FIRST CONTACT PHYSIOTHERAPIST(FCP) AND FRAILTY IN GENERAL PRACTICE

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ROLE OF FCP IN PRIMARY CARE

- Patient has a Musculoskeletal (MSK) problem
- Patient contacts GP practice and is given appointment with FCP
- Patient is assessed and may be:
  - Given advice
  - Given analgesia
  - Given exercises to commence
  - Referred for bloods
  - Referred for imaging
  - Referred onwards

MSK PHYSIOTHERAPY

1. Physiotherapy helps restore movement and function when someone is affected by injury, illness or disability.

2. The profession helps facilitate recovery in injured/ deconditioned people, enabling them to remain independent for as long as possible.



Older people are defined as those age 65 years or over

- Frail older people are defined as: older people with complex needs, typically with multiple co-morbidities and often a combination of physical disability and cognitive impairment.

- Frailty: syndrome of shrinking, slowing, and weakness with low activity and energy.

How can an MSK assessment identify frailty?

Silver book recommendations for assessment of frailty in the first 24 hours of accessing urgent care:	
Pain	Delirium/ dementia
Depression	Nutrition /Hydration
Skin integrity	Sensory loss
Falls and mobility	Activities of daily living
Continence	Vital signs
Safe-guarding issues	End of life Care

Physios typically have input into the highlighted areas in normal MSK assessment but to variable degrees.	
Pain	Delirium/ dementia
Depression	Nutrition/ hydration
Skin integrity	Sensory loss
Falls and mobility	Activities of daily living
Continence	Vital signs
Safe- guarding	End of life care

Recognising frailty in Subjective assessment

HPC – identifies symptoms like pain, sensory loss, dizziness, cognitive function, cause, e.g. falls

Aggravating / easing factors – indicate impacts on normal function.

Differential questions: help identify problems as either local or more global.

PMH and DH - presence of co-morbidities and medications that impact the frail.

Mandatory questions - identifies continence issues, fatigue levels, general health, weight loss or gain

SHx - Functional level and physical activity level, need for assistance, safeguarding issues may come to light.

Recognising frailty in Objective Examination

- Observe physical appearance – loss of muscle bulk, wasting, swelling, redness, bruising, ability to move freely, balance, proprioception. Difficulty with hearing, vision. Loss of sensation identified by burns or marking on skin. Skin changes – hairlessness, palor, dryness, shining, ulceration

- ROM – are there restrictions in movement, is it confined to one joint or multiple

- Strength – detecting weakness

- Neurological assessment – detects sensory loss, potential mobility problems.

- Palpation – pain local or general

Identifying the Pre-frail

Early Signs that indicate frailty more likely :

"Various frailty classifications exist, but most widely cited is the frailty phenotype described by Fried and colleagues,[6] which defines frailty as the presence of three or more out of five indicators: weakness (reduced grip strength), slowness (gait speed), weight loss, low physical activity, and exhaustion. People with one or two indicators are classified as pre-frail. "

Frailty and pre-frailty in middle-aged and older adults and its association with multimorbidity and mortality: a prospective analysis of 493 737 UK Biobank participants
Citation DataThe Lancet Public Health, ISSN: 2468-2667, Vol: 3, Issue: 7, Page: e323-e332
Publication Year2018

Clinical frailty scale - an easy-to-use APP

CFS 9 levels of frailty

7-9: Severely frail - think about supportive care rather than cure.

6: Moderately frail - actively seek out and manage frailty syndromes, e.g. Falls.

1-5: Fit/mildly frail – Care as usual but address reversible issues.

PREDICTORS OF FRAILTY



Low physical activity



Loss of muscle mass



Dietary intake:

- Low energy intake: <21kcal/kg
- Low serum micronutrients –Vit D, E, Folate, carotenoids
- Low protein intake
- >3 nutritional deficiencies

Fried 2001, Batali 2006, Semba 2006

Frail Older Adults can Increase muscle Mass, strength and exercise tolerance:

Via exercise programs and community-based approaches to enhance usual physical activity

These increases result in improved performance on objective measures, e.g., get up and go test and can reduce frailty and disability.

