ACI Frailty Forum – Friday 7 February 2020

Summary of Sli.do questions and answers

These questions were posed to presenters at the Frailty Forum via use of Sli.do. Due to time constraints, not all questions were able to be addressed on the day of the forum. Following the forum, presenters were emailed a verbatim list of the questions asked and have provided the answers in this document.

Contents (by name of presentation)

A Consumer Perspective: "Weed if you must"

Dr Keith Watson - Retired Academic
Sarah Hobson - Transitional Aged Care Program & Compacks Manager, Northern Sydney LHD (NSLHD)

1. **Keith is an inspiration!! Well done Keith and thank you.**
   Thank you

2. **What if you want to refer but there are no available packages in TRANSPAC?**
   Unfortunately, we do get periods where TRANSPAC is full – we do engage a waitlist and hope that a client can come onto the program before being discharged from hospital. If not, we try and direct down some other channels of support. Unfortunately we have to wait for a vacancy and usually this is either when a client returns to hospital or they have completed their TACP journey. We project ahead how many packages we have coming available each week.

3. **If a tool like CrisTAL were used, would it have suggested Keith should not have had the option of ICU? Does this illustrate the difficulty of using tools to predict?**
   Sorry, I am not familiar with CrisTAL- I think Keith's journey was interesting because he might have been more pertinent to come to the residential aspect of TACP (NSTCU) Transition Care Unit prior to coming onto a community package. Keith's medical progress was such that he was referred for the community portion of the package and this worked well for him this time.

4. **Is the Frail scale risk assessment a tool that you devised?**
   No, the one I used to score Keith was one being used by Sydney North Health Network: Frail Scale Risk Assessment (Frailty management / Decision Tool)

5. **Mental health support?**
   We can provide support either via pre-existing services in community e.g. OPMS (Older Persons Mental Health Service) if client is known or make a new referral. We can also access a neuropsychology review as required.

6. **What was the time between referral (whilst in hospital) to discharge home with services under the package and who initiated the referral?**
   Time in hospital from accident was 1.5 months – from referral to coming on program was assessed by ACAT 31/1 and started program 11/2 so 10 days. The referral was initiated by a Social Worker.

7. **You have a small number of residential packages. Is that the TCU or do you also provide packages within other RACF's.**
   We only have 18 beds/ packages for NSTCU (Northern Sydney Transition Care Unit) - the residential portion of the TACP program. At present the packages are based at Wesley Gardens (a RACF which is a Uniting facility). This is a tendered process. So 18 of their beds are transferred to use for the TACP program as Transition beds, used more when clients require increased time after a hospital stay/non weight bearing/live alone etc.

Keynote Presentation: Frailty in Clinical Practice

Professor Sue Kurrle – Geriatrician, Hornsby & Ku-ring-gai and Eurobodalla Health Services; Clinical Director NSLHD Rehabilitation & Aged Care Network

1. **If a patient is admitted from a residential aged care facility to Hornsby Hospital, is the approach to frailty the same? What are follow-on recommendations?**
   If the resident is mobile then we will look at what needs to be done. If they are palliative care, or bed fast and near the end of life we would not intervene.

2. **What tool do you all use for assessing Frailty? Are they all validated measures?**
   I am comfortable with the physical frailty phenotype so I either use the FRAIL Scale to screen for frailty or do the full Fried Frailty tool with handgrip strength and walking speed, weight loss, self-reported exhaustion, and measure of physical activity. These are well validated, and are useful because they tell you what intervention is appropriate. Other frailty measures can tell you if a patient is frail, but it is not always clear what should be done.

3. **Are you aware of any work that has looked at the onset of frailty in those aged under 65 years?**
   There is work in Mental Health looking at sarcopenia, frailty and falls in those younger people who are on high doses of psychotropic medication. There has been education done, and interventions including resistance training and aerobic exercise suggested. I am not aware of any trials in the area.

4. **How important do you feel it was to implement the exercises intervention in the home (in your FIT trial)?**
   Very important as if participants got used to doing the exercises in a familiar environment using their own furniture or ankle weights that we had given them, then they are more likely to continue the exercise.

5. **Are the eMR forms across LHDs on Cerner?**
   Just in Northern Sydney as far as I am aware.

6. **Do think addressing isolation is just as important as physical exercise in addressing frailty?**
   Exercise is what we have the very strong evidence for. Once frail people become stronger with the exercise, hopefully they are more confident to go out and then their isolation can be addressed.

7. **Can frailty be reversed in people living in residential aged care? Or is the benefit prior to possible admission?**
   Definitely there is evidence in older people in residential care for improving strength and mobility and reducing falls. You would need to pick your participants well.

8. **Do you use the word 'frail' with patients? We've had conflicting advice regarding the potential to disengage consumers if using the word frail.**
   Yes I use the word and then note that this is a diagnosis that they can do something about. I also tell them the bad things that can happen if they don't do something! Although I do choose whom I say that to fairly carefully!

