Perceptions, practices and educational needs of community nurses to manage frailty

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ABSTRACT

Early intervention on frailty can help prevent or delay functional decline and onset of dependency. Community nurses encounter patients with frailty routinely and have opportunities to influence frailty trajectories for individuals and their carers. This study aimed to understand nurses' perceptions of frailty in a community setting and their needs for education on its assessment and management. Using an exploratory qualitative design we conducted focus groups in one Health Board in Scotland. Thematic content analysis of data was facilitated by NVivo© software. A total of 18 nurses described the meaning of frailty as vulnerability, loss and complex comorbidity and identified processes of caring for people with frailty. They identified existing educational needs necessary to support their current efforts to build capability through existing adversities. Our study indicates that current practice is largely reactive, influenced by professional judgement and intuition, with little systematic frailty-specific screening and assessment.

KEY WORDS

◆ Frailty ◆ Nurses' perceptions ◆ Community nursing ◆ Education ◆ Integrated care

Frailty is a major public health challenge often associated with ageing (World Health Organization, 2015; Cesari et al, 2016), and it is linked with falls, disability, hospitalisation, care home admission and even death (Clegg et al, 2013). Definitions of frailty are based either on a specified, five-point phenotype (weight loss, exhaustion, low physical activity, slowness and weakness) (Fried et al, 2001) or as an accumulation of deficits on different domains, including the cognitive and physical domains (Rockwood et al, 2005). Both definitions have negative connotations, such as being vulnerable or incapable (Nicholson et al, 2016). The contested nature of frailty can be even more prominent in diverse socio-cultural contexts (Hanlon et al, 2018). The prevalence of frailty is around 11% in people over the age of 65 years living in the community (Collard et al, 2012). Nevertheless, frailty can be prevented by early intervention to reduce the rate of functional decline and dependency (Travers et al, 2019). Proactive interventions and integrated approaches in the community can prevent frailty and optimise intrinsic capacity (British Geriatrics Society, 2014).

In the UK, over 50% of people over the age of 80 years live in their own homes (Collard et al, 2012). Community nurses are ideally placed to identify those at greatest risk of frailty, prompt early intervention and coordinate care to support older people at home. Britton (2017) indicated a need to increase the understanding of and confidence among community nurses to manage frailty. With frailty education for community nurses still in its infancy, practice-focused education is required to expedite better care (Windhaber et al, 2018). This paper reports qualitative findings from the initial phase of the Frailty Matters project (http://frailtymatters.uws.ac.uk/), which aims to identify and address gaps in education for community nurses to manage people with frailty.

Methods

Aim and design

Through an exploratory qualitative design, the authors set out to understand the perceptions of community nurses about frailty; training and use of educational materials on frailty; learning needs in relation to identification, assessment and management of people with frailty; and

their leadership role in interdisciplinary practice within community teams.

Sample and setting

Community nurses providing care to people living with frailty in an area covered by one health board area in Scotland were invited to participate in focus group interviews. The health board selected is projected to see a 55% increase in those aged over 70 years between 2015 and 2035 (Scottish Government, 2010), and it is developing novel models of integrated care for this population. The lead nurse in each of the three Health and Social Care Partnerships identified study participants. Participants included nurses (n=17)with a wide range of experience ranging from 2 to 20 years (district nursing team leaders, district nurses with a formal specialist practitioner qualification, community registered nurses and clinical support workers). Focus groups were carried out at locations suitable to the community nurses, within their own localities. Team leaders of community nursing teams within these areas were also invited to participate in one-to-one interviews.

Ethics

The regional ethics committee granted ethical approval for the project, and permission to collect data was provided by the local NHS Research and Development office. Data collection complied with the requirements of the GDPR and Data Protection Act 2018.

Data collection

In October 2019, 17 community nurses attended three focus groups (FGs) (duration, 53–70 minutes); one community nurse team leader was interviewed separately. Interviews were conducted using an interview schedule, which was informed by analysis of published literature and national educational materials on frailty and was ratified by the project's steering group. Interviews were conducted by JB and facilitated by JM. The interviews were transcribed verbatim using an authorised secretarial service.

Data analysis

Data were analysed using thematic content analysis (Braun and Clarke, 2006; Braun, 2013). NVivo© 12 was used to facilitate data organisation. Transcripts were first read several times (step 1) to become familiar with the data. Initial coding followed (step 2), whereby the researcher (JB) created codes that were then organised into sub-themes (step 3) related to the research objectives and then further refined (step 4). Final themes (step 5) were identified and named by focusing on points of agreement or disagreement. The analysis process was discussed with a researcher experienced in qualitative analysis (CP) before being agreed by the wider project team.

