Effective Care Planning

Selwyn Foundation Conference 2017

Dr Michal Boyd, RN, NP, ND, FCNA(NZ), FAANP
The University of Auckland
School of Nursing

What is a “CARE PLAN”?

- Coordinated, problem solving approach
- Documenting:
  - The identified problems or health promotion needs
  - Individualised interventions
  - Goals of interventions
  - Reassessment of intervention effectiveness

Age Related Residential Care Services Agreement

Key points relating to Care Plans are:

- Based on initial assessment that includes:
  physical, psycho-social, spiritual and cultural aspects.
- Documented by an RN within three weeks of admission
- Considers the experiences and choices of the resident.
- Provides the resident and family/whānau input
- Addresses needs/deficits and personal preferences and individual habits, routines and idiosyncrasies
- Addresses personal care needs, health care needs, rehabilitation/habitation needs, maintenance of function, and care of the dying

2008 Health and Disability Services Standards

- Plans are individualised, accurate and up to date
- Describe the desired support and/or intervention to achieve the desired outcomes identified by the on-going assessment process
- Demonstrate service integration
- For mental health consumers, they show early warning signs and relapse prevention
- Are communicated in a manner that is understandable to the consumer and service provider responsible for the implementation and with consent their family/whānau of choice.

Your poll will show here

1

Install the app from pollev.com/app

2

Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help

or

Open poll in your web browser

Your poll will show here

1

Install the app from pollev.com/app

2

Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help

or

Open poll in your web browser

Care Plan Translation Issues

- Length of the care plan (e.g., 15 to 20 pages)
- Listing of routine assessments or basic elements of nursing practice in the care plan
  - E.g COPD: Listed routine assessment parameters: respirations, color, cyanosis, dyspnea, and wheezing, rather than as “assess respiratory status” (RN/EN) or “monitor respiratory status” (HCA)
  - Lack of prioritsation of problems
- Redundancy in interventions relevant to multiple problems
  - “observe for signs and symptoms of hypoglycemia or hyperglycemia” for three different problems (e.g., diabetes, nutrition, falls) on the same care plan.
  - Variability in the language used for care plan problems
- Not all together and not easy to find

Adams-Wendling L, Piamjariyakul U, Bott M, Taunton RL, (2008). J Gerontol Nurs. 34(8): 50–56.

Dellefield, Interdisciplinary Care Planning and the Written Care Plan in Nursing Homes: A Critical Review. *Gerontologist* 2006; 46 (1): 128-133.

Care Planning
Recommended Best Practice

- Make it achievable.
  - realistically aimed at either improving or maintaining the resident's level of health and independence with the available interventions and resources.
- Make it understandable.
  - not the one with the longest words and technical jargon but the one written in such a way that all staff, especially caregivers, can understand
- Make it comprehensive.
  - CAPs and Outcome Measures highlight the areas where intervention will make a difference
- Make it collaboratively.
  - Do the resident and their family/whānau fully understand and agree?

5 Steps to Writing a Nursing Care Plan

1. Collect Information
2. Analyse
3. Think About How
4. Translate
5. Transcribe

https://www.nrsng.com/writing-nursing-care-plan/

Step 1: Collect Information

- Get information from all sources together
  - InterRAI assessment
  - Your head to toe assessment
  - Conversations with patient and loved ones
  - Observations (lab values, vital signs)
  - Chart review and notes
  - Discussions with health care team members

Step 2: Analyze

- Look at all information
- Include triggered CAPs and interRAI subscales
- What are areas in which this resident has trouble and therefore needs to progress in?
- Think about the ways you could see the resident improving and how you would know they were improving
- Write down the general issues, how you'd help them progress in that area, and how'd you'd know they were progressing
- PRIORITISE THE PROBLEMS TO THE MOST IMPORTANT FOR THAT RESIDENT

Step 3: Focus
How do you know this is a problem?

- Think about ***how*** you knew these were issues -
  - E.g. How did you know he was in pain? Did he tell you? Did you observe it? Was he getting pain medications? Assessment tool results?
- Related Factors - Add any issues that positively or negatively affect the problem
- What can be done to make this better? (Interventions)
- How would you know it got better? (Evaluation)

Step 4: Translate

- Expected Outcomes - Add the resident's goal for this area
  - Add any individualised issues for that resident
- Use a resource to look up best care for problems
  - E.g. RN Care Guides
  - Facility policies and procedures
  - Use standardised resources help for standard problems
- Look up the official terms for the problem(s) and write them down
- Look up outcomes and interventions that may align with what you identified as problems

Step 5: Transcribe

- Use a template for common issues and then individualise it for specific resident issues
- Scheduling - Identify the ‘when, how, who, and what’ of the ‘Interventions’
- Put the pieces together (problem + related to factor(s) + defining characteristics and ”hows”)
- Write out your interventions and outcomes and evaluation

InterRAI CAPs

Decide which ‘CAPs’ will be included in the Care Plan

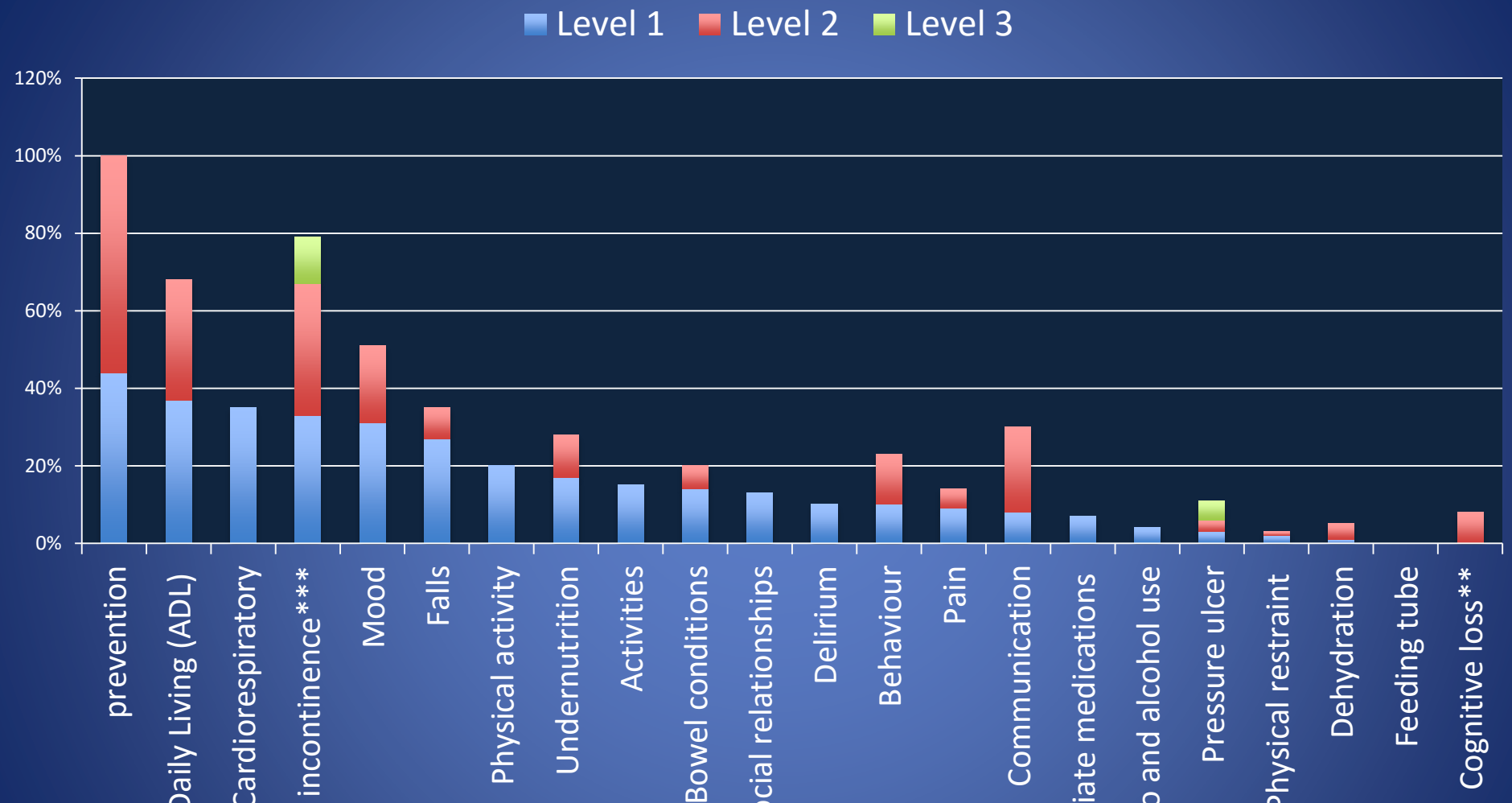
- At what level – 1,2,3 or high, medium or low
- Identify ‘CAPs’ to be included in the Care Plan by ticking the box ‘Addressed in Care Plan’
- Include reasoning in text box for each cap included in the care plan

