General Practice

Quality Improvement Toolkit

Frailty Management in Primary Care

A practical guide to identify patients at risk of frailty in Primary Care and to support healthy ageing initiatives as a CQI activity and for PIP QI and CPD purposes.

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Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and traditional practices of the families of the Yugambeh Language region of South East Queensland and their Elders, past, present and emerging.

Artwork: Narelle Urquhart. Wiradjuri woman.
Artwork depicts a strong community, with good support for each other, day or night. One mob.

Gold Coast Primary Health Network
ABN: 47 152 953 092

Level 1, 14 Edgewater Court, Robina 4226
PO Box 3576 Robina Town Centre Qld 4230
t 07 5635 2455 | f 07 5635 2466
info@gcphn.com.au | www.gcphn.org.au

Contents

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Gold Coast PHN if you have any feedback regarding the content of this document.

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About the Frailty Management in Primary Care Toolkit

"Frailty is the most significant challenge to 'ageing well' in Australia. More than 20% of people become frail as they age," states Professor Ruth Hubbard, Geriatrician, University of Queensland and international ageing researcher.

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

The GCPHN region has a higher proportion of older adults aged 65 years and over compared to the rest of the country. There are high utilisation rates of primary healthcare, particularly GP attendances which are higher for older people on the Gold Coast, when compared to the national population.

Older adults in the GCPHN region are more likley to live alone than in other Southeast Queensland regions. This, combined with higher numbers of older people relocating to the Gold Coast in their later years, who may lack informal care and support networks, raises concerns of social isolation and limited ability to access services without support (GCPHN Needs Assessment - Gold Coast Primary Health Network, 2021).

People with frailty have 2 to 3 times the health care utilisation of their non-frail counterparts and experience higher morbidity, mortality as well as lower quality of life.

Frailty can increase functional decline, increase the risk of falls, contribute to longer length of hospital stays and increase the chance of institutionalisation and death (RACGP - Frailty 2022).

Many of the causes of frailty can be managed and, in some cases reversed, to create better health outcomes and quality of life. It is therefore important to identify older people who are living with frailty.

This toolkit provides resources, guides and templates to support a frailty management continuous quality improvement (CQI) activity. Implementing the steps of this toolkit will assist with the development of an accurate register of patients to work with, maintain the accuracy of the register and the sustainability of the general practice system for future use.

Aim of the toolkit

To provide a simple and practical guide to implement a frailty management CQI activity to increase screening for frailty to support healthy ageing.

Benefits of using the toolkit

The toolkit provides a step-by-step approach to:

- Increase understanding of the concept of frailty and its impact on ageing.
- Increase use of the frailty screening tool to recognise older people with or at risk of frailty, thus supporting treatment options and referral pathways for frailty which can assist in reducing further decline and supporting an older person to live at home independently for as long as possible reducing early entry into RACFs.
- Successfully implement a frailty management CQI activity.
- Document the implementation of a frailty management CQI activity for PIP QI and CPD purposes.
- Make measurable and sustainable improvements to patient care in a feasible manner.
- Increase knowledge of CQI principles and their practical application.

How to use the toolkit

There are six steps to implement a frailty management CQI activity.

STEP 1 Planning and preparation

STEP 2 Use data to set goals and identify suitable patients

STEP 3 Implement improvement actions

STEP 4 Regularly review your CQI activity

STEP 5 Sustain and maintain improvements

STEP 6 Document your activity

Step 1 Planning and preparation

1.1 Team meetings

- It is important at the beginning of any CQI activity to arrange a practice meeting to identify members of your QI team and agree, plan, and prepare for its implementation. This will also demonstrate that a team-based approach was used to meet your PIP QI requirements.
- As a minimum, your meeting would include a GP, the practice manager, a member of the administrative team and a practice nurse. In smaller practices, the same individual may have more than one role. If it is not possible to have the whole team meet, each staff group should be represented and the best way to share information on your CQI activity with the wider practice team should be identified.
- Planned meetings on a regular basis to review progress towards your CQI goal/s is recommended, especially during and at the conclusion of the activity to reflect and review what's working well, how you are tracking towards your goal and to include this information in your QI Action Plan document.
  Practical considerations for your meetings:
  - Add CQI as a standing agenda item on your usual team meetings; or you could set up specific meetings for this purpose.
  - Examples of practice meetings and templates are available online.
  - Ensure that you have access to data report during meetings to inform your approach to planning and review of your CQI activity.
  - Consider using a QI Action Plan template during meetings to help guide you through the six simple steps of the CQI process. There is also a guide to assist completing the QI Action Plan.

