HSC Clinical Education Centre

Business Services Organisation

Northern Ireland Frailty Network



# Development of Frailty Education

Louise van der Linde
Senior Education Manager CEC

HSC Clinical Education Centre

@HSCCEC

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- Frailty education provided by Frailty network prior to August 2025
- Frailty education framework launched in August 2025 (DoH Big Discussion)
- Tier 1 and Tier 2 provided by HSC CEC on LearnHSCNI platform
- Tier 3 live session provided by Frailty network until April 2026
- From 1 April 2026: HSC CEC took over management and delivery

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support • confidence • strength

Ulster University

HSC Public Health Agency

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Tier 1 available on LearnHSCNI

Frailty Awareness Tier 1 eLearning (CEC)

Learning Outcomes

- Why Frailty awareness matters
- What contributes to Frailty
- Ways to reduce the risk of Frailty

Audience – universally relevant to service users, family and carers and all health and care staff.

Tier 2 available on LearnHSCNI

Frailty: An introduction eLearning (CEC) *due name change when updated version launched*

Modules:

- Frailty (Tier 1) must be completed to move onto Tier 2
- Frailty Awareness
- Falls Universal
- Fundamentals of Delirium and Frailty
- Fundamentals of Nutrition and Frailty
- Continence Awareness and Frailty
- Frailty Assessment

Audience – all health and care staff in Northern Ireland working in direct patient care who wish to find out more about Frailty.

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# Numbers so far...

(From Dec 2025)

**Frailty Awareness Tier 1 eLearning (CEC)**

CURRICULUM

→ 10,545




**Frailty: An Introduction eLearning (CEC)**

CURRICULUM

→ 5,723







→ 518 (Since 1 April 2026)

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# Frailty tier 3:
## What's in it?

Wai-Fun Wong
Nurse Education Consultant, CEC

## Aim

To develop participants' ability to assess, manage and support older adults living with frailty through the application of key Frailty assessment tools, comprehensive geriatric assessment, medicines optimisation and personalised care planning.

## Learning Outcomes

- Assess Frailty using the Clinical Frailty Scale (CFS).
- Explore the relationship between Frailty and cognition.
- Apply key principles of Comprehensive Geriatric Assessment (CGA).
- Recognise and address polypharmacy in Frailty.
- Enable person-centred 'What Matters Most' and Advance Care Planning discussions.

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- **Assess Frailty using the Clinical Frailty Scale (CFS).**

*As team lead, I aim to ensure Frailty assessment is mandatory in nursing assessment at clinic and CFS completed on encompass*

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**NI Frailty Network recommend the Clinical Frailty Scale**

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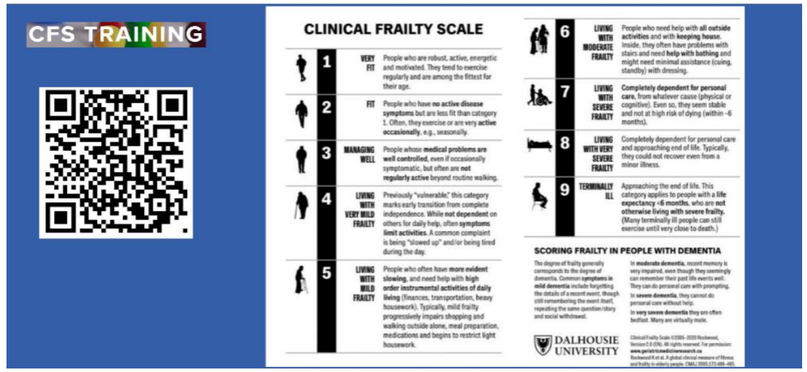


*Session was extremely informative – interactive throughout, case studies were a great way to understand what was being taught.*

*Most beneficial:*
- *learning how Frailty can be measured and using Frailty score*
- *Use of CFS and different domains of CGA*

*I plan to utilise Clinical Frailty Scale to support early recognition of vulnerable patients*

- Study of 68000 CFS scores in ED
- ED outcomes: each 1 point increase CFS = 12% lower odds for discharge home
- Increased CFS scores = higher reattendance risk
- CFS scores strongly associated with ST and LT mortality
- Presenting complaints significantly correlated with CFS scores

- THUS: CFS score reliability should be explored as means to support proactive treatment

Ellis et al, 2025

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**MRS GREEN, 87**

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- Son lives with her in 2 storey home
- Had a few falls and is now fearful when walking with her two sticks

**Medical history:** COPD, Osteoporosis, Previous hip fracture
**Medications:** Tiotropium, Salbutamol, Aldendronic acid, Calcium/ Vit D