Findings

Two key themes were identified: (i) concept of frailty and (ii) knowledge about frailty. Each theme was expanded upon via two subthemes.

Concept of frailty

Meaning of frailty

When asked to describe the meaning of the word 'frail' or 'frailty', participants used the term 'vulnerable'. This vulnerability was conceptualised in two ways: the need for input from different services and coordination of these services due to increasing complexity.

> *'There's a lot of people out there who have issues, be it physical, mental, psychological … it makes them very vulnerable. I think, often, 'vulnerable' and 'frailty' sometimes go kind of hand in hand.' P008–FG2*

The term 'frail' was perceived to include not only being old in age, but also having multiple long-term conditions and complex care needs. Participants generally considered the ageing process to be inevitable, but frailty could be reversed or at least slowed down.

Frailty was also linked to different types of losses: loss of hope, loss of identity, loss of the person's ability to make decisions and loss of social connections. When discussing loss of identity within the context of ageing and frailty, some participants suggested that their patients also experienced a loss of purpose or role, which ultimately exacerbated the individual's state of frailty.

> *'I think the culture we live in now is, you're old, you're frail, there's no role for you. There is no role for people to play. They feel useless. That's another thing that does increase frailty.' P012–FG3*

This loss of purpose and identity could adversely impact the individual's mental health and, in turn, affect their ability to exercise choice and control and make decisions, particularly when multiple caregivers (professional or family) are involved in the person's care:

> *'Someone comes in and just takes her clothes off a hanger, or her daughter sets her clothes out in sections. So she doesn't have a choice of colours, what she's wanting to wear … that was a big part of her independence. She thought it was the last thing that she was going to lose, her decision-making.' P016–FG3*

The negative impact of loss of social interaction and loneliness on people with frailty was stressed, led by changes in family structure. Previously, families would live either in the same house or in the community, meaning that older family members were looked after better:

> *'In the past, culture would have been very different. Grandparents would have had a place in a home. I know, obviously, in a lot of European cultures that's still the same, and elderly people*

do have a role to play in nurturing families. Whereas, unfortunately, I think the culture we live in now is, you're old, you're frail, there's no role for you …' P012–FG3

Loneliness could also affect people's mental health. Participants reported the lack of socialising facilities in local communities as a contributing factor. Nurses could be the sole human contact that some older people would have on a day, or even a week:

'The startling thing that I've found over the last 5 years is the amount of people, elderly, that are really quite depressed. They really feel quite sad, and the more frail they get, the less people are coming into the house.' P012–FG3

'We are the only person in a week that person can see sometimes, and I think just going in and having a 10- or 15-minute chat with them and seeing that it makes a difference … it kind of reduces their loneliness.' P004–FG1

Processes of caring for the frail

When reflecting on their caseload, participants stated that community nurses were well placed to deliver care to people who were frail and still living at home or within a homely environment. Management of patients living with frailty involved a number of processes, including assessment, care planning and securing and coordinating a range of services:

'The key is to try and anticipate what's going to happen and make sure there's things in place, to make the journey as smooth as it possibly can be. And to ensure that these people are, most importantly, kept safe at home.' P004–FG1

When asked how they identified people who are frail, many stated they used their observational skills as part of a general nursing assessment. While some described identifying a progressive, general physical decline, others recognised an intuitive element in the process, a 'gut instinct', based on their years of experience in the community:

'We've got vastly experienced nurses, and that becomes second nature. But when you've newly qualified nurses, that is a different ballgame. They'll come back with observations and raise concerns, and then it would be the nurse's intuition that would review that patient and then see something completely different.' P010–FG3

'We've got documentation, we have the nursing profile and, within that profile, is activities of living, and basically that's our framework for assessment.' key informant interview

Nurses clearly articulated the need to holistically assess each individual patient based on clinical history and, equally important, within the context of their home, family circumstances and physical environment:

'You open a cupboard, and there's medication falling out. You open a fridge, there's no food. We're not just going in to look at the patient's leg, we're actually carrying out that holistic assessment as you're chatting to the patient.' P012–FG3

Considering the unique clinical and environmental circumstances of each individual, participants agreed that getting to know patients and families was integral within their role. Strengthening this therapeutic relationship was considered crucial for patients living with frailty. Comprehensive assessments of the person and their environment allowed potential problems to be anticipated and addressed as part of the care planning process, thereby reducing patient risk.