Tip

*Regular meetings help to maintain momentum and keep the team on track to successfully complete the CQI activity. CQI activity templates can be used as evidence for PIP QI, and accreditation purposes. A **Frailty Management QI Action Plan** can be found here.*

1.2 Agree on CQI roles and responsibilities

- It is important to define and delegate specific roles and responsibilities in the CQI team to ensure every team member has a clear understanding of their role and responsibility to achieve a shared CQI goal. Potential roles for different team members are included in Appendix.
- Consider in your team who has the skills, ability and capacity to complete each task. You could ask staff to gauge their confidence out of 10 to complete an allocated task - this can help identify learning needs and training that may be required for each team member to fulfil their CQI role.
- Ensure all team members are aware who has responsibility for creating data reports and how data will inform QI Actions.
- Remember to share your drafted CQI Action Plan with the whole practice team to ensure that everyone is aware of the activity, including their roles and responsibilities.

1.2.1 Multidisciplinary Team-Based Care

- Collaboration and multidisciplinary team-based care are essential for the optimal care of older people. A multidisciplinary team involves a range of health professionals, from one or more organisations, working together to deliver comprehensive patient care.
- Multidisciplinary teams convey many benefits to both the patients and the health professionals working on the team. These include improved health outcomes and enhanced satisfaction for clients, and the more efficient use of resources and enhanced job satisfaction for team member (RACGP - Frailty 2022). The ideal multidisciplinary team for the delivery of care could include:
    - general practitioners
    - practice nurses
    - allied health professionals - such as physiotherapists, exercise physiologists, dieticians and pharmacists
    - medical specialists

*The **GCPHN/AGPAL eLearning Platform** provides fully funded, CQI training for all general practice staff.*

*The **GCPHN QI Team** have identified that practices with a team-based approach to QI make greater improvements than those without a team-based approach.*

1.3 Set realistic time lines

- It is important to specify the key steps of your Frailty Management CQI activity and to estimate how long each step will take to complete. It is also important to agree on dates in advance when progress will be reviewed to ensure the team is on track to meeting the final goal within the agreed time frame.
- Allow some flexibility with the time lines and expect and plan for delays. Some of the factors to consider when you set your time lines include:
    - where you are in the cycle of accreditation
    - staff leave and capacity
    - seasonal priorities and anticipated workload, i.e. the winter period tends to be particularly busy

Internal factors you can control:
Develop a calendar of known periods of specific activity to align with CQI focus to support proactive planning.
External factors and factors outside your control:
Ensure disaster management plans and business continuity plans are up to date and all staff are aware of their roles and responsibilities.

Step 2 Use data to set goals and identify suitable patients

2.1 Current performance and future goals

- Ask the following questions to assess current and future performance using your practice data:
  - Do we have a current process in place to identify those patients who may be pre-frail or frail?
  - Is there an opportunity to improve performance? If so, by how much? Your goal can be expressed as the number of patients who are found on the Primary Sense - Frailty Management report with one or more frail indicators.
  - How will you improve your current system or develop new systems to regularly review patients?
  - How long will it take to achieve this goal?
- A CQI activity is simply a structured, focused, and coordinated approach to reduce or close the quality gap between your current performance and your future goal. Practice teams that set SMART goals are more likely to be successful. The acronym SMART describes some of the desired characteristics of a goal: specific, measurable, achievable, relevant and timed.
- Two examples are provided to illustrate the difference between SMART and non-SMART goals.

SMART goal example
Practice A decides to focus on assessing all patients with 1 or more frailty indicators over a 12-week period. There are currently 50 patients - the practice team calculate that they will achieve this goal by reviewing 5 patients per week. This provides the practice with a small buffer of time to achieve their goal. They agree to review their progress every two weeks.

Non-SMART goal example
Practice B decides to focus on assessing all patients with 1 or more frailty indicators. They agree that their GPs and practice nurses will identify patients during their routine work and see how they go in a few weeks.