9. **Could frailty be considered a consequence of poor lifestyle choices in middle age?**
   Yes it may be due to lack of exercise and poor diet, but often people are unaware of the consequences of that sort of behaviour so it is always worth giving them a second chance.

10. **Cultural/ethnicity differences with frailty?**
    Not sure of the answer. Japanese older ladies can look frail but actually be very active and strong, and I am sure that is the situation with other groups. It is the ongoing commitment to activity and exercise that is really important.

11. **How do you integrate frailty assessment and management with current models of care for inpatient, clinics and community services?**
    Just starting to work on this with the use of the FRAIL scale in acute hospital wards and in general practice.

12. **Has there been any published work with CALD and Aboriginal communities on their perspectives of frailty and approaches to enabling improvement?**
    Not that I am currently aware of.

Northern Sydney Perspective: Focus on Frailty

Jordana Panetta – Physiotherapist, Hornsby Ku-ring-gai Hospital
Lara Pasternak – Dietitian, CHSP, Hornsby Ku-ring-gai Hospital
Chanelle Stowers – Manager, Service Integration & Design, Sydney North Health Network & NSLHD
Annie Yu – Clinical Pharmacist, Hornsby Ku-ring-gai Hospital

1. **What is considered as polypharmacy?**
   Annie Yu: We classify a patient is polypharmacy when they take more than 5 regular medications.

2. **What issues impact the acceptance of de-prescribing in the event of polypharmacy?**
   Annie Yu: I work at acute hospital. The main issue is that most of the recommendations of deprescribing may not be related to the reason for admission. Some specialists are willing to deprescribe while others may just leave it for GP to review. Also, I find that hospital doctors are more confident in deprescribing 'statins'. I have a better success rate in it.

3. **Could you tell more about your discharge plans of the patients you see- dietician physio pharmacist**
   Pharmacy: We included all the recommendations for deprescribing and other pharmacy interventions for medication monitoring. Also, we recommended GP to organise Home Medication Review.
   Physiotherapy: Once a patient is discharged from hospital, they go home with their exercise program made for them in hospital. They are told to talk to their GP regarding exercise programs that take place in the community. Follow up physio is not provided/arranged for patients in the program but the frailty physio. Please keep in mind the ward physio is responsible for discharge planning and discharge destination if home is not suitable post hospital admission.
   Dietetics: Patients are discharged with education resources in line with goals arranged during hospital stay. The interventions are outlined in the GP consult letter. A follow up dietitian assessment it suggested in the GP consult letter however not arranged for patients. Similarity to physio, the ward dietitian is responsible for discharge planning.

   A prepopulated template for a frailty discharge letter is available in eMR. This is completed by the team for issue to the persons GP on discharge.

4. **Do you think there is any benefit in other AH staff providing standard education for pts in the community considered frail? E.g. team with no dietitian**

   As we are not formally trained in another profession it is out of our scope of practice to deliver other disciplines information. The goal of the frailty initiative is to have individualised approaches to care. If we are delivering generalised information this means it does not meet patient's individual needs. Therefore, there would be minimal benefit in other AH staff providing standard education for frail patients in the community.

5. **Are there any outpatient departments at Hornsby Hospital completing frailty assessments? And if so, are they also using the frail scale?**

   Pharmacy: none for pharmacy
   Physiotherapy: nil outpatient involvement
   Dietetics: No outpatient involvement unfortunately, however the community dietitian and community nurses do use the Frail Scale.
   NSLHD (Lyn Olivetti) – Ryde Hospital and Mona Vale Hospital outpatient rehabilitation and aged care services are using frailty assessments, as are Northern Sydney Home Nursing Service, with FRAIL scale forms available in NSLHD's eMR.

6. **Approximately how many patients are on the program at a given time? Also what level of staffing do you have for the whole team (including admin)?**

   Pharmacy: There is 0.4FTE pharmacy service and we had almost 420 patient referred to pharmacy in 2019 (since mid-Jan). The number of patient referred each week may vary.
   Physiotherapy: There is 0.4FTE for physiotherapy. The amount of patients at one time depends on the amount of frail patients on the ward. We do not cap a number of people on the program.
   Allied Health Assistant: There is 1.0 FTE. The AHA does all the screening for all three AH professionals. The AHA also does the ongoing treatments for the physiotherapist. The AHA cannot mobilise the patient until assessed by the frailty physio. The AHA does most of the admin work.
   Dietetics: There is 0.4FTE for dietetics. The case load depends on the number of frail patients at one time in the acute setting. The numbers can vary each week between 0-6 patients screened as frail in one day. The busiest time appeared to be winter.
   In short: if they are 'frail' they are referred – there is no limit to the amount of participants.

7. **Did you change anything based on feedback from participants?**

   Pharmacy: Speak to the medical team and try to include the deprescribing information in discharge summary. From my past experience, GP restarted the deprescribe medication because of lack of information about deprescribing.
   Physiotherapy: We found that our feedback from patients was not feasible to implement. For example one particular feedback was "stay in hospital longer to do the exercises."
   Dietetics: Participants were very grateful for the follow up phone calls, this allowed

education refreshers and arrangement of community referrals. This will be considered in the next round of evaluations.
Feedback received from RACF nursing staff regarding communication of information about Frailty Program. Staff would appreciate information in discharge summary, and education sheets faxed through for nursing handover.

