RCN initial response to HSJ Frailty Commission Consultation 2014

Background

The Royal College of Nursing (RCN) is the UK’s largest professional association and trade union for nurses, with over 410,000 members. The RCN works locally, nationally and internationally to promote high standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is pleased to see this commission as recognition that frailty is a major issue in healthcare services.

With growing numbers of older people and related prevalence of frailty and co-morbidities¹ health and social care services need to adapt to meet the complex needs of this group of people. Despite its importance, and growing evidence of the association between frailty and adverse health outcomes for older people, frailty is not generally well understood, particularly in services where there are no specialists in older people’s care.

1. What is happening now in care for the frail elderly in your organisation and health economy?

Members report that frailty services are developing in different ways around the country with a range of frailty definitions, indicators, pathways, models of service and new roles focusing on frailty.

A number of new initiatives are currently being led by Nurse Consultants across the UK, who are working closely with Consultant Geriatricians and multidisciplinary teams.

Difficulties arise if there is a lack of consensus about ‘frailty’ across services. Some services define frailty according to the frailty syndromes described in ‘The Silver Book’ (Banerjee & Conroy 2012). Others find these vague and difficult to apply when communicating with Adult Social Service Teams; they use the Clinical Frailty Scale (Rockwood et al 2005). A shared understanding of frailty which includes a range of risk factors, is essential in initiating appropriate supportive responses for treatment and reducing adverse events.

Some services use exclusion criteria, for example cardiac problems or stroke, these patients will not be placed on a frailty pathway. Common co-morbidities such as dementia and delirium can impact on frailty, but the introduction of specific clinical pathways can result in people having frailty needs overlooked. Pathways therefore need to be combined so that people receive holistic assessments.

Recent RCN initiatives have focused on supporting the needs of frail older people and those with dementia within inpatient acute care services. These include guidelines for ensuring safe staffing levels in older people’s wards, which recognise the increased acuity and dependency needs of older people. (RCN 2012a) plus a call to action to improve care (RCN 2012b). The SPACE principles set out in the Commitment to the care for people with dementia in hospitals settings (RCN 2012c) offer a benchmark to ensure the needs of people with dementia and are being used widely to support and evaluate improvements in care.

2. What needs to change to improve care for this important section of the population?

Fundamentally, to effectively support frail older individuals, multiprofessional collaboration is essential, including geriatricians, specialist nurses, therapists and adult social care.

Despite the fact that nursing frail older people requires knowledge and skill, as well as empathy, emotional reserve and common sense, there is no nationally recognised specialist qualification in nursing care for older adults. Increasingly access to post registration education and training is restricted to ‘mandatory’ issues like ‘health and safety’ so nursing staff are not able to access the most up to date nursing practice.

Frail older people need reliable holistic (bio-psychosocial) assessment; multidisciplinary care planning; advance planning to avoid predictable emergencies; care co-ordination; excellent nursing; excellent communication and collaborative relationships between staff, patients and carer (Cornwell 2012).

Frailty definitions or clinical frailty scales should be able to identify individuals who are frail or vulnerable to frailty, ideally at an early stage so that support can be offered in their homes. In addition services need to establish an agreed definition of frailty, comprehensive assessment processes and clear frailty pathways, which align with other condition specific pathways.

It follows therefore that a comprehensive assessment, commonly known as comprehensive geriatric assessment (CGA), should be multiprofessional and multidimensional; this should identify the individual’s key problems and formulate a personalised care plan. The CGA should be able to transfer to Adult Social Services. Definitions of CGA are diverse but one ‘starter’ definition of a CGA is that two professionals from different professions discuss the patient, formulate a list of problems and a plan for treatment and care.

There should be clear frailty pathways which incorporate all elements of care including predictive and preventative services, adult social services, urgent and intermediate care, hospital discharge support, care homes and end of life services.
Workforce strategies can then be developed so that resources can be allocated across pathways to support integrated ways of working.

Integrated care systems in the community that can manage urgent care scenarios in patients’ homes can prevent inappropriate hospital admissions where older people go through the urgent care treadmill and undergo inappropriate investigations. Once on the wrong pathway it can be difficult to redirect these patients.

Transfer of information is important so that older people come into hospital with details of their past history, care needs, expectations and advance care plans. Clinical Commissioning Groups need to develop information systems that can be used across the whole economy – social care, acute, community, primary care, out-of-hours services and ambulance services.