- Carers calls each morning to help with washing and dressing and ensure has breakfast
- Son leaves out sandwiches for lunch
- Carer in evening to get ready for bed
- Spends most of the day sitting
- Gets out one day a week when son takes her to church

ANSWER: CFS 6

6 LIVING WITH MODERATE FRAILTY
People who 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.

*I use the CFS daily in my work so this course gave me more information to be aware of when deciding on a score*



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# DR EVANS, 82

- Lives alone
- Retired GP
- Recently diagnosed with dementia



- Manages personal care and meals
- Manages medications via blister pack
- Son calls 3 times per week and helps with shopping and supports finance
- No longer drives

**Medical history:**
Alzheimer's disease, HTN
**Medications:**
Donepezil, Amlodipine

ANSWER: CFS 5



**5**

**LIVING WITH MILD FRAILTY**

People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

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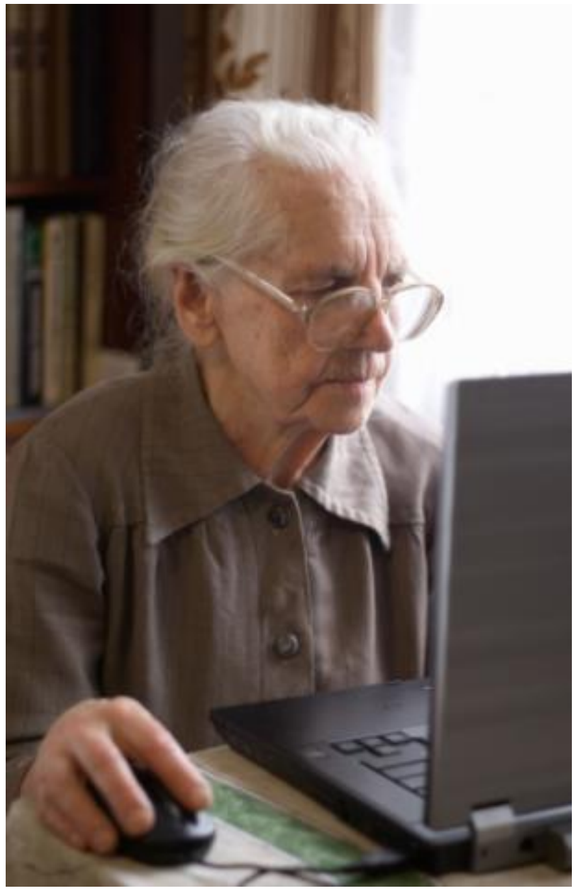
# MRS WHITE, 88

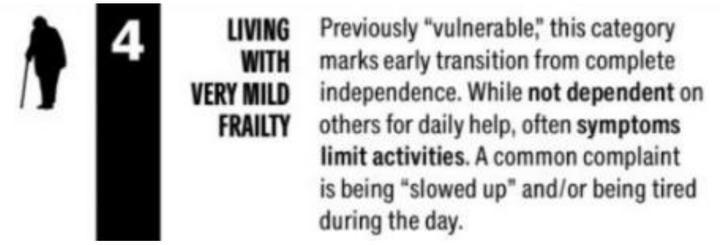
- Living alone in a bungalow

**Medical history:**
Osteoarthritis
**Medications:**
Paracetamol, Codeine



- High BMI
- OA of knees
- Uses stick when inside
- Mobility scooter when outside for last 5 years
- Manages washing, dressing, cooking, shopping and meal preparation
- Manages medications via online services from GP
- Managing finances via banking App

ANSWER: CFS 4



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# MRS HUGHES, 91

- Nursing home resident
- Bedbound
- Dependent on all aspects of care: washing, dressing, toileting, feeding and repositioning
- Unable to communicate needs, requires staff to anticipate them

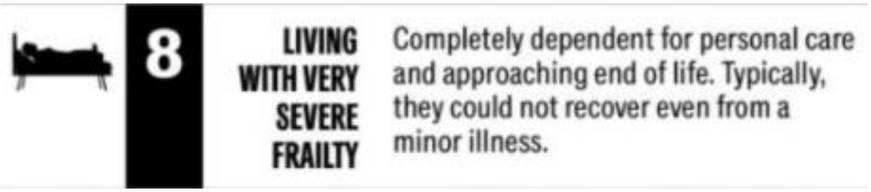


- On Modified diet, requires assistance with feeding
- Less and less interest in food, refusing or holding food in mouth
- Lost 4kg over 2 months
- 2 recent hospital admissions with pneumonia, frailer each time