8. What inclusion/exclusion criteria is used to identify appropriate patients for the frailty program?

Pharmacy: Inclusion: anyone screened as frail should have medication review. Exclusion: end of life patient
Physiotherapy: Once a patient has been referred to physio, the physiotherapist will use clinical reasoning to determine if a patient is not appropriate to participate. Some examples include: end of life/palliative care patients, those that are medically unwell and not medically stable to participate in mobility/exercises currently. Also those that cannot follow instructions/can't participate. Please note all these patients stay on the list so that when/if their condition changes they can then be assessed by the physio.
Dietetics: Frail patients with a score for weight loss are referred to the dietitian. Clinical judgement determines if patients are suitable for the programs; patients on end of life pathway on comfort feeds are not appropriate. Patients with end stage renal failure may also be excluded as not suitable for high protein diet. These patients will then be seen by the ward dietitian.

9. Have Occupational Therapists been involved in program? Environmental modifications, falls prevention, Assistive technologies, re-ablement strategies etc.?

Currently no OT's have been involved in Hornsby's program.

10. As mood and cognition are also contributors towards frailty, are these assessed in your frailty and how are they addressed?

Pharmacy: not specifically assessed
Physio: also difficult to assess/address. Potentially if they are from a RACF a handover can be provided to educate/reiterate the importance of mobility and exercise once discharged if the patient has known cognitive impairments.
Dietetics: Mood is documented on patient's progress notes

11. It looks like the evaluation is not integrated between the different areas. Why?

Northern Sydney's Frailty Steering Group (NSLHD and Sydney North PHN) had an overarching implementation plan together with an evaluation framework. The aim was to understand the feasibility and impact of Frail Scale screening with targeted intervention implemented by both the RNSH in-reach rehabilitation team and the team at Hornsby over a 6 month period. There is corresponding evaluation within Primary Care. Evaluation for in-hospital screening included the profile of people screened, their frailty scores, HACs and

readmission rates to hospital at 28 days. In addition, the time investment in intervention was tracked.

At Hornsby, each AH discipline has undertaken discipline specific evaluation after discharge as part of departmental CPI, however report this back to the Hornsby implementation team.

Having established the feasibility and usefulness of the screening, the Hornsby team is now undertaking further research.

12. Does the Hornsby Hospital Frailty Project have data yet on changes in re admission rates, or decreased presentation to GPs?

The readmission rates were extracted by the Performance Unit. While the Hornsby team did note if these people were readmitted to their ward in their data collection, the team didn't know if they have been admitted to another ward or facility. Readmission rates have been compared with an aged-matched cohort on the same ward in the previous year but no significant difference has been identified for the initial 6 month period at this stage.

13. Where does the treating of depression and mental health come in and the use of psychologists?

Chanelle Stowers: This area is flagged under the first risk screening question for fatigue - intervention and management suggestion is (among other things) to use a depression scale, consider referral to psychologist /mental health plan and consider loneliness support.

14. Can you please talk about how the program is being evaluated?

Chanelle Stowers: Evaluation is difficult in primary care as there are multiple eMRs being used and little standardisation for documentation. The PHN has developed a Frailty app that can be used across some eMRs (PEN Topbar) that will allow the frail scale screen to be recorded and monitored remotely to track screening rates and scores. We are also commencing a deep dive frailty pilot project so we can gather more in depth data and information on referrals and workflows to understand how frailty screening can work optimally.

Lyn Olivetti: The Northern Sydney Frailty Steering Group (NSLHD and SNPHN) have an evaluation framework aligned with the implementation plan. The aim is to understand the feasibility and impact of Frail Scale screening with targeted intervention implemented by both the RNSH in-reach rehabilitation team and the team at Hornsby over an initial 6 month period (Jan to June 2019). There is corresponding evaluation within Primary Care. Evaluation for in-hospital screening included the profile of people screened, their frailty scores, HACs and readmission rates to hospital at 28 days. In addition, the time investment in intervention was tracked. Allied Health departments involved in screening and intervention at Hornsby have undertaken followup after hospital discharge. This will inform department CPI as well as further research being undertaken by this multidisciplinary team.

15. **How to engage GPs visiting RACFs in assessing Polypharmacy and performing de-prescribing? How to foster the role of primary health care services in de-prescribing?**

    Chanelle Stowers: We have not focussed the frailty project directly on RACFs yet (due to resourcing) but from those who have attended our education and commenced screening there are examples of success - one RACF that undertook deprescribing in an RACF on a patient reduced the frail scale from 5 to 3 with amazing outcomes - so definitely works.

