ORIGINAL RESEARCH

Perceptions of Frailty in Long-Term Care

Kayla Atchison, MSc[1], Pauline Wu, BSc[1], Ann M. Toohey, PhD[2], Daniel Gaetano[1], Jacqueline McMillan, MD[1], Jenna Naylor, MHLP[3], Sharon Kaasalainen, RN, PhD[4], Michelle N. Grinman, MD[1], Vivian Ewa, MD[1], Jessica Simon, MD[1], James Silvius, MD[1], Aynharan Sinnarajah, MD[5], Beth Gorchynski, MSc[6], David B. Hogan, MD[1], Jayna Holroyd-Leduc, MD[1], Zahra Goodarzi, MD[1]

[1]Department of Medicine, University of Calgary, Calgary, AB; [2]Department of Community Health Sciences, University of Calgary, Calgary, AB; [3]Brenda Strafford Centre on Aging, University of Calgary, Calgary, AB; [4]Department of Family Medicine, McMaster University, Hamilton, ON; [5]Department of Medicine, Queen's University, Kingston, ON; [6]AgeCare, Calgary, AB

https://doi.org/10.5770/cgj.28.817

ABSTRACT

Background

An early palliative approach to care may best suit the care needs of older persons with frailty living in long-term care (LTC). The study objective was to evaluate the barriers and facilitators to care for frailty in the LTC setting.

Methods

Semi-structured interviews were completed with physicians, nurse practitioners, registered nurses, allied health-care providers, care partners, and residents with care experience in LTC. Framework analysis methods that leveraged behaviour change theories were used to analyze the interview data and produce practice-oriented findings.

Results

Twenty-eight interviews were completed. Seven themes were identified: resident characteristics related to frailty; frailty detection and diagnosis; frailty treatment and care planning; frailty and prognosis conversations; palliative and end-of-life care; communication amongst LTC collaborators; and the LTC environment. All codes were labelled as barriers or facilitators and assigned to a primary domain within the Theoretical Domains Framework.

Conclusions

The lack of clinical recognition of frailty in the LTC setting was a key barrier to clinical pathway implementation. There is a need for frailty to be linked to prognosis and care decisions, for frailty to be directly addressed through individualized treatments, and for an early palliative approach to care to be accessible to residents. Identifying barriers to care for frailty is a critical step toward clinical care pathway implementation which may improve care and outcomes for residents of LTC.

Key words: frailty, palliative care, long-term care

INTRODUCTION

Frailty is a medical condition characterized by reduced function and health in older adults that impacts resilience to stressors.[1] Frailty is an established predictor of mortality,[2] and factors like multiple morbidities, poor physical performance, disability, poor nutrition, social isolation, and polypharmacy are thought to contribute to frailty.[1] Nearly all older adults living in long-term care (LTC) are thought to be experiencing frailty or pre-frailty.[3]

Various frailty measures exist, including the frailty phenotype[4] or index[5] for use within research settings, or clinical or laboratory-based frailty scales for use within the care context.[6,7] Measurement strategies focus on assessment of the individual's day-to-day function, co-morbidities, physical exam, and laboratory findings.[8,9] Early identification of frailty enables patients and health-care providers to consider person-centred interventions to reduce further decline and avoid undue harm from potentially inappropriate interventions. Targeted interventions focused on issues such as symptom control, medication review, mood, physical function, exercise, nutrition, and optimizing socialization can be effective.[10,11] Additionally, person-centred discussions around risk and goals can help align care plans across providers.