Include a ‘CAP’ in the Care Plan to:

- Resolve the problem
- Reduce the risk of decline
- Utilise potential for improvement

- Not all triggered ‘CAP’ have to be included in the Care Plan
  - However, the reason a triggered CAP is not included is to be documented in the ‘Assessment Summary’ text box

2015-16 InterRAI Triggered CAPs



https://centraltas.co.nz/assets/interRAI/2015-16-National-interRAI-Data-Analysis-Annual-Report.pdf

Prevention

- The prevention CAP is almost always triggered in New Zealand.
- This is because the time frame for a resident to be seen by a General Practitioner (GP) is longer than international standards
- Make a note on the outcomes page why it isn’t included because it was triggered

Activities of Daily Living Data Collection

- Ability to dress, perform personal hygiene, walking, toileting, changing position in bed, and eating

- Level 1 – Facilitate improvement
- Level 2 – Prevent decline

ADL (Activities of Daily Living) Self-Performance Hierarchy Scale

- Groups ADL performance levels into discrete stages of loss
  - early loss: personal hygiene
  - middle loss: toileting and locomotion
  - late loss: eating

ADL Hierarchy Scale

- **0–6**
- Higher scores indicate greater decline (progressive loss) in ADL performance.

ADL Long Form

The ADL Long Form is more sensitive to clinical changes than the other ADL scales.

- **0–28**
- Higher scores indicate more impairment of self-sufficiency in ADL performance

  - Personal hygiene
  - Dressing upper body
  - Dressing lower body
  - Locomotion
  - Toilet use
  - Bed mobility
  - Eating

Analyse

- What could be improved?

  Hartford Institute for Geriatric Nursing

  Consultgeri: https://consultgeri.org

- What needs to be maintained?
- What does the resident want?
- What does the family want?
- What does the team think?

Working Through Triggered CAPs: Activities of Daily Living (ADLs)

Problem	Goals	Triggers	Guidelines
(Facilitate Improvement) Need assistance with tasks such as dressing/bathing/eating And appear to have some acute even t which could be reversible. **(Prevent Decline)** Receive assistance with ADLs and not likely to be reversible	Preserve current level of independence as long as possible Address acute problems to reverse functional loss Improve performance if functioning below capacity Target ADLs where improved capacity is possible	**Facilitate improvement)** Receive help in some ADLs but not totally dependent 2 or more indicators of an acute event **(Prevent Decline)** Same as above but less than 2 indicators for acute event	**(Facilitate Improvement)** Manage the acute onset problem and work to return the person to their pre- acute functioning level if possible **(Prevent Decline)** Develop a plan that maintains current level of independence Watch for acute health problems and treat as soon as possible

Risk factors that can should be addressed in Care Planning

- Risk factors for functional decline include
  - injuries
  - acute illness
  - medication side effects
  - pain
  - depression
  - malnutrition
  - decreased mobility
  - prolonged bed rest (including the use of physical restraints)
  - changes in environment or routines.

How could this be done?

- Encourage the resident to make choices (e.g. clothing, time for bathing, method of bathing, time to get up, etc.).
- The resident will be encouraged to perform self care with ADL's with supervision, independently, or with limited assistance, etc.
- If the resident shows change in level indicated on the care plan report to the nurses.

Translate/Transcribe Example

- Encourage the resident to make choices (e.g. clothing, time for bathing, method of bathing, time to get up, etc.)
- The resident will perform self care with ADL's with supervision, independently, or with limited assistance, etc.
- If the resident shows change in level indicated on the care plan report to the nurses

Translate/Transcribe

- Encourage activity, including routine exercise, range of motion, and ambulation to maintain activity, flexibility, and function
- Judiciously use medications, especially psychoactive medications
- How much, how often, by whom?

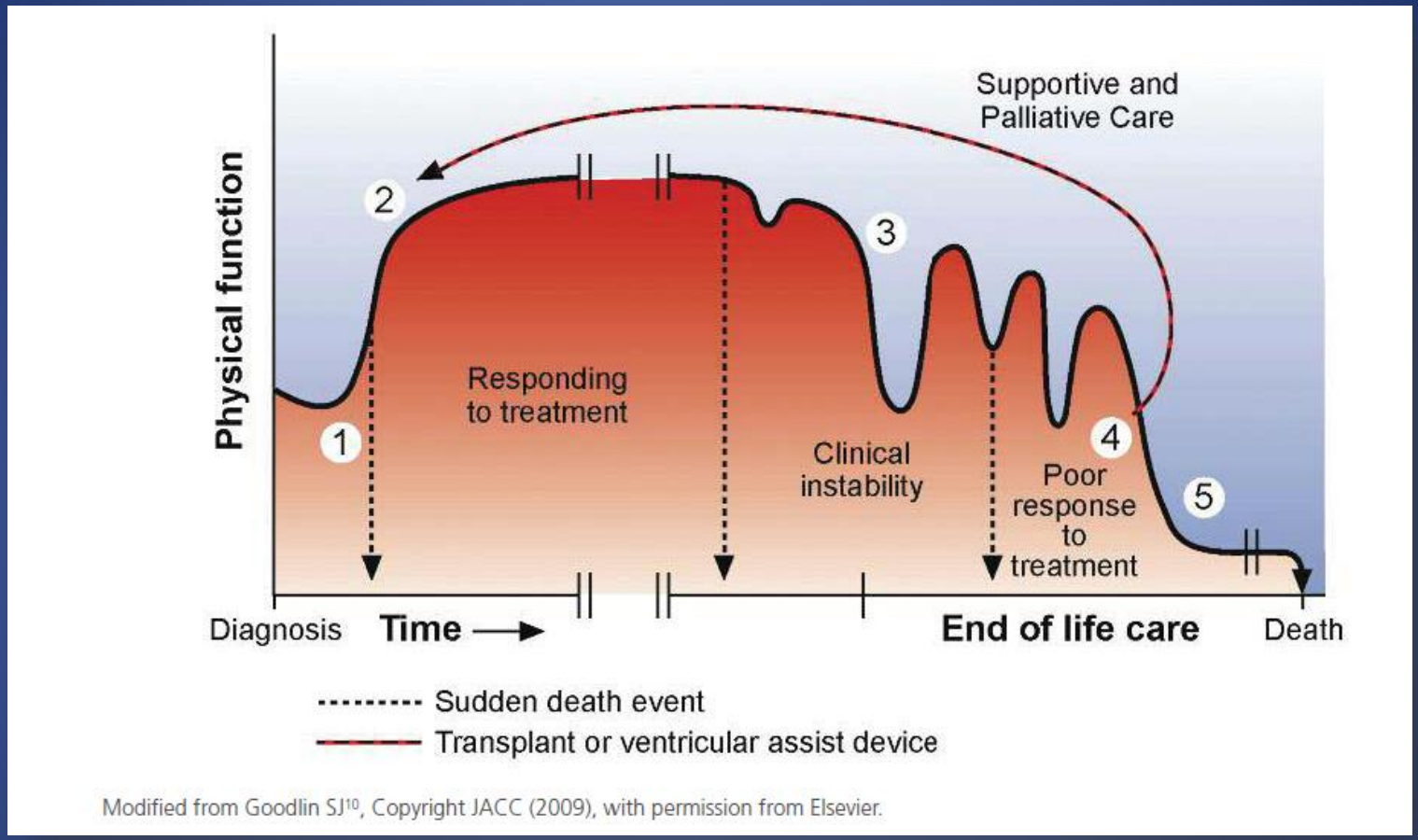
Outcome Examples

- Maintain safe level of ADL and ambulation
  - As evidenced by ADL Long form
  - Timed up and go
- Make necessary adaptations to maintain safety and independence, including assistive devices and environmental adaptations
- Strive to attain highest quality of life despite functional level