16. **How are you integrating with the GPs involved? Are you providing education to your local GP community?**

    Chanelle Stowers: Yes the PHN has provided 3 education session to date on frailty (with more to come) as well as relevant website resources and Frailty HealthPathways. Our primary care engagement team have visited 64 practices and discussed the project delivered resources. We are currently reviewing some potential online resources to support frailty awareness to roll out later in the year.

    Lyn Olivetti: In the admitted care setting, a pre-populated template has been written in eMR for the team to send a discharge letter to GPs containing information about their frail scale score, intervention during admission and recommendations post discharge.

17. **Is 'My Health Record' a useful tool to coordinate a person's complete care?**

    Chanelle Stowers: Not yet, it is a useful patient portal to a summary of care but isn't a complete record yet.

18. **What are best strategies to work as one team from multiple funded sources in frailty pathways?**

    Chanelle Stowers: Key is collaboration and co-design. Getting all interested parties together to ensure messaging across sectors is aligned is really important. Spending longer in planning to ensure the rights things are discussed upfront means less confusion later down the track. It's counterproductive if different hospitals or services are sending completely different messaging to GPs and expecting different outcomes or measures etc. - try to use one scale and an agreed set of managing principles etc.

19. **Who pays for the GPs to attend training?**

    Chanelle Stowers: Most training is after hours and GP/nurses will attend on their own time but receive the training for free, they will get training credits. If workshops occur during business hours and the PHN has requested their input - the PHN will pay them for their time.

20. **Are RACF residents excluded from frailty initiative?**

    Jordana Panetta: RACF residents are included in the initiative (this is the case for all Allied health disciplines)

21. Do you follow up the clients in the community post discharge or do you link them up with any community physiotherapy service?

Jordana Panetta: No, unfortunately we do not follow up face-to-face with people in the community, nor do we link them up with any community physio. This is mainly due to the fact that we don't have any appropriate place to refer onto. Also, it becomes tricky when patients are out of area. If appropriate, they are sometimes given healthy lifestyles programs. This responsibility is left up to the GP currently.

Lyn Olivetti: A discharge summary from the frailty team is being sent to GPs including the FRAIL scale score, intervention while admitted and any recommendations made to the person on returning home.

22. What outcome measures did you use on your patients in Physiotherapy?

Jordana Panetta: We are not using any functional outcome measures. The reason for this is because we don't do formal face-to-face follow ups. Doing a functional outcome measure does not seem appropriate as we don't have capacity for re-assessments. Our outcome measures were the Sarc-F and Frail Scale. These can both be done over the phone.

23. Do you take any physical assessments - such as TUG, grip strength as follow up? How do you encourage patients to come back at 3 months for evaluation?

Jordana Panetta: We do not do face-to-face follow ups. Our follow ups are done over the phone only. Currently no functional outcome assessments are done. This is due to the fact that we do not do face-to-face follow ups to be able to assess a clinical change.

24. Would a project like this be feasible within current staffing levels, or do you feel additional funding/staffing is required?

Jordana Panetta: It is hard but it can be done. When we haven't had a frailty physio due to sickness/leave, the ward physio would have capacity to see some of the frailty patients. The issue with this is it increases the workload demands of the ward physio. This is because they have to see their normal ward patients and then see the frailty patients on top of that. It was easier when the patient had a referral for both frailty and ward physio – then only one assessment would need to be done. As the physio only does the initial assessments and AHA does the follow up physio it makes it slightly more manageable. However keep in the mind the quality of your assessments and treatments may be reduced when increasing caseload. It also means that non-clinical frailty work would be a low priority and this is initially important if you need to collect data. If you are using current staff levels then you will have to make sure that there is an AHA that can work most days on the ward to see the ongoing frailty patients.

Lyn Olivetti – at RNSH, FRAIL scale screening and intervention was successfully implemented by the in-reach rehabilitation team. They had time-limited part-time enhancements for dietetics and pharmacy, with mobility related recommendations managed within usual team resources. This has not continued beyond the initial 6 month trial period, but delivery of frailty screening and intervention was feasible using the in-reach rehabilitation model of care. For this to be

sustainable there would need to be reconfiguration of the team profile (there is definitely a need for additional clinical pharmacy to manage polypharmacy), revision of eligibility criteria and identification of any overlap with existing allied health services in acute care.

25. When we talk about weight gain in our elderly, how can we optimise muscle gain as opposed to fat gain as is commonly the case?

Lara Pasternak: Equal distribution of good quality protein at main meals (25-30g), with a focus on the amino acid Leucine (2 grams at each meal). This is equivalent to 20grams of whey protein isolate, 4 tbsp. of skim milk powder, 3 eggs or 100g cooked meat. Multi-disciplinary team involvement; a patient requires good diet of regular meals containing protein and ongoing resistance exercise as recommended by physiotherapist.

26. Can a recommendation of incorporating whey powder into cooked food be made?

Lara Pasternak: Adding the whey powder slowly into ensure there are no lumps formed. Including the powder into cold milk for coffee and tea and then heating up to avoid lumps. The addition of skim milk powder can also be a great (and cheap) way to boost the protein content of meals.

