Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

The University of Auckland
Te Whare Wānanga o Tāmaki Makaurau
New Zealand

Frailty care guides
Ngā aratohu maimoa hauwarea

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Best Care for Everyone

Residential Aged Care Integration Programme Workgroup

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Health Quality & Safety Commission New Zealand

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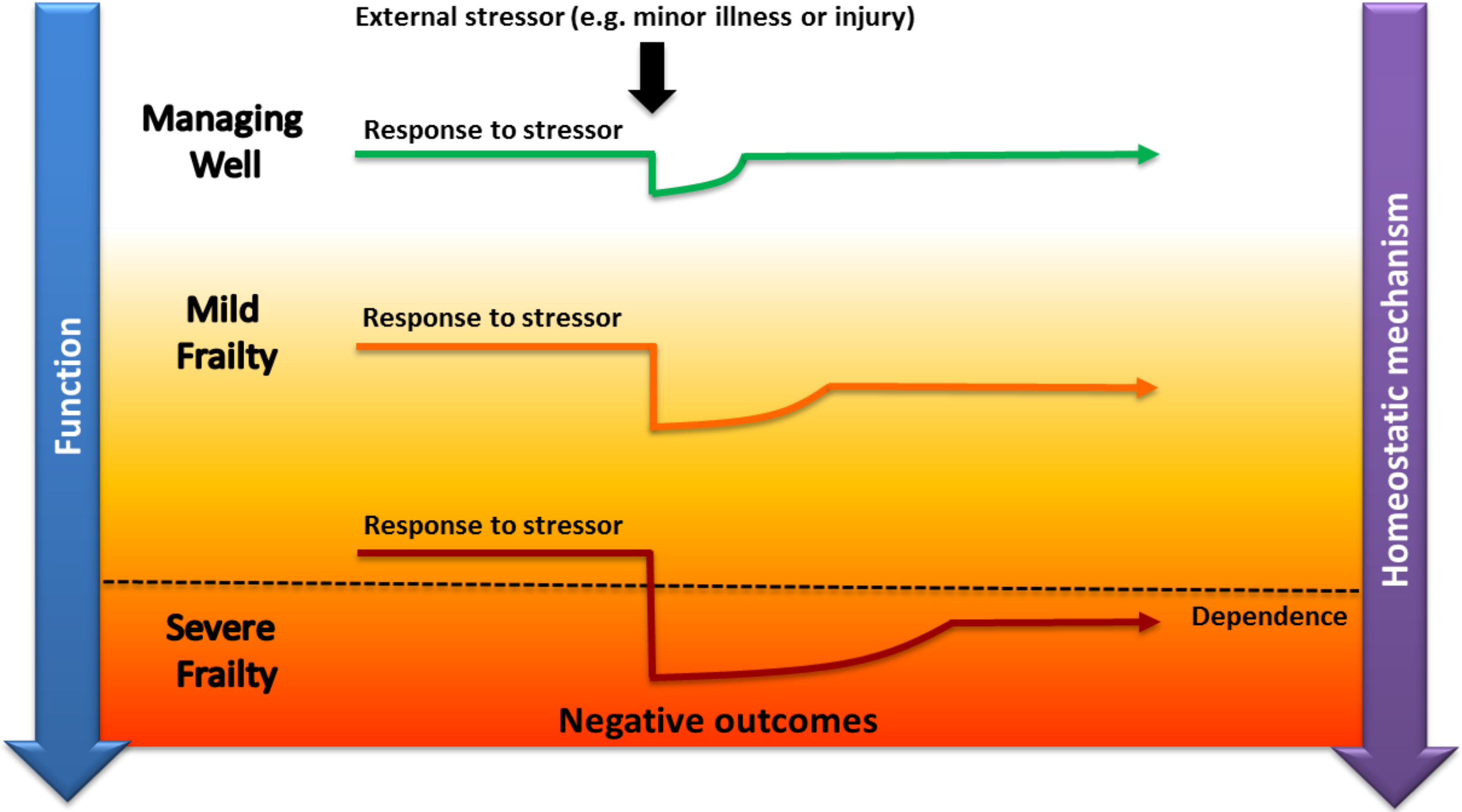
https://www.hqsc.govt.nz/our-programmes/aged-residential-care/publications-and-resources/publication/3818/

Frailty

'A medical syndrome with multiple causes and contributors characterised by diminished strength, endurance, and reduced physiologic function that increases an individual's vulnerability for developing increased dependency and/or death'

(Morley et al 2013).

Age increases the chance of Frailty – but it isn't the same as ageing


External stressor (e.g. minor illness or injury)
Managing Well
Response to stressor
Mild Frailty
Response to stressor
Response to stressor
Severe Frailty
Dependence
Negative outcomes
Function
Homeostatic mechanism

Frailty

People have the condition of 'Frailty' – they themselves are not Frail

"Well, I don't want to be thought as frail. I want to be thought as, you know still, still vital."

"So, now that I'm as far as I got myself, they say … how did you do it? I say, 'Because I didn't let you stop me."

"And that, that's the kind of thing that as you're getting older, I think if, don't give up, you know, you just keep, just keep on."

Pan E, Bloomfield K, Boyd M. Resilience, not frailty: A qualitative study of the perceptions of older adults towards "frailty". International journal of older people nursing. 2019 Aug 2:e12261.

Treating Frailty

Physical frailty can potentially be prevented or treated with specific modalities, such as:

- exercise
- protein–calorie supplementation
- vitamin D
- reduction of polypharmacy
- any other intervention that can increase resilience overall

(Morley et al 2013)

BEWARE

It is important to recognise and treat all possible causes of increasing frailty and gradual deterioration before assuming the person has reached the end of their life.