Cardiorespiratory

- Most often triggered CAP
  - Congestive Heart Failure
  - Pneumonia
  - COPD
- Care planning Step 1: Gather data
  - What are the signs and symptoms?

Heart Failure (CHF) Disease Course



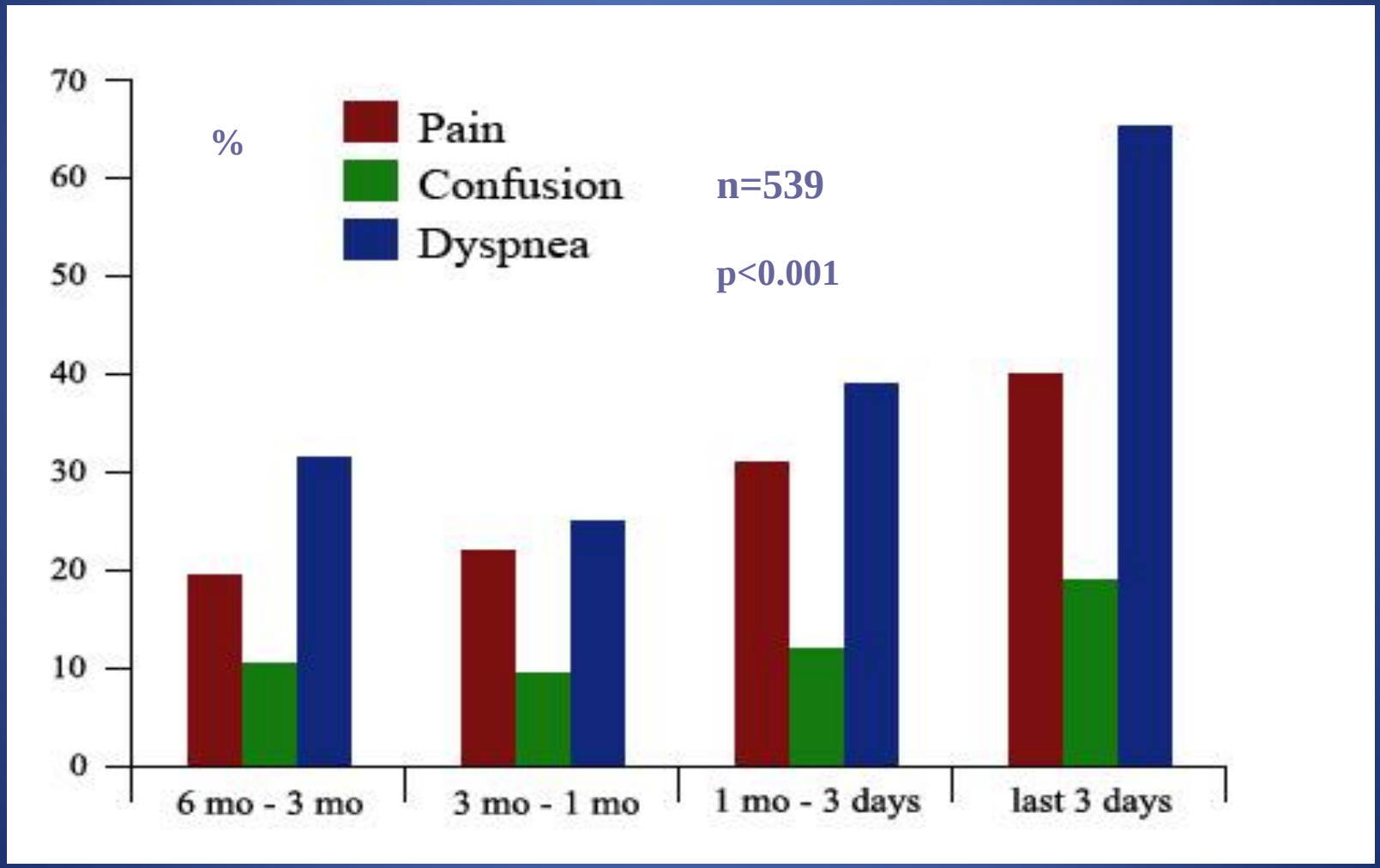
Modified from Goodlin SJ[10], Copyright JACC (2009), with permission from Elsevier.

Grade 1 and 2 – median survival 5 years

Grade 3 and 4 – median survival 1 year

5-year mortality rate 75% after 1st hospital admission

The last six months of life for patients with congestive heart failure



Levenson JW et al. *J Am Geriatric Soc* **45(5 Suppl):S101, 2000**

31

Heart Failure Pain

- Pain inadequately dealt with in 90% of people with CHF
- Angina 41-77%
  - Treated with anti-anginals, stenting
- Abdominal pain due to liver capsule stretching
  - Treated with diuretics
- Opioids first-line agents for moderate to severe pain
    - No NSAIDS
    - Methadone prolongs QT interval

Ward C. The need for palliative care in the management of heart failure. Heart 2002;87:294–8

CHF and Fatigue

- Treat underlying causes
  - Anaemia, infection, dehydration, electrolyte abnormalities, low nutritional intake, thyroid dysfunction, depression, sleep apnoea

- Non-pharmacological techniques
  - physical therapy/exercise (esp. for muscle wasting)
  - training in aerobic exercise
  - energy conservation

Cardiac Advanced Care Planning
RN Care Guides

- Palliative Care Approach Consideration

Palliative care should be considered for patients with the strong possibility of death within 12 months and who have advanced symptoms e.g. NYHA Class IV, and poor quality of life, resistant to optimal pharmacological and non-pharmacological therapies. Strong markers of impending mortality include.

- Advanced age
- Recurrent hospitlisation for decompensated heart failure and/or a related diagnosis
- NYHA Class IV symptoms
- Poor renal function
- Cardiac cachexia
- Low sodium concentration
- Refractory hypotension necessitating withdrawal of medical therapy

34

Heart Failure – Fluid Overload

Evidenced by:

- Orthopnea
- Oedema
- JVD >3 cm
- Weight gain
- Respiratory distress
- SOB with activity
- Crackles lung bases
- Anxiety
- Poor appetite

Interventions:

- Weigh daily
- Assess for increased JVP/Oedema
- Change position frequently. Elevate feet when sitting. Inspect skin surface, keep dry, and provide padding as indicated.
- Assess lung sounds and SOB daily
- Provide small, frequent, easily digestible meals
- Consult with dietitian
- Collaborate wit NP/GP regarding medication adjustments

Your poll will show here

1

Install the app from pollev.com/app

2

Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help

or

Open poll in your web browser

Prognostic indicators of Chronic Obstructive Pulmonary Disease mortality

- Very severe airflow obstruction
  - FEV1 < 30 per cent of predicted.
- 2 or more severe exacerbations and hospital admission in the preceding year.
- Housebound by disability
  - Reduced activities of daily living.
- BMI <20 and weight loss.
- Established respiratory failure or previous ventilation for respiratory failure
- Receiving long-term oxygen therapy
- Evidence of cor pulmonale