**Medical history:** IHD, T2DM, CKD, cognitive impairment, HTN, severe osteoarthritis
**Medications:** Paracetamol, Aspirin, Bisopolol, Statin

ANSWER: CFS 8 – very severely Frail

Why? Completely dependent, bedbound, approaching EoL but not clearly dying



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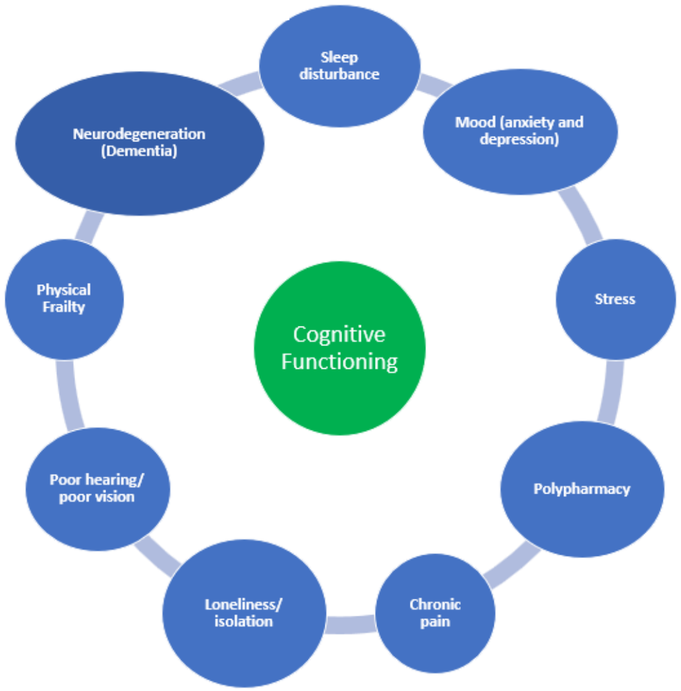
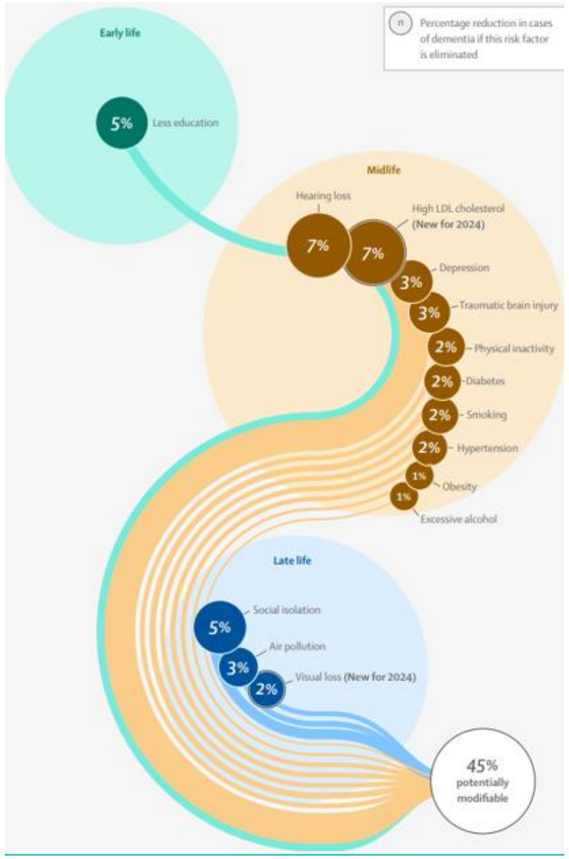
- **Explore the relationship between Frailty and cognition.**




*The importance of modifiable factors for Frailty for quality of life for individuals*



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- **Apply key principles of Comprehensive Geriatric Assessment (CGA).**

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## Comprehensive Geriatric Assessment

*Rubenstein 1991, British Geriatric Society 2014*

Describes CGA as a **multidimensional interdisciplinary** diagnostic process focussed on determining a frail older person's medical, psychological, and functional capability in order to **develop a co-ordinated** and **integrated plan** for treatment and long term follow up.




