Frailty: a term with many meanings and a growing priority for community nurses

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What is frailty? This is not a question that can be answered easily. Frailty is a complex and multifactorial construct, proving very difficult to succinctly define, making it challenging for clinicians to engage with. Lally and Chrome (2007) submit that:

> ***'Frailty comprises a collection of biomedical factors which influences an individual's physiological state in a way that reduces his or her capacity to withstand environmental stresses.'***

While this makes an attempt at a definition, it supports how complex frailty is to quantify, with no clear inclusion criteria. Frailty is not a formative diagnosis.

There are several schools of thought surrounding models of frailty, and how frailty is defined. Fried's Frailty Phenotype (Fried et al, 2001) describes a group of patient characteristics:

- Slow walking speed
- Unplanned weight loss
- Impaired muscle strength
- Self-reported fatigue
- Low physical activity.

The presence of three or more characteristics predicts the presence of frailty (Fried et al, 2001; Fried et al, 2004). This model, however, does not grade 'degrees' of frailty; it allows only a 'yes' or 'no' to being frail, and is not detailed enough for use as a robust assessment tool. However, it does attempt to offer a definition. Clear links of underlying pathological markers have been made to Fried's Frailty Phenotype (Fried et al, 2001), supporting this study as clinically relevant (Topinková, 2008).

The Cumulative Deficit Model, offered by Kenneth Rockwood, Canadian geriatrician, aims to classify frailty as a 'syndrome'. This alludes to frailty as a state of vulnerability that increases as the number of predetermined deficits, from a list of 70, increases. A deficit is something that is wrong with you (symptom, sign, disease or disability), and in effect the more deficits, the higher the proportion of frailty the patient possesses (Rockwood et al, 2005; Song et al, 2010). This approach supports the idea of frailty being a continuous process, and not simplified to a yes or no outcome. This theory is based on a large, good-quality population-based cohort study, and detailed patient assessment and analysis of the patients' outcomes and progress supported their conclusion.

Patients presenting to services with reduced mobility, new urinary incontinence, falls, impaired cognition, or older patients experiencing side effects from medication, must be assessed for frailty. The presence of these factors in isolation does not confirm frailty. However, they form key characteristics, and may describe the initial presentation to healthcare services (British Geriatric Society, 2014).

ABSTRACT

The question of exactly what frailty is and what that may mean for patients is extremely complex. This is a very conceptual problem requiring a broad and long-term solution. It is not a disease or a condition that can be treated in isolation. Frailty is a collection of contributing factors that culminate in an individual being susceptible to poorer outcomes following health-care interventions and minor illness. The solution to such a complex problem lies in engaging and empowering staff to understand and champion frailty. Once better understood, it will be possible to educate and enable this workforce to recognise the signs of frailty, poor prognosis and patients requiring more specialised palliative care. Informing staff working within a health-care economy of this issue must be the first step in a shift towards managing patients with frailty more appropriately, and streaming their care towards the correct care pathways sooner. This article discusses what frailty is, what it may mean for patients, and attempts to expand on why the construct of frailty is a prevalent issue for community nurses. The link between frailty and mortality is discussed and how targeted appropriate advanced care planning may be used to address this demographic challenge.

KEY WORDS

frail elderly • community health nursing • palliative care • advanced care planning