Scullion J, Holmes S (2011)Nursing Older People. 23, 4, 32-39[37]

COPD Pain

- Chest pain is often reported by people with COPD

- May be caused by respiratory muscle hypoxia and/or musculoskeletal problems which are common in inactive older populations

Kelly, C. (2009) An overview of acute exacerbations of COPD. *Nursing Times;* 105: 13

Breathlessness

Inhalers

- Bronchodilators
- Positioning
- Fans

Anxiolytics

Opiates

- Codeine 30 mg TID (cough suppressant)
- Morphine 5 mg q 4 hours - should be low dose

Managing breathlessness in palliative care. BPJ 47 October 2012

Your poll will show here

1

Install the app from pollev.com/app

2

Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help

or

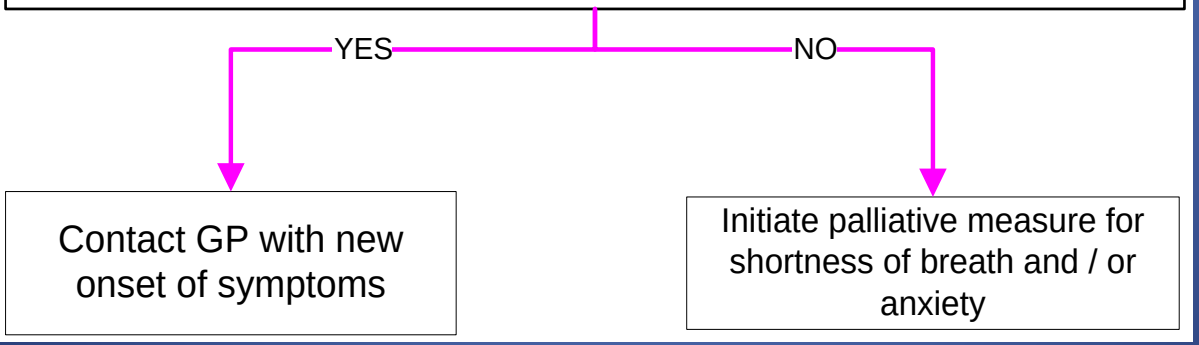
Open poll in your web browser

Pneumonia - Referral

ARE 2 OR MORE OF THE FOLLOWING SYMPTOMS PRESENT?

- New or worsening cough.
- Increased or newly purulent sputum, unable to expectorate?
- New crackles or wheezes heard on chest exam.
- Decline in cognitive (see CAM pg xx), physical or functional status.
- New agitation.
- Fever or hypothermia – ↑↓ from baseline.
- Dyspnoea (difficulty in breathing, SOB).
- Tachypnea (respirations >30/min or 10/min over baseline).
- Chest pain (pleuritic – worse with breathing?).
- New or worsening hypoxaemia (pulse Ox<90%).
- Systolic BP<20 mm/hg from baseline.

If unarousable call ambulance and GP.



Shortness of Breath Care Plan

As evidenced by:

- Increased respiratory rate
- Increased cough
- SPO_2 <90%
- Increase or decrease temperature
- Increased rhonchi
- Increase SOB with exertion

Interventions:

- Monitor respiratory status
  - SPO2
  - Respiration rate
  - Cough and sputum production
  - SOBOE
  - Temperature
- Contact NP/GP if signs/symptoms of respiratory deterioration
- Monitor pain
- Monitor weight and nutrition status

Incontinence

- Type of incontinence
  - Urge
  - Stress
  - Functional
- Urinary Tract Infection

URINARY INCONTINENCE CARE GUIDE

RESIDENT INCONTINENT

New or worsened — YES → Assessments & Tests

NO → **Refer care plan and continue/implement relevant interventions**

Treatable/reversible cause found? — YES → Treat & review

NO

Definite indication for referral? — YES → **Discuss referral with Interdisciplinary Team**

NO

STRESS

Involuntary loss of urine that occurs with increased abdominal pressure e.g. coughing etc.

- May occur as a result of weakened pelvic floor muscles or malfunction of the urethral sphincter.
- Stress and urge incontinence often occur together in women. Known as 'mixed incontinence'.

Pelvic floor muscle exercises (3 months)
Schedule toileting
Oestrogen cream
Surgery

URGE

Involuntary loss of urine that occurs with sudden need to urinate due to bladder spasm or contradictions.

- This occurs regardless of the amount of urine that is in the bladder.
- May result from neurological injuries e.g. spinal cord injury or stroke, MS, Parkinson's, Alzheimer's.
- Other causes: infection, bladder cancer, bladder stones, inflammation or bladder outlet obstruction.

Bladder training to increase capacity (6 weeks)
Scheduled toileting
Pelvic floor muscle exercises
Anticholinergic medications e.g. Oxybutynin to reduce bladder urge to empty urine

OVERACTIVE BLADDER SYNDROME (OABS)

Where no cause can be found for repeated and uncontrolled bladder contractions (e.g. not due to urine infection or enlarged prostate).

- OABS is sometimes called an 'irritable' bladder or 'Detrusor (bladder muscle) instability'.
- Symptoms include urgency, frequency, nocturia and urge incontinence.

Bladder re-training to increase capacity
Anticholinergic medications e.g. Oxybutin

OVERFLOW

Resident never feels the urge to urinate, the bladder never empties and small amounts of urine leak continuously.

- Overflow is prevalent with enlarged prostate.
- Seen rarely in women.
- May be caused by weak bladder muscles, loss of bladder sensation or obstruction e.g. due to enlarged prostate, constipation, urethral stricture, tumour or stones.
- Signs and symptoms include bladder never feeling empty, nocturia, inability to void and urine dribbling even after voiding.

Alpha 1 antagosists e.g. terazosin (Hytrin)
BPH – Hytrin (or other medications)
Neurological Diseases (MS, Parkinson's Disease) – Anticholinergic – e.g.Oxybutynin
Intermittent self catheterisation/ permanent IDC

FUNCTIONAL

Problems with thinking, moving or communicating that prevents the resident from reaching a toilet although the urinary system is normal.

- May not recognise the need to go to the toilet, where the toilet is or get there on time.
- Urine loss may be large.
- Causes include confusion, dementia, poor eyesight, poor mobility, poor dexterity, unwillingness to toilet because of depression, anxiety or anger. Mental confusion may prevent both recognition of the need to void and locating a bathroom.

- Scheduled toileting
- Bed side commode/handheld urinal

STILL INCONTINENT?

NO → **Update Care Plan with appropriate interventions**

YES

Your poll will show here

1

Install the app from pollev.com/app

2

Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help

or

Open poll in your web browser

Incontinence CP

POTENTIALLY REVERSIBLE CONDITIONS

- Stool impaction
- Urinary tract infection
- Depression
- Congestive heart failure
- Drug side effects:
  - rapid acting diuretics, anticholinergics, narcotics, calcium channel blockers, alpha-adrenergic agonists, psychotropic drugs
- Irritation or inflammation in or around lower urinary tract
- Atrophic vaginitis or urethritis
- Metabolic (hyperglycaemia, hypocalcaemia)
- Impaired ability or willingness to reach a toilet

Depression Rating Scale

- **0–14**
- A score of 3 or more may indicate a potential or actual problem with depression
  - Made negative statements
  - Persistent anger with self or others
  - Expressions, including non-verbal, of what appear to be unrealistic fears
  - Repetitive health complaints
  - Repetitive anxious complaints/concerns
  - Sad, pained or worried facial expressions
  - Crying, tearfulness