Palliative care is a key component of management in LTC and for those experiencing frailty, with a multi- and interdisciplinary approach focused on reducing suffering and optimizing quality of life in those with conditions which are life-limiting.[12] Palliative care teams can help persons experiencing frailty with common symptoms such as pain and distress, and provide nuanced care for frail older adults.[13]

Residents of LTC are well suited to a palliative approach to care; however, often they do not receive palliative care as

a formal palliative care model for LTC in Canada does not exist.[14] Further, a standardized screening protocol for frailty in most LTCs does not exist.[15] In the absence of regular screening, frailty remains under-recognized and under-documented in LTC.[16] Due to the medical complexity experienced by many persons living with frailty in LTC, a palliative approach to care focused on pain and symptom management, versus life-saving interventions, should be considered.[12,13,17]

Few studies connect frailty identification to management, including palliative care.[13,18] Patients would benefit from person-centred care realized through the early identification of frailty, and tailored interventions that reflect their goals and wishes.[13,19] In response to the lack of effective and practical strategies for early palliative care for older adults living with frailty in LTC, our research team leveraged existing evidence and expert opinion to develop a clinical care pathway focused on frailty and early palliative care in LTC.[20] To develop the clinical care pathway, it is important to identify the potential barriers and facilitators to detecting and diagnosing frailty, discussing prognosis, and incorporating potential interventions (e.g., palliative approach) where appropriate.

The present study was undertaken to evaluate the barriers and facilitators to early frailty identification, management, and palliative care from the perspectives of persons living with frailty in LTC, care partners, and health-care providers. Understanding the barriers and related behaviours that exist to care for frailty in LTC is a key step toward clinical care pathway implementation.

METHODS

Study Context and Population

Long-term care residents, care partners, and health-care providers were identified as key knowledge experts for the present study. Residents had to be living in a LTC setting and care partners had to be a friend, family member, or agent of a resident. Health-care providers included physicians of any specialty, registered nurses, allied health-care providers, and health-care aides with experience providing care in the LTC setting. LTC is characterized by the provision of 24-hour nursing and personal support for those with high care needs.[21]

Participant Identification and Recruitment

Eligible participants had experience with the LTC environment, could independently consent to participate in the study, and spoke English. Health-care providers and care partners were recruited online across multiple LTC sites, while residents were recruited in person at a single LTC site. Members of the study team and participating organizations sent out recruitment emails to their networks. Persons who received the study recruitment email were encouraged to share the study information within their networks.[22] Potential participants emailed the research team to receive more information about the study, provide informed consent, and schedule a remote interview.

Resident participants were recruited by a member of the research team who attended a single LTC site at scheduled times for the purpose of recruitment. Staff at the LTC site identified and approached residents who could consent to participate and introduced the study. If willing and interested, the resident provided consent for the researcher to approach, discuss participation, and schedule an in-person interview at a time of the resident's choosing.

Data Collection

Semi-structured interviews were completed with participants. The interview guide was developed based on findings from the clinical care pathway study[20] and included input from knowledge users to ensure the coverage of topics important to frailty and palliative care in LTC. Interview questions were based around the 14 domains of the Theoretical Domains Framework (TDF). Interview questions were adjusted for each collaborator group, but the interview topics remained consistent.

Interviews were completed by one researcher between September 2021 and March 2022. All interviews took place over Zoom®. Interviews ranged from 15 to 60 minutes in duration. Interviews were transcribed by the same researcher who performed the interviews.

Theoretical Framework

The TDF underpinning the present research contains 14 different behavioural domains. The TDF functions to assess behavioural or implementation issues, and can be used to inform the design of behaviour change interventions.[23]

Framework Analysis

A framework analysis was completed to identify practice-oriented findings intended to support the implementation of the clinical care pathway.[24] Each transcript was inductively coded line by line by two independent researchers. Themes from the data were identified, a thematic framework was developed, and the remaining data were indexed according to the thematic framework. The TDF domains were used to chart the data according to participant role. Interview transcripts were coded and no further interviews were completed when repetition in the codes was identified. Each code was labelled as either a barrier or a facilitator. A second researcher independently verified the TDF domain and barrier/facilitator assignment. Disagreements in code assignment were resolved through discussion amongst researchers. The codes, charted to domains of the TDF, were then mapped to the Behaviour Change Wheel to identify intervention functions to address behavioural barriers in future work.[25] The interview data were managed and analyzed using NVivo software (QSR International, Melbourne, Australia).