27. Did you find a correlation with frailty and refeeding syndrome throughout your project?

Lara Pasternak: Yes, we have seen a correlation between frailty and refeeding syndrome. We regularly have community frail patients admitted with risk of refeeding syndrome due to chronic poor oral intake prior to admission. Especially those with the progression of dementia and poor oral intake. Some of the refeeding syndrome patients are also malnourished.

28. Health professionals need to differentiate between patients gaining weight due to fluid retention rather than gaining muscle mass

Lara Pasternak: Yes this is true. If a patient has gained weight due to fluid retention this is taken into consideration on assessment and documented in patient's notes. A Subjective Global Assessment is conducted; a validated tool to assess malnutrition, to determine muscle gain and recognise any oedema. This shows the importance of ongoing nutritional monitoring including recording serial weights from admission to assist with the accuracy of muscle gain vs. oedema.

Dealing with the "F" word – Frailty Integrated Care Model – Community Program/Vitality Clinic

Associate Professor Peter Gonski – Geriatrician, Director of Aged Care, Sutherland Hospital

1. **How do you deal with health literacy with this population when developing and implementing these interventions?**
   Health literacy for both health care providers and the community will increase as more interventions and strategies are implemented. Health literacy is maintained by good communication with medical and allied health staff. Plenty of time is given for questions. Paper information and websites are given for further clarification and help. Follow-up is part of the service.

2. **Do you know how much Allied Health input there is?**
   Exercise physiologists do the initial and two follow-up assessments (1hour for new, 0.5 hour follow-up per participant). Exercise classes require two allied health for two hours each session (10 participants)

3. **How long was the intervention in Peter Gonski's program? Could the length of intervention have impacted on the impact on frailty scale?**
   Intervention is 12 weeks. The numbers in the pilot did not affect average frailty scores but some individuals improved by 1 on the score. This frailty clinic is for community dwellers.

4. **How should we add more of these services to RACFs using this approach?**
   A similar service could be and should be provided for suitable participants in aged care facilities. Funding is no doubt the issue.

5. **What is the evidence for grip strength as a deterrent for overall strength!?**
   Grip strength is a marker for overall strength given its limitations i.e. arthritis in hands etc.

6. **Please explain the orthogeriatric model?**
   The Orthogeriatric Model is a shared care approach to the management of elderly patients who are admitted to hospital with acute fractures. Admission is under an orthopaedic team and geriatric medical team from Emergency. The orthopaedic team deal with the treatment of the fracture, the geriatric team deal with any acute or chronic medical issues and subsequent geriatric issues e.g. delirium and the rehabilitation if the patient is suitable.

Strength for Life Model

Kamilla Haufort – Strength for Life Coordinator, Council on the Ageing (COTA), NSW

1. **Great model. When might this include severe frailty model and make transportable for RACF?**
   Hopefully this is one of the questions we will be addressing as part of the Task Force.
   Severe frailty is obviously an important part of the frailty spectrum.
   SFL Tier 1 is suitable for severely frail people as they are run by allied health.
   We would love to partner with RACFs to bring the program to residents, this is already happening in South Australia where COTA works with several of the big age care providers, including ACH, ECH and Lifecare.

2. **Can COTA lobby the government to increase the Enhanced Primary Care sessions to at least 10 treatments for Allied health in a calendar year?**
   I will put this to our policy/advocacy officers, however, here is the link to our recent pre-budget submission
   https://www.cotansw.com.au/COTA%20Pre%20Budget%20Submission%20202021.pdf

3. **How is Strength for Life funded?**
   It is part funded under the Sport Australia Better Ageing grant, however, it only covers basic operation and part of the funding agreement requires us to operate as a social enterprise and thereby charge for training and licencing albeit small fees. We work with implementation partners such as leisure centre, gyms, physio/EP clinics, mobile instructors operating out of community centres. These providers sign agreements to keep the cost affordable but it also needs to cover their costs.

4. **Can you clarify the index you use to assess - was it 'free & frailty'?**
   Most of our program use a selection from the older adult's fitness test battery to measure function and balance.

5. **COTA - What a great model to apply not only to our aged population, but middle aged upwards in frailty intervention. Can you do this?**
   Absolutely, Strength for Life is for anyone over the age of 50 and certainly does not have to be only frail older adults, the intention is to prevent frailty and particularly our tier 2 providers will service this population group. This question points out the importance of frailty being potentially present at any age. However, most people working in this area start with an arbitrary cut off in order to achieve some change and later tackle the younger groups. Maybe the same approach is appropriate for the younger groups. Little work as yet apart from stating the problem that, yes, it does occur in younger people.

6. **Understanding that at least 70% of people diagnosed with dementia continue to live in the community how is this taken into account when undertaking a program?**
   We touch on Dementia in our training workshop and we have meet with Dementia Australia and are looking at developing a re-accreditation module for our providers around Dementia, so they will have a better understanding of how to understand this complex condition when delivering the program.