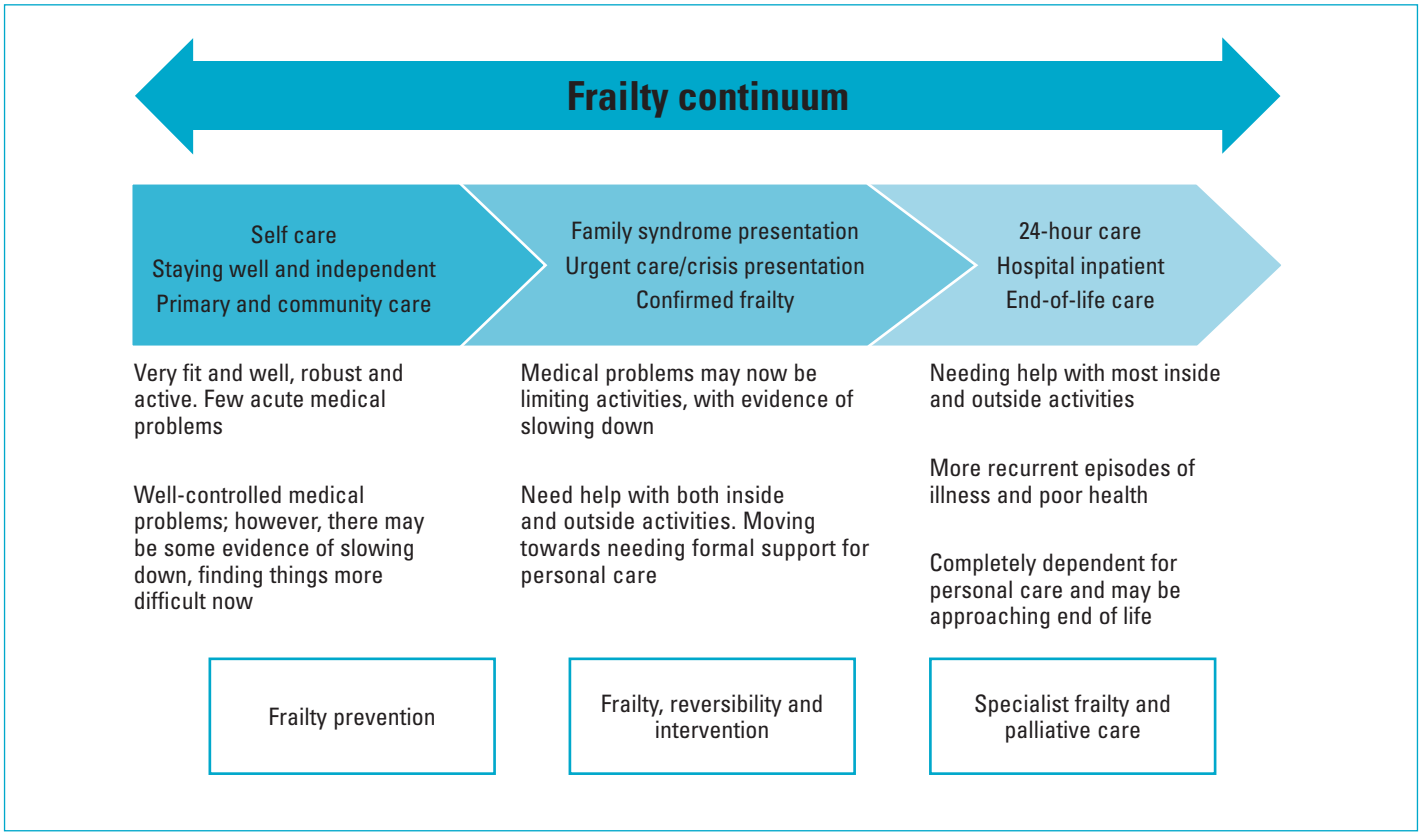

Figure 1. The Frailty Continuum

The impact of frailty on our patients

Frailty is not an inevitable consequence of ageing. It has been suggested between two-thirds and three-quarters of the population over 85 years of age do not live with frailty (Clegg et al, 2013). Health professionals must advocate a non-ageist approach of viewing frailty, reinforcing that populations must not be labelled as frail simply by age—not all older adults are frail (Fried et al, 2001). It must be remembered that frailty exists in the minority and not the majority of the ageing population, therefore correctly identifying frailty is an important issue.

There is a risk of significant harm when health interventions are planned when patients' frailty is not recognised and taken into consideration (British Geriatric Society and Royal College of General Practitioners, 2015). Addressing frailty is essential across all healthcare settings, as mild to moderate frailty can be reversible (Morley et al, 2013). Certain steps, such as nutrition assessment and interventions, increasing intake of protein, correcting calcium and vitamin D insufficiencies and reducing the number of unnecessary medications prescribed for frail patients, will have a positive impact on patient safety and frailty (Morley et al, 2013).

Several studies found adverse effects, such as death, falls, delirium and long-term decline in function, are all more likely to occur as a consequence of frailty following a period of illness (Fried et al, 2001; Song et al, 2010; Eeles and O'Mahony, 2012). Seemingly small events, such as a viral chest infection, or a simple urinary tract infection, may result in a substantial loss of function (Rockwood and Hubbard, 2004; Beswick et al, 2008; Royal College of Physicians, 2012; British Geriatric Society, 2014). Improving skills in recognising frailty plays an important role in preventing more serious consequences to what would be usually recognised as a non-serious illness or event. Improving skills in recognising frailty has a preventative role within health and social care services.

Why is frailty our business?