Data quality improvement:
Consider implementing or reviewing current database management processes to ensure your clinical software has an accurate "active" database (RACGP recommend 3 visits in 2 years). This ensures you can identify your regular patients to focus CQI activities on.
*A database cleansing **QI Action Plan** is available on the GCPHN QI webpage.*

2.2 Data sources to support frailty management CQI activities

- Primary Sense is currently the population health management tool that is fully funded by GCPHN for Gold Coast practices. Primary Sense can support frailty management CQI activities in the practice.
- Using a data extraction and analysis tool helps you to use your practice data in a meaningful manner. The main applications of data tools in CQI activities are:
    - To identify specific groups of patients – also referred to as samples of patients – who may benefit from being included in a CQI. The best data tools have the capability to generate lists with the names and information of all the patients in your sample.
    - To track your progress towards your goal over the course of the CQI activity.
    - To compare your performance with the performance of your peers inside or outside of the practice (optional).
    - To establish your performance baseline.
- The quality of your practice data, and whether the data is used to inform improvement, are more important considerations than which tool you use.
- Baseline data is your current performance. Baseline data for QI activities can be obtained from multiple sources, e.g.:
    - Practice management software
    - Data analytic tools, such as Primary Sense. Baseline data for a Frailty Management QI activity can be found using, for example the Frailty Care Management report.

Videos on how to use Primary Sense and reports can be found here.

2.3 Select a sample (or group) of patients

- The next step is to identify a suitable group (sample) of patients who have been identified with one or more frailty indicators.
- GCPHN suggests using Primary Sense User Tips (if needed - consider narrowing sample down by):
    - Frailty Care Management report
        - Offer a 75 years and over health assessment or 65 years and over GP management plan to patients who already have an existing appointment.
        - Focus on patients with lower complexity scores initially (Adjusted Clinical Groups (ACG) category 2-3). Specific age groups. E.g. 65-75-year-olds.
        - Focus on patients with a hospital risk score of 80% or more.
        - Focus on particular frailty indicators (e.g. history of falls, lives alone).
- Feasible samples are typically between 50 and 100 patients. Larger and more ambitious practice teams may opt to increase the size of their sample further.

Selecting a suitable sample and picking the right sample size can be challenging decisions for many practice teams. Contact your GCPHN QI Team if you would like to discuss this further.

Step 3 Implement improvement actions

3.1 Agree specific improvement actions

- Now that you have identified your sample of patients, it's time to decide what improvement actions or interventions will be required to reach your SMART goal. In other words, what is it that needs to be done for every patient in your sample?
- Consider patient engagement/experience and activation. How will you include patient communication and feedback in your CQI activity? A practical example of this is to add questions to your accreditation survey and offer survey participation to the patients in the CQI sample.

Ideas for change can come from a variety of sources: critical thinking about the current system, creative thinking, observing the process, a hunch, an idea from the scientific literature, or an insight gained from a completely different situation.

3.2 Examples of improvement actions in a frailty management CQI activity

3.2.1 Be Aware of Frailty

- All staff are to be aware of what frailty is and should know how to recognise the concept of frailty and its complications. For example:
    - Reception staff may notice a patient is wearing more clothes and is complaining of the cold. This lack of thermo-regulation could be a sign of frailty. Reception could flag this with the nurse/ GP prior to commencement of the appointment.
    - Observe patients with frailty in mind - Pay attention to how easily patients get up from waiting room chairs and walk to the consultation room. This can tell you a lot about leg strength and how steady or unsteady patients are on their feet.

3.2.2 Early Identification

- Identify patients with 1 or more frailty indicators using the Primary Sense report - Frailty Care Management.
- Clinical staff to become aware of the FRAIL Scale and how to use it, as it assists recognition of older people with or at risk of frailty.
- Increase the use of the frailty assessment tool by incorporating it into regular encounters with older people. For example, integrating into 75 years and over health assessments and care plan templates for all people 65+.
- Consider integrating the following into health assessments:
    - Objective measures of frailty as they are predictive of mortality, disability, falls, hospitalization, and risk of surgery of complications (Asia Pacific Clinical Practice Guidelines for the Management of Frailty, 2017).
        - Measuring walking speed: people aged 75 and over who take longer than 5 seconds to walk 4 metres are at high risk of frailty.
        - Grip strength measurement to indicate muscle weakness – your practice should consider purchasing a grip strength dynamometer.
    - Mini nutrition assessment (MNA) as it is a validated nutrition screening and assessment tool that can identify older patients 65yrs and over who are malnourished or at risk of malnutrition.
- Consider concurrently linking this activity with a health assessment QI activity to increase the number of health assessments completed, thus increasing FRAIL assessments. Review the Health Assessment QI Toolkit here.

