The role of the nurse – frailty

In care homes with nursing the numbers of residents with frailty syndromes are large. If a resident has one or more of the following syndromes, you should think about formally identifying if the individual has frailty.

- Falls (e.g. ‘collapse’, ‘legs gave way’, ‘found lying on floor’)
- Immobility (e.g. sudden change in mobility, ‘gone off legs’ ‘stuck on toilet’)
- Delirium (e.g. acute confusion, worsening of pre-existing confusion/short term memory loss)
- Incontinence (e.g. new onset or worsening of urinary or faecal incontinence)
- Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants)

It is important to check whether the resident has already had a diagnosis of frailty from the nursing or GP record or hospital discharge details. If there is no diagnosis of frailty and the person exhibits muscle weakness, poor mobility, poor balance, cognitive decline, reduced physical activity or a lack of endurance, there are some simple assessments that can be done. These include:

- Gait speed: taking more than 5 seconds to walk 4 metres
- ‘Timed up-and-go test’ (TUGT): a cut off score of 10 seconds to get up from a chair, walk 3 metres, turn round and sit down.

(Sometimes there are health problems that can cause “false positives” for example a fit older people with isolated knee arthritis or a fracture causing slow gait speed).

What to do if you suspect someone has frailty that has not already been recognised or has not been reviewed for some time?

The “gold standard” evidence based intervention is Comprehensive Geriatric Assessment, sometimes called Comprehensive Old Age Assessment. It is defined as ‘a multidimensional, interdisciplinary diagnostic process to determine the clinical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up’ (BGS, 2014). This can be done by a team led by an appropriate nurse, usually an older peoples advanced nurse practitioner, GP or geriatrician and sometimes by allied health professionals such as a physiotherapist. It is important that your residents have access to this assessment and you may need to make referrals to your local services.

What interventions can we do as nurses?

As nurses we are very well placed to help our residents live well with frailty. We are educated to deliver person centered care and to produce sophisticated care plans and this is exactly what people living with frailty need. There is evidence that in individuals with frailty, a person-centred, goal-orientated comprehensive approach reduces poor outcomes and may reduce hospital admission. Care plans which are individual often focus on exercise and nutrition as well as ceilings of care and personal wishes. They can also set out the interventions someone needs if they have an acute exacerbation of their long term
conditions. We know that people with frailty who join a care home are likely to have short life expectancy and their care plans may also include end of life wishes.

As well supporting the resident through their frailty journey, their friends and family will also need education and support. There are many misconceptions about what frailty is and the role families can play in preventing further decline. Nurses have a clear role in explaining frailty; this might be done through education sessions, support groups posters or individual conversations. For example, we know that exercises that improve strength and balance (Clegg et al, 2013) can be helpful, and families might like to support residents in undertaking them: equally, nurses should make sure the exercises or exercise groups in your place of work focus on these elements.

Similarly, improving nutritional intake to ensure residents have a normal BMI is important: this should be done through the provision of nutritious food. There is limited evidence about effective nutritional interventions but recommendations include optimising protein intake and promoting adequate vitamin D intake (Fiatarone et al, 1994).

National Voices (2014) suggest the following mechanism for co creating a care plan to help improve the wellbeing of someone living with frailty.

Step one: Prepare
- Always start from the point of view of the person.
- Gather necessary information and make it available upfront.
- Allow time to reflect and consider options.

Step two: Discuss
- Take a partnership approach.
- Focus on staying well and living well and, for some, dying well.
- Identify the actions a person can take.
- Identify what care and/or support might be needed from others.

Step three: Document
- The main points from discussions are written up, included as part of the person’s health and/or social care records, and owned by the person and shared, with explicit consent.

Step four: Review
- Consider options for follow up and set a date for review.

Want else can we ensure happens?

Nurses have a key role in co-ordinating care for residents, particularly those who are living with frailty. An important intervention is the regular review of medication, as older people are more sensitive to drug dosage and drug actions. When administering medication, registered nurses should be considering the efficacy of the medication the resident is taking, its interactions, side effects and appropriateness. Regular medication review is important.Polypharmacy affects older people most with the increasing prevalence of long-term conditions with age. The oldest 15% of the population are known to receive 40% of all drug prescriptions (Nicholl, 2006). Registered nurses should refer residents to GP’s and pharmacists for regular review or if they are concerned by the effects of medication.
Equally, ensuring access to dental and optical care is very important for people living with frailty. Good nutrition status is affected by a resident’s oral health and falls risk is increased with visual impairment.

In addition to providing excellent physical health care support, the nurse must encourage activities that have been shown to improve mental wellbeing. Care home staff are uniquely placed to develop a deep understanding of a resident’s mental health needs and support the activities and interests of individuals. Careful consideration of the presence of depression or dementia is important and to recognise when referral to others is required.

There is a wide range of research about frailty and encouraging both staff and residents to engage with this agenda through groups such as the National Institute for Health Research (NIHR) Enabling Research in Care Homes (ENRICH) initiative is also important.
NIHR ENRICH: [http://enrich.nihr.ac.uk/pages/research-ready-care-home-network](http://enrich.nihr.ac.uk/pages/research-ready-care-home-network)

Where can I get support for my role?

There are many resources to support nurses: in your own organisations colleagues will have a wealth of experience and knowledge, and local NHS staff will also have a lot to offer. Frailty is of national importance and there are a large number of online resources: a good place to start is the Royal College of Nursing webpage.
RCN frailty resource: [https://www.rcn.org.uk/clinical-topics/older-people/frailty](https://www.rcn.org.uk/clinical-topics/older-people/frailty)

Conclusion

In this article we have seen the major role nurses have in recognising frailty, helping residents with frailty to live well and to prepare for the future, and in co-ordinating the support residents’ need. Nurses are uniquely skilled and have an essential role to play not simply for the resident but for the wider health and social care community.

References