ROCKWOOD: CLINICAL FRAILTY SCORE

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

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

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

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

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

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

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

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

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

Scoring frailty in people with dementia

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

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

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

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

DALHOUSIE UNIVERSITY

Defining and Recognising Frailty

Rockwood - Accumulation of Deficits Model, based on functional characteristics as depicted in the Clinical Frailty Scale below

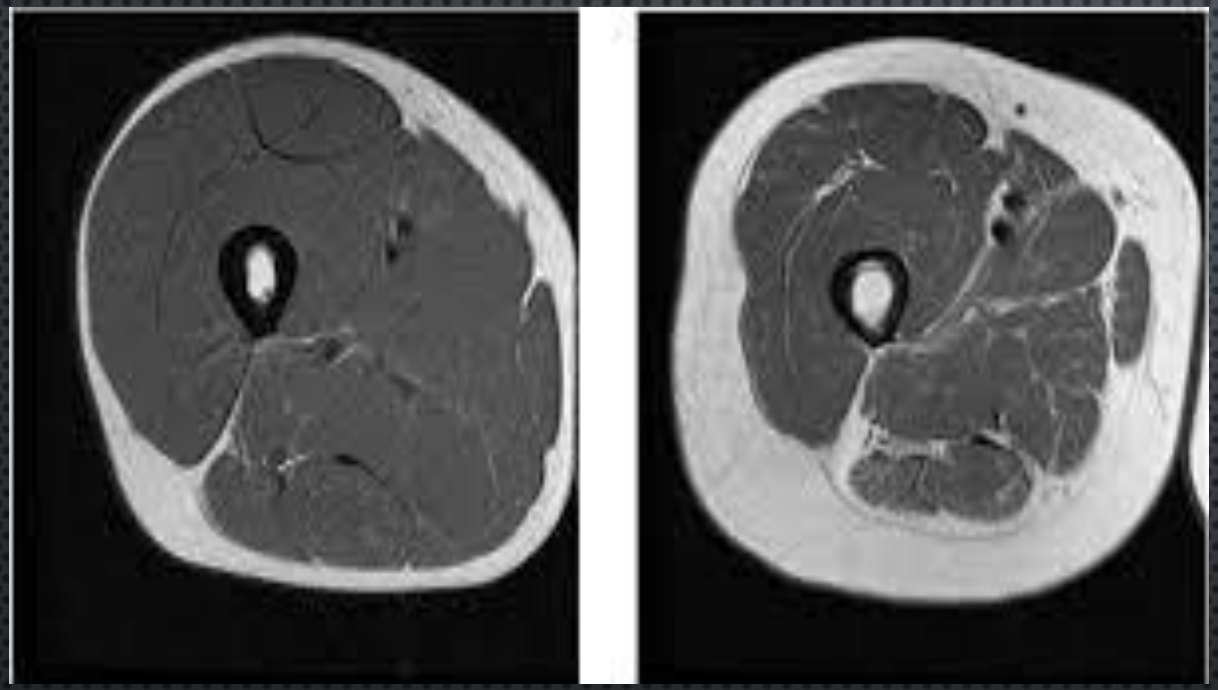
Rockwood Frailty Index: Below is an example of how to determine a frailty index (FI). Total items assessed (e.g. 26 below) divided by total number of deficits the person has.

0-5 deficits – 0/26 to 5/26 = 0.0 to 0.19: Frailty Index classification *Non-frail*
6-7 deficits – 6/26 to 7/26 = 0.23 to 0.27: Frailty Index classification *Pre-frail*
> 8 deficits – 8/26 or more = 0.31 or higher: Frailty Index classification *Frail*

Rockwood Frailty Index

1. Congestive heart failure
2. Cerebrovascular accident
3. Dementia, not specified type
4. Atrial fibrillation
5. Depression defined as PHQ score >5
6. Arthritis
7. Hip fracture
8. Pressure sores
9. Urinary incontinence
10. Polypharmacy >6
11. Physical help with dressing
12. Fatigue with self report or staff observation, included in PHQ >9
13. No spouse
14. Weight loss
15. Mobility impairment
16. Anything other than a regular diet
17. Bowel incontinence
18. Cancer
19. Renal disease
20. Pneumonia
21. Urinary tract infection
22. Wound infection
23. Diabetes mellitus
24. Malnutrition
25. Psychotic disorder
26. Respiratory failure

FRIED: FRAILTY RISK FACTORS



Age 25 Age 63

Sarcopenia

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).