Ethical Considerations and Reflexivity

The interview study was approved by the University of Calgary's Conjoint Health Research Ethics Board (REB20-2212). The present analysis was led by Dr. Zahra Goodarzi, a geriatrician with expertise in clinical care for older adults. As an integrated knowledge translation project, knowledge users (e.g., palliative care clinicians, geriatricians, researchers,

LTC representatives, and patient partners) were engaged and included throughout.

RESULTS

Participants

Twenty-eight participants completed interviews about frailty and palliative care in LTC. Participants were grouped according to their role in LTC. Respondents were either physicians or nurse practitioners (n=6), registered nurses (n=8), allied health-care providers (n=4), care partners (n=5), or residents (n=5). Twenty-two participants identified as women, 25 spoke English as their primary language, and 20 were born in Canada (Table 1).

Barrier and Facilitators Identified

The results are presented by theme, and the key barriers and facilitators within each theme are highlighted. Supporting participant quotes were selected by researchers and are presented in Table 2.

Resident Characteristics & Perceptions of Frailty Label

Participants viewed residents currently entering LTC as frailer than cohorts previously seen and having high care needs. Residents entering LTC were thought to likely not improve, and dementia was identified as a prevalent comorbidity. Residents experiencing frailty were thought to be more medically complex, and the importance of considering frailty in relation to comorbidities was noted.

Frailty was discussed as a factor with an impact on activities of daily living, resilience, homeostasis, mobility, and function. Frailty was viewed as a combination of many aspects of health with many indicators or symptoms. Although frailty was perceived as having an impact, frailty, as a term, was not perceived to be used or was viewed as a new concept that was not previously recognized. In practice, if a resident was identified as frail, participants did not think that frailty was linked to care-related decision-making for the resident.

Labelling a resident as frail was thought to have both positive and negative implications. Being labelled as frail was viewed by some as an accurate and helpful description that could lead to more holistic care and was not associated with negative consequences. To others, labelling residents as frail was viewed as a negative, as it was perceived that providers viewed frailty as a reason to withhold care or helpful interventions, resulting in nihilism or apathy. For example, "if they're inappropriately labelled, there may be a reluctance to offer more advanced interventions" (Participant 10, Physician/Nurse Practitioner). Labelling a resident as frail was also thought to lead to extra work for staff in educating families.

Frailty Detection & Frailty Diagnosis

When detecting or screening for frailty in the LTC population, the lack of a clear definition, awareness, and understanding of frailty was a barrier to its identification and diagnosis. The lack of understanding of frailty was a barrier to health-care providers' appreciation of how frailty is part of the global decline in residents and how it can influence care. Participants thought that care partners and residents accurately identify frailty without prompting from health-care providers, and that the impact of frailty—including how it can be a cause of death—was becoming more recognized. A team approach was recommended for identifying frailty; practices like regular care assignments, formal documentation of frailty, complete assessments, day-to-day monitoring, discussions at interdisciplinary rounds or care conferences, and staff training were thought to facilitate identification.

TABLE 1.
Demographic details of interview participants

	Number (%)
Total Number of Interviews	28
Sex	
Female	22 (78.6)
Male	6 (21.4)
Gender	
Woman	22 (78.6)
Man	6 (21.4)
Age Group	
18-34	3 (10.7)
35-49	6 (21.4)
50-64	9 (32.1)
65-74	5 (17.9)
75-84	3 (10.7)
85+	2 (7.1)
Highest Level of Education for Care Partners and Residents	
≤ Grade 12	3 (30.0)
College/University	7 (70.0)
Average Length of Stay in LTC (months)[a]	26.1
Role	
Allied Health-Care Provider	4 (14.3)
Care Partner	5 (17.9)
LTC Resident	5 (17.9)
Physician or Nurse Practitioner	6 (21.4)
Registered Nurse	8 (28.6)
Years in Health-care Role	
1-5 years	2 (11.1)
6-10 years	7 (38.9)
11-15 years	1 (5.6)
≥16 years	8 (44.4)
Language(s) most spoken at home	
English only	25 (89.3)
English and another language	3 (10.7)
Place of Birth	
Canada	20 (71.4)
Other	8 (28.6)

[a]Asked to resident participants only.