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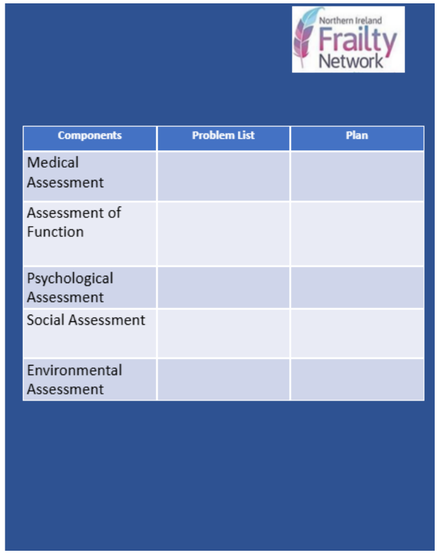
Group work (10 mins)

- Each group take one component of CGA
- Nominate one member to feedback to main group

There are five main aspects to the assessment: what do you think is included under each heading?




| Components | Elements |
|---|---|
| Medical Assessment | Problem list, Co-morbid conditions and disease severity, Medication review, Malnutrition Screening/Referral for Nutritional Assessment |
| Assessment of Function | Basic activities of daily living, Instrumental activities of daily living, Activity/exercise status, Gait and balance. |
| Psychological Assessment | Mental state (cognitive) testing, Mood/ depression testing |
| Social Assessment | Informal support needs and assets, Care resource eligibility / financial assessment |
| Environmental Assessment | Home safety, Transportation and Tele-health. |

## MARY:

Cognitive Function

Pressure Ulcer

Nutrition & Hydration



**"I'm feeling quite sad that I have had to leave my home. I have been in so much pain with this pressure ulcer that developed during my time in hospital and I will be so much more comfortable once it has healed. I really hope that my daughter will be able to visit me regularly, as I don't want to feel cut off from the only family member I have"**

### My health history:

Mary is 73 years old and was diagnosed with Parkinson's disease 17 years ago and developed Atrial Fibrilation after a heart attack 10 years ago. Over the years, Mary has managed her condition well and has been living on her own, however in recent months Marys health has been on the decline leaving her feeling exhausted. Mary is seeing a decrease in her mobility – walking speed has slowed, now uses a walking stick and has had several falls.Mary's daughter assists with meals and Mary can't leave house without help

### My network

- Care Home Staff
- Daughter

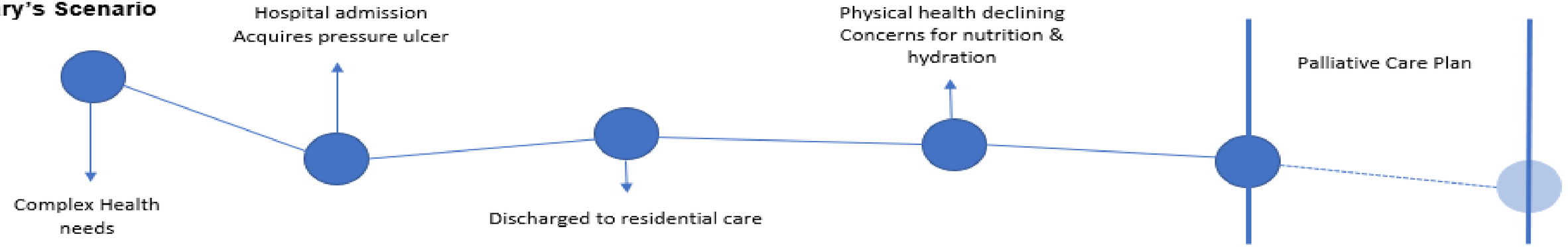
### My goals:

- Staying well and settled in my new home
- Having my daughter visit me
- Avoiding trips and falls

### Joy: A residential care perspective

'Mary came to us from the hospital with a really nasty pressure ulcer, the community nurses have been visiting Mary and training our team to help her heal. We've all had tissue viability training on what to look out for in our other residents. It feels good to be proactive and preventing anyone else being harmed. However, Mary has had Parkinson's disease for 17 years and her symptoms are worsening along with her Frailty, therefore we need to ensure Mary is receiving the right medication for her evolving state'

