Frailty has become synonymous with vulnerability and is a state caused by many factors, including disability, recurrent infection and multiple co-morbidities. The Gwent frailty service recognises the importance of an interdisciplinary approach to care, including timely recognition of frailty in patients and referral to the most appropriate services to optimise management and treatment.

The aim of this article is to explore the role of the nurse caring for a frail patient, using a case study example. The Gwent frailty service is used as a model to highlight best practice. In this model the principles of assessment and co-ordination of care are categorised into three themes: comprehensiveness (holism), compatibility and accessibility (Alter and Hage 1993, NHS Wales 2011). After reading this article and completing the time out activities you should be able to:

- Recognise the signs and symptoms of frailty.
- Assess patients who present as frail and co-ordinate their care, using the Gwent frailty service model as a guide.
- Identify interventions that may prevent unnecessary admission of frail patients to hospital.

Frailty is characterised by a combination of factors, including the ageing process, chronic illness and a weakness in vitality (Clegg and Young 2011). Additional physical, behavioural, social and environmental risk factors or stressors exacerbate frailty and may make the individual susceptible to infection, disability, increased dependency, hospital or care home admission, and possibly death (Walston et al 2006, Strandberg and Pitkälä 2007). Frailty is an important indicator of a person’s health and needs, and an ability to recognise this state is essential to prevent further deterioration.

In Wales, several government policies (Welsh Assembly Government (WAG) 2005, 2006, 2009) have influenced the development of a community service providing care for frail people. The service was developed in light of local research in Gwent that identified how...
services had affected older peoples’ lives and what was important to them when accessing such services and support (Murray et al 2009). This article focuses on the care of a frail patient using the Gwent frailty service as a model to highlight best practice.

Complete time out activity

Defining frailty

Although frailty is common there is no agreed definition of the term. Fried et al (2001) defined it as a clinical syndrome, while Barrett (2006) viewed it as an ‘outcome of the relationship between the individual and his or her environment’. Clegg and Young (2011) stated that people who are considered frail have an unpredictable health status and often present to healthcare services because of a trigger or stressful event. There are many examples where people present with an underlying physiological problem combined with a trigger or stressful event; for example, a patient who has chronic respiratory disease, but experienced a recent infection; an older person with cardiovascular disease who has fallen; or someone who presents with delirium as a result of a urinary tract infection (Smith and Lindley 2009). It is important to recognise any triggers that may exacerbate frailty, resulting in increased dependence and possible admission to hospital.

In the past, frail people requiring assessment and care following a trigger or stressful event were admitted to hospital. In the hospital setting, frail people, particularly those who are older, may rapidly lose independence, which often results in an extended hospital stay and the involvement of a number of services following discharge (Johnston et al 2008). This often meant that the patient required long-term and continuing NHS care, which can be costly to the patient and the NHS. In Wales, the cost of NHS long-term and continuing care has been estimated at £114 million or 3% of the total Welsh NHS budget of £4.4 billion (Shepherd and Addis 2007).

Key indicators of frailty

- Anorexia or unintentional weight loss of approximately 10Lb in the past year.
- Exhaustion or fatigue.
- Weakness, such as reduced grip strength.
- Reduced walking speed.
- Reduced physical activity.
- Cognitive impairment.
- Feeling sad or depressed.
- Incontinence.
- Use of five or more prescription medicines.
- Need for physical or social support.

(Fried et al 2001, García-González et al 2009)

Gwent frailty service

In England, policies such as Equity and Excellence (Department of Health 2010a) advocate integration of decision making and information sharing between healthcare professionals and service users to deliver personalised care for people who have complex needs. Setting the Direction (WAG 2010) focuses on the fragmented service interface between primary, community and secondary care services, which do not meet the needs of the service user. The fragmentation of service provision can mean that it is hard to find the right services to meet patients’ needs. The strategic delivery programme advocates an integrated, proactive, co-ordinated and preventive approach to care provision that is focused on the service user (WAG 2010), instead of a system in which older people are transferred from one service to another without their needs being met.

There are 560,000 people living in Gwent, approximately 20,000 of whom are classified as frail (Gwent Frailty 2010). In Wales, acute and community services are integrated and planned and delivered through health boards (as opposed to trusts). Gwent is comprised of one local health board (five at the time of development) and five local authorities, which were required to work together to deliver a service to meet the complex needs of frail patients. Murray et al (2009) hosted two focus groups comprising 92 older people aged between 50 and 90 years. The researchers listened to the participants’ experiences of existing services to understand what they

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valued, their expectations of such services and what they felt could be done differently. Following focus group discussions, the Gwent frailty service was developed with a single point of access. The single point of access is a telephone number that healthcare professionals, such as GPs and social workers, can use to make referrals. These referrals are then processed by staff and allocated to an appropriate local community resource team through an electronic system. These teams are managed by a joint community resource team manager and comprise allied health, social care, medical and nursing professionals. The service opened in April 2011.