7. **Given the overwhelming evidence of the benefits of physical activity to enhance health. Why aren't we finding ways of redirecting existing resources to this?**
   This question is important and one I believe the work of the Task Force will result in a major shift of resources around patient needs and choices. For example, most elderly people with varying degrees of frailty would rather be managed in the community, not in acute hospitals.

   Completely agree, I would love to see more funds provided for community embedded exercise programs, which we know are critical both in the management and prevention of chronic health conditions, as well as support older adults stay connected with others. However, we need to work with what we got and therefore work in close collaboration, we plan to work with NSW Health, TAFE NSW, Primary Health Networks, Local governments, as well as Private providers to ensure there are program available to communities across the state.

Integrated Patient Optimisation Program (IPOP)

Kerry Gourlay - CNS, St George Hospital

1. **Does IPOP integrate with OACCP?**
   Every part of health has its own acronyms. I don't know what these mean. The Frailty Task Force by its very nature has different specialties. We should, where-ever possible, use words. (IPOP) Integrated Patient Optimisation Program. At St George, IPOP can refer to Integrated Care.

2. **Who do you refer to for Physio?**
   The Quick Response Program which is a MDTeam of OT's PT's and RNs post-acute community service in area. If patient out of area, would talk with GP to refer to allied health.

3. **Has there been consideration of the consequences of the proposal to open ACAT to tender on supporting people who are frail in the community?**
   As I don't work with the ACAT I can't comment.

4. **With IPOP, was there any challenges with ethics approval for this and any issues with patients consenting to this intervention?**
   Each patient is asked to consent to program on initial screen. There have not been issues, without consent they are not part of program.

5. **Are there plans and/or have the interventions presented been published in research journals?**
   The two review articles with the lead author Elsa Dent are the ones that we usually refer to. They are recent and have a comprehensive list of references. In summary, there needs to be a lot more research and perhaps we could include this as part of our evaluation strategy.

6. **Can the IPOP be rolled out to people who come in from ED?**
   I know what ED is but not IPOP! Currently reviewing about unplanned surgical patients coming though ED.

7. **Great to have increased my aged care referrals. Who is addressing ongoing struggle for getting services needed to those referred with long waiting lists?**
   See above comments on the inevitability of resource redistribution as the Task Force does its work. Referrals to IPOP are not through MAC. Patients are referred directly though surgeons GPs, RNs and Booking Clerk at St George Hospital.

8. **Question for Kerry- is there any similar assessment for patients under 65???**
   As I work in aged care I'm only screening patients 70+

9. **What type of interventions are offered within the short time the patients have before their surgeries?**
   This could be part of our initial work on elective surgery pre-surgical geriatric review, OT, PT, dietitian, S/W, comprehensive Aged care assessment by RN, fast tracking to rehab prior to surgery, referral to MAC for services ACAT if required, liaising with GP and family, Home visit by RN if living in area, staging Geriatrician to N/H.

Fail proofing

Professor Maria Fiatrone-Singh MD – John Sutton Chair of Exercise and Sport Science, University of Sydney
Sandeep Gupta – Head of Physiotherapy, Balmain Hospital, Rehabilitation Network Co-Chair

1. **Where do you conduct your programs and who are your referrers?**
   The supervised programs we do are at Cumberland Campus in Lidcombe. People self-refer in general, although we can also get referrals from clinicians. However as these are all RCTs, the person needs to consent in any case.

2. **Do you have to do both legs (left forwards/right forwards) for the tandem stance?**
   Maria: Either leg forward is ok. I think testing both legs is really only necessary for one legged stand clinically (for research purposes only one is needed). For the one-legged stand, the balance may be quite different if there is unilateral weakness or knee or ankle instability that affects the time. Generally for the semi-tandem or tandem stand, it is not very different no matter which foot is in front.

   Sandeep: In the 4 point balance test – technically, it is performed with one leg forward based on patient/person preference, not both legs. So to score the 4 point balance test, if the person is able to perform tandem stance for 10 seconds, then they would score at least 3/4. However, there can be a difference between the two legs, therefore, as a clinician, I would do both legs and note down the time for each. When re-assessing, I again would be assessing both legs to note the change (if any) of the legs.

Development and health impact of protein-enriched foods and drinks for elderly people: learnings from a Dutch project for application in Australia

Dr Janne Beeleen – Sensory & Consumer Researchers, CSIRO Agriculture & Food

1. **Why are the protein supplements always in containers that the aged just don't have dexterity to open?**
   I don't know why… often the surface of the lids are too small to grasp and twist really firmly by older people, I sometimes even struggle to open that type of bottles. During the interviews this was one of the biggest frustrations of the elderly; for most other categories

(sealed in soft plastics) they would use scissors to open the package. So for the liquids (juice, dairy drinks and soups) this was something we actually paid attention to in the Cater with Care project: the drinks and soups were produced by the same company and we chose to have a beaker with a "skirt" serving as the seal. At the beginning, the skirt was not as long and it was difficult for older people to open it, so we redesigned the packaging and we intentionally used more material to make sure there was enough surface space to grasp and firmly pull the seal off.