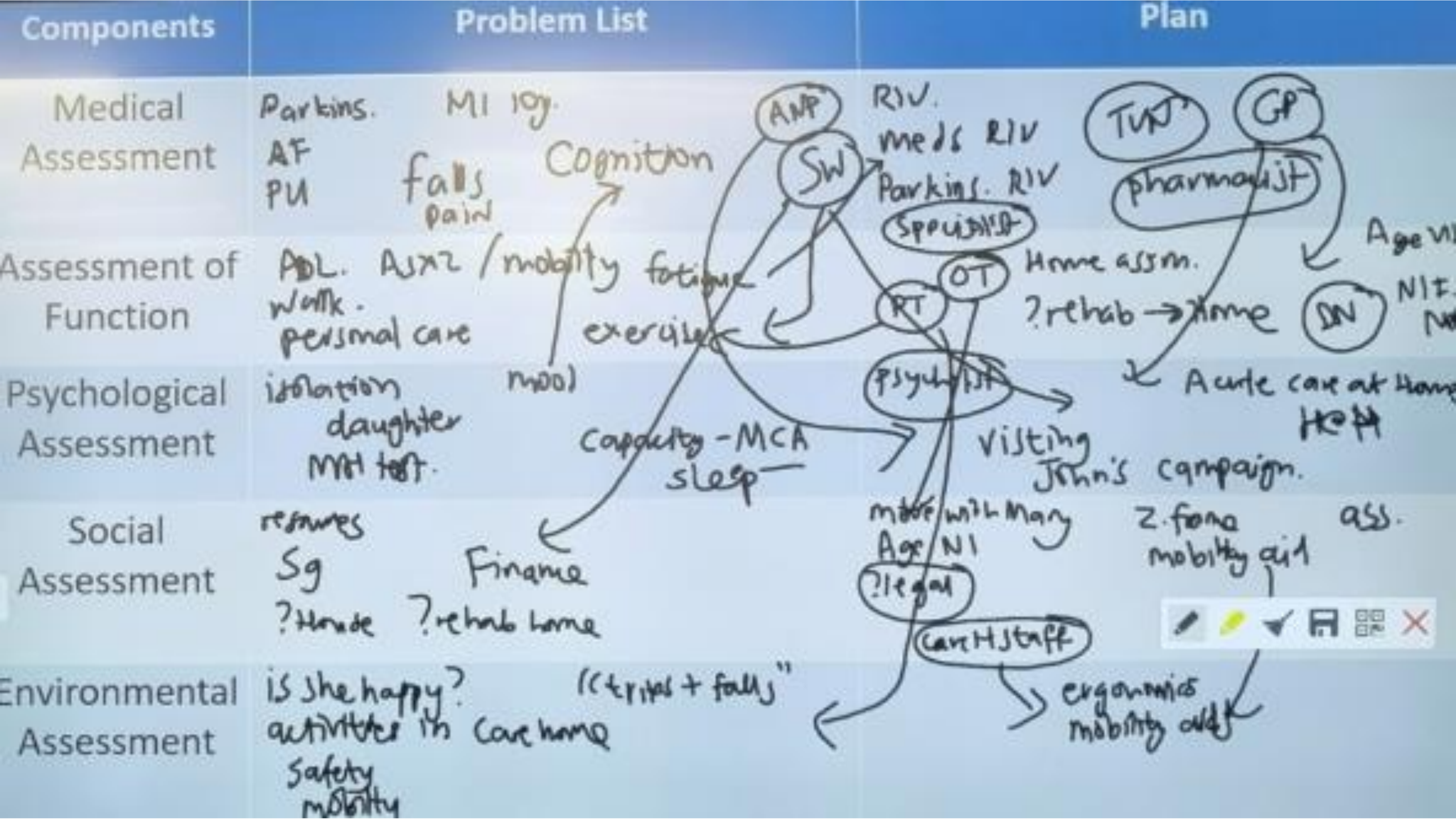
### Mary's Scenario



| Components | Problem List | Plan |
| --- | --- | --- |
| Medical Assessment | | |
| Assessment of Function | | |
| Psychological Assessment | | |
| Social Assessment | | |
| Environmental Assessment | | |

| Components | Problem List | Plan |
| --- | --- | --- |
| Medical Assessment | Parkins. AF PU<br>MI 10y. | ANP SW<br>RIV. meds RIV Parkins. RIV Specialist<br>TWT GP pharmacist |
| Assessment of Function | | |
| Psychological Assessment | | |
| Social Assessment | | |
| Environmental Assessment | | |

| Components | Problem List | Plan |
| --- | --- | --- |
| Medical Assessment | Parkins. MI 10y. AF PU falls pain Cognition | |
| Assessment of Function | PADL. AJX2 / mobility fatigue exercise walk. personal care | |
| Psychological Assessment | isolation daughter MMH test. mood | Capacity - MCA sleep |
| Social Assessment | resources Sg ?Hoarde Finance ?rehab home | |
| Environmental Assessment | IS she happy? activities in care home "trips + falls" Safety mobility | |



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## Functional Assessment

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- Basic ADLs
- Frailty Assessment
- Instrumental ADLs
- Activity/Exercise Status
- Gait and Balance



*Most beneficial was case studies, listening to group feedback, MDT representation*