Role of the nurse

The role of the nurse in the community resource team includes urgent clinical assessment, working with medical colleagues to provide care in the home, rapid response intervention (subacute care), reablement (learning or relearning the skills necessary to cope with living with an illness), and falls management and prevention (Box 2). One of the aims of the Gwent frailty service was to minimise the number of healthcare professionals that the patient comes into contact with by matching the needs of the patient with the appropriate skills and knowledge of the community resource team. This is essential to resolve subacute needs, such as an exacerbation of chronic obstructive pulmonary disease, in a timely manner, avoid duplication of care and reduce stress on family carers (Leutz 2005, Leff et al 2006, Ricauda et al 2008, Engelhardt et al 2009).

Complete time out activity 2

BOX 2

Role of the nurse in the Gwent frailty service

- Co-ordinate assessments and services.
- Adapt and manage risks.
- Work autonomously.
- Work as part of a multidisciplinary team.
- Manage acute episodes in the patient’s home:
  - Perform a full clinical assessment.
  - Monitor vital signs.
  - Administer medicines.
  - Interpret results and provide appropriate care.
  - Identify and use appropriate health promotion skills to enable the patient to self-care.

Case study

Rose is 62 years old and lives with her husband in a terraced house. She is housebound and has cor pulmonale (alteration in the structure and function of the right ventricle) (National Institute for Health and Clinical Excellence 2010). She has been unable to go to the GP surgery for her annual review with the practice nurse because of increasing immobility. The district nursing team have arranged to visit Rose at home to assess and manage her condition. She has been prescribed oxygen and the district nursing team undertake an annual risk assessment and review her use of oxygen. Rose has experienced repeated admissions to hospital because of recurring exacerbations of chronic obstructive pulmonary disease over the past year. Her symptoms include increased shortness of breath, a temperature of 37.6°C, frequent coughing and increased volumes of green sputum. The GP felt that there were two options, either to admit Rose to hospital or refer her to the Gwent frailty service. The decision was made on this occasion to refer Rose to the Gwent frailty service.

The Gwent frailty service community resource team is a multidisciplinary team of professionals, including nurses, consultant geriatricians, physiotherapists, occupational therapists and social workers. The service is accessible seven days a week from 8am until 8pm. Rose was referred to the service by the GP and the district nursing team who cared for her following a previous admission to hospital. On presentation, Rose is unkempt and is experiencing lack of sleep, weight loss as a result of decreased appetite, nausea and inability to eat her usual food because of breathlessness, increased weakness and exhaustion, and anxiety.

It is clear that Rose is showing signs of frailty, including weight loss and reduced mobility. To assess the extent of frailty and Rose’s clinical needs, it is important to consider the themes of comprehensiveness (holism), compatibility and accessibility (Alter and Hage 1993). This will enable the nurse to understand the complexity of Rose’s needs, and develop and co-ordinate personalised and appropriate care (Fairhall et al 2011).

Comprehensiveness

To act comprehensively the nurse should consider the patient as a whole person and his or her place within society. In the case study example, the nurse requires detailed knowledge about Rose’s condition and her needs. Rose’s
position within the family and community also need to be considered. This information will enable the nurse to meet the needs of the patient (holistic care) more effectively.

A comprehensive assessment of need can be achieved using a standardised framework, such as the Unified Assessment Process in Wales (WAG 2002), the Single Assessment Process in England (DH 2002) or the Single Shared Assessment in Scotland (Scottish Executive 2001). In Wales, the Unified Assessment Process comprises enquiry, contact and overview, as well as specialist and comprehensive assessment (WAG 2002). The specialist or in-depth assessment in this context is the Gwent frailty nursing assessment. This incorporates the Fundamentals of Care (WAG 2003), which is similar to Essence of Care (DH 2001, 2010b) in England, and promotes quality of care for adults by meeting their basic care needs. Improved quality of care is achieved through a collaborative relationship between the patient and the nurse. An outline of the Gwent frailty nursing assessment tool is provided in Box 3. It was developed using the Neuman Systems Model (Neuman and Fawcett 2011) and the Unified Assessment Process (WAG 2002). Assessment requires an understanding of the patient’s interdependence – ‘shared dependence or the action of being joined together with a common bond’ (Beeber 2008) – with his or her family and community. This is essential to understand how the patient’s independence can be promoted and maintained in the community setting and thereby prevent unnecessary hospitalisation.