Frailty is an area of increasing interest and discussion within health and social care. Since the Francis Report (Francis, 2013) and Berwick Report (National Advisory Group on the Safety of Patients in England, 2013) it has been scrutinised whether UK healthcare services are fit to care for the frail elderly population they serve. Providing excellent services to all patients in communities is a shared goal in provider organisations, especially the specialist support for patients often referred to as frail. Understanding what frailty means and how best to measure it is important to enable to provision of high-quality pathways of care for patients.

The UK has an ageing population, as well as significantly decreasing health and social care resources (Appleby, 2013). Changing the way clinicians think about frailty, using a greater awareness and knowledge of frailty to influence decision making, will involve deep engagement with the topic, and a shift in culture to build this into practice long

term. Developing a strong culture to address frailty is a broad and long-term goal affecting the entire patient pathway within all settings, with multiple factors contributing to the problem. Addressing care culture must be viewed as more significant than policies or protocols on patient safety (National Advisory Group on the Safety of Patients in England, 2013). As an example, practice nurses work with GPs very closely, and play an important role in influencing the culture of individual practices and contribute to new innovations within primary care. If frailty can be elevated as an issue within the practice, a congruent approach to assessing frailty will follow, and the impact this has on quality may be evaluated, further enhancing the evidence base. Within strong healthcare cultures, staff are encouraged to make decisions, and empowered within their role to deliver change (West et al, 2015).

Soong et al (2015) attempted to quantify the prevalence of frailty in hospital and observed an increase in patients coded as frail, with admissions doubling in an 8-year period. Over the same period hospital mortality has fallen; however, readmission rates have increased, particularly in the over 85 year age group. Mytton et al (2012) suggest between 21% and 32% of admissions to an elderly secondary care unit were completely avoidable had decision making been different in community and primary care.

NHS England has released a primary care initiative to reduce unplanned admissions to hospital, and this places an increased incentive and emphasis on frail patients, and proactive appropriate care planning (NHS England, 2014). A toolkit document produced to support general practice to achieve this goal indicates this is a responsibility for both GPs and general practice and primary care nurses (Lyndon and Stevens, 2014). The Department of Health's *Transforming Community Services Agenda* (2009) supports a shift in care from hospital to home. Bringing acute services closer to home encourages vulnerable people to be supported at home, with both a reduced length of stay in hospital and a higher threshold for admission to hospital. Community nurses are encountering patients with significant frailty more with this shift in care, and understanding frailty, traditionally a specialist geriatric problem, is a growing priority.

Figure 1 demonstrates the full continuum of frailty, and explores where different nursing roles and interventions may be able to target their impact. Regardless of its role in the community, frailty presents a broad issue for many different facets of community nursing. The frailty continuum describes how patients can move up and down the continuum in the context of their frailty, and that a frailty state is fluid and can be influenced by health and social care intervention. This continuum correlates well with 'the Clinical Frailty Scale' classification of frailty (Rockwood et al, 2005), and simplifies the approach to intervention into three categories:

- Prevention
- Intervention
- Palliation (to relieve or lessen without curing).

There are significant roles for community nurses in prevention and patient education, such as in practice nursing, public health policy application and health training. There is a cohort of patients where frailty may be reversible, and intervention and coordinated case management of long-term conditions may have a significant impact. And there are the significantly frail patients, where health professionals must understand frailty as an independent risk factor for end of life and provide targeted specialist palliative care appropriately.

As care shifts into the community, responsibility and complexity shift also. When highlighting new priorities for practice, it is important not to add burden to the already pressured workloads of community nurses. The aim must be to enhance existing clinical practice to appropriately recognise and address frailty, not create new work. The construct of frailty is not new; however, new learning is showing us that more appropriately targeted services and intervention will help address this growing demographic for the future. Adding frailty screening into core nursing assessments, and building frailty triggers into pathways, will offer a more targeted approach to care. It is not appropriate to transform roles and responsibilities completely to address frailty, but to shape what exists to ensure that the context of a patient's frailty is acknowledged within existing service delivery. By investing time and expertise now to consider a strategy for this problem, it will support future services and delivery. Frailty directed Commissioning for Quality and Innovations (CQUINs) and Quality and Outcomes Framework (QOF) indicators will increase as this problem grows. These frameworks are rewards and incentives for achieving certain targets or goals within services. CQUINs pertinent for CCG-funded services and QOFs form part of the part of the General Medical Services (GMS) contract for general practice.

