The role of the registered nurse in supporting frailty in care homes

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ABSTRACT

People in nursing and residential homes are more likely to suffer frailty. Registered nurses are a crucial component of the care delivery service and can offer support to patients who have complex care needs and comorbidities and are at risk of unplanned admissions to secondary care. This article explores frailty and the role of the nurse in assessing for frailty. Three aspects of patient care—nutrition status, polypharmacy and exercise and cognitive function—are discussed as areas where nurses can target their interventions in order to support those considered as frail, aiming to reduce the impact of frailty and negative health outcomes.

Key words: Older people ■ Comorbidities ■ Assessment ■ Care pathway ■ Deterioration

Nurses need education in managing patients with frailty in care homes to equip them for the *NHS Long Term Plan* (NHS England and NHS Improvement, 2019). Many nurses have contact with frail residents in care homes as part of their routine activity. The term 'care home' includes homes with and without nursing provision (British Geriatrics Society (BGS), 2016). The role of nurses caring for frail patients in care homes is important due to patients' complex care needs, comorbidities, long-term conditions, disability and polypharmacy.

When nurses have contact with patients in care homes, often for routine activity such as wound care, medication administration or continence management, nurses can use this as an opportunity for an assessment of the patient for frailty.

> **'Any interaction between an older person and a health or social care professional should include an assessment which helps to identify if the individual has frailty.'**
>
> ***BGS, 2014***

Identification of frailty is important because it may be reversible by addressing the contributing factors (Uchmanowicz et al, 2018). By identifying patients who are frail, nurses have an opportunity to work in partnership with patients, carers, GPs, pharmacists and the wider multidisciplinary team (MDT) to address factors that may contribute to frailty, leading to better health outcomes for patients.

What is frailty?

Frailty is considered a long-term condition affecting 10% of people over 65 years and up to 50% of those over 85 years. Gobbens et al described it as:

> **'A dynamic state affecting an individual who experiences losses in one or more domains of human functioning (physical, psychological, social), caused by a range of variables and which increases the risk of adverse outcomes.'**
>
> ***Gobbens et al, 2010: 175***

A combination of age, genetic and environmental factors contribute to a decline in multiple body systems leading to vulnerability with regard to sudden health status changes, often triggered by minor stress, illness or personal events (Clegg et al, 2013). Consequently, frailty is prevalent in elderly patients, which is linked to risks of adverse health outcomes, including poor quality of life, hospitalisation, disability and mortality. Frailty is one of the most challenging consequences of an ageing population, although it is not necessarily synonymous with getting older (Uchmanowicz et al, 2018).

In the UK, approximately 405 000 people aged over 65 years live in a care home. This includes 16% of the population who are over 85 (BGS, 2016). There are more than twice as many people living in care homes in England and Wales as there are inpatients in hospitals (National Institute for Health Research, 2019). However, research on frailty in care homes is lacking (Kojima, 2015), despite these residents being vulnerable and having multiple needs in terms of complex care and comorbidities (Care Quality Commission, 2012; Smith et al, 2015; Healthwatch, 2017). Frailty is characterised by increased vulnerability due to a decline in homeostatic reserve and secondary to dysregulation in multiple systems (Uchmanowicz et al, 2018).

Dutta (2015) found that 50% of older people who are frail receive ineffective healthcare interventions. Robbins et al (2013) argued that neither GPs nor care home staff have enough time to meet the complex needs of patients and that many staff lack prerequisite skills and training. As a consequence, older people who live in care homes often have poorer access to health care and do not benefit from the range of services that can meet their complex needs (Robbins et al, 2013; Gordon et al, 2014).

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Box 1. Frailty indicators

- Falls (collapse, legs give way, found on the floor)
- Immobility (sudden change in mobility, 'off legs')
- Delirium (acute confusion or being 'muddled')
- Incontinence (a change in continence or worsening of incontinence)
- Susceptibility to side effects of medications (eg confusion with codeine, hypotension with antidepressants)

Source: British Geriatrics Society, 2014; Royal College of Nursing, 2018

Box 2. Assessment tools

- PRISMA-7 Questionnaire. This is a seven-item questionnaire which is used to identify disability. A score of more than three is considered to identify frailty (Raîche et al, 2008; Herbert et al, 2010
- Walking speed (gait speed). Gait speed is usually measured in m/s and has been recorded over distances ranging from 2.4 m to 6 m in research studies (Turner, 2014)
- Timed up and go test (TUGT). The TUGT measures, in seconds, is the time taken to stand up from a standard chair, walk a distance of 3 metres, turn, walk back to the chair and sit down. The longer this test takes, the higher the indication of frailty