The knowledge and skills required for assessment are ‘both profession-specific (for example, models, theory, physical examination, measurement) and generic (for example, communication skills, listening and observing)’ (Wallace and Davies 2009). Assessment is essential to identify patient needs and the most appropriate intervention. It requires the use of standardised scales and tools, such as the Waterlow Pressure Ulcer Prevention/Treatment Policy (Waterlow 2005) and the Malnutrition Universal Screening Tool (BAPEN 2010), as well as non-standardised approaches such as observation of physical appearance and gathering information from family and/or carers (Hibberd and Boyle 2010).

Compatibility
Compatibility within the community resource team involves demonstrating knowledge about

<table>
<thead>
<tr>
<th>BOX 3</th>
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<tbody>
<tr>
<td><strong>Gwent frailty nursing assessment tool</strong></td>
</tr>
<tr>
<td>1. Capacity and consent to:</td>
</tr>
<tr>
<td>a) Assessment and subsequent treatment.</td>
</tr>
<tr>
<td>b) Share information.</td>
</tr>
<tr>
<td>c) Inspection.</td>
</tr>
<tr>
<td>2. Religion.</td>
</tr>
<tr>
<td>3. Method of communication.</td>
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<tr>
<td>4. Patient and/or carer’s view of reason for referral.</td>
</tr>
<tr>
<td>5. Past and present medical status.</td>
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<td>6. Vital observations and investigations.</td>
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<tr>
<td>7. Medication.</td>
</tr>
<tr>
<td>8. Allergies.</td>
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<tr>
<td>9. Present service provision, for example:</td>
</tr>
<tr>
<td>a) District nursing.</td>
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<tr>
<td>b) Private care provision.</td>
</tr>
<tr>
<td>c) Local authority funded care.</td>
</tr>
<tr>
<td>d) Voluntary care.</td>
</tr>
<tr>
<td>e) Mental health service.</td>
</tr>
<tr>
<td>f) Palliative care.</td>
</tr>
<tr>
<td>g) Continuing health care.</td>
</tr>
<tr>
<td>h) Telecare or telehealth.</td>
</tr>
<tr>
<td>i) Long-term conditions.</td>
</tr>
<tr>
<td>10. Living arrangements:</td>
</tr>
<tr>
<td>a) Alone.</td>
</tr>
<tr>
<td>b) Key safe, a device that enables workers to access the homes of people receiving routine health and social care services.</td>
</tr>
<tr>
<td>c) Property type.</td>
</tr>
<tr>
<td>d) Tenure.</td>
</tr>
<tr>
<td>11. Carer assessment</td>
</tr>
<tr>
<td>a) Is the carer or patient coping with the current provision of healthcare services and support?</td>
</tr>
<tr>
<td>12. Mobility, including manual handling.</td>
</tr>
<tr>
<td>13. Falls risk and assessment.</td>
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<tr>
<td>14. Identification of further assessment or action required in relation to:</td>
</tr>
<tr>
<td>a) Continence.</td>
</tr>
<tr>
<td>b) Nutrition.</td>
</tr>
<tr>
<td>c) Mental health.</td>
</tr>
<tr>
<td>d) Activities of daily living/instrumental activities of daily living, for example personal care, domestic activities, community and leisure, financial issues, communication, sensory or perception needs.</td>
</tr>
<tr>
<td>e) Wound care, pressure area care, breathing, pain, sleep, sex and sexuality.</td>
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<tr>
<td>15. Identification of hazards or alerts.</td>
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<tr>
<td>16. Intervention service provided by the community resource team, including:</td>
</tr>
<tr>
<td>a) Consultant or GP.</td>
</tr>
<tr>
<td>b) Emergency social care.</td>
</tr>
<tr>
<td>c) Other professionals from occupational therapy, physiotherapy, nursing, social care, mental health, dietetics, speech and language therapy.</td>
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<tr>
<td>d) Environmental assessment, such as adaptations and equipment.</td>
</tr>
<tr>
<td>e) Falls assessment programme.</td>
</tr>
<tr>
<td>f) Support and wellbeing worker.</td>
</tr>
<tr>
<td>g) Intermediate care – step-up bed referrals received from the community or care home setting.</td>
</tr>
</tbody>
</table>

(Based on Neuman and Fawcett 2011, WAG 2002)
the timely and appropriate fit and sequencing of assessments, and planning of treatment and services for an individual (Scott et al 2008). This is essential for effective co-ordination of care (Sagan et al 2004) and requires that the nurse has knowledge about what further assessments and services are required. In addition, the nurse should have up-to-date knowledge and skills relating to sharing patient information, informed consent and the development of an integrated care plan. An understanding of the patient’s values and past experiences of treatment and care will influence how the patient responds (physically and psychologically) to any planned assessments and care delivered in the patient’s home.