3.2.3 Targeted Intervention

- Once a person has been assessed as pre-frail (i.e. score of 1-2) or frail, (i.e. score > 3) using the FRAIL Scale Risk Assessment Tool, a management plan that addresses the relevant deficits of the person's FRAIL scale should be developed. A Frailty Management and Decision tool can be utilised to support the plan. The targeted approach could include:
    - Tge patient's own goals.
    - Healthy eating to stay strong and independent (e.g. addition of a protein powder).
    - Managing weight loss (muscle loss). Did you know people 65 years and over lose 2% their of muscle mass a year? Older patients need a high protein diet.
    - Referral to an appropriate allied health professional (e.g. a physiotherapist exercise physiologist or dietitian).
    - Discussion about simple resistance exercise to build muscle or resistance exercise classes (e.g. Active & Healthy Program classes (Active Ageing section)).
    - Reviewing medications, consider de-prescribing and or/ refer to a pharmacist for a Home Medicine Review (HMR).

*Don't forget the recommendations from the **Asia Pacific Clinical Practice Guidelines for the Management of Frailty**.*

- Focus on the Older Persons Quality Care 5Ms:
    - What Matters Most
    - Mobility
    - Mentation
        - Depression
        - Dementia
        - Delirium
    - Medicines
    - Malnutrition

Remember: What Matters to the patient? What is their goal? E.g. to be able to garden again or to take walks with their husband.

- Consider affordability and provide options that are suitable for the patient. For example:
    - If the patient has private health insurance, some prevention activities will be subsidised. This may help them better utlise their insurance.
    - Some patients might prefer to pay to attend group classes which have a social element.
    - Others might prefer or require one-on-one consultation (e.g. with a physiotherapist or exercise physiologist).
    - Some patients might prefer to do their own exercises at home (e.g. following exercises in information leaflets) to save service and transport costs.
- Schedule a follow up appointment to discuss risk factors and make a frail management plan with the patient if you cannot complete all frailty management activities associated with the FRAIL scale in one appointment.

***City of Gold Coast - Active & Healthy Program** If your organisation would like to receive printed copies of the guide, please contact **activehealthygc@goldcoast.qld.gov.au**.*

*Starting exercise can be overwhelming to some patients. Consider starting your patients with some simple at **home exercises** first to build confidence.*

MBS ITEMS TO SUPPORT IMPLEMENTATION

- Health Assessments (Items 701, 703, 705, 707)
- Chronic Disease Management / Team Care Arrangement or contributions to plans (Items 721 to 732)
- Service provided to a person with a chronic disease by a practice nurse (Item 10997)
- Medication Management Reviews (Items 900 and 903)
- Case Conferences (item 735)

GPs are required to make sure each patient meets the MBS criteria prior to claiming each item number.

Step 4 Regularly review your CQI activity

During Step 1: Planning and Preparation, you would have identified the timelines and activity review points which should now be implemented as it is important to monitor your progress regularly.

Practical considerations:

- Set the frequency of CQI progress reviews according to the timeline of your activity. For example, it would be reasonable to check the progress of a 12-week activity every fortnight.
- Use your practice data at each checkpoint (review) to determine your progress towards your goal.
- Identify any barriers or challenges to your progress during the review. Are solutions required, if your Healthy Ageing Clinic doesn't have good uptake? Would further marketing of existing clinic details benefit or does the day/time need to be changed?
- The following questions may be helpful to work through during your CQI activity reviews:
    - Successes - what has worked well so far?
    - What are the challenges and barriers?
    - Were you able to overcome the challenges and barriers? If not, what do you need to do next?
    - If you were able to overcome challenges or barriers, what did you learn, and how can you use that in future?
- During the **final review meeting**, when you conclude your CQI activity, it is important to consider and document:
    - What worked well?
    - What could have worked better?
    - What were your learning points, learning needs and were learning needs met?
    - What changes did you make to your practice policies and procedures or systems because of this CQI activity (if any)?

Step 5 Sustain and maintain improvements

- Once performance has been improved, it usually requires regular reviews to maintain the gains.
- It is important to establish a reliable procedure to ensure your improved performance is sustained.
- New processes that are developed need to be documented and communicated to the wider team to ensure ongoing implementation is achieved.
- Agree the intervals at which you will review your performance relating to this activity, decide who will be responsible for the review, and the actions that will be taken if performance falls short of your new standard.
- Consider potential topics for a new CQI activity, and how your experience with this activity can help you to be more efficient and effective.
- Share your CQI activity, its successful outcomes and learning points with everyone in the practice team.
- Consider displaying the information on the practice tea room wall, on your practice website (internal and external), in your practice brochure/newsletter, on your practice social media, or other areas where the improvements can be socialized.