Depression Rates
Home Care and Aged Care

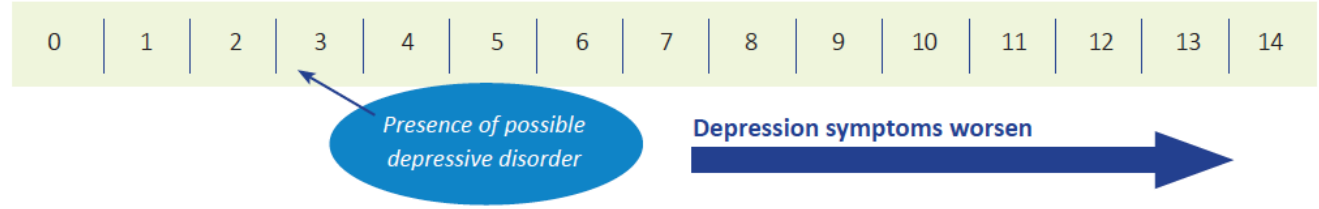


Figure 42: Home Care assessments – DRS scores

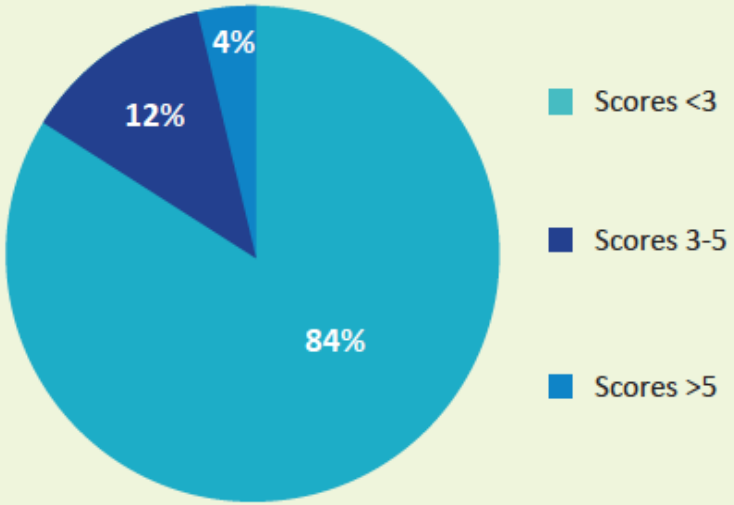
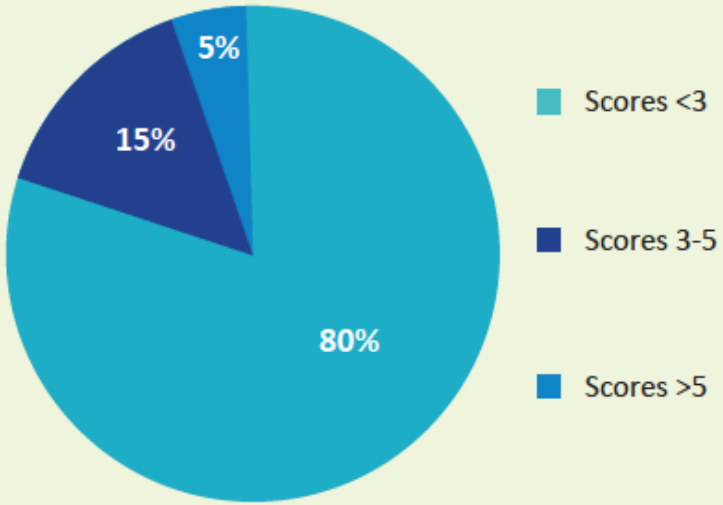


Figure 43: LTCF assessments – DRS scores



Source: National interRAI Software Service New Zealand, data 2014/15.

Treating Depression: Non-pharmacology approaches

- Positive effect for those with dementia & mild cognitive impairment
- (Ortega et al. 2014)
  - Cochrane review of 6 RCTs comparing psychological intervention
  - Mixed community & care based participants, MCI, dementia
  - Cognitive/behavioural therapy, relaxation training, psychodynamic, supportive or counseling therapies, some multimodal (e.g., tai chi + CBT)
  - Positive effects
    - On depression
    - Clinician rated anxiety but not self rated or carer rated anxiety
  - No effects on other outcomes (e.g., QoL, activities of daily living, neuropsych Sx)

To Treat or Not to Treat

Byers & Yaffe, *Nature Reviews Neurology* **7**, 323-331 (June 2011)

- Although experts recommend treating depression in Alzheimer's Disease
- Findings from controlled pharmacological trials are inconclusive
- SSRI's appear to decrease symptoms initially, but after 13-39 weeks there is no difference with controls

Depression Medication in Older People

- NICE Guidelines: first line treatment for minor depression
- Others recommend non-pharma as first line approach (e.g., AGS, 2003)

Types:

- SSRI (citalopram, fluoxetiine)
- Atypicals (mirtazapine)
- SNRI (venlafaxine)
- Tricyclic Antidepressants (nortryptline)

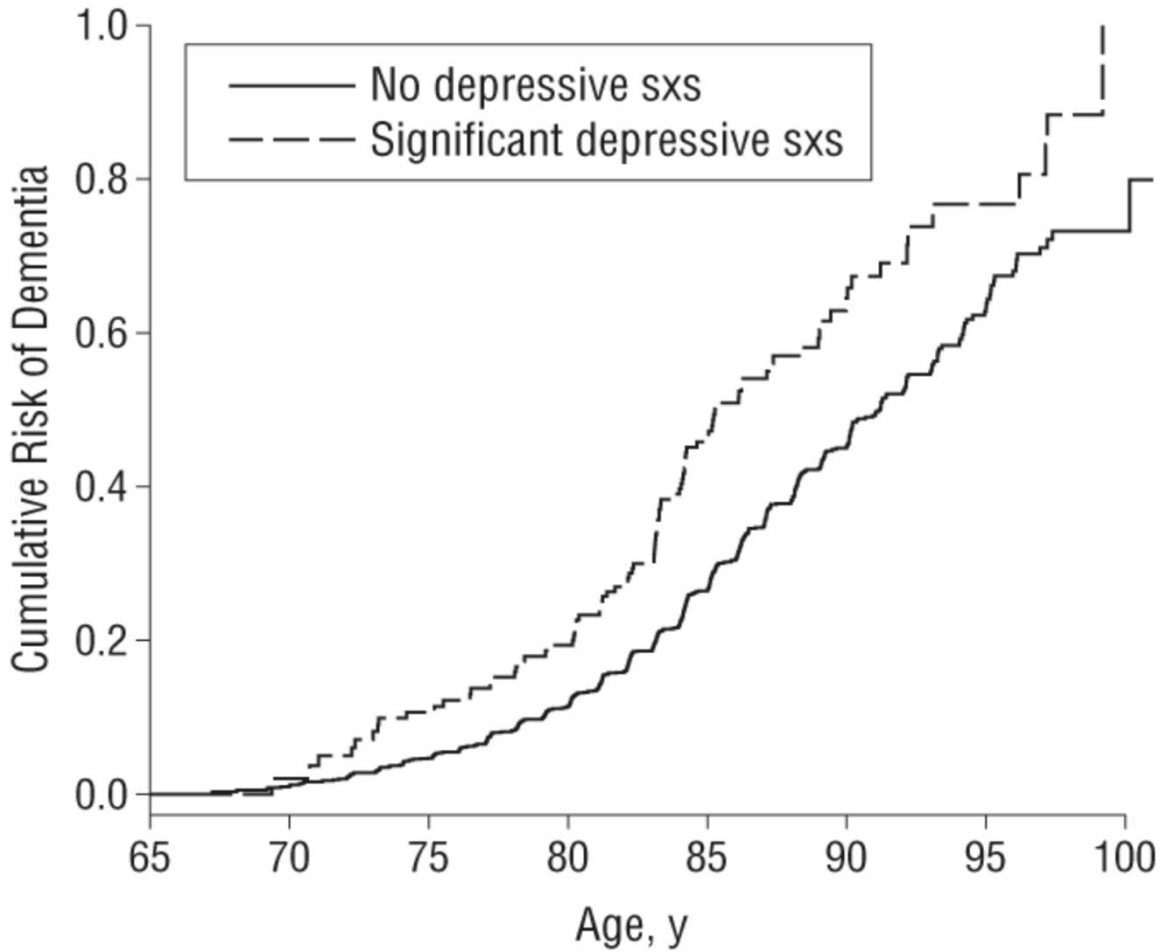
All have potential side effects:

- Falls
- Hyponatraemia
- QTc interval prolongation

Thakur et al., 2008; Snowden et al., 2003, Blake et al., 2009

Depression and Dementia

Kaplan-Meier cumulative risk curves for dementia by baseline depressive symptoms (sxs) status based on the 11-item version of the Center for Epidemiologic Studies Depression Scale score.