*CGA assessment very informative*

*Will be used to identify and provide holistic interventions to Frail patients in acute settings*

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## Social & Environmental Assessment

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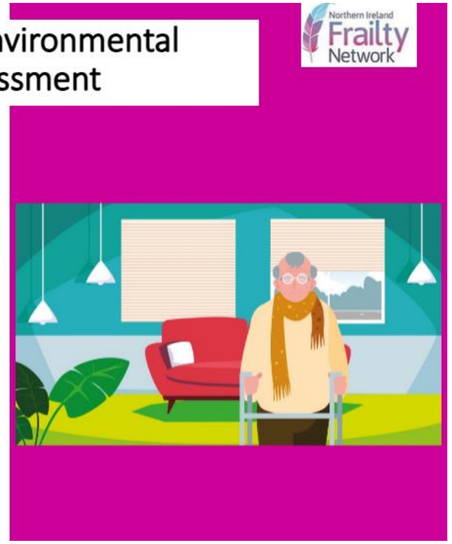
- Support needs and Resources
- Care Resource Eligibility/Financial assessment
- Personal Safety
- Transportation
- Living Conditions



*Thinking about a complex geriatric review and what it looks like from different healthcare professionals*

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- **Recognise and address polypharmacy in Frailty.**




## Prescribing Cascades

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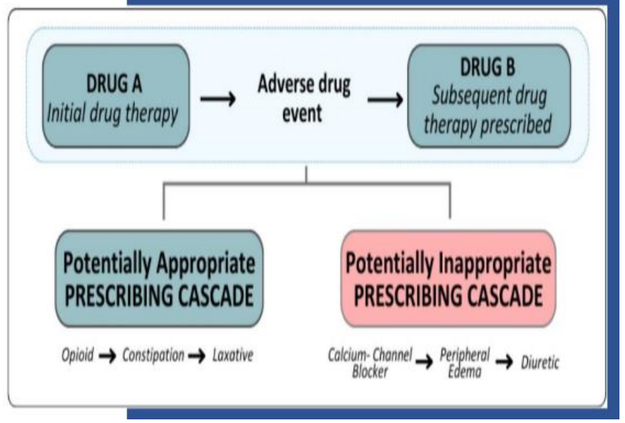
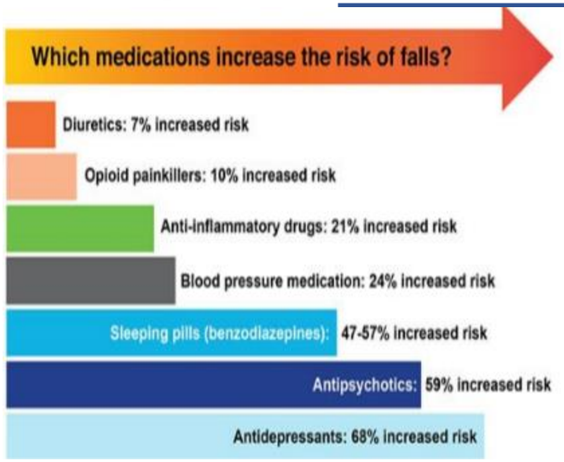



## STOPPFall

(A Screening Tool of Older Persons Prescriptions in older adults with high fall risk).



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- **Recognise and address polypharmacy in Frailty.**

*The pharmacist talk was most beneficial for my job role (Heart failure nurse) and resources she directed me to in relation to polypharmacy*

*Session on polypharmacy and deprescribing was useful as an independent prescriber, I will be more mindful of this in the future*

*The polypharmacy was very good, and the case study was very helpful in looking at polypharmacy*