TABLE 2.
Quotes selected to highlight participant views informing themes

Theme	*Quote(s)*
Resident characteristics and perceptions of frailty label	"If you're telling me that she's very frail, which we can see with our own eyes that she is very frail, and that they've now come up with a diagnosis – because frailty's not a term that they tend to use very much. And, yet we in our family use it quite a bit – that she's very frail. Cause we can see the decline in her. We use the term but it's not a term…it's not a term that I hear very much from the facility." -Participant 1 (Care Partner)
Frailty detection and frailty diagnosis	"I would like to see frailty up there every time I look at the past medical history or diagnosis list. It's not there because they don't recognize it. That it's a diagnosis. And so, once they understand what we're talking about is frailty and how that all comes together in the global decline and overall failing of multi-systems for these individuals, their approach and management might be a little bit different." -Participant 17 (Registered Nurse)
	"Yeah, I mean, never in my career did we do any active scoring or testing. I think it was just sort of a perception or almost an assumption that if you're in LTC, you are frail…We just knew that people in LTC were there because of dependency and multiple conditions and all of that. All the things we now recognize as frailty." -Participant 15 (Physician/Nurse Practitioner)
	"I think it really is an interdisciplinary approach. If we're going to list frailty as a diagnosis, then I think it's up to anyone from the interdisciplinary team who is working with an individual to bring it up, and if there are benefits to having that specifically as a diagnosis. If we're looking at a specific care pathway, then of course, a diagnosis would be important so that we could implement that…It's the physicians who do diagnose, but I think it's the team who recognizes where concerns are. And it's the team who helps to develop some of that plan and to alert the appropriate people to address those things." -Participant 27 (Allied Health-Care Provider)
Frailty treatment and care planning	"I don't think we're specifically like oh, this person is frail, so we offer this now. I think it all is on that spectrum of where they're at and that global big picture of how they're doing. And then we would offer things based on that." -Participant 10 (Physician/Nurse Practitioner)
	"I have not seen on our care plans that specific goal of frailty. On our care plans, we have custom goals, and the aim for the outcome, and then the interventions that are going to be provided. There's nothing there that's labelled as frailty." -Participant 28 (Allied Health-Care Provider)
Advance care planning, goals of care, and frailty and prognosis conversations	"It's the skill and ability and the language and the template to have those serious illness conversations. I think that should be rolling out in LTC because you need it not only while you're doing your advance care planning and your goals of care designation, you need it all the way along. The ability to say, I noticed this, I worry about that, this might mean for us…There's a way of asking and leading the person or the family through a serious conversation about their illness and their frailty. I know that it's being used in a few places, but I think that should be basic training for all the interdisciplinary staff in LTC…"-Participant 11 (Registered Nurse)
	"I find it very helpful, to be honest with you. I use frailty when I'm explaining appropriate goals of care and potential prognostic outcomes. I find that in most cases, families understand that." -Participant 14 (Physician/Nurse Practitioner)
Palliative care and end-of-life care	"I would say that most people who are entering LTC are palliative to some degree or have palliative aspects that can be helped because palliative care is improving the quality of living and dying. It's symptom management and that needs to be addressed…Most palliative care will be delivered by the LTC staff: the health-care aides, the LPNs, and RNs. I'm sure it varies by site, how much education, what they're actually providing, but palliative care is happening every day." -Participant 11 (Registered Nurse)
	"To me, palliative care means end-of-life care where they keep them [the patient and family] comfortable. They're there to alleviate any discomfort for anybody…" -Participant 1 (Care Partner)
Roles and communication	"I think there needs to be the commitment to having conversations with the wider support network so that everybody is on the same page and has that understanding of what exactly has changed, what is going on, and what is needed in terms of support…" -Participant 9 (Care Partner)
LTC environment	"Creating an environment that's homelike and being very familiar so that you're able to assess any changes as fast as possible. But establishing that continuity of care is really important." -Participant 18 (Registered Nurse)