Depression effects up to 50% of people with dementia

Thielscher, et al., Arch Gen Psychiatry. 2011;68(9):970-977. doi:10.1001/archgenpsychiatry.2011.86

CHESS

Changes in Health, End Stage Disease and Signs and Symptoms

- This scale detects frailty and health instability and was designed to identify persons at risk of serious decline
  - Change in decision-making (C5)
  - Change in ADL status (G5)
  - Vomiting (J3n)
  - Peripheral edema (J3u)
  - Dyspnea (J4)
  - End-stage disease, 6 or fewer months to live (J7c)
  - Weight loss (K2a)
  - Dehydrated or BUN/creatinine ratio >20 (K2b)
  - Fluid intake <1000 ml/day (K2c)
  - Fluid output exceeds input (K2d)
  - Decrease in amount of food or fluids usually consumed (K2e)

CHESS

- This scale detects frailty and health instability and was designed to identify persons at risk of serious decline.

- **0–5**
- Higher scores are associated with adverse outcomes, such as mortality, hospitalization, pain, caregiver stress and poor self-rated health.

Predicting Death In Residential Aged Care

Study	Year	Setting	Tool	Predictors	Area Under the Curve
Porock et al [1] MMRI	2005 6 months	Nursing homes US	MDS	ADL function SOB, loss appetite, gender, weight loss, CHF, CRF, cognition (CPS), dehydrated, cancer, age, recent admission, deteriorating condition, Interaction terms	0.75
Porock [2] MMRI-R	2010 6 months	Nursing homes US	MDS	Gender, hospitalisation, SOB, appetite, weight loss, CHF, CRF, dehydrated, cancer, age, ADL function, cognitive deterioration, interaction terms	0.76
Flacker Kiely [3]	1998 1 year	Long-term care homes US	MDS	Functional impairment, weight loss, SOB, male, BMI <22, swallowing problems, CCF, age	0.77
Flacker Kiely [4]	2003 1 year	Nursing homes US Newly admitted and long-stay groups	MDS	32.1% 1y mortality Newly admitted cohort Cancer, SOB, CCF, bedfast, unstable conditions, male, >25% food left, poor function, swallowing prob, BMI<23, bowel incontinence Long stay cohort SOB, feeding tube, unstable conditions, male, >25% food uneaten CCF, poor function, weight loss, BMI<23, DM, age	0.73 (new) 0.71 (long-stay)
Mitchell et al [5] ADEPT	2010 6 month	Nursing homes US Advanced dementia	MDS	Recent admission, age, male, SOB, pressure ulcers, bedfast, poor ADL function, insufficient intake, bowel incontinence, BMI<18.5, weight loss, CCF	0.67

InterRAI CHESS

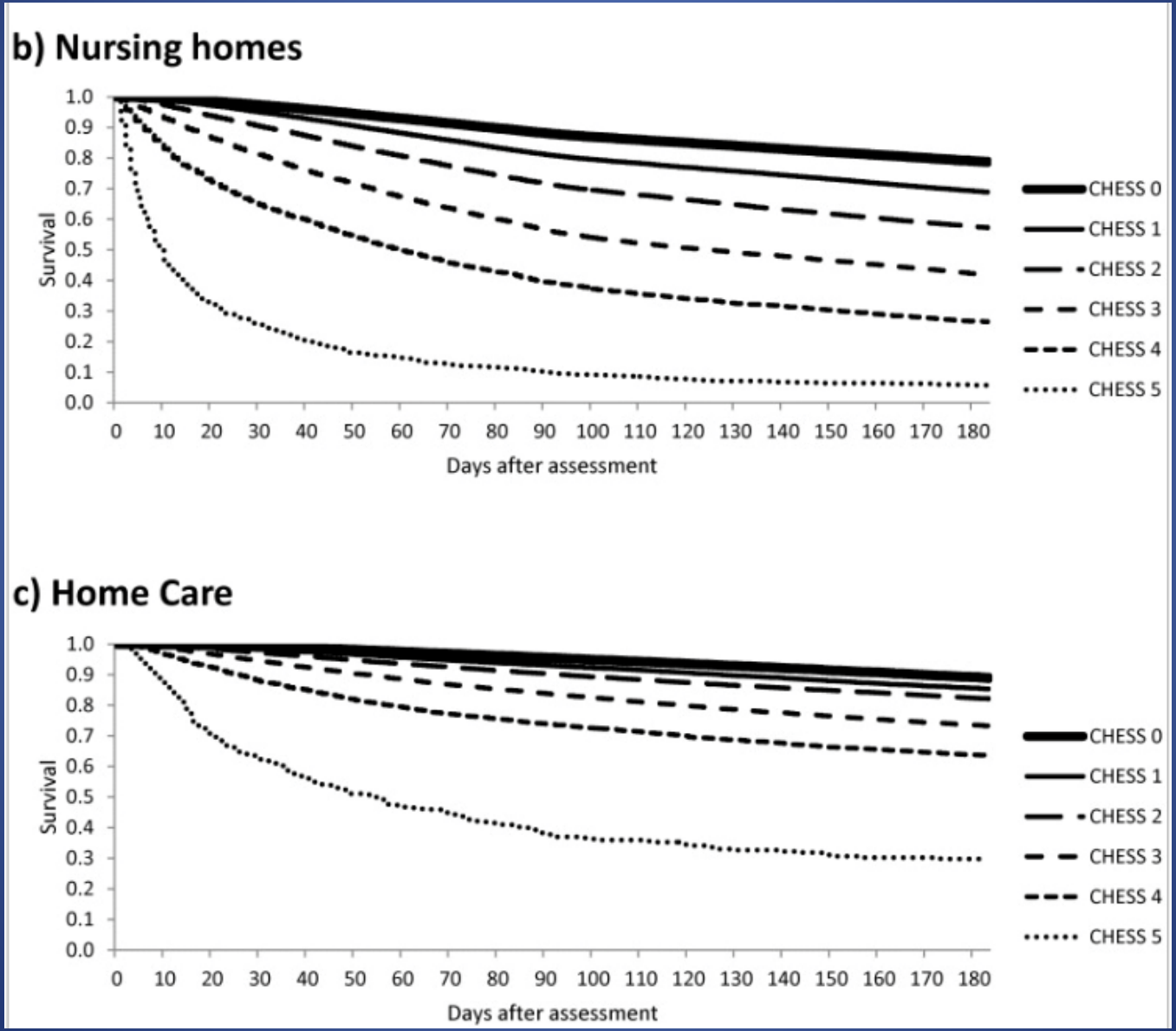
Medical complexity and health instability scores range from 0 to 5.

Items:

- Vomiting
- Dehydration
- leaving food uneaten
- weight loss
- shortness of breath
- oedema
- end-stage disease
- decline in cognition and ADL

Hirdes JP, Frijters D, Teare G. (2003) The MDS CHESS Scale: A New Measure to Predict Mortality in the Institutionalized Elderly. Journal of the American Geriatrics Society 51(1): 96-100.