Source: British Geriatrics Society, 2014

Gordon et al (2014) examined the health status of care home residents and found that they were frequent users of NHS resources, on average having contact once a month. Smith et al (2015) found that care home residents have up to 50% more emergency admissions and emergency department attendances than the general population aged 75 years and over. Robbins et al (2013) argued that primary care is not organised to deliver effective health care to meet the needs of care home residents, suggesting that care is predominantly ad hoc and reactive. They suggested care is poorly placed to anticipate gradual or acute deterioration, facilitating proactive management. Consequently, NHS England has developed new care models for frailty (NHS England, 2014), which recognise that good health, health care and social care are mutually dependent and need to be approached together (National Institute for Health Research, 2017). The BGS (2011) argued that hospital admissions may be reduced by increasing proactive care to those in care homes and recommends that quality of care can be improved by nurses working as case managers:

> **'… who could compensate for deficiencies in the scope of usual primary care. This could supplement general medical services and serve as a clinical and communication bridge to specialists and other community health services, thus improving resident outcomes and resource use.'**
>
> ***BGS, 2011***

However, it is recognised that high standards of care delivery in care homes is dependent on many factors, including skill mix, staff turnover, recruitment and retention, and staffing levels (Royal College of Nursing (RCN), 2012; Allan and Vadean, 2017). Nevertheless, this is an opportunity for nurses to undertake assessments and work in partnership with patients, carers, GPs and the MDT to address the needs of frail patients in care homes, reducing the negative impact in terms of health outcomes and associated healthcare costs.

Identification of people living with frailty

Recognising frailty is important for nurses so that patients who live in care homes are cared for proactively. Up to 50% of those in care homes are considered frail (Kojima, 2015). Importantly, 40% are considered pre-frail and could be targeted by interventions for frailty prevention or treatment. Uchmanowicz et al (2018) argued nurses have a critical role in identifying older patients who may benefit from interventions aimed at reducing frailty, as well as preventing or delaying adverse outcomes.

Frailty in patients can be considered when three out of the five indicators in *Box 1* are recognised. If nurses identify these indicators, they should use this as the stimulus for a more comprehensive assessment and a mechanism to support others involved in a patient's care to develop care plans and prioritise factors that can contribute to frailty.

To support assessment of frailty, nurses should use assessment tools. Turner (2014) argued that the accuracy of tests for identifying frailty is uncertain. Furthermore, Sutton et al (2016) identified 38 different assessment methods for frailty. Despite this, the BGS (2014) undertook a literature review and, based on this, recommended three assessment tools, to support nurses in identifying frailty (*Box 2*).

Care planning

The complex range of professionals that frail patients come into contact with often means that their care can be fragmented (Uchmanowicz et al, 2018). This is compounded by a gap between healthcare requirements and available GP time, reactive or proactive health care, discord between healthcare philosophy and knowledge, and tensions in the responsibility for the health care of residents, staffing levels, skill mix and education (Robbins at al, 2013; Allan and Vadean, 2017). However, by using a holistic assessment, nurses are in an excellent position to act as care managers for frail patients and work in partnership, coordinating individualistic care. The National Institute for Health and Care Excellence (NICE) provides guidance on caring for patients with complex comorbidities (NICE, 2018). It is essential that care home staff are involved in this process because they play a crucial, yet often unrecognised, role in delivering health care to residents. Nurses can use the NICE framework to support carers to implement care, or refer to others as appropriate, recognising that care home managers and staff are crucial to healthcare delivery, regardless of a perceived role in social care provision. Nurses can prioritise care based on interventions that may make the biggest impact when caring for frail patients. Patients with frailty benefit from a person-centred, comprehensive approach to care, which can reduce poor outcomes and may reduce hospital admissions (, 2018).

Uchmanowicz et al (2018) identified three areas that nurses can focus on: nutritional status, polypharmacy and exercise and physical activity.

Nutrition

Guyonnet et al (2015) suggested that the clinical determinants of frailty correlate with nutritional status in the elderly population, including low energy, psychomotor retardation, weakness, decreased physical activity or weight loss. Patients in care

homes are at high risk of malnutrition due to several factors, including complex healthcare needs, disability, comorbidities and polypharmacy (Uchmanowicz et al, 2018). Furthermore, intrinsic factors include hormonal imbalance; specifically, a reduced secretion of the 'hunger hormone' in the stomach, which results in reduced appetite. Elderly patients experience loss of appetite, which correlates with a decrease in physical activity, weight loss and disability (Landi et al, 2010), which correlates with the clinical determinants of frailty (Uchmanowicz et al, 2018).