What can FCP do to address frailty?

Prevention better than cure – Encourage all patients to look at physical activity levels and make changes where possible to meet DOH minimum recommendations:

Aim to be active daily

Over a week this should amount to 2.5 hours of moderate intensity exercise. E.g., 30 min bouts 5 days a week.

Moderate intensity exercise should make the individual, warmer, breathe harder and increase heart rate, but they should still be able to converse.

How much activity should I be doing each week?

For a healthy heart and mind complete

75 vigorous intensity minutes of running or sport



OR

150 moderate intensity minutes of walking or swimming



AND

In addition 2 days per week of



Gym Pilates Dance Tai Chi

To keep your muscles, bones and joints strong and reduce your chance of falling

Don't forget the aim is to sit less so doing something is better than doing nothing!

Quick guide:
visual reference

01761 471771

For full Expert Consensus Statement visit **nos.org.uk/HCPexercise**

Key recommendations: physical activity and exercise for osteoporosis

Strong

Build bone and muscle strength

Weight-bearing/impact exercise for bones

50 impacts per session

Frequency
Most days

With osteoporosis
Moderate impact



Lower impact



Low impact - weight bearing



Frequency
Most days

Build up gradually

Build muscle

Frequency
2-3 days / week

Weights & resistance bands





3 sets, 8-12 reps of max weight

Progressive resistance training

Sports and everyday activities



Vertebral or multiple fractures, or less able

Some extra caution
Exercise up to lower impact
Individualised advice
Ensure safe technique



Steady

Improve balance

Activities like tai chi or dance



Frequency
2-3 days / week

Or a challenging balance class



Positive approach

Reassurance - 'how to' not 'don't do'

Benefits of exercise for osteoporosis



Keep active
– something is better than nothing

- Build bone and muscle strength
- Improve balance
- Improve pain, posture and movements

Aiming for fewer fragility fractures and improved wellbeing

Straight

Improve pain, posture and movements

Manage pain from vertebral fractures

Daily back muscle strengthening exercises



Frequency
Daily



Improve posture and movements

Learn safe moving and lifting



Hip hinge for safe bending



Posture exercises



Frequency
2-3 days / week

Use alternatives

Extreme or loaded flexion



Avoid

Inactivity and prolonged sitting



What can FCP do to address frailty?

1. refer patient to online resources. - e.g. Move with Mary videos on you-tube

2. Signpost patients to local council run facilities

3. Provide keeping well at home booklet

https://www.publichealth.hscni.net/sites/default/files/2021-03/Keeping%20Well%20at%20Home%20Dv.01-NI%2019%20June%202020-WEB.pdf

4. Direct to local walking groups, community associations, etc

5. refer to GP, MDT secondary care.

Being busy is not the same as being physically active.

Exercise is like medicine – the “dose” is important for maximum positive impact.

Where can frail patients be referred to in the SEHSCT?

Physiotherapy	(CCG) MSK problems Respiratory problems Continence problems Walking aids Community rehab Falls prevention
Occupational Therapy	(CCG) Aids and appliances Rehab Home adaptations
Podiatry	(CCG) foot care and health

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Where can frail patients be referred to in the SEHSCT?

Strength and Balance Referral Form

For Clients aged 65 years and over – use with algorithm overleaf

*under 65 years will be considered by the services on an individual basis

Client HCN		Date of Birth	
Client Name		GP	
Address Post Code		GP Address	
Telephone/Mobile			
Relevant Past Medical History (PMH)			

Inclusion Criteria:	YES	NO
Client lives within the South Eastern Health & Social Care Trust area, is aged over 65 years and has a history of falls/ fear of falling/ unsteady when walking?		
Client is medically stable?		
Client has **none** of the contraindications to exercise below? • Unstable Angina • Resting SBP >180 mm Hg or resting DBP > 100 mm Hg • Tachycardia >100 bpm • Acute illness (e.g.flu, infection) • Unstable diabetes • Uncontrolled Dizziness • Significant drop in BP during exercise • Unstable or acute heart failure • Recent injurious fall without medical examination		
Have all medical investigations been completed?		
Is client committed to participating in an exercise programme?		