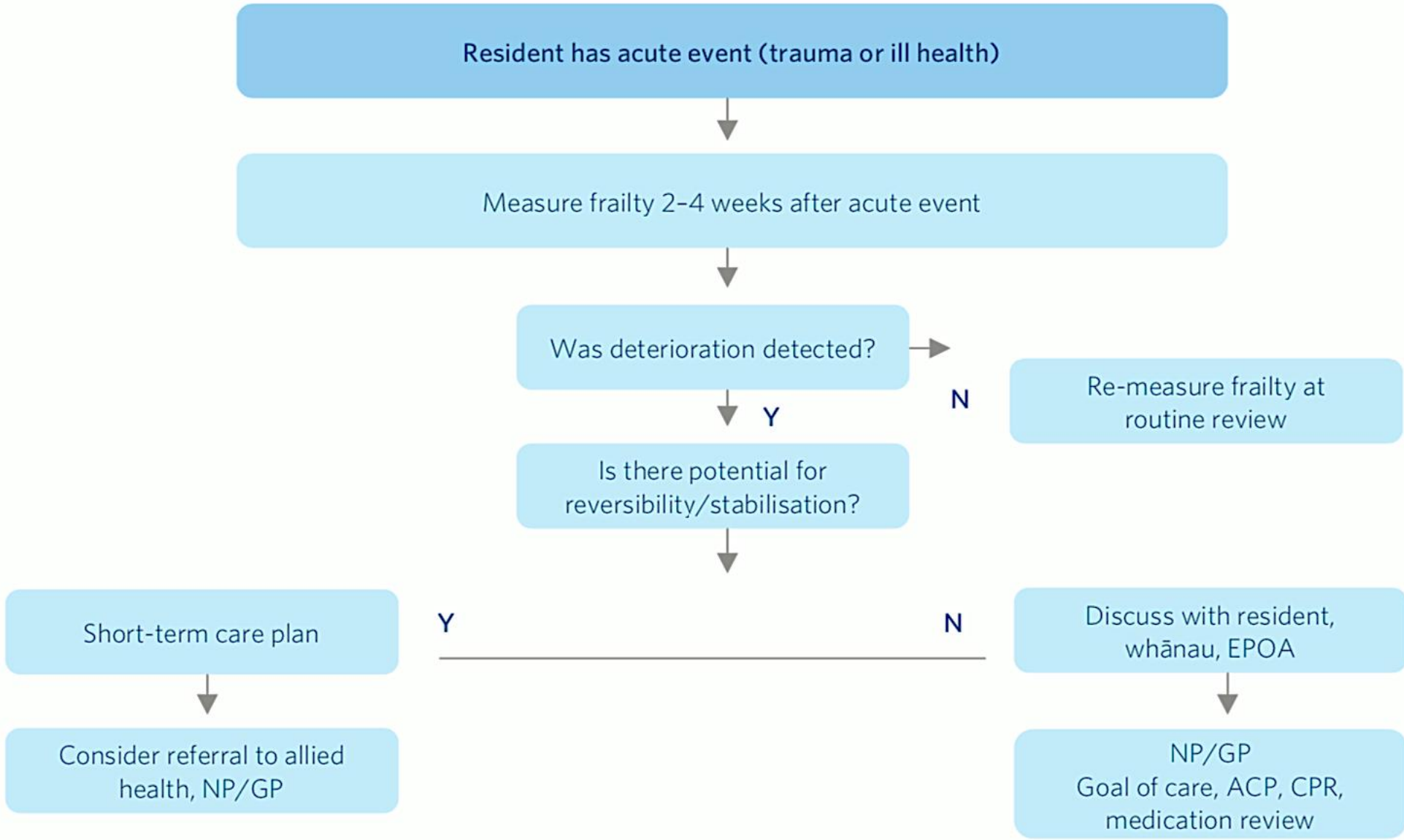
FRAIL-NH

	0	1	2
Fatigue	No	Yes	PHQ-9 ≥10
Resistance	Independent Transfer	Set Up	Physical Help
Ambulation	Independent	Walker	Not Able/WC
Incontinence	None	Bladder	Bowel
Loss of Weight	None	yes	xxxx
Nutritional Approach	Regular Diet	Mechanically Altered	Feeding Tube
Help with Dressing	Independent	Set Up	Physical Help
Total			0-13

Nonfrail (0-5), Prefrail (6-7), Frail (≥8)

Kaehr E, Visvanathan R, Malmstrom TK, Morley JE. Frailty in Nursing Homes: The FRAIL-NH Scale. *J Am Med Dir Assoc* 2015;16(2):87.

Identify and treat frailty progression after acute event



Created by Julie Daltrey, NP

Short-term care plan *EXAMPLE*

Identification label

Start date:	Resident identified as frail – slow (potentially reverse) progression of frailty syndrome. Frail NH score:	
Goal:	Intervention: *How will we do that?*	Evaluation: *Did it work?*
Measurable gain in lean muscle mass in four weeks	• Ensure eats 2g/kg/day protein (sources include milk, supplements, whey powder, meat, nuts) • Assess and optimise physiological and psychological issues impacting on eating (includes tooth and gum health, food modification, preferences, timing, assistance, social eating patterns, mood, self-assessed quality of life) • Monitor food intake (food charting, 'blue plate' system, weigh weekly) • Referral for professional assessment • Work with family regarding additional nutritional treats, eg, trip out to eat, bring food in, extra stuff aged residential care can't supply	**Date:**
Measurable gain in strength in four weeks	• Physiotherapy assessment for individual activity plan; includes strength and stamina training • Intense support to implement PT plan • Agree small specific daily activities that increase activity • Measure against baseline activity at weekly intervals	
Optimise medication regime	Work with NP/GP to: • review BP (lower BPs in frail older adults have worse outcomes) • optimise analgesia • consider mental health prescribing (depression worsens fatigue, as does hyponatraemia ADE) • consider vitamin D prescribing	
Optimise medical management	Review and work with NP/GP to optimise chronic condition management (eg, inhalers and SOB, glucose and DM, fluids and HF, rest and sleep cycle, cognition and activities)	

RECOGNISING ACUTE DETERIORATION

STOP AND WATCH	
S	Seems different than usual
T	Talks or communicates less
O	Overall needs more help
P	Participates less in activities
A	Ate less, difficulty swallowing medication
N	No bowel motion > 3 days, diarrhoea
D	Drank less
W	Weight change
A	Agitated or more nervous than usual
T	Tired, weak, confused or drowsy
C	Change in skin colour or condition
H	More help walking, transferring, toileting

Assessment	Review/action
Step 1	**Review what could be causing the change or decline overall** a) Review recent history, b) do observations, c) are there recent medication changes? Review acute deterioration clinical reasoning guide (see next page) and SBAR form to review possible causes of symptoms.
Step 2	**Take observations – review warning signs that indicate serious illness or sepsis (see sepsis screening tool)** **Take into account baseline observations:** • **Respiratory rate > 24/minute (see respiratory care guide).** • **Increased respiratory rate is one of the most sensitive indicators of acute illness** • SPO_2 < 90% • Temperature > 37.7°C or low temp < 36 °C • New heart rate > 100 bpm • New systolic BP < 100 mmHg
Step 3	**Assess for recent labs or other results (eg, X-rays)** Consider need for labs: CBC, CRP, electrolytes, creatinine, LFTs, MSU, BGL
Step 4	**Review hydration status** • Start input/output chart, ensure input/output equal in 24 hours • Offer fluids orally every 1–2 hours to increase oral fluid intake to 1,000–1,500/24 hours • **If unable to take oral fluids, consider normal saline SC (500 ml/12 hrs) and review diuretics (in consultation with prescriber)**

CLINICAL REASONING TOOL

THE 8 STEPS

Step 5	**Assess for delirium** • Delirium screen: Neuro changes, increased falls, functional change and/or confusion. • Neuro assessment: pupils, extremity, power, face and body symmetry, weakness. See delirium care guide and 4AT delirium screen
Step 6	**Review pain status** Assess for pain location, type and severity. Review for pain intervention (use OLDCART)
Step 7	**Review for constipation or diarrhoea** Bowels not open for three days or watery bowels? Review available laxatives and clear bowels for constipation. Use loperamide and assess for dehydration for diarrhoea
Step 8	**Review goals of care** What does the resident/family/whānau want to happen now? **Review again after assessment goals of care** • For hospitalisation? Antibiotics? • How does the family/whānau feel about the situation? What would they like to happen now? • For comfort care only? If comfort care only, see palliative care guide – palliative care is an ACTIVE process • Develop a plan of care based on the above assessment

SEPSIS WARNING SIGNS

Known or suspected infection

↓ PLUS

Any two of the following

- Acute mental status change
- Hyperglycaemia
- Hyperthermia or hypothermia < 36 or > 37.5
- High white blood cell count (or low blood cell count)
- Tachycardia HR > 100 bpm
- Tachypnoea > 24 respiration/minute

May indicate sepsis – contact GP/NP

↓ POSSIBLE SHOCK

Indications of septic shock or organ dysfunction include

- Hypotension
- Increasing oxygen requirement (SPO_2 > 90%)
- Elevated creatinine (kidney impairment) or bilirubin level (liver impairment)
- Low platelet count
- Petechial rash (tiny purple, red or brown spots on the skin)