CHESS and Mortality



New Zealand InterRAI CHESS Scores

0 - No symptoms	1 - Minimal health instability	2 - Low health instability	3 - Moderate health instability	4 - High health instability	5 - Highest level of instability

Figure 23: Home Care assessments – CHESS scores

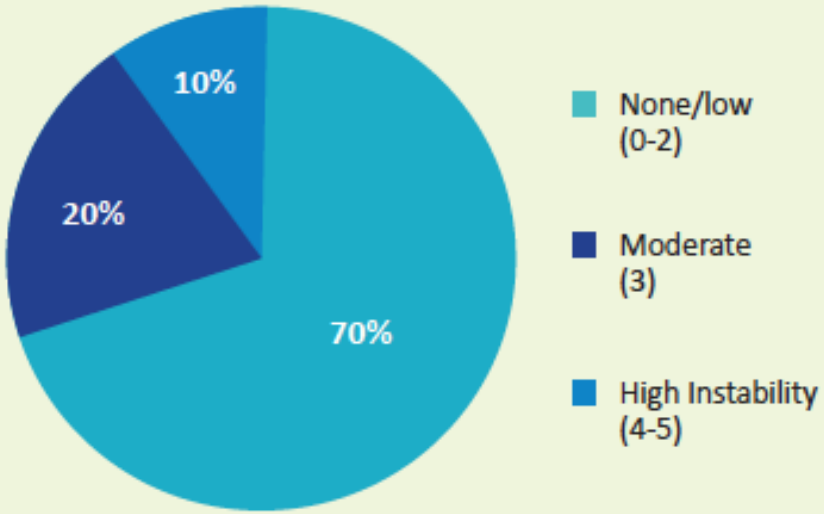
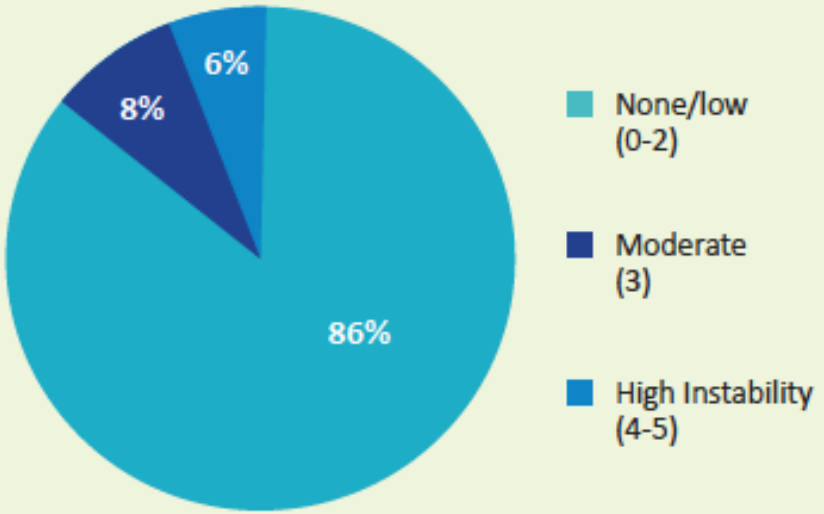


Figure 24: LTCF assessments – CHESS scores



Source: National interRAI Software Service New Zealand, data 2014/15.

Frailty Risk Factors

Sociodemographic and Psychological

A. Female gender

B. Low socioeconomic status

C. Race/ethnicity

D. Depression

Disability

A. Activity of daily living disability

Frailty is defined as 3 or 5 Components (Fried 2001):

- unintentional weight Loss
- slow walking speed
- self-reported exhaustion
- low energy expenditure
- weakness

Espinoza and Fried, 2007, Clinical Geriatrics,15(6).

Frailty Risk Factors

Physiologic

A. Activated inflammation

B. Immune system dysfunction

C. Anaemia

D. Endocrine system alteration

E. Underweight or overweight

F. Age

Medical Illness &/or Comorbidity

A. Cardiovascular disease

B. Diabetes

C. Stroke

D. Arthritis

E. Chronic obstructive pulmonary disease

F. Cognitive impairment/cerebral changes

Espinoza and Fried, 2007, Clinical Geriatrics,15(6).

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

Clinical Frailty Score (cont)

7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

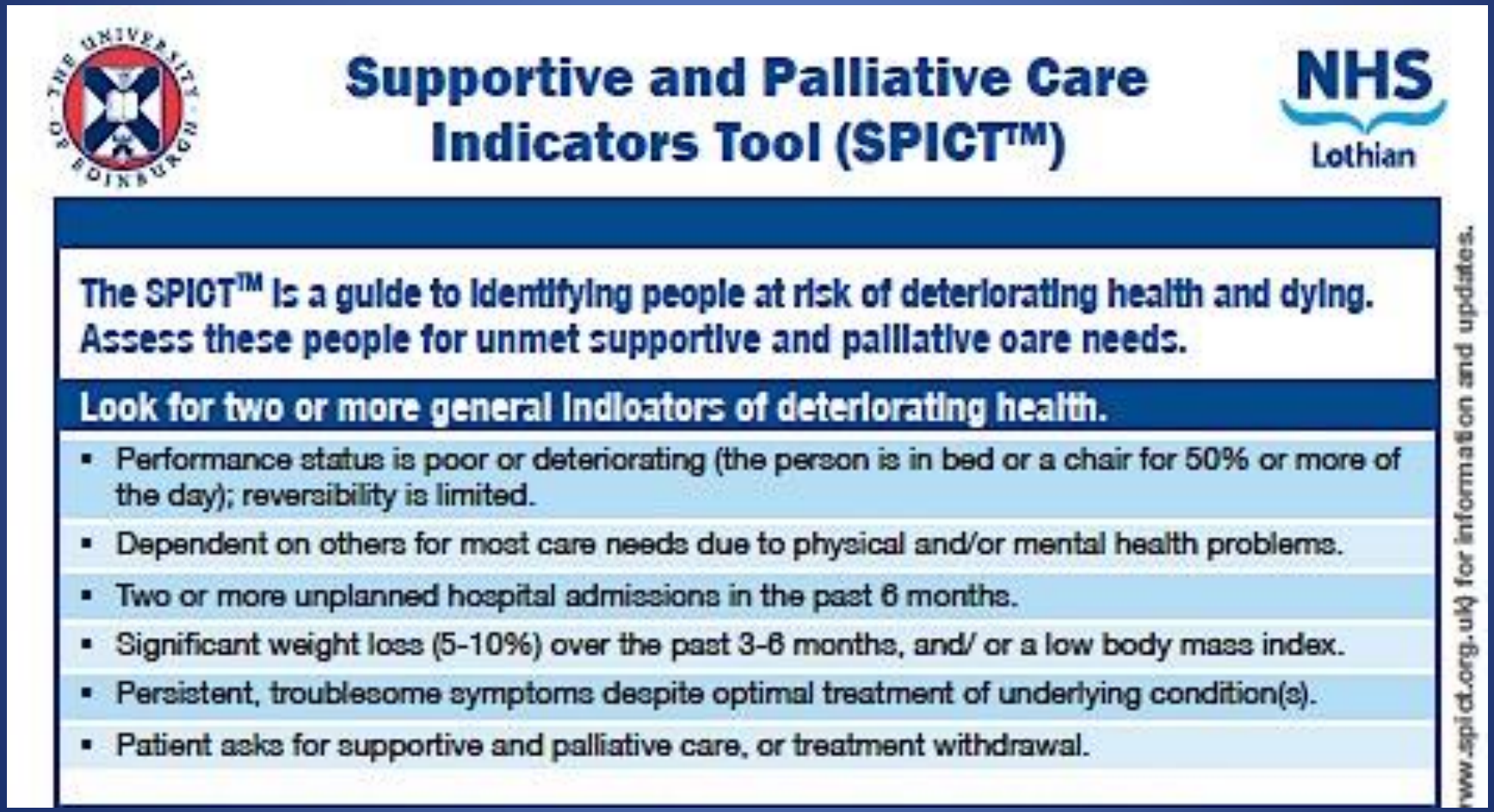
In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