Around 2.5 million people over 75 have some kind of informal care at home from close family members, neighbours and friends and a quarter of carers are themselves 65 or older (The Information Centre 2010b). Working in partnership and assessment of carers needs is therefore essential to the care of frail older people. The Triangle of Care for dementia (Carers Trust/ RCN 2013) offers a useful framework with practical guidance for routinely involving and supporting carers, to ensure better outcomes for this group.

A strong geriatrician voice is important in promoting the importance of co-ordinated frailty services. In some areas geriatricians spend part of their time in acute care and part in the community, for example in an intermediate care team, thus facilitating ongoing review and support. Nursing or therapy posts which rotate between acute and community services can help build understanding of the capacity of people and communities to support risk in the home setting and assist in hospital discharge planning.

Palliative care services are now broadening their remit from the management of symptomatology and end of life in cancer to encompass more older frail individuals with multiple long-term conditions.

The nursing contribution to care for frail older people is central. All nurses working with older people should understand frailty and the expertise of Older People’s Specialists and Consultant Nurses is essential in developing and leading frailty services. However, the emphasis on older people and frailty in nursing education programmes needs to be stronger so that all nurses understand frailty and frailty pathways and are competent to assess and care for older people living with frailty.

Older people who are in hospital often have highly complex needs which require skilled care and enough time to meet their needs in a dignified way. Nursing staff with the right educational preparation, clinical skills and physical resources need to be able to meet these needs now and in the future. The RCN’s recommendations of
issues like staffing levels and skill mix (RCN 2012a) identify a range of factors that underpin safe, dignified care:

- sufficient numbers and skill mix of nursing staff
- on duty at the times when they are needed
- strong leadership at ward level
- empowerment of ward sisters/charge nurses for ensuring safe staffing
- proper workforce development, skills and training
- appropriately resourced clinical environment
- development of appropriate metrics and measures of patient experience and outcome of compassionate care giving.

3. **What examples of imitable and scalable good practice in care for the frail elderly have you used or observed?**

Setting up new frailty services has been challenging.

In Cornwall*, a team led by a Consultant Nurse with support from Commissioners and geriatricians is currently setting up a new Frailty Unit in which the Medical Assessment Unit will become a short-stay medical ward. Patients who are frail can be identified on admission and taken to the Frailty Unit for 48 hours. This Unit will become the link to the community.

This service is set up to support frailty levels 5, 6 and 7 on the clinical frailty scale (Rockwood et al 2005) and plans to try to identify people at level 4 in order to prevent frailty developing. Patients at level 6 and 7 trigger a personalised care plan, so concentrating potential resources. Alongside this another Consultant Nurse is working with the local area team to lead on the development of a cross organisational pathway of care for frail older people. This 'end to end' pathway looks at all elements of care including urgent care, intermediate care, case management, preventative/predictive services, care homes and end of life.

The idea is to develop a pathway with underpinning standards that all organisations sign up to. Resources will then be reallocated across the pathway and a workforce strategy developed to support new integrated ways of working. Frailty screening will be carried out across the pathway and all frail patients will receive CGA and a personalised care plan supported by a key worker within a Virtual Ward approach.

These services are linking with a university research department to collect data that will monitor the system and shape the development of service and education.
4. What errors or bad practice should be avoided?

Bad practices or errors in practice are often the result of a complex series of factors. The following submissions are snapshots taken from general comments from members on the issue.

- When older frail patients are at the front door of an acute hospital particularly in A&E, a four-hour (or any arbitrary time frame) target can be detrimental. It can skew decision making and take the focus away from person centred need. This can lead patients being inappropriately admitted simply to avoid ‘breaching’ the target.

- Related to the above, significant time spent on a trolley in A&E can be highly detrimental to older people with frailty and particularly those with cognitive impairment or a dementia.

- Providing a calm environment with orientation cues can be particularly important for people with cognitive impairment. It follows therefore that caring for frail elderly people in ‘revolving door’ assessment centres; rapid turnover general surgical or medical environments, etc can be disruptive, emotionally distressing, and ultimately detrimental to patients’ recovery.

- Moving patients and putting them onto any available ward can be particularly detrimental for older frail people. Repeated bed moves can disrupt effective communication and reduce access to appropriate clinical support. Some hospitals have an Outlying Policy in place with the aim of preventing this.

The RCN is pleased to acknowledge the expertise and contribution of members of the British Geriatrics Society Specialist Nurse and Senior Practitioner Group in the development of this summary response

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Notes:

**Definition:** Frailty has been defined as ‘a diminished reserve capacity or a reduced resilience which is a consequence of cumulative decline in many physiological systems during a lifetime’ (Clegg et al. 2013).

**Terminology:** National multiprofessional symposia have suggested appropriate terminology as ‘older people living with frailty’.

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