Functional Tests

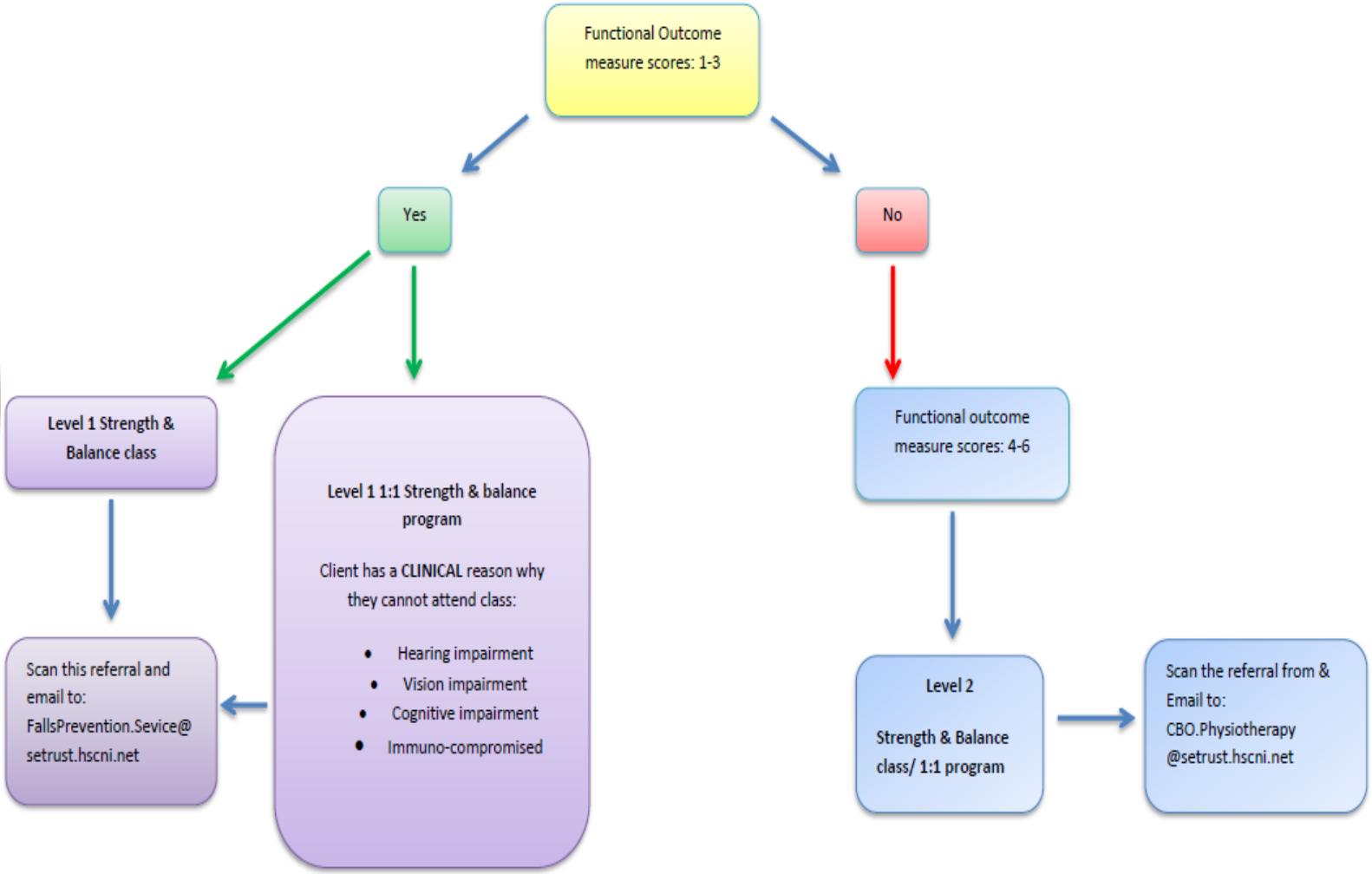
1	2	3	4	5	6
Timed Up and Go Test		Time taken (secs):		Walking Aid:	
Able to rise from the chair easily, walk unaided, turn without dizziness or stumbling. Faster than 8 seconds	Able to rise from the chair without arms, walk unaided, turn without stumbling. Between 9 and 15 seconds	Difficulty on rising from chair, walks aided or unaided but takes between 16 and 24 seconds	Difficulty on rising from chair, walks aided or unaided but takes between 25 and 40 seconds	Difficulty on rising from chair needs walking aid, unconfident or dizzy turning- or takes over 40 seconds	Unable to rise from chair, walk or turn without help
180° Turn		Number of steps taken:			
Able to turn safely in 4 steps or less	Able to turn safely in 6 steps or less	Able to turn safely in 8 steps or less	Needs close supervision and verbal cueing for safety. Takes 9-12 steps	Needs assistance from 1 person or furniture to turn	Needs assistance from 2 people to turn
Functional Reach		Distance reached (cms):			
Reaches >35cm	Reaches 25-34cms	Reaches 16-24cms	Reaches 10-15cms	Reaches <10cms	Unable or afraid to reach forwards