2. **Is it possible to include protein in water to be tasteless like collagen?**
   There are some new technologies that could encapsulate protein so there isn't a flavour, but we would need to see how stable this is and if it would change the mouthfeel of a liquid. Definitely worth looking into.

   I did do qualitative research with elderly who were malnourished and dietitians who were treating malnourished elderly to see what causes could be found, as you may know these vary a lot. From grieve and social isolation, to illness, to just not having appetite, thinking they don't need so much because they are not active anymore (afraid of gaining weight), and sometimes it's related to polypharmacy (including dry mouth), and I'm sure I'm forgetting some other causes now as well.. We know from previous research that you can stimulate older people to eat by placing them close to the kitchen so they can smell cooking odours which leads to salivation, furthermore really simple but effective: dress up the restaurant where they are eating with nice table cloths, some flower decoration, eat with real crockery. This has been shown in at last 1 large trial that it's really effective to get people to eat more.

Research: Improving mouth cleanliness

Dr Jenny Gibney – Speech Pathologist, Nepean Hospital

1. **In my experience many older people have oral thrush which impacts on their taste and motivation to eat effectively.**
   I agree anecdotally, however I have not specifically looked at this within my research. However if a patient has mouth pain or taste changes (think Nilstat coating on tongue) of which oral thrush may be a cause then I suspect yes it does impact eating and enjoyment of eating. Further taste changes as we age, our taste buds tend to prefer sugary types of food rather than savoury which may be why high levels of dental decay is evident in this age group. Future interprofessional studies are required to look at this perspective as nutritional status was not part of our study outcomes.

2. **With oral cleanliness presentation to patients - How do you present this with non-English speaking patients?**
   Our oral cleanliness presentation is not targeted at patients as it was educating nurses on the acute aged care wards. However, independent patients had visual prompts (A3 poster of the oral hygiene routines) in the designated patient bathrooms.

3. **Did improving the mouth cleanliness with nurse training have an impact on hospital acquired pneumonia?**
   In relation to aspiration pneumonia/Hospital Acquired Pneumonia (HAP) this was not an outcome of the studies and as such the discussion has not specifically focused on this topic. It is however acknowledged as a potential consequence of poor oral health. Further studies are required to specifically target this outcome, especially given that HAP is difficult to diagnose definitively given there is conjecture on diagnosing an aspiration pneumonia event as other variables may cause an aspiration eg. vomitus and reflux pneumonitis (Marik et al 2001, Petroianni et al 2006 & Gon Son et al 2017). Therefore the benefits of improving oral cleanliness of these patients still needs to be studied further.

   Although oral hygiene training is reported in professional nurse training across all nursing university courses. Studies have reported unsatisfactory oral hygiene training in relation to direct skill training, particularly in relation to appropriate work positions and assessment of the oral cavity (Mehl et al 2016 & Lewis et al 2018). The researchers in both these studies concluded this lack of education will directly impact the nurse's ability to effectively conduct oral hygiene with their patients. When it comes to amount of time spent on oral hygiene education and practice the majority of nurses appear to have received about 2-3 hours during their university courses and this usually involved self-assessment and web-based learning modules (Mehl et al 2016 & McAuliffe, 2006). Mehl et al also found nurses that had three or more hours of oral hygiene education tended to have more knowledge about oral hygiene than their counterparts who had less than 3 hours.

Revealing dysphagia: swallowing screening and education of frail elderly individuals

Rachel Kingma – Speech Pathology Manager, War Memorial Hospital

1. **Are you prescribing swallowing exercises in conjunction with MBS?**
   Yes, currently those patients who go onto a dysphagia rehab programme following 1:1 dysphagia assessment have an MBS as required.

2. **Do you have a resource you would recommend for a physio to access to help address mild dysphagia in the course of an existing exercise session?**
   I don't have such a resource at present. In that context I'd suggest you speak with their current speech pathologist, or refer them to a speech pathologist if their dysphagia hasn't yet been assessed.

   Additionally to this, you could have a look at the Takatori et al (2016) article for an interesting read on their exercise programme, aimed at pre-emptively targeting falls prevention and aspiration prevention concurrently. They refer to a range of home-practice based exercises that they evaluated in their research, some (not all) of which may prove useful in an exercise context. Although, note that those subjects were elderly and at risk of frailty however did not have diagnosed dysphagia. Your dysphagic patients would need a more tailored programme. I am looking at some other exercises that may prove useful, but they need further research on them before I would feel confident to suggest them to you. [Takatori K, Matsumoto D, Nishida M,et al. Benefits of a novel concept of home-based exercise with the aim of preventing aspiration pneumonia and falls in frail older women: a pragmatic controlled trial. BMJ Open Sport Exerc Med 2016;2]

Supporting advanced care planning for frail residents of aged care facilities

Karen Errington – CNC RACF Outreach Team – Aged, Chronic Care & Rehab, SLHD

1. **How do you work with allied health? Often allied health in RACF are limited. How do incorporate their holistic care in your service?**
   No allied health clinicians in our team. Most RACFs have P/T and O/T employed. RACFs have arrangements with private S/P and dietitians for ongoing review. GP complete Enhanced Care Plan for other allied health e.g. podiatry.