Getting Ready to Escalate to GP/NP

- **Review Resident Record:** Recent progress notes, labs, medications, other orders
- **Assess the Resident**
- **Review / activate care pathway (if available)**
- **Have Relevant Information Available when Reporting**
  - *(I.E. medical letters, blood tests and investigations, ceiling of intervention orders, allergies, medication list)*

Created by Lou Fouler, NP, BOP DHB

SITUATION

Staff Name and designation: _____

Signature_____
Date ____ / ____ / ____ Time (am/pm)_____

The current change in condition, symptoms and concerns are

This started on _____ / _____ / _____ at _____ am/pm

Since this started it has gotten: ☐ worse ☐ better ☐ stayed the same

Things that make the problem ***worse*** are_____
Things that make the problem ***better*** are_____

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No
Treatment for last episode:

Other relevant information or problems:

BACKGROUND

Resident Description
This resident is in the facility for: ❑ Rest Home ❑ Hospital ❑ Dementia ❑ Other _____
Primary diagnoses:

Relevant medical/social history:

Allergies / alerts:

Medications
Currently on:
❑ Warfarin: last INR: _____ Date ___/___/___ ❑ other anticoagulant ❑ oral hypoglycaemic ❑ Insulin ❑ Digoxin
❑ Other:
❑ Medication changes in the last week:

Resident and/or family advanced care planning / preferences for care:

Weight: ❑kg: stable ❑ increased ❑ decreased ❑ By: ❑kg Over past: ❑Days ❑ wk ❑ Months

Bowels: Days since last motion ❑ Number of motions in last week ❑
Motions pebbles Yes/No Motions diarrhoea/runny Yes/N

ASSESSMENT

Respiratory Rate: **Heart Rate:** **regular ❑** **irregular ❑**
Blood Pressure: Lying: **Standing:** **BGL:**
Temperature: **SpO2: _____ % on Room air _____% on O2_____l/min**
Changes since last set of obs:
General appearance:

COGNITIVE
❑ alert & orientated
❑ confusion
❑ fluctuating ❑ consistent
❑ other signs of delirium
❑ baseline MOCA:

❑ altered level of consciousness
❑ hyperalert
❑ sleepy/lethargic
❑ difficult to rouse
❑ unresponsive

NEUROLOGICAL
❑ headache
❑ dizziness
❑ numbness / tingling
❑ seizure
❑ Face droop
Arm / body weakness
Speech changes

❑ GCS score

RESPIRATORY
❑ shortness of breath
❑ new ❑ increased
❑ at rest
❑ on exertion
❑ SOB affecting speech or sleep
❑ cough
❑ productive
❑ non-productive
❑ laboured
❑ rapid
❑ cheyne stoke
❑ wheeze
❑ crackles

CVS
❑ chest tightness ❑ pain
❑ dizzy / lightheaded
❑ oedema
❑ irregular pulse
❑ resting pulse >100 or <50
❑ JVP <3cm

ABDOMINAL
❑ tenderness ❑ pain
❑ decreased food / fluid
❑ nausea
❑ vomiting
❑ constipation
date of last BM:
❑ diarrhoea
❑ bowel sounds
❑ absent ❑ hyperactive
❑ bloody stool or vomit
❑ distended abdomen
❑ jaundice

GU
❑ tenderness ❑ pain
❑ painful urination
❑ urgency
❑ frequency
❑ nocte increase
❑ decreased or no urine
❑ incontinence
❑ blood

PAIN
❑ yes
❑ new or ❑ increased
❑ OLDCART assessment
❑ intensity 1-10:
❑ non-verbal signs:

BEHAVIOURAL
❑ depressed
❑ social withdrawal
❑ aggression
❑ verbal ❑ physical
❑ personality change
❑ other:

MSK
❑ decreased mobility
❑ increased weakness
❑ needing more assistance with ADL
❑ falls in last month:

❑ symptoms of fracture
Site:
❑ swallowing difficulty

SKIN
❑ discolouration
❑ Redness
❑ tracking
❑ itch / rash
❑ contusion
❑ open wound
Site:
❑ pressure injury
Site:
Grade:
❑ chronic wound
Type:
Site:

RECOMMENDATION / RESPONSE

Nursing Diagnosis (what do you think is going on?):

Nursing Interventions (what are you going to do):

- ❑ observations _____ hrly for _____ hrs
- ❑ safety interventions _____
- ❑ prn medications: _____
- ❑ other:
- ❑ urinalysis
- ❑ additional assessment _____
- ❑ increase oral fluids
- ❑ activate symptom management plan:
- ❑ review recent bloods
- ❑ family discussion, place of care / goals of care

GP Notified ? Yes/No :_____ Date ____ / ____ / ____ Time (am/pm)_____

Recommendations / plan from GP:

- ❑ ongoing monitoring every _____ hrs and GP review in _____
- ❑ IV or subcutaneous fluids:
- ❑ Oxygen:
- ❑Other:
- ❑ New or change medication(s):

❑ Transfer to the hospital (non-emergency / emergency) *(send a copy of this form)*

Goals of transfer:

Name of Family Notified:_____

Date ____ / ____ / ____ Time (am/pm)_____

RED FLAGS FOR GRADUAL DETERIORATION AT SIX-MONTH ASSESSMENT

Increased falls

- Triggered interRAI falls CAP
- Falls prevention frailty care guide

New urinary or bowel incontinence

- Triggered interRAI urinary CAP
- Triggered bowel continence CAP
- Urinary incontinence and constipation frailty care guides

Increased urinary or respiratory tract infections

- Review infection rates and antibiotic use
- Review urinary incontinence, constipation and gastrointestinal, and respiratory frailty care guides
- Review advance treatment planning frailty care guide

interRAI CHESS score

- See interRAI CHESS score
- Review advance treatment planning frailty care guide

Frailty score increased

- Triggered physical activity CAP
- See defining and recognising frailty frailty care guide: clinical frailty score or FRAIL–NH
- Comprehensive assessment to assess for reversibility of any geriatric syndrome

Pain

- Triggered interRAI pain CAP
- Review interRAI pain scale
- Pain assessment and management frailty care guide

RED FLAGS FOR GRADUAL DETERIORATION AT SIX-MONTH ASSESSMENT

Non-healing wounds or pressure ulcers

- Triggered interRAI pressure ulcer CAP
- Review interRAI pressure ulcer risk score
- Skin wounds frailty care guide

Weight loss

- Triggered interRAI under-nutrition CAP
- Review BMI interRAI scale
- Nutrition and hydration frailty care guide

Low mood or anxiety

- Triggered mood interRAI CAP
- Review interRAI depression rating scale
- Review depression frailty care guide

New behaviours of concern

- Triggered interRAI behaviour CAP
- Review interRAI aggressive behaviour scale
- Dementia and behaviours that challenge frailty care guide

Delirium episodes

- Triggered delirium interRAI CAP
- Delirium frailty care guide

AN IMPORTANT TOOL TO MONITOR GRADUAL DETERIORATION IS TO PRINT OUT THE INTERRAI TWO-PAGE SUMMARY

DISCUSS AT THE NEXT MULTIDISCIPLINARY REVIEW AND/OR FAMILY AND WHĀNAU MEETING.