In order to address nutritional status, all patients should be assessed using a validated nutritional screening assessment tool such as the Malnutrition Universal Screening Tool (MUST) (BAPEN, 2018; Murphy et al, 2018). However, Frank et al (2015) argued that this is not always used in clinical practice. Regardless, the NICE (2012) quality standard supports the use of MUST. Nurses can support those caring for frail patients in care homes to undertake nutritional assessments and plan individual interventions based on patient's needs.

The Royal College of Nursing (2019) makes simple suggestions to support those who are having difficulty eating and drinking, which would be appropriate for carers or patients themselves to adopt. Malnutrition in frailty is preventable or treatable with specific interventions, including exercise, dietary supplements, vitamin D, and reduction of polypharmacy (Morley et al, 2013). Nurses can work with others in following these steps to help ensure the adverse effects of malnutrition, which can impact frailty, are reduced (*Box 3*).

Box 3. Supporting nutrition

- The person has the opportunity to use the toilet and wash his or her hands before eating
- Their mouth is clean and moist
- The person is sitting comfortably and the immediate environment is clear of mess, clutter and, if possible, noise
- The area is well lit, the person has their glasses on (if worn) and dentures are in place
- The food is presented attractively, not in huge portions, and is arranged and cut to enable the person to eat it easily
- A glass of water or preferred drink is easy to reach
- The person is offered gentle encouragement and praise as they progress through the meal
- There is a record of what the person has eaten and drunk on the appropriate charts; any concerns about an apparent change in the person's appetite, and food/fluid intake or ability to chew and swallow, are reported immediately to the manager or supervisor

Adapted from Royal College of Nursing, 2019

Polypharmacy

Up to 50% of elderly patients are affected by polypharmacy and more than 1 in 10 by severe polypharmacy (Wilson et al, 2011). Polypharmacy refers to four or more medications being prescribed. Severe polypharmacy is defined as the use of 10 or more medications, which includes self-medication and the use of over-the-counter drugs (Zia et al, 2015). The UK Care Homes' Use of Medicines Study (CHUMS) found that care home residents take an average of eight medications each (Barber et al, 2009).

Appropriate medication regimens for older patients should be determined by age-related changes in pharmacokinetics and pharmacodynamics, including the number of concurrent medications, comorbidities and functional status (Barry, 2018). An important distinction is to differentiate between those patients who are taking too many drugs (inappropriate polypharmacy) and those who have polypharmacy that may be entirely appropriate. Another feature of polypharmacy is 'pharmacological cascade', which occurs when reactions to medication are viewed as a new clinical problem, which is often non-specific and difficult to diagnose (Zia et al, 2015). For example, there may be a correlation between polypharmacy and falls. Falls are often associated with medications such as anti-hypertensives, diuretics, antidepressants and cardiovascular drugs (Woolcott et al, 2009; Wilson et al, 2011).

Nurses can follow some basic principles for medication reviews and in supporting concordance with medication regimens for patients with regard to frailty. Nurses can help coordinate medication reviews, simplifying dosage and medication regimens (Cowan, 2002; Uchmanowicz et al, 2018). Polypharmacy should be monitored by carers, nurses and community pharmacists (Pulignano et al, 2010; Payne and Duerden, 2015). The Royal Pharmaceutical Society and NICE suggest each resident should have a pharmacist-led medication review at least annually, with any change in medication, or if residents move between care settings (Chaplin, 2016; NICE, 2018). Prescribers can be helped to make evidence-based decisions on 'deprescribing' specific medications, as part of a comprehensive medication review (Scott et al, 2015). The Screening Tool of Older People's Prescriptions (STOPP) can potentially help stop inappropriate prescribing (O'Mahony et al, 2014).

Those providing care should be especially involved with the administration of medications because this raises particular issues around dispensing, administration and monitoring of treatment, as well as staff training (Payne and Duerden, 2015). One mechanism to support patients and carers in the administration of medicine is by adopting a monitored dosage system (MDS). However, using MDS can lead to omissions as staff may be unable to identify which individual drugs within a single compartment may have been taken, or there may be problems if it is a liquid medication (Payne and Duerden, 2015). Nevertheless, nurses have an important role in supporting patients and carers by providing information in regard to medication administration, encouraging self-medication, where appropriate, and encouraging care home routines that reduce work and time pressures during medication rounds and education (Cowan et al, 2002; Lilley et al, 2006; Pountney, 2010).

Exercise and cognitive function

Nurses who are caring for patients in residential or nursing homes need to consider the importance of exercise with regard to frailty and physical function.