There was no formal process in place, or participants were unclear on the process, for identifying, documenting, or re-evaluating frailty. Health-care providers noted that they do not formally screen for frailty or use a standardized approach for its detection because there is the perception that everyone in LTC is frail. While persons in LTC do experience frailty more than the general population, there is a range in the severity of frailty. It was noted to be important to match care planning to the severity of frailty as the severity informs interventions and prognosis. Although frailty was not being formally screened for, there was an identified need for a standardized tool or measure that could be built into regular assessments to detect and reassess frailty over time. Barriers related to the use of standardized tools for frailty detection included that training would be required to use this approach, and that otherwise accepted approaches may not be applicable when a resident has a palliative diagnosis or dementia. Participants noted that standardized screening instruments for frailty exist and may be adequate for use. Tools like the Palliative Performance Scale, FRAIL Scale, Frailty Index, Frailty Phenotype, Clinical Frailty Scale, Resident Assessment Instrument, or using existing data sources were identified as potential methods to screen for frailty.

Care teams did not recognize frailty as a diagnosis with clinical indicators. Barriers to diagnosing frailty included the lack of resources specific to frailty, including standardized assessments and processes, as well as a lack of understanding and knowledge about frailty. Some participants viewed frailty as easy to diagnose given the prevalence in LTC, and considered the constellation of resident appearance, comorbidities, mobility, nutrition, sarcopenia, falls, and physical examination findings as ways to diagnose it. Diagnosing frailty was thought to better describe a resident's condition, enable appropriate treatments, evaluate outcomes, involve more team members, and facilitate changes to the care plan. A diagnosis was perceived to improve residents' quality of life only if changes to care that met the resident's needs occurred as a result.

Frailty Treatment & Care Planning

The lack of detection, assessment, or diagnosis of frailty was a barrier to the treatment of frailty. Frailty was not thought to be directly managed or treated; instead, the holistic needs, other medical conditions, or symptoms a resident was experiencing were targeted for management. Some participants thought there were sufficient resources available for frailty management. There was a perceived lack of awareness, education, and care team engagement, including physician reluctance or discomfort, around frailty management. The inability to treat or change certain outcomes despite intervention was identified as one of the greatest challenges to managing frailty. When delivering care to residents, staff members were perceived to provide more task- versus person-orientated care. Issues with information sharing were also noted as a barriers to care. Enablers to treating frailty included: resident's attitudes; access to experienced providers who are knowledgeable, open, engaged, and take their time; communication, education and awareness; family support; a focus on quality of life; and policies that help define staff roles and responsibilities. Frailty was perceived to be managed both formally and informally, and with both pharmacologic and non-pharmacologic treatments. Formal management was thought to be easier to assess and monitor if some goals and outcomes could be evaluated. Frailty, as well as resident goals of care, was noted to impact how patients are cared for, with safety and pain management identified as important aspects of care. Care pathways and clear documentation are noted to facilitate appropriate, timely treatment.

Care plans were viewed as amalgamations of assessments from different team members that were living documents and ever-changing. Care plans were changed or developed at annual assessments, care conferences, when concerns were reported, or when goals of care were changed. Care plans for frailty were not thought to exist. Barriers to creating care plans included a lack of understanding of how to develop a care plan, as well as having no formal process in place for creating one. Additional challenges to care planning for frailty were including input from all team members, the process of shared decision-making, and managing family expectations.

Advance Care Planning, Goals of Care, Frailty & Prognosis Conversations

Participants stated that discussions about goals of care and appropriate health management strategies occurred. Residents noted that they had advance care planning documents in place that had been shared with their families. The care team in LTC was generally thought to not have advance care conversations with residents and families after admission, with frailty and prognosis conversations often occurring before residents entered LTC. A perceived barrier to care conversations was physician accessibility. Communication was thought to be required to support a common understanding of frailty, prognosis, and care. Policy, education, and training for staff about advance care planning and goals of care were noted as being needed to ensure the timely and accurate completion of these discussions and related documentation.