Referral to	Level 1	strength & balance class	NDA [ ]	Downe [ ]	Lisburn [ ]
	Level 1	1:1 strength & balance programme *Please state clinical reason for 1:1 programme*	NDA [ ]	Downe [ ]	Lisburn [ ]
	Level 2	strength & balance class	NDA [ ]	Downe [ ]	Lisburn [ ]
	Level 2	1:1 strength & balance programme	NDA [ ]	Downe [ ]	Lisburn [ ]

Strength and balance class referral form

Where can frail patients be referred to in the SEHSCT?

Strength and Balance classes



Where can frail patients be referred to in the SEHSCT?

Tissue Viability service – takes referrals form MDT

Lymphoedema service – takes referrals from MDT

Falls class - (G.P. or patient self referral)

65 or older
lives in SEHSCT area
12-week rolling program.

Ards/ Bangor/ Comber
Downe/ Castlewellan

WHERE CAN PATIENTS BE REFERRED TO IN THE SEHSCT?

For patients with dementia who live in the community a falls class is not suitable.

The falls team can do home visits for such patients.

The patient must have a relative or friend available who will be able to help patient with recommended exercise regime.

Telephone number of friend/ relative should be on referral.

The falls team can offer potentially 2 home visits

WHERE CAN FRAIL PATIENTS BE REFERRED TO IN THE SEHSCT?

STAT: short term assessment team

- staffed by Physio and OT

- Patients must be 65+

- Referrals are accepted for those patients who are at risk from falling

- Aim is to prevent hospital admission or to facilitate timely discharge

- Patient, family, GP, FCP can all refer patient to service

- For SEHSCT staff referral forms can be accessed on I-connect under forms – older people short term assessment team – referral either for North Down and Ards (NDA), Lisburn or Downe areas.

- In primary care referral letters can be emailed to:
  - OlderpeopleSTAT.Down@setrust.hscni.net
  - OlderpeopleSTAT.NDA@setrust.hscni.net
  - olderpeopleSTAT.Lisburn@setrust.hscni.net

Where can frail patients be referred to in the SEHSCT?