Speak with GCPHN if you would like support to showcase your work and share with your Gold Coast peers.

Step 6 Document your CQI activity

- Ensure you document your CQI activity to meet PIP QI guidelines. Documentation is also a requirement for CPD purposes.
- GCPHN have a Frailty Management QI Action Plan to support this CQI activity and record your progress.
- Documentation must be kept for 6 years as evidence of PIP QI should your practice be audited by the Department of Health and Aged Care.
- It is important to document your baseline and improved performance, and list improvement actions and learning points.
- If your CQI activity has resulted in changes to your policies and procedures, they can be included in the documentation as attachments and evidence for accreditation purposes.
- There are three main types of documents that are required for a CQI activity. The fourth type of document is desirable but not essential. All documents are 'living' in the sense that they can be updated throughout the CQI process. The four types are:

1. **Meeting documents -** A CQI activity requires at least two team meetings – one at the beginning and one at its conclusion. It is strongly recommended to also record minutes for your review meetings or 'check points'.

2. **Data documents** - For a frailty management QI activity these could include:
    - Primary Sense reports
    - spreadsheets

3. **CQI documents** - Document this entire CQI activity using the **QI Frailty Management Action Plan Template.** This template is suitable for PIP QI and CPD purposes.

4. **Practice policies and procedure documents** - reminder that changes can be saved as evidence for PIP QI.

There is no single 'right way' to document a CQI activity. The types of documents and templates we provide in this Toolkit are intended as examples. Practice teams can modify them to suit their own needs.

Additional support and information

PIP QI

- The GCPHN AGPAL eLearning Platform is a fully funded CQI training opportunity for Gold Coast general practice staff to support their practical CQI skills.
- For your Frailty Management CQI activity to be suitable for PIP QI purposes, you must ensure that all the requirements have been met.
    - PIP QI requirement information can be found on the GCPHN website.
- The GCPHN QI team can provide virtual/face to face meetings or access to recorded webinars that will assist with your frailty management CQI activity.

CPD

- If general practitioners would like to be eligible for CPD points for participating in the frailty management CQI activity, further information can be found on RACGP and ACRRM webpages.
- GPs can also assess if a clinical audit can be included as a component of the QI activity.
- Certificates of completion are available for modules on the GCPHN AGPAL eLearning Platform.

Email practicesupport@gcphn.com.au or phone (07) 5612 5408

Health Professional resources

- FRAIL Scale and Management/Decision Tool
- British Geriatrics Society "Fit for Frailty"
- RACGP resources:
    - Guidelines for preventive activities in general practice, Red Book 9th Edition
    - Putting prevention into practice, Green Book 3rd Edition.
    - Aged care clinical guide (Silver Book) 5th Edition
    - Smoking, nutrition, alcohol, physical activity (SNAP)
- Home Instead- -When Seniors Say No! A guide for overcoming resistance to assistance
- Commonwealth Home Support Package (CHSP) Reablement package
- Nutrition Professionals Australia
- Medication Management Reviews: Information for medical practitioners
- Home Medicines Review - Pharmacy Programs Administrator

- Accessed via the Syndey North Health Network:
    - Asia Pacific Clinical Practice Guidelines for the Management of Frailty
    - Nutritional Interventions in Sarcopenia
    - Effects of physical exercise interventions in frail older adults
    - The Effectiveness of Exercise Interventions for the Management of Frailty: A Systematic Review
    - Interventions for Treating Sarcopenia: A Systematic Review and Meta-Analysis of Randomized Controlled Studies
    - Inappropriateness of Medication Prescriptions to Elderly Patients in the Primary Care Setting
    - Beliefs and attitudes of older adults and carers about deprescribing of medications

Relevant HealthPathways

- Frailty in Older Adults Community HealthPathways Gold Coast (to be localised in 2023)

Consumer resources

- LiveUp - Australian healthy ageing initiative designed to help patients stay independent, and live their life to the full.
- Positive Ageing Tool (PAT) - Patients can complete their own online positive ageing screening and there is a collection of helpful information for better ageing.
- Programs & activities for seniors | City of Gold Coast
- City of Gold Coast - Active & Healthy Program - If your organisation would like to receive printed copies of the guide, please contact activehealthygc@goldcoast.qld.gov.au.
- Queensland Health, Staying healthy for seniors
- Ageing with vitality: Your everyday guide to healthy active living
- Queensland Stay On Your Feet - Helping older Queenslanders stay healthy, active, independent and on their feet
- Meals on Wheels
- Carer support information
- Nutrition Australia
- Active Ageing
- Dietitian Connection
- Seniors Enquiry Line: linking seniors with community information
- Friendline
- Be Someone For Someone | Tackling Loneliness Together

Other GCPHN CQI Toolkits

GCPHN has developed a range of toolkits which are available on our Quality Improvement webpage.

