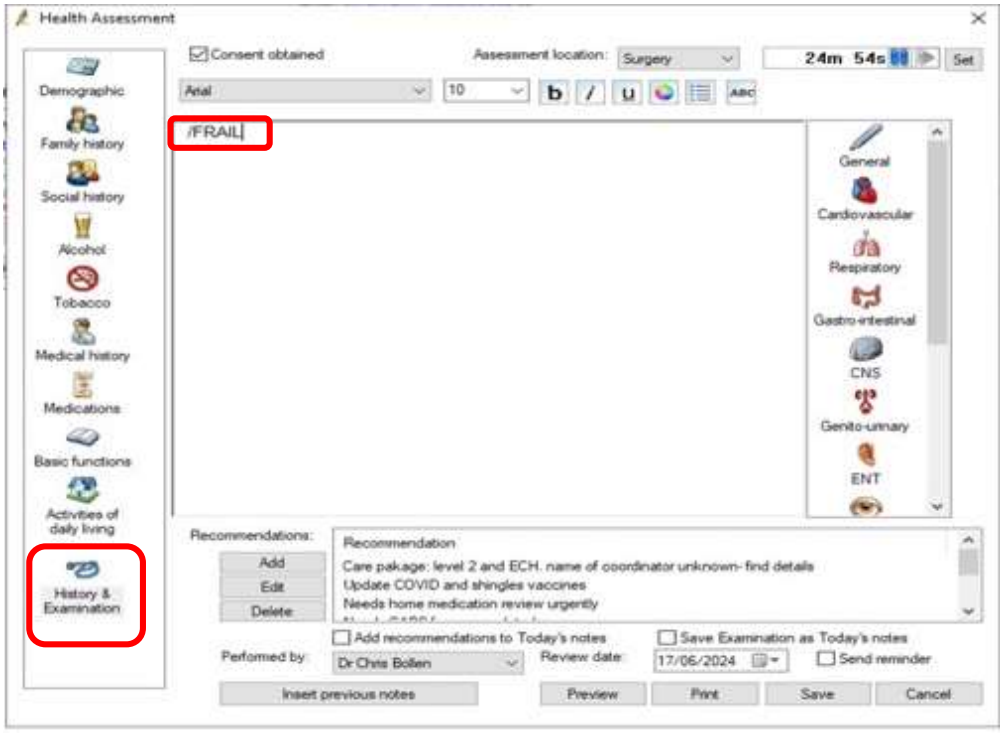


5. Add a “shortcut name” (e.g. /Frail) - include the forward slash, or the autotext will all appear anytime a person types “Frail” in the notes! And tick the “available to all users” box so all the practice can use.

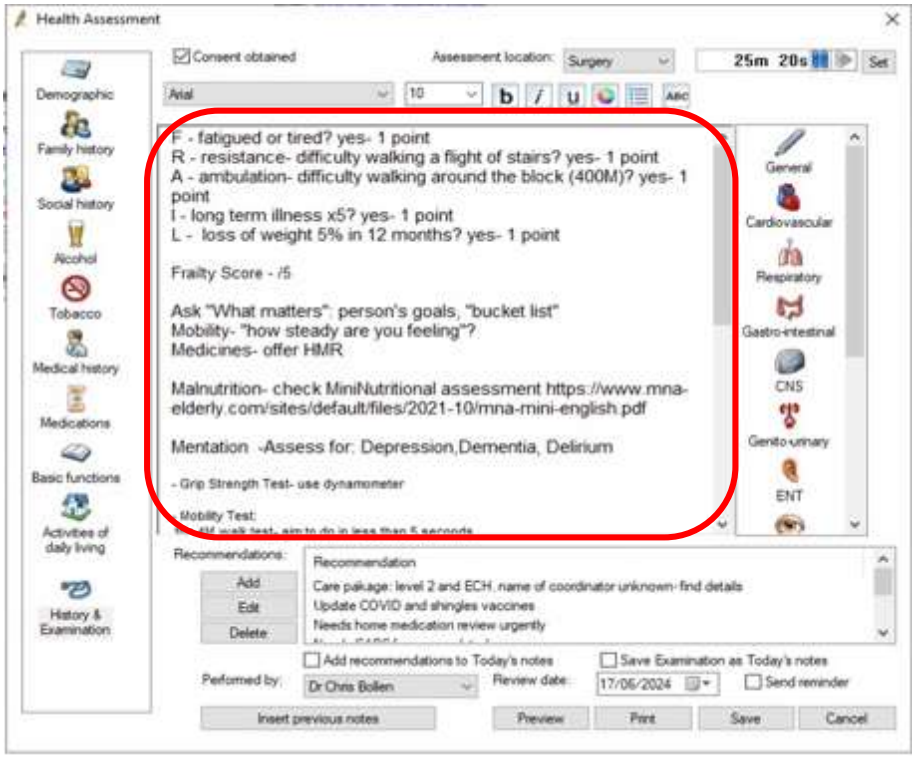


Using the autotext during a health assessment

Option 1 - Type “/Frail” in the health assessment “History and Examination” box.



This will ensure the FRAIL screen and other information will appear in the printed version of the health assessment.



Option 2 - Click the “Autotext” button at bottom of the consult notes, find the “/Frail” shortcut, click “Insert”, and it will appear in the consult notes.

However, this method will **not** document the FRAIL screen and other information in the printed version of the health assessment.