Two participants highlighted the impact of poverty on people living with frailty and the importance of discussing financial concerns during assessment and care planning processes. They noted a 'vicious cycle', where the presence of poverty increased the risk of harm for a person who was already living with frailty.

'Seeing this vulnerable, frail, older person in a house with no carpets, no one to wash their hands. I've come across people who have not got enough bedding, they've got no food in the fridge, there's no heating.' P009–FG2

Incorporating environmental factors and benefits maximisation in the overall assessment and care planning process was key. This offered an opportunity to involve other services to reach the best outcome. Care coordination and being able to find timely solutions in order for each person to reach their own goals was highlighted as the most satisfying part of the role.

'I absolutely love the complexity, and I want it sorted. I'm just a nurse that's got heart, and I want it sorted for them. But I want them to engage in getting it sorted. I want to motivate them to do it.' P016–FG3

Knowledge about frailty

Educational needs

All participants thought specific education on frailty was required and suggested this should be incorporated into undergraduate and postgraduate nursing programmes. Very few nurses recalled the last educational session on frailty they had attended. Six stated they had never attended one, while others thought it might have been included within other topics, such as long-term condition management.

'I don't think we're actually, education wise, we're getting the right resources … we need to learn a lot more about frailty when you listen to other specialist areas talking.' P016-FG3

Only one participant made reference to a formal frailty tool, which was in use in the acute setting. However, most recognised that a screening tool could promote an objective and consistent assessment, especially for less experienced nurses in the community setting:

'More, just … awareness about frailty, recognising when it can be acted upon. Discussion around the clinical frailty score, it was kind of acute based, but it was how we could look into putting that into community services. More just general discussions rather than any sort of teaching.' P006-FG1

'It's a prompt that they're not missing anything. It's like following a pathway, and we don't have that. Especially when we have taken on a lot of new nurses recently and they're not all newly qualified, but they are new to community. So something like that for them would be, I think, really beneficial'. P010-FG3

Building capability in the context of adversity

Although participants could clearly identify the aspects of their role that provided a strong sense of job satisfaction, they also identified barriers that caused a degree of frustration when managing frailty. These ranged from constrained staffing levels, limited time with patients, challenges communicating with other services and difficulties navigating or accessing services or community assets that could offer potential solutions for their patients with frailty.

'So you just don't have time, and staffing levels are much lower. We're just trying to make the best we can. And we do a good job. We do provide a good service. It's just not the service that we would be hoping to provide.' P011-FG3

The lack of time to coordinate care effectively and facilitate problem-solving to help older people achieve their outcomes was highlighted. As a result, participants reported that, at times, their role had become task-focused rather than person-centred:

'Genuinely, we no longer have the time, [with] the increase in population and the workload demand. The complexity of the demand is so much greater that they can no longer meet the demand in the way we were able to meet that demand before. So we've lost some of the human side of nursing.' P012-FG3

Nurses described the considerable time taken up in communicating with other professionals and services and the difficulty they often face in accessing timely resources to enable their patients to remain in their own homes. Some participants provided examples of going beyond their usual duties to bridge gaps in services to enable older persons to remain at home.

'We were stepping up to the mark, we were making her [the patient] dinners.' P001-FG1

Participants stated that they continue to experience disjointed working and communication challenges when multiple services are involved, leading to more fragmented care for some patients and their carers.

'I just think we should all be joint together, and not be working in two separate teams.' P009-FG2

Participants welcomed the opportunity of a person-centred coaching and educational development programme to build their confidence in mitigating the above frustrations and challenges:

'I think, maybe, by this piece of work, it might identify areas where we could improve … because we could all improve.' P002-FG1

Discussion

The Frailty Matters project aims to build nurse capabilities to manage frailty in a UK community setting. This study supports existing evidence on how frailty is still perceived as vulnerability and loss, while providing an in-depth understanding of the care practices, knowledge and education requirements of community nurses around frailty.

The participants in this study associated the term 'frailty' with negative attributes, such us being vulnerable and old, experiencing various losses and having multiple health conditions. Consistent with previous studies (Gwyther et al, 2018; Obbia et al, 2020), negative perceptions of frailty are still dominant within healthcare. The need to reconsider the language on frailty adopted within healthcare systems has been on the agenda for several years (Nicholson et al, 2016), as has awareness of negative stereotyping of older persons in the media (Ng et al, 2015). This suggests a need for a more inclusive and holistic approach, with a greater focus on capabilities, autonomy and empowerment of individuals (Evans et al, 2019).