2. **How many people are in your team?**
   SLHD RACF Outreach team members - 2 geriatricians , 0.5 geriatrician, 2 Geriatric Advanced Trainees, 2 TNP, 2 CNC grade 3, 1 CNS 2, 2 RN.

Being your best: an innovative co-designed approach to frailty

Professor Judy Lowthian PhD – Principal Research Fellow & Head of Research, Boston Clarke Research Institute

1. **Can you expand on the options for cognitive stimulations?**
   Cognitive stimulation will include on-line and paper-based activities designed to improve attention, memory, speed of processing, problem solving and flexibility e.g. word games, crosswords, scrabble sudoku, Lumosity, community group activities

NSW Ambulance: a unique perspective

Daniel Simpson – Coordinator, Integrated Care, Clinical Systems Integration, NSW Ambulance
Lauren Cowgill – Extended Care Paramedic Program Coordinator & Clinical Educator, NSW Ambulance

1. **How do ECP know who to refer to if they need any multidisciplinary referrals? E.g. how do they know if they can refer straight to a clinic etc.?**
   Alternate referral destination pathways have been formalised with NSW Ambulance and participating teams. ECPs will also work with the patient and any community or non ED plans that the patient has. An example would be a patient who has a COPD community plan. An ECP would contact this team if they were to attend this patient and the patient fit within the plan.

2. **Can you provide an example of a patient you had and what you did?**
   Answered on the day. But a general example would be a palliative care patient. We would attend this patient and depending on their cognitive status either work with the patient or the patient's carer/family to continue with their palliative care plan. This may also involve contacting the palliative care team and discussing treatment options or direct referral bypassing ED if deemed necessary.

3. **Is it just ECP's that identify frailty and link into appropriate services?**
   At this stage ECPs are best equipped to do so but NSW Ambulance has just made this area a mandatory training package for all NSW Ambulance Paramedics. Training commenced in February and will remain in focus for the next 18 months (we have 4000 paramedics to train).

4. **Thank you to extended care paramedics for being able to come and redo a catheter for my dad several times.**
   Our pleasure.

5. **What if you review the patient and they don't need to come into hospital but you identify the need E.g. Intensive physio & speech pathology. How do you involve?**
   Response by Carla Sunner: We have an arrangement with the Laverty pathology that even though they aren't an emergency service they will take bloods within 3 hours with a request form, any other allied health can be done visually from the ED, there may be private clinicians that do home visit for Speech therapy HNE LHD do this would be escalated through the GP in an emergency situation we would link up with telehealth if we could. Physios as previous stated.

   Response from Lauren Cowgill: We would in the first instance make contact with the identified need and discuss the patient's presentation and appropriateness for a referral. This may depend on urgency and capacity of the receiving team. This is always done with the patients consent and where they have a regular GP we will always inform the patient's GP.

PACE-IT – Partnerships in aged care emergency services using interactive telehealth

Carla Sunner - PACE-IT Project Manager, Hunter New England Nursing & Midwifery Research Centre

1. **There is very little allied health in RACF. How do you tackle this?**
   We utilise the extended care paramedics (ECPs) a lot and liaise with a private physio that will go out and apply and remove back slabs/plaster if the resident can pay. We are predominately looking at falls injuries in the acute stage. This availability is difficult in country areas with the addition of visual telehealth we can provide expert clinical advice visually to educate and empower others.

Interstate perspective - End PJ Paralysis

Eleanor Sawyer – Project Lead: Care of the older person clinical Network, SaferCare Victoria

1. **Interested in how hospitals dealt with additional time taken to dress patients and then change them back into PJs at end of day.**
   Many wards saw that the time invested in helping patients to dress and to mobilise meant that they would not be as heavy in a few days' time (with increased nursing needs for continence, feeding etc.), so it was worth it in the long run.

2. **Do you think the nursing staff would be able to manage the increased changes of clothes for patients if many need help to change when unwell?**
   The sites were able to manage the increased changes of clothes. Some utilised families to help (if appropriate), or Health Assistants in Nursing.

3. **How did acute ward services manage with clothes if they had a lot of attachments?**
   The wards encouraged patients to wear shirts that were button up or loose fitting to enable space for attachments. If a patient had a catheter, they would either use a leg bag and loose track pants, or thread the catheter over the top of their waist band.

4. **Did you see a decrease in the amount of hospital gowns used on wards?**
   Yes, there was a decrease in the amount of gowns used on the wards.

5. **Do you think hospital volunteers could work in well with helping patients/staff with changing in/out pjs?**
   You would need to work with your volunteer coordinators, and check your insurance regarding if that is in their scope of practice at your facility. Many wards in Victoria encouraged family members to support patients to put on clothes as appropriate.