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

DALHOUSIE UNIVERSITY
Inspiring Minds

SPICT TOOL



Supportive and Palliative Care Indicators Tool (SPICT™)

NHS Lothian

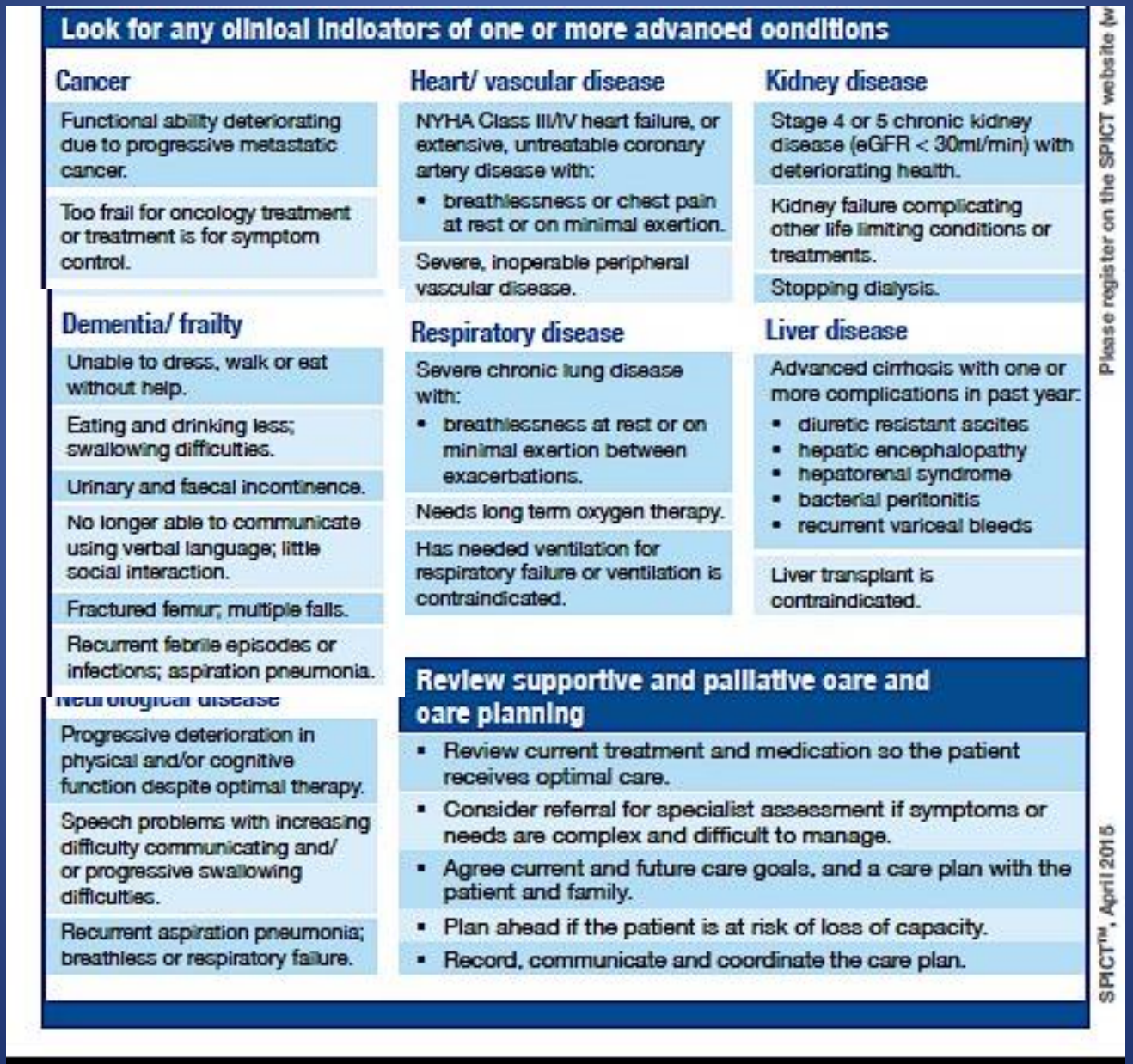
The SPICT™ is a guide to identifying people at risk of deteriorating health and dying. Assess these people for unmet supportive and palliative care needs.

Look for two or more general indicators of deteriorating health.

- Performance status is poor or deteriorating (the person is in bed or a chair for 50% or more of the day); reversibility is limited.
- Dependent on others for most care needs due to physical and/or mental health problems.
- Two or more unplanned hospital admissions in the past 6 months.
- Significant weight loss (5-10%) over the past 3-6 months, and/ or a low body mass index.
- Persistent, troublesome symptoms despite optimal treatment of underlying condition(s).
- Patient asks for supportive and palliative care, or treatment withdrawal.

www.spict.org.uk) for information and updates.

SPICT Tool



Look for any clinical indicators of one or more advanced conditions

Cancer

- Functional ability deteriorating due to progressive metastatic cancer.
- Too frail for oncology treatment or treatment is for symptom control.

Dementia/ frailty

- Unable to dress, walk or eat without help.
- Eating and drinking less; swallowing difficulties.
- Urinary and faecal incontinence.
- No longer able to communicate using verbal language; little social interaction.
- Fractured femur; multiple falls.
- Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

- Progressive deterioration in physical and/or cognitive function despite optimal therapy.
- Speech problems with increasing difficulty communicating and/ or progressive swallowing difficulties.
- Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart/ vascular disease

- NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:
  - breathlessness or chest pain at rest or on minimal exertion.
- Severe, inoperable peripheral vascular disease.

Respiratory disease

- Severe chronic lung disease with:
  - breathlessness at rest or on minimal exertion between exacerbations.
- Needs long term oxygen therapy.
- Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

- Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.
- Kidney failure complicating other life limiting conditions or treatments.
- Stopping dialysis.

Liver disease

- Advanced cirrhosis with one or more complications in past year:
  - diuretic resistant ascites
  - hepatic encephalopathy
  - hepatorenal syndrome
  - bacterial peritonitis
  - recurrent variceal bleeds
- Liver transplant is contraindicated.

Review supportive and palliative care and care planning

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals, and a care plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Record, communicate and coordinate the care plan.

Please register on the SPICT website (w

SPICT™, April 2015

Pain Scale

- This scale summarizes the presence and intensity of pain. This scale validates well against the **Visual Analogue Scale**.

- Frequency with which person complains or shows evidence of pain (J6a)
- Intensity of highest level of pain present (J6b)
- **0–4**
- Higher scores indicate more severe pain.

interRAI PURS
Pressure Ulcer Risk Scale

- **0–8**
- Higher scores indicate a higher relative risk for developing a new pressure ulcer

    - Walking (G1e)
    - Bed mobility (G1i)
    - Bowel Continence (H3)
    - Dyspnea (J4)
    - Frequency with which person complains or shows evidence of pain (J6a)
    - Weight loss of 5% or more in last 30 days or 10% or more in last 180 days (K2a)
    - Prior Pressure Ulcer (L2)

Cognitive Performance Scale (CPS)

- Cognitive Skills for Daily Decision-Making (C1)
- Short-term memory OK (C2a)
- Making Self Understood (D1)
- Eating (G1jA)

- **0–6**
- Higher scores indicate more severe cognitive impairment

CPS
Cognitive Performance Scale

The chart illustrates how the RAI-MDS 2.0 CPS scores relate to the MMSE scores.

CPS Score	Description	MMSE Equivalent Average
0	Intact	25
1	Borderline Intact	22
2	Mild Impairment	19
3	Moderate Impairment	15
4	Moderate/Severe Impairment	7
5	Severe Impairment	5
6	Very Severe Impairment	1

Thank You.

Michal.boyd@auckland.ac.nz