Reablement - service run by occupational therapy

OT lead and reablement support worker
Service offers assessment within 3 days of referral or discharge form hospital.
Patients must be 65+
Must require a support package or an increase in current package

Refer to reablement in SEHSCT:

North Down & Ards Area

Finance Building
Ards Hospital
Newtownards BT23 4AS
Tel: (028) 91510250

Down Area

Ward 22
Domicilary Care Services 1st Floor
Downshire Estate Ardglass Road Downpatrick BT30 6RA Tel: (028) 44838278

Lisburn Area

Level 1
Lisburn Health Centre
Linenhall Street
Lisburn
BT28 1LU
Tel: (028) 92633735

Where can frail patients be referred to in the SEHSCT?

Day hospital LVH – staffed by physiotherapy, nursing and OT services. Team meet x 1 a week with consultant in elderly medicine to address patient issues.

Nursing:	checks bloods does medicines management addresses postural hypotension continence issues, provides simple dietary advice organizes onward referrals Arranges district nursing
Physio:	assesses mobility with appropriate provision of aids falls prevention strategies exercise education appropriate rehab goals set
OT:	checks functional and cognitive status assessment of ADLs – e.g. kitchen toileting assessments orders appropriate equipment arranges handrails and adjustments

Where can frail patients be referred to in the SEHSCT?

The Rapid Assessment Centre (RAC) is located on the first floor in the Downe Hospital.

It is a facility that accepts referrals from all qualified health care professionals General Practitioners, District Nursing, NIAS Paramedics AHPs and Specialist Medical and Community Services.

The aim of the unit is to offer same-day assessment and treatment to older patients with a medical need and prevent unnecessary ED attendances and hospital admissions.

The service will provide timely, local medical assessment and a better patient experience rather than travelling to the UHD ED.

RAC REFERRAL CRITERIA

- **Patient Inclusion Criteria**
  - Patients referred must be resident in the South Eastern Health Trust Area **AND** would normally have been transported to the Downe or Ulster Hospitals
  - Patients should be > 65 years
  - Frailty Syndrome, Falls, Reduced Mobility
  - Delirium
  - Thrombo-embolic disease: Lower limb DVT, Low risk PE, Pleuritic chest pain
  - Clinical Covid 19 patient with **CFS*** > or equal to 5.
  - Community Acquired Pneumonia
  - Chest Infection
  - Exacerbation of COPD
  - Infective Exacerbation of Bronchiectasis

RAC REFFERAL CRITERIA cont.

Patient inclusion criteria

- Cellulitis of limb
- Urinary Tract Infection
- Pyelonephritis
- Exacerbation of Heart Failure
- Uncontrolled AF
- Hypertension
- Anaemia
- Atraumatic headache
- Dehydration

RAC REFERRAL CRITERIA cont.

Patient exclusion criteria

Acutely, unwell patients, for whom HDU/ITU management would be considered. These patients are likely to need immediate resuscitation or for those who would normally require standby should be transported directly to the Ulster Hospital ED

The following patients should be transported directly to the UHD ED:

- Suspected Covid-19 infection in a non-frail adult
- Acutely unwell patients, likely to need immediate resuscitation or for those who would normally require standby
- Patients with an acute surgical presenting complaint
- Patients with a gynae/obstetric presenting complaint
- Patients with a suspected stroke or TIA (FAST positive)
- Patients with suspected heart attack, fracture or GI bleed

RAC REFERRAL CRITERIA cont.

Patient exclusion criteria cont:

- Patients with tracheostomies
- Patients with traumatic injuries
- New pain in a prosthetic joint.
- Suspected DKA
- Suspected or confirmed Neutropenic Sepsis
- Anyone under the age of 65, unless *CFS > or equal to 5.

One Stop Assessment clinic in Ulster Hospital – Similar purpose and referral system to RAC

Home safety checks

- Home safety checks are available in Lisburn and Castlereagh Council (LCC) and Newry Mourne and Downe District Council.
- Checks are free
- Service users must be over 65
- LCC – will supply where appropriate equipment to make home safer.
- Ards and North Down – home safety checks suspended during covid pandemic and not yet operational again.

QUESTIONS?