ALWAYS REVIEW THE ADVANCED CARE PLANS AND GOALS OF CARE WHEN COMMENCING ANY PLAN OF CARE FOR INCREASING FRAILTY AND GRADUAL DETERIORATION.

FRAIL-NH

	0	1	2
Fatigue	No	Yes	PHQ-9 ≥10
Resistance	Independent Transfer	Set Up	Physical Help
Ambulation	Independent	Walker	Not Able/WC
Incontinence	None	Bladder	Bowel
Loss of Weight	None	yes	xxxx
Nutritional Approach	Regular Diet	Mechanically Altered	Feeding Tube
Help with Dressing	Independent	Set Up	Physical Help
Total			0-13

Nonfrail (0-5), Prefrail (6-7), Frail (≥8)

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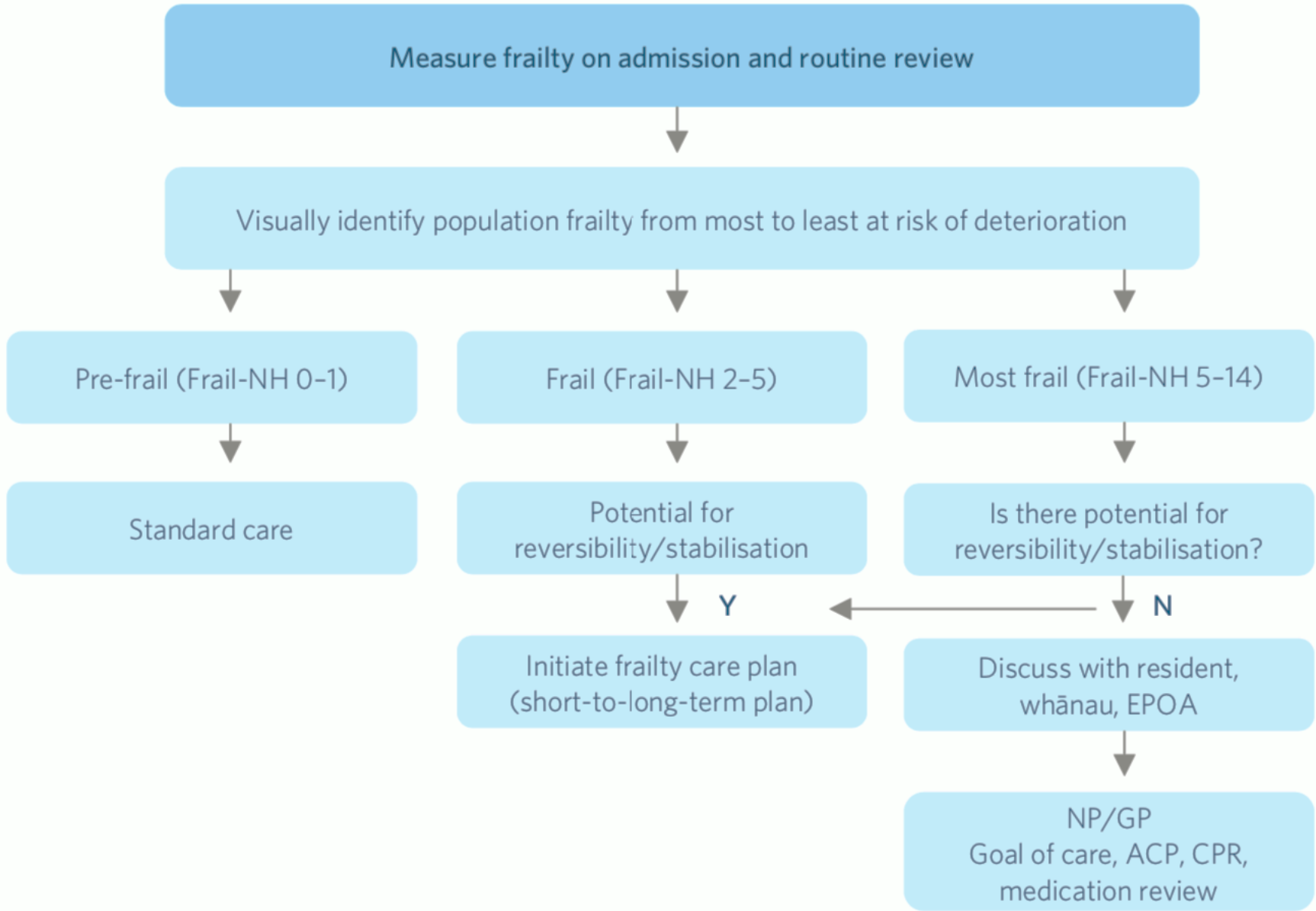
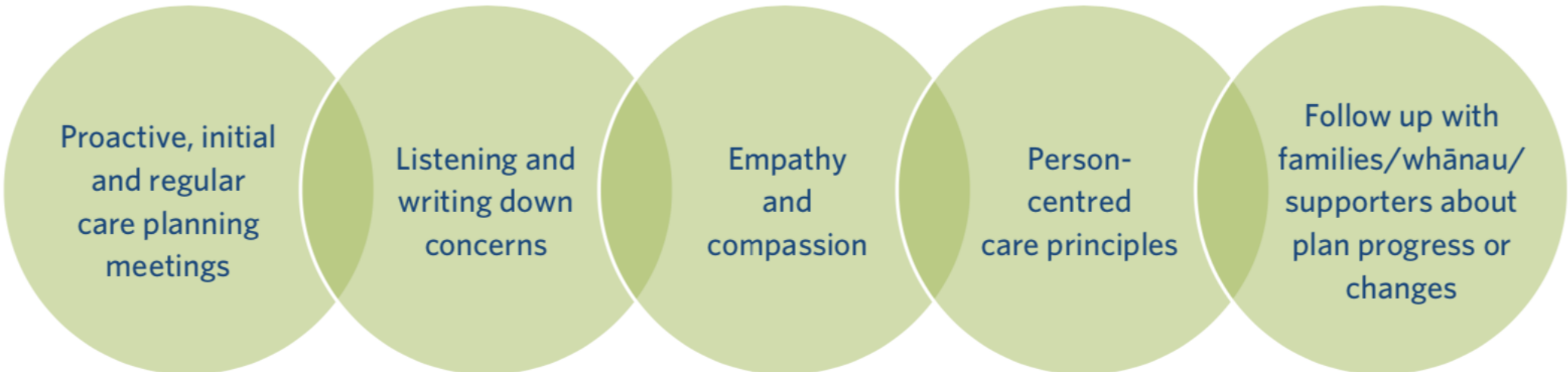
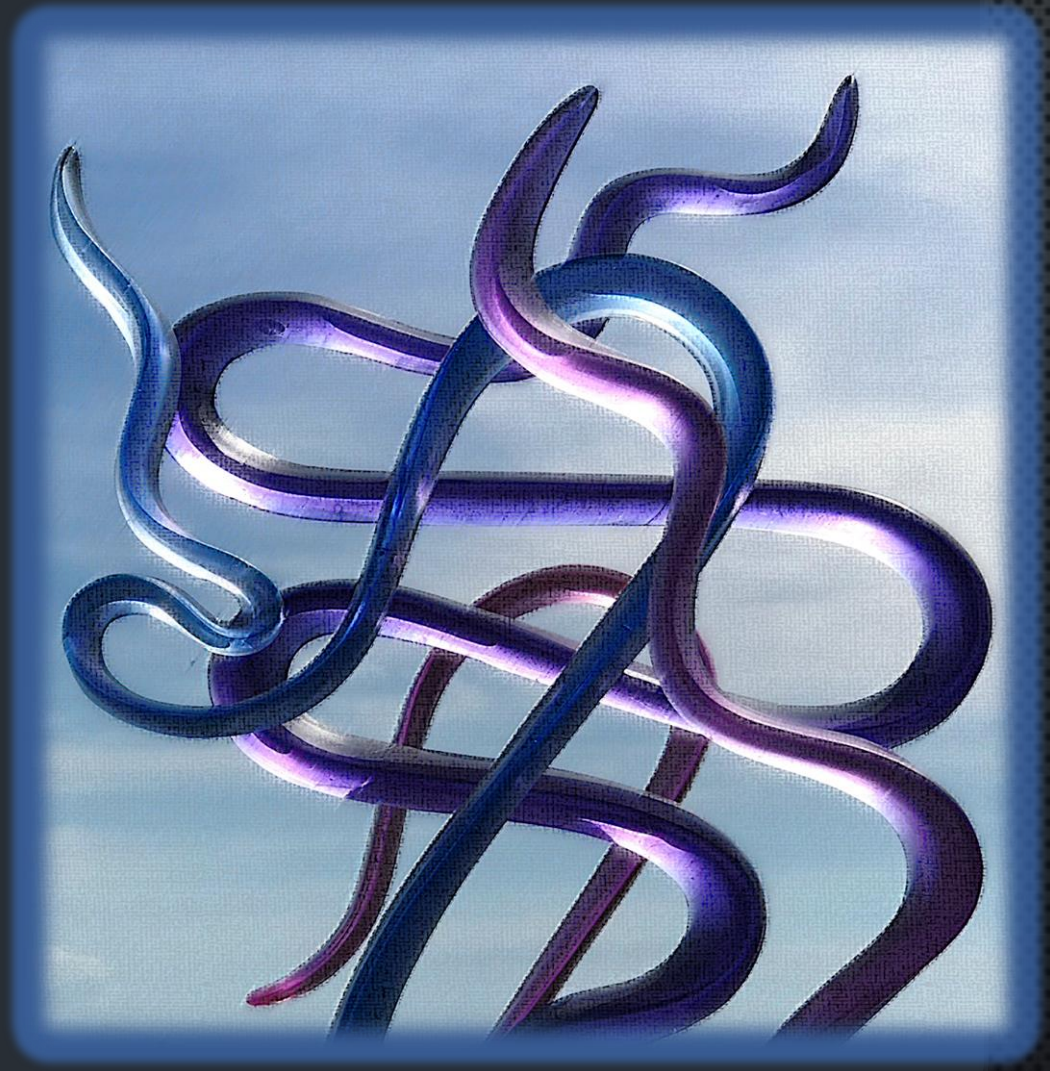
Identify and treat gradual deterioration



Communication | Te whakawhitinga



“WHAT IS YOUR UNDERSTANDING OF…”



Communication with and about older people

Person-centred approaches that recognises the whole person and fosters dignity and respect

- Avoid ageist attitudes in communication:
  - – Remember that older people feel young on the inside.
  - – Be aware of and avoid disrespectful, dismissive language and attitudes, ignoring or
  - 'talking' over.
- Avoid baby talk, patronising, infantilising language and tone, or parental 'bossy' language and
- Don't underestimate the older person's ability to communicate.
- Understand the older person: impaired communicative capacity is frequently interpreted as impaired cognitive capacity.
- Communicate and treat those with cognitive impairment as adults.
- Ensure hearing and vision aids are in place.
- Dedicated orientation and mentoring of new staff to promote:
  - – dignity of and respect for residents
  - – kind, caring and empathic responses
  - – role modelling of respectful and non-ageist communication

Important ways to encourage a cooperative relationship between families/whānau/supporters and professional staff

- Schedule an initial meeting to review plan of care and goals of care with senior nurse, GP/NP or other staff members, family/whānau/supporters and the older person.
- Ask the older person if it is all right to also have a private conversation with family/whānau/supporters. Family/whānau/supporters are often uncomfortable talking about sensitive care issues in front of the older person.
- Provide a written care plan summary (including only the top three to five agreed care priorities), so it is not too overwhelming for family/whānau/supporters.
- Provide regular written or telephone updates to family/whānau/supporters.

Communication barriers

- Defensiveness shuts down communication.
- Taking criticism personally rather than seeing it objectively and looking for solutions to the problems raised.
- Ignoring concerns or complaints.
- Lack of follow-up of conversations in which concerns were raised.