*Speakers were very knowledgeable of the topics and learnt from the pharmacist*

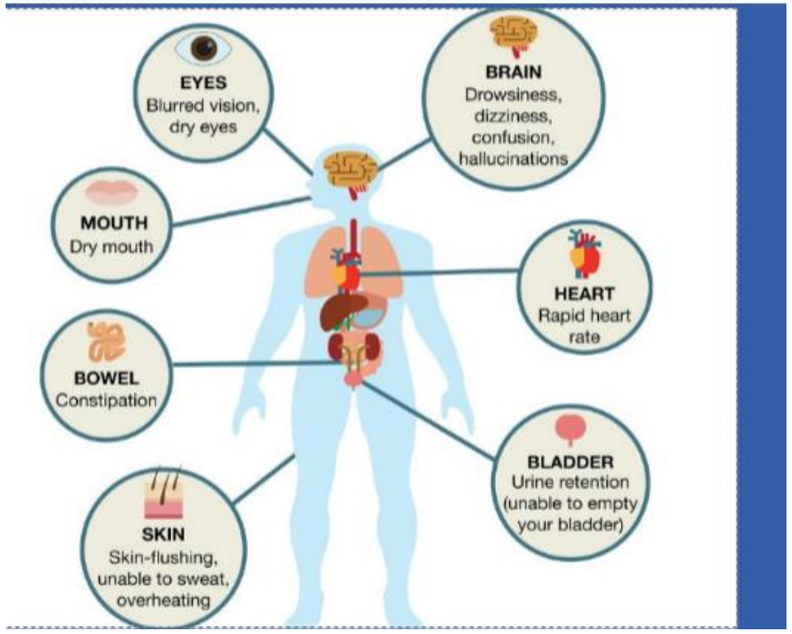
*Polypharmacy and describing most beneficial as I am a pharmacist and that is key part of my role in Frailty interventions*

*Pharmacology section made me think about patients and even family members polypharmacy and how to rectify*

*What did you find most beneficial:*

- *The pharmacy element*
- *Pharmacology was really interesting*
- *Discussion around pharmacy*
- *Talk from pharmacist was great*
- *Pharmacy discussion was very interesting*
- *Pharmacology lecture highlighted things I didn't previously know*

## Anticholinergic Burden (ACB) Effects



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- **Enable person-centred 'What Matters Most' and Advance Care Planning discussions.**




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**For Now and For The Future**

**Advance Care Planning**

To enable participants to develop their understanding of the advance care planning process in Northern Ireland and to prepare them to initiate, facilitate and record Advance Care Planning (ACP) discussions.

*Learning about the new ReSPECT form that is being launched*

Discussed new implementation of ReSPECT forms, didn't hear about this until today

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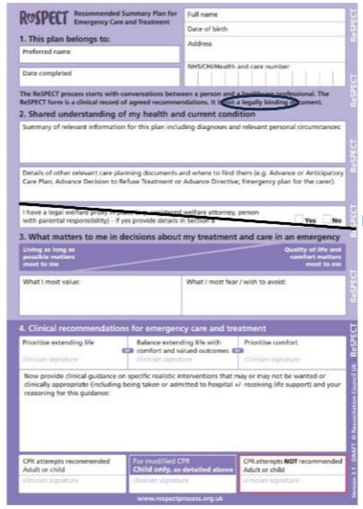
Resuscitation Council UK

**KEY POINTS TO CONSIDER**

- NOT YET LIVE IN NI
- Will replace DNARCPR in NI
- More than DNARCPR: is a personalised emergency care plan
- Not legally binding
- Intended to travel with person
- Reviewed and updated
- If person lacks capacity, best interests

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As the MCA (NI) is not yet fully enacted, NI does not currently have a system of Lasting power of attorney for health and welfare decisions. No individual can act as medical proxy on behalf of another person. This section will therefore require amendment prior to launch.

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**What is *your* role in ACP?**