Loneliness and social isolation were also recognised as complicating frailty. Tackling social factors, such as poverty and inappropriate housing conditions, which are known risk factors of frailty (Zhang et al, 2020), requires action at national and local government levels. Often, community nurses are the sole regular interaction for a socially isolated person with frailty. This situation can increase staff stress levels and create feelings of guilt. Tackling this requires a supportive infrastructure that offers health professionals the time for reflection (Sundström et al, 2018). The study

participants had a strong sense of both professional and social responsibility, which often meant extending beyond their usual nursing role to tackle domestic care duties, including cooking.

Contrary to previous evidence (Shaw et al, 2017; Gwyther et al, 2018; Obbia et al, 2020), the participants did differentiate between the inevitability of the ageing process and the potential for frailty to be reversible or preventable. With comprehensive assessment and early multi-dimensional interventions targeting exercise, nutrition, pharmaceutical care and social support, frailty can be reversed (Cesari et al, 2016). For community nurses to be able to support patients with frailty, better service coordination was deemed necessary, as well as having the required skills to deal with complexities within caseloads. Coordination of care for frailty requires an integrated and interdisciplinary approach and effective communication across care settings (e.g. primary care, hospital and social care) to improve the quality and outcomes of care (Hendry et al, 2019; Lawless et al, 2020). Communication, continuity and care coordination are too often elusive. Lack of staff capacity and constraints on financial resources often affect the timely availability of services for patients and also limit opportunities for professional development of the staff involved. As a result, the workforce and systems are increasingly stretched in their attempt to maintain the quality of care based on past, often obsolete, staffing, funding and service models.

The study participants expressed a need for frailty-specific education, particularly around assessment. Different approaches to identifying frailty were described, ranging from comprehensive assessments to professional judgement based on experience. A number of educational initiatives have been developed to promote frailty-specific knowledge for multidisciplinary teams, such as the National Frailty Education Programme in Ireland (Lang et al, 2018) and the Healthcare Practitioners Programme: Frailty offered by the Royal College of Nursing (RCN) (RCN Frailty Resource Collection, 2020). However, until recently, few programmes focused on providing specialised training on frailty to community nurses. Thus, additional effort is required.

Addressing the contextual education needs of health professionals in the community setting is strongly advocated (Travers et al, 2019). Community nurses play a pivotal role within complex, integrated teams and systems; thus, leadership skills and confidence are paramount in delivering interdisciplinary care that is person-centred and compassionate. Training programmes combining knowledge on how to identify, assess, prevent and manage frailty in practice while building confidence in dealing with complexity and enhancing communication and influencing skills for working with other professionals and agencies, would be a valuable alternative to the ad hoc approach to educating community nurses on frailty that is in place.

This study is not without its limitations. Nurses were recruited from a single health board area in the UK, and the findings, therefore, need to be interpreted with caution in terms of their transferability to different settings and contexts. This area, however, has a rapidly ageing population with wide variability in the social deprivation index. Staff serving both affluent and deprived areas were included, although specific demographic details were not captured. Lastly, only the views of community nurses were sought, excluding other health professionals. A more interdisciplinary sample could widen the range of views on frailty and education requirements.

Conclusion

Frailty is a significant public health challenge, viewed through the lens of vulnerability, loss and complex comorbidity. Community nurses acknowledge there is potential for earlier intervention to prevent functional decline, but practice remains reactive and guided by experience and intuition, rather than a systematic use of evidence-informed, frailty-specific screening and assessment. Missed opportunities for early intervention create dependency, further increasing demand on an already stretched community service. There is an urgent need for training to support community nurses to proactively identify, assess and manage frailty to delay dependency, and improve outcomes for people and for the system. The content and approach of this education must equip community nurses with knowledge on frailty and build confidence and capability for them to play a leadership role in integrated teams. Such educational interventions will only effect change in practice if structural issues, such as staffing levels, are tackled and the complex relational dimensions of working in community-integrated teams are acknowledged and supported. **BJCN**

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KEY POINTS

- Community nurses deliver and coordinate care and support to enable people to live well at home
- Community nurses are key in identifying older people living with frailty in the community but lack frailty-specific knowledge and skills for optimal early intervention
- There is an urgent need for context-specific multi-dimensional education on frailty for community nurses
- The content and approach to training should equip community nurses with critical knowledge on frailty and build their confidence and capability to lead practice change and coordinate person-centred integrated care and support within interdisciplinary teams

CPD REFLECTIVE QUESTIONS

- Do you assess frailty as part of your current clinical practice? If yes, what type of assessment tool do you use?
- What challenges do you see in the provision of frailty-sensitive care?
- Regarding frailty-specific training, what knowledge gaps do you identify?

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