Sexuality and intimacy

Sexuality and intimacy is a normal part of life for all adults

Enjoyment of physical intimacy and sexuality does not cease just because someone is older or lives in residential aged care.

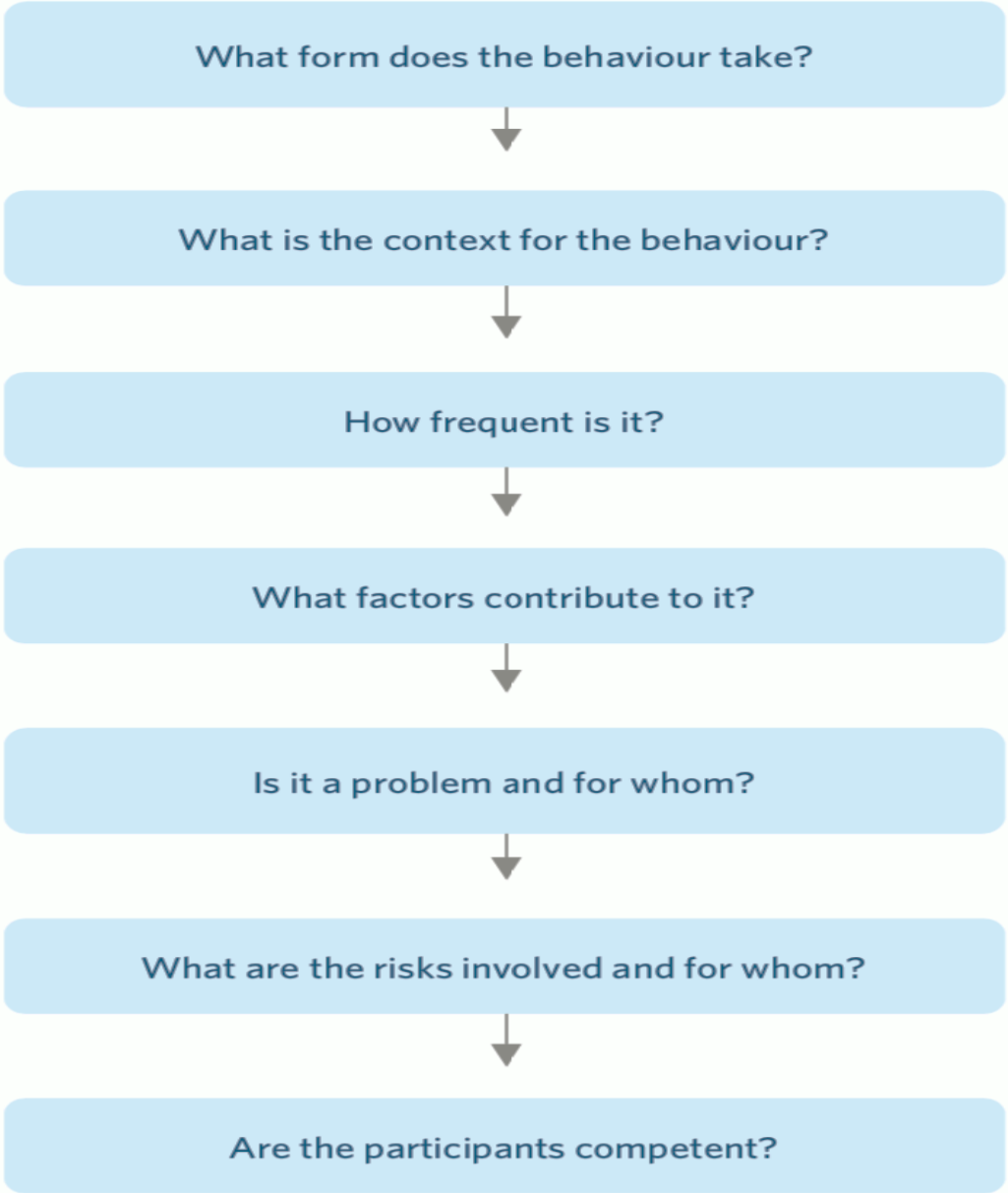
It is a basic human right to be able to express sexuality

- the right to be treated with respect
- the right to be free from discrimination and exploitation
- the right for dignity and independence
- the right to give informed consent

Ability to consent to sexual relations

- To what extent are the residents involved capable of making their own decisions?
- Does the resident with dementia have the ability to recognise the person with whom they are having the relationship?
- Could they have mistaken the person for their original partner?
- Is the resident with dementia capable of expressing their views and wishes within the relationship through either verbal or nonverbal communication?
- Can the residents involved understand what it means to be physically intimate?
- What is the resident's ability to avoid exploitation?
- What is the resident's ability to understand future risk?
- How may the resident be affected if they are ignored, rejected after intimacy or the relationship ends?

SEXUALITY QUESTIONS



Capacity assessment

- Always presume a person has the capacity to make all decisions for themselves.
- Never assume a person lacks capacity based on their age, appearance, disability, behaviour, beliefs or diagnosis or disease state.
- An enduring power of attorney (EPOA) has no legal force, unless it has been activated.

Consider whether the person can:

- understand the facts involved in the decision
- understand relevant information
- know the main choices that exist
- understand the potential consequences and their effects
- communicate their decision

The person must be told about the purpose of the assessment

Involving a team with capacity assessment process

Capacity is decision-specific, therefore assessment and tests will be based on the problem in question.

ADVANCED TREATMENT PLAN

A. Capacity to communicate and make decisions: To be completed by medical or nurse practitioner.

In my opinion the resident ☐ **does** or ☐ **does not** have capacity to make and communicate an informed consent about medical and mental health treatment. (Check applicable)

B. Cardiopulmonary resuscitation (CPR): To be completed by medical or nurse practitioner in collaboration with resident if they have decision-making capacity or family/enduring power of attorney (EPOA) if resident lacks capacity. (Check applicable)

☐ CPR/attempt resuscitation

☐ DNR/do not attempt resuscitation (allow natural death)

☐ Attempting CPR would be medically futile in my opinion due to the resident's underlying medical co-morbidities

GP/NP printed name:_____ Date:_____

Signature: Review date: _____

C. Enduring power of attorney for health and welfare: To be completed by nursing/management staff in collaboration with resident and/or family (if resident lacks capacity) (along with D below).

Is there a designated EPOA for health and welfare?