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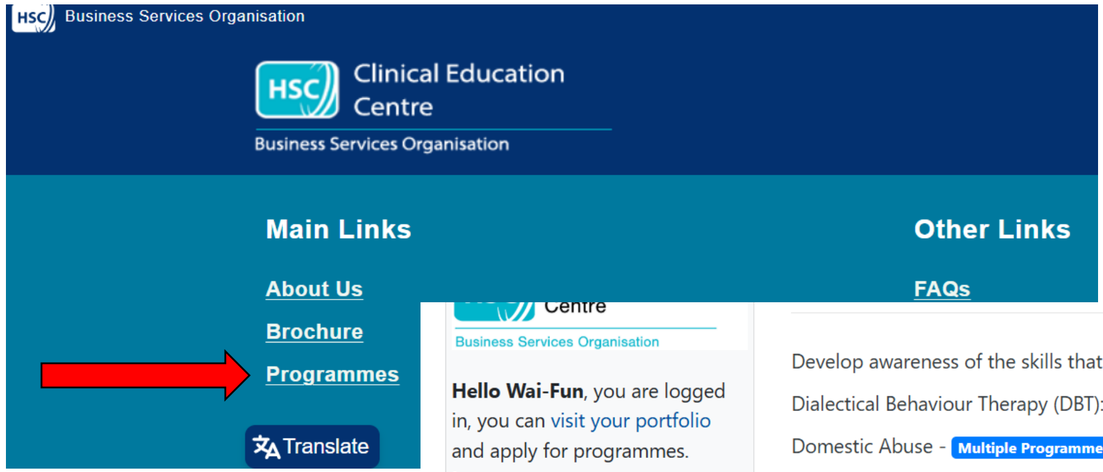
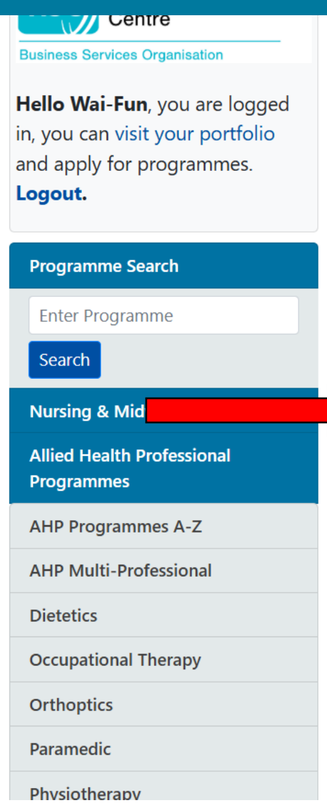
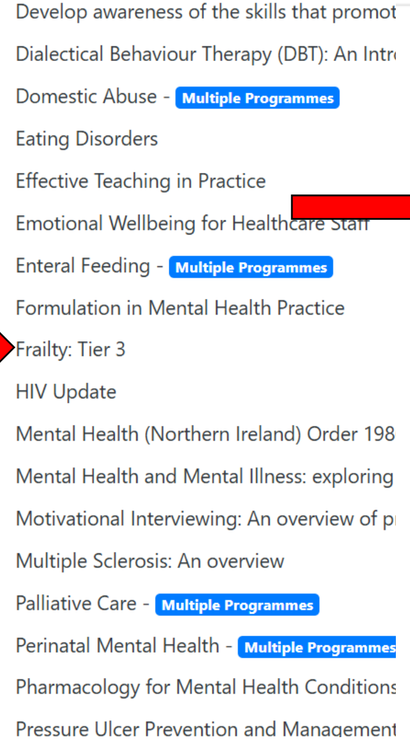
cec.hscni.net









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# Some dates

| DATE/ TIME | LOCATION |
|---|---|
| 12 OCTOBER 2026; AM | Clady villa |
| 15 OCTOBER 2026; AM | Altnagelvin |
| 21 OCTOBER 2026; AM | Lurgan |
| 5 NOVEMBER 2026; AM | Clady Villa |
| 27 NOVEMBER 2026; AM | Fern, Antrim |

Email us at:

Wai-fun.wong@cec.hscni.net

Louise.VanDerLinde@cec.hscni.net

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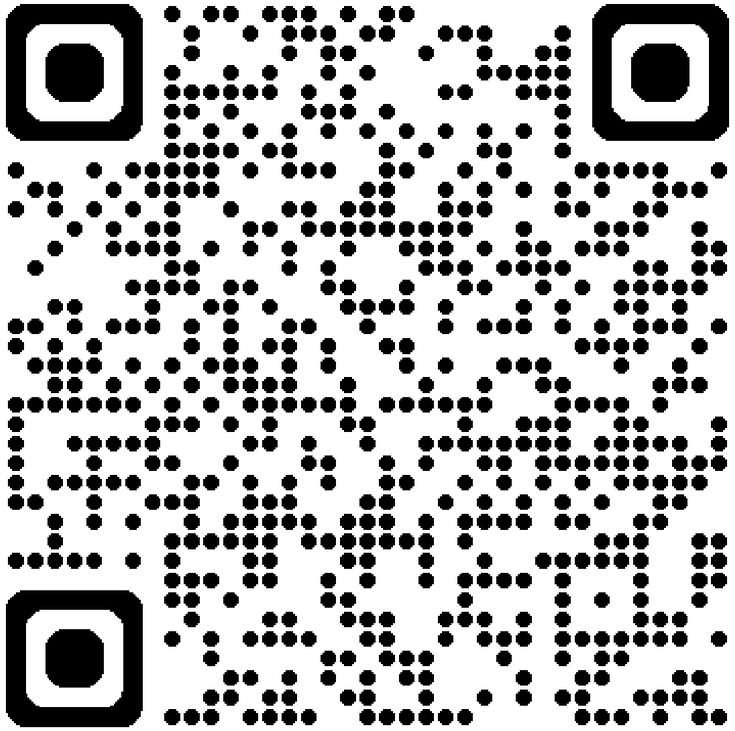
# Scan QR code for CEC Brochure



Placeholder

[Brochure | Clinical Education Centre]

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