The community resource team achieves compatibility through the use of the standardised framework for sharing information across agencies, such as the Unified Assessment Process (WAG 2002). As previously mentioned, an understanding of Rose’s interdependence is important to establish future care, with the aim of promoting independence and wellbeing. However, the interdependence of healthcare professionals within the community resource team also needs to be considered. The nurse needs to have an understanding of colleagues’ roles; the assessments they conduct and treatments they deliver; and how everyone can work together effectively and undertake shared decision making (Sagan et al 2004, Fairhall et al 2011).

After visiting Rose and using the frailty assessment tool (Box 3), the nurse noticed that there were several pets in the patient’s home. While talking to Rose and her family, the nurse noticed that she was particularly fond of her dog, regularly patting it affectionately. However, as the nurse went to pet the dog she noticed that it had a mucky nose. She enquired about the dog’s health and established that the dog had developed some spots around the folds of skin on its face, including its nose. After further questioning the nurse established that the dog had been experiencing this skin condition for some time, a little longer than Rose had been experiencing repeated admissions to hospital.

**Complete time out activity 3**

Rose required various assessments so she was referred to the occupational therapist, consultant geriatrician and physiotherapist. She also received intravenous therapy and a programme of routine daily activities from different professionals in the community resource team. Her dog also required assessment and diagnosis by the local veterinary surgeon. It transpired that the dog had acquired pseudomonas on his nose and when Rose coughed and patted her dog they were re-infecting each other. This was the trigger or stressful event that led to Rose’s repeated hospital admissions. Rose’s inability to mobilise and wash her hands after contact with her dog and blowing her nose led to a cycle of re-infection.

**Accessibility**

Accessibility involves demonstrating an understanding of local services available to the patient (Alter and Hage 1993). This skill is particularly important during intensive case management for patients with complex needs and at high risk of hospital admission. These patients need to be directed to the most suitable services to prevent unnecessary hospital admission (Sutcliffe et al 2010, Fairhall et al 2011). Therefore, a working knowledge of service eligibility and triggers for referral is essential. It is also important to ascertain the level of flexibility of a service to meet the intermittent and varying needs of the patient (Fairhall et al 2011). Therefore local health and social care services may include short and long-term services such as day centres, transport, meal provision, dentistry, optometry, audiology and support groups.

Having an accurate up-to-date directory of services is key to effective co-ordination of care, and will form an essential element of the development of a communications hub – a single system that processes referrals and shares information across health and social care services (WAG 2009, 2010). The lead GP in the Gwent frailty service developed a database providing information on NHS, local authority and voluntary sector services available in the five Gwent boroughs.

Rose accessed the Gwent frailty service through the single point of access – the central communications hub – that manages all referrals to the service and directs patients to the most geographically appropriate community resource team. Rose’s referral was handled by the appropriate community resource team. The first visit to assess Rose was undertaken by a nurse within two to four hours following referral (Figure 1). Access to other professionals, such as district nurses and practice nurses, to obtain background information before treating Rose would have

**TIME OUT**

3 Make a list of some of the assessments and investigations that you think Rose might need.
been essential for the nurse within the community resource team. Using knowledge of the local area and its services, and the directory of services, the nurse was able to identify the most appropriate services to meet Rose’s needs throughout the assessment and treatment phase. Rose recovered without going into hospital, increasing her mobility, activities of daily living, such as washing, and instrumental activities of daily living, such as meal preparation. She experienced no further exacerbations of chronic obstructive pulmonary disease due to recurring infection. She felt able (with support) to consider resuming some of her social activities with her friends and family.

All professionals working in a community resource team are required to undertake a certain amount of care co-ordination. The purpose of co-ordination is to ‘obtain the resources and expertise necessary to produce needed outcomes’ (Alter and Hage 1993). Alter and Hage (1993) suggested that, to work in a co-ordinated way, a nurse should be able to demonstrate the principles of comprehensiveness, compatibility and accessibility. Achievement of these three components within a service results in a continuum of care. For example, Engelhardt et al (2009) evaluated the Advanced Illness Coordinated Care Program in the United States, showing its effectiveness in improving quality of care for patients with advanced illness.

**References**


Department of Health (2001) The Essence of Care: Patient-Focused


States, which combined co-ordination of care with health counselling and patient education to support patient adaptation to individual circumstances. The study findings highlighted that for care co-ordination to be successful it was essential to match the design of the service with the specific problems it sought to solve.

Conclusion
Frailty is a state of vulnerability that is characterised by several factors, including weight loss, exhaustion, fatigue and low physical activity, depression and incontinence. It is often described as an unpredictable underlying state of health, which may be exacerbated by a trigger or stressful event, leading to a downward spiral of frailty, increased dependence and hospital admission. Assessment and co-ordinated care is essential to identify and treat the frail patient. The Gwent frailty service provides a model that can be used to enable thorough and appropriate assessment and co-ordination of care so that the patient has access to the most appropriate services and unnecessary hospital admission is avoided. 