☐ Yes ☐ No

Is there a copy of the EPOA document at the facility?

☐ Yes ☐ No

Who is the designated EPOA for health and welfare?

Name: _____ Relationship: _____ Phone: _____

Has the EPOA for health and welfare been formally activated?

☐ Yes ☐ No

Is there a copy of the EPOA activation document at the facility?

☐ Yes ☐ No

ADVANCED TREATMENT PLAN

D. Desired level of care in the event of acute medical illness

These are a guide only for the medical and nursing staff to assist them in arranging appropriate care.

Desired level of care as stated by resident (or family/EPOA if resident lacks capacity) (as per above):

☐ Comfort care ☐ On-site active care ☐ Acute hospital care

Hospitalisation:

☐ Yes, transfer if acutely unwell ☐ No hospitalisation (unless there is a traumatic injury)

Antibiotics:

☐ Yes, to reverse illness and prolong life ☐ Not to prolong life, only for comfort

Artificial hydration:

☐ No artificial hydration ☐ Trial period of artificial hydration

Resident signature: Date: _____

Or if lacks capacity:
Input from: _____ Relationship: _____

Signature: Date: _____

Witness: _____ Designation: _____ Date: _____

Comfort care

- Keep me warm, dry and pain free
- Do not transfer me to hospital unless necessary
- Only give measures that enhance comfort or minimise pain
- Sub-cutaneous lines and injections only if it improves comfort
- No x-rays, blood tests or antibiotics unless given for comfort

On-site active care

- Antibiotics should be used sparingly
- Intravenous therapy may be appropriate
- A trial of appropriate drugs may be used
- No invasive procedures
- May transfer to hospital if needed

Acute hospital care

- Transfer to acute hospital if treatment cannot be provided on site
- Emergency surgery may be appropriate
- Treatment aimed at preserving life as well as enhancing comfort

ADVANCED TREATMENT PLAN

To be completed by resident (or family if resident lacks capacity):

This is what I (or my family) want others (including health care team) to know about me.

1. What matters to me and makes my life meaningful:

2. What worries me:

3. My cultural and religious beliefs include:

4. If I become unable to make or communicate decisions related to my health: (check applicable)

   ☐ I want my activated EPOA for personal care and welfare to make decisions using information in this summary
   ☐ I don't have an EPOA. I would like my health care team to decide, considering what matters to me and consultation with the following people:

5. Treatment and quality of life:

   ☐ I would like my treatment to focus on quality of life. If my health deteriorated I would like to be assessed and given any treatments that may help me to recover and regain my quality of life. (On-site active care or acute hospital care as per above)
   ☐ I would like to receive only treatments which look after my comfort and dignity rather than treatments to prolong my life. I do not want to be resuscitated. (Comfort care as per above)
   ☐ I cannot decide at this point. I would like my health care team to decide taking into account what matters to me and consultation with the following people:

POST FALL ASSESSMENT

Resident falls

- Witnessed or unwitnessed?
- Find out how/why they fell

- Did they hit their head?
- Are they on an anticoagulant (warfarin/dabigatran)?

Wait – DO NOT MOVE for at least 5 minutes until an assessment is completed

Before moving, check for:
bleeding, limb misalignment, hip/shoulder/elbow/groin pain with palpation,
stroke signs/symptoms, back pain, level of consciousness

POST FALL ASSESSMENT

No apparent injury

- Alert
- No pain
- No wounds or bleeding
- No limb deformity
- Mobility unaffected

↓

- Assist resident to a comfortable place (using hoist/manual handling aid)
- Observe for 24 to 72 hours (observation/neurology) per facility protocol
- Inform relatives
- Post-fall review GP/NP
- Complete facility post-fall protocols/incident forms

Minor injury

- Minor bruising
- Minor skin wounds
- Mild discomfort

↓

- Assist resident to a comfortable place (using hoist/manual handling aid
- Observe for 24 to 72 hours (observation/neurology) per facility protocol
- Treat minor wounds, pain relief medication
- Post-fall review GP/NP
- Complete facility post-fall protocols/incident forms

Major injury

- Airway or breathing problems
- Loss of consciousness or unresponsive
- Acute confusion
- Suspected head injury to resident taking anticoagulant (warfarin/dabigatran)
- Head injury or trauma
- Pain in limbs or chest
- Bleeding or extensive bruising

↓

Do not move the resident
(except for resuscitation)

Call 111 for ambulance

- Inform relatives and record the discussion
- Complete facility post-fall protocols/incident forms

Observation

- Temperature, SPO_2, pulse, respiration rate, sitting and standing BP

Neurology assessment

- Pupils equal and reactive, no changes in Glasgow Coma Scale

↓

- Resident alert, no new confusion
- Always inform relatives of any falls
- Provide emotional support to the resident.

If any changes are causing concern, phone GP/NP or 111.

POST FALL ASSESSMENT FORM

Post-fall assessment

Name of resident	
Date and time of fall	
Place of residence	
Name and signature or person assessing	
Date and time of assessment	

		✓ Tick and sign
Level of consciousness	Responsive as normal	☐
	Less responsive than usual – Glasgow Coma Scale	☐
	Unresponsive or unconscious (call 111) – Glasgow Coma Scale	☐
Pain or discomfort	No evidence of pain or discomfort	☐
	Showing signs of pain or complaining of pain	☐
Where is the pain?		
Injury of wounds	No evidence of injury, bleeding or wounds	☐
	Evidence of swelling, bruising, bleeding or deformity/shortening/rotation of limb	☐
Where is the injury or wound/s?		
Movement and mobility	Able to move all limbs as normal for the resident	☐
	Able to move limbs but has pain on movement	☐
	Unable to move limbs as normal for the resident or there is a major change in mobility	☐

Observations including neurological observations

✓ Tick and sign

Pulse	Resp rate	Sitting BP	Standing BP	Blood sugar	SPO2	Neuro-obs chart	

Conclusion of assessment

✓ Tick and sign

No apparent injury or minor injury ☐	Give first aid treatment	☐
	Commence observations (use post-fall assessment chart and complete body map)	☐
	Inform relatives	☐
	Complete an incident form	☐
Major injury ☐	Give first aid/resuscitate and call 111. **DO NOT MOVE RESIDENT**	☐
	Commence observations (use post-fall assessment chart and complete body map)	☐
	Inform relatives	☐
	Complete an incident form	☐

HE TANGATA, HE TANGATA, HE TANGATA

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

THANK YOU.

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