Frailty and mortality: it's time to take note

People can be supported to live with frailty for many years. However, frailty has been reported to be the most common condition leading to death in older people (Gill et al, 2010). Frailty represents the largest group of patients requiring palliative care in the UK (Lynn, 2001), with an average of 7 to 8 deaths per GP per year (Free et al, 2006).

The clinical work and teachings of Scott Murray have been very influential in exploring the link between frailty, life expectancy and the trajectory of the decline (Murray et al, 2005a; Murray et al, 2005b). This work synthesises the idea there are three potential trajectories of illness:

- A short period of evident decline (typically cancer)
- Long-term conditions with intermittent serious exacerbations
- Prolonged dwindling or frailty.

This was some of the first work to suggest that frailty should be viewed as an independent area contributing to end-of-life care. Health and social care professionals must not neglect palliative care planning for patients where there is uncertainty around prognosis and life-limiting conditions, very much the case with frailty (World Health Organization, 2004).

One of the most significant failings in end-of-life care is the delay in identifying patients who are approaching death (Thomas, 2010). Prognostication of illness and predicting decline is extremely complex and challenging. The common failure is to underestimate approaching end of life, leaving less time for advanced care planning and end-of-life care discussions. This has been described as particularly common in non-cancer patient groups (Murray et al, 2005b; Free et al, 2006). The Gold Standard Framework (GSF) has been devised to offer a systematic, evidence-based framework for all patients approaching the end of life. It is aimed at generalist frontline care clinicians, improving the quality of care provided through training, and provides accreditation to formally recognise good practice (National Gold Standards Framework Centre, 2016). The use of the GSF in primary care has been embedded in the GP Quality Outcome Framework (NHS Employers, March 2014).

The Frailty Index (Mitnitski et al, 2001) was found to positively predict mortality in nursing home residents (Tabue-Teguo et al, 2015); non-survival from the intensive care unit (Zeng et al, 2015); and mortality following hip surgery (Krishnan et al, 2014). Frailty also presents an increased risk of an individual requiring 24-hour residential or nursing care (Rockwood et al, 2004; Gill et al, 2006; Clegg et al, 2013).

Various frailty screening methods have been validated for use as prognostication tools, as discussed in a systematic review of frailty measurement (De Vries et al, 2011). There is some contradiction in the use of prognostication tools, a feeling that less emphasis should be placed on the value specific clinical prognosis offers and more focus on holistic care principles (Murray et al, 2005a).

A gap in the research seems to be a direct comparison of all frailty assessment tools' ability to positively predict or correlate with mortality. A secondary analysis review paper concludes there is a significant difference in the ability of eight frailty assessment tools in predicting all-cause mortality (Theou et al, 2013). This paper looks at the predictive ability of the tools, but acknowledges more work is needed to explore the specificity and strength of each tool.

KEY POINTS

- Frailty is complex and difficult to define; however, understanding it and engaging with the concept is the first step towards delivering safer, better care
- Frailty is a growing priority for community nurses and should form part of everyone's core business values
- Frailty is linked to poorer health outcomes. The impact frailty has on patients is significant
- Frailty and mortality have a correlation that must not be ignored. Better understanding will bring expert palliative care forward
- Individualised advanced care plans are a must for frail patients in the community

Advanced care planning: a must do

The literature is overwhelmingly supportive of the clinical correlation between frailty and palliation; however, there are no clear recommendations as to how to implement this link in practice. The British Geriatric Society (2014) published a document *Fit for Frailty* in association with the Royal College of General Practitioners and Age UK. This offers guidance for providing care to frail elderly patients. The document describes the importance of identifying frailty, and how understanding a patient's frailty can improve healthcare delivery. The document strongly advocates individualised care plans, advanced care plans and recommends a robust system for monitoring and reviewing these plans at regular intervals with patients. It provides opportunity to reassess frailty, map changes, amend the care plan accordingly, escalating any concerning deterioration for the GP's attention.

A commitment to screening for frailty as a core part of community nursing assessment processes, and using this information to trigger appropriate advanced care planning and palliative care will enhance care for patients living with significant frailty. The above literature unequivocally supports that acknowledging frailty is the right thing to do for patients, and that a patient with frailty has an increased risk of poorer health outcomes and mortality. To gain a lasting impact on such a large and complex problem, true and deep engagement with all staff of the issues raised in this paper must be achieved. Health professionals must strive for a shared vision for the future of all patients identified as frail, with this group being proactively managed, reviewed and appropriately cared for. They should aim to guarantee access to expert palliative care services at the point of need every time. **BJCN**

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