> **'Physical frailty is a medical syndrome with multiple causes and contributors that is characterised by diminished strength, endurance, and reduced physiologic function that increases an individual's vulnerability for developing increased dependency and/or death'**
>
> ***Morley et al, 2013***

Box 4. Further resources

- NHS England frailty resources: https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/frailty-resources

This has links to more information on frailty as a long-term condition, including:

- Skills for Health, NHS England and Health Education England. Frailty Framework of Core Capabilities. http://tinyurl.com/y34y9c3p
- National Voices, Age UK, UCL Partners. I'm Still Me... a narrative for coordinated support for older people. 2014. http://tinyurl.com/y2g9n5gz
- Britain Thinks. Frailty: Language and Perceptions. A report prepared by BritainThinks on behalf of Age UK and the British Geriatrics Society. 2015. http://tinyurl.com/yysz3vtb
- NHS England. Toolkit for general practice in supporting older people living with frailty. 2017. http://tinyurl.com/yxr9jxr7
- NICE information relevant to frailty. http://tinyurl.com/yy6l65c6
- Janet's story: Frailty. NHS RightCare resource comparing a suboptimal care pathway with an ideal pathway. http://tinyurl.com/y3fnf3jb
- National Institute for Health Research. Comprehensive Care: Older people with frailty in hospital. NIHR Dissemination Centre themed review. 2017. http://tinyurl.com/y3b99jhl
- Centre for Reviews and Dissemination, University of York. Effectiveness Matters—reviews of interventions including recognising and managing frailty in primary care, reducing polypharmacy in older people. http://tinyurl.com/yy4csc9n
- British Geriatric Society. Comprehensive Geriatric Assessment (CGA) toolkit for general practitioners and medical and healthcare professionals working in primary care settings. 2019. http://tinyurl.com/y6zt885f

Physical exercise programmes have a beneficial and effective impact on the health, and on the physical and cognitive functioning, of frail patients (Chodzko-Zajko et al, 2009). Valenzuela (2012) found resistance training exercise led to improvements in muscle strength and functional performance in regard to chronic diseases, sedentary habits, and functional disabilities for older people in institutions. Brett et al (2017) found a physical therapist-led activity intervention helped improve physical performance and reduced agitation in patients with dementia. Patients reported that exercise programmes improved their physical functions and mood, as well as providing the opportunity for stimulating meetings with other people (Lindelöf et al, 2017). Pereira et al (2018) found that a 10-week psychomotor-intervention, using cognitive and motor simulation, reversed the typical loss of cognitive and motor abilities in patients in nursing homes and that multimodal exercise programmes may help to maintain or improve functioning.

However, physical exercise should not be considered the exclusive domain of physiotherapists or occupational therapists; nurses and carers can work in partnership, and play a core role in making physical exercise for patients an essential component of their care. Tao et al (2017) found that home exercise programmes and behavioural support provided by trained nurses were effective at helping patients to remove barriers to engaging in exercise training. Although this study involved patients in their own homes, its findings are relevant for patients residing in care homes. Nurses can link with carers, occupational therapists and physiotherapists, private providers and the voluntary sector to develop integrated exercise programmes centred on cognitive and psychomotor activity as a way to address and reduce the impact of frailty.

NHS England (2014) has provided guidance aimed at commissioners on care models for older people living with some degree of frailty. *Box 4* lists some sources of further information on frailty, its impact, and resources for health professionals likely to encounter frail patients.

Conclusion

This article has considered 'frailty' in the context of patients in care homes and the important role nurses have in identifying and supporting these patients. Frailty is not an inevitable part of ageing, but older patients in care homes may have several factors that contribute to an increased risk. To support a nursing assessment of frailty, three assessment tools have been discussed, which can support nurses to determine a diagnosis of frailty. From this assessment, nutrition, polypharmacy, and exercise and cognitive function are areas where the nurse can work in partnership with patients, carers and the wider MDT in order to support patients in reducing the impact of frailty and improving health outcomes. **BJN**

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KEY POINTS

- The UK has an increasingly ageing population, and nurses who have contact with people in care homes have an important role to play in managing frailty
- Nurses can make use of their skills to be proactive in identifying and managing frailty in people in care homes
- By using appropriate assessment tools to inform their clinical decisions and care planning, nurses can enhance care and promote positive outcomes for frail people in care homes

CPD reflective questions

- What can you do to enhance the safety of patients in your own clinical setting?
- Consider the assessment tools cited in the article. Identify which one you could use in your clinical practice
- How can you encourage others caring for frail people in care homes to adopt the use of these tools to support residents?