Appendix

Potential Frailty Management CQI activity roles and responsibilities of practice team members

General Practitioners

- Understand what frailty is, the benefits of early intervention, and how to use the FRAIL screening tool.
- Provide clinical oversight and governance of the activity.
- Lead discussion of the issues relating to healthy ageing and frailty across the practice.
- Identify people at risk of frailty.
- Talk about mobility/steadiness/loss of independence with at-risk patients (e.g. during immunisation, wound care, 75 years and over health assessment, 65 years and over GP management plan, etc.).
- Develop a management plan and go through some of the frailty prevention resources with patients.
- Oversee embedding FRAIL screening tool, MNA, 4 metre walking test and grip strength assessment into 75 years and over health assessments (all evidence-based inclusions).

Practice Nurses

- Support the implementation of the activity.
- Understand what frailty is, the benefits of early intervention, and how to use the FRAIL screening tool.
- Provide support in generating reports from Primary Sense.
- Identify, recruit and send out recall letters to people at risk of frailty.
- Develop a management plan in collaboration with the GP and go through some of the frailty prevention resources with patients.
- Talk about mobility, balance, muscles of independence, simple exercises for muscle strengthening, and the importance of protein in diet to build muscle particularly with patients at risk of falls (e.g. during immunisation, wound care, 75 years and over health assessment, GP management plan, etc.)
- Help GPs assess for risk factors and follow-up with the patient's progress.
- Develop a folder of localised services for patients after a management plan is developed.
- Embedding FRAIL screening tool, MNA, 4 metre walking test into 75 years and over health assessments.

Practice Manager

- Understand what frailty is, the benefits of early intervention, and how to use the FRAIL screening tool.
- Maintain up-to-date patient registers.
- Analyse practice data.
- Identify the best way to share and monitor the CQI Action Plan with the whole practice team.
- Ensure the CQI team have access to Primary Sense desktop to review relevant reports.
- Identify and support implementation of training for the CQI and practice team.
- Establish and oversee recall/reminder systems.
- Monitor progress against CQI activity, adjust approach if progress towards goal is not being achieved.
- Review and update new systems to ensure sustainable change.
- Document policy and procedures and support implementation across the team.
- Support with simple ways of identifying patients who may be frail at the front desk.
- Support clinical staff with awareness of services available in the region for patients after a management plan is developed.

- Support reception staff training regarding healthy ageing, frailty and benefits of 75 years and over health assessments.

Reception Staff

- Understand benefits of 75 years and over health assessments, what frailty is, and why screening is important.
- Order and maintain supplies of resources (e.g. patient information).
- Add flags or clinician reminders for patients in the activity.
- Support the practice team to identify patients eligible for relevant reminders and contact patients either via letter, text message, phone call etc.
- Support with simple ways of identifying patients who may be frail at the front desk.

Other Multidisciplinary Team Members

- Understand what frailty is, the benefits of early intervention, and how to use the FRAIL screening tool.
- Allied Health
    - Pharmacist to be involved in the Domiciliary Medication Management Review (DMMR) (Item 900).
    - Physiotherapist, exercise physiologist involvement for patients requiring individual exercise prescription for example through a care plan.
    - Dietitian for nutritional intervention, increasing protein uptake etc., this could be through a care plan.
- Other non-GP specialists for example a Comprehensive Geriatric Assessment by a Geriatrician.

Medical and Nursing Students (if relevant)

- Understand what frailty is, the benefits of early intervention, and how to use the FRAIL screening tool.
- Consider tasks that medical or nursing students could implement during clinical placements to support your CQI activities.

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An Australian Government Initiative

Level 1, 14 Edgewater Court Robina QLD 4226 | PO Box 3576, Robina Town Centre QLD 4230
P 07 5635 2455 | E info@gcphn.com.au | W www.gcphn.org.au

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