Participants thought that the identification or diagnosis of frailty should be linked to progression and prognosis. The severity of frailty was widely identified to impact prognosis and to contribute to earlier palliative care conversations. A resident's frailty status was perceived to help clinicians recognize potential outcomes and facilitate explanations of goals of care and prognosis. Various roles were identified as being involved in goals of care conversations. Residents and families were involved in advance care planning, while nursing staff and allied health-care providers facilitated frailty conversations being points of contact and advocates for the resident. The palliative care team was identified as helping to manage expectations and facilitate understanding in residents and families, as well as facilitate the communication of frailty, goals, prognosis, and advance care planning. Participants described how the palliative care team also educated, modelled, coached, and mentored staff in prognosis conversations so that they could undertake them independently.

Advance care planning and frailty prognosis conversations were noted to happen at admission, on an annual basis, and at care conferences, and were facilitated by policy and new diagnoses. Care partners reported that discussions about frailty and prognosis with health-care providers were superficial and brief, leading to feelings of dissatisfaction. Staff reported not feeling confident in their ability to conduct conversations about frailty and prognosis, and voiced a need for practice or training. Participants noted that frailty and prognosis conversations should be aligned with residents' wishes, consider frailty outcomes and care in place, and focus on quality of life.

Palliative Care & End-of-Life Care

Palliative care resources were reported to be available in LTC, but participants voiced a lack of clarity on when and what palliative care services should be consulted. The palliative care consultants and resources available were perceived to differ by site and how much education was required at the site. Palliative care resources were available for education, capacity building, and engagement, and functioned to meet resident and family needs. Staff members reported having relationships with palliative care experts and could contact them for help anytime. Participants thought that standardized palliative care education, including training in end-of-life care for health-care providers, would benefit care. There was also a noted need for palliative care and comfort care to be initiated earlier in the care trajectory. Participants viewed LTC in general to have a palliative approach to care, regardless of prognosis; however, the involvement of palliative care teams and delivery of palliative care were determined on an individual basis. Palliative care was thought to focus on quality of life, pain, and symptom management, and was viewed as a good care option for frailty.

Participants often perceived palliative care to be synonymous with end-of-life care. Participants highlighted that staff should have conversations with families to prepare them for an increased decline in the resident, as well as end-of-life. Although end-of-life pathways exist in LTC, at times there was an unnecessary push for the use of these pathways. Residents described having experience with others going through end-of-life and reading about the topic as resources that they have used to prepare for end-of-life. Participants noted that there was a desire to avoid suffering and emphasize quality of life at end-of-life, and identified that palliative resources, including spiritual care, were available to support the resident and family.

Roles & Communication

Staff members were thought to lack understanding of frailty and the complex care needs and conditions of residents. There was thought to be a need for more role clarity, understanding of the roles of others, and support for medical leadership in LTC. Providers viewed it to be difficult at times to involve residents in care and give residents the time that they need to participate, while care partners were unclear as to how they could best support or advocate for residents. Various roles including geriatric specialists, geriatric psychiatrists, allied health-care providers, and palliative health-care providers were identified as being involved in or available to consult on care.

The care team was perceived to be more receptive and involved when the resident was new to the facility. The receptiveness of the care team to concerns raised about a resident was thought to depend on how well the providers knew the resident. Health-care providers were viewed as receiving concerns about residents appropriately, with concerns being addressed at meetings, interdisciplinary rounds, and care conferences. Residents noted that they discussed their worsening condition or would do so with their families.

Physicians were noted to see residents only for a snapshot in time and to rely on staff to communicate updates on the resident. Participants found it challenging to describe and communicate a resident's condition, and difficult to ensure staff documented and communicated key findings. It was thought to be important to document, discuss, and communicate concerns about the resident with the family and care team. Participants viewed open, ongoing communication between the care team, resident, and family to build trust and as necessary to provide the best care. Facilitators to communication included the involvement of all agents in conversations, having referral processes in place to ensure the voices of all health-care providers were heard, and the existence of support networks to help care partners and families.

LTC Environment

Within the LTC setting, frailty was thought to be common and obvious. To create an ideal LTC environment, participants thought that the built environment and daily activities should be individualized and included as a component of frailty assessments. Health-care providers were noted to be slow to bring in resources to address frailty. Participants stated the importance of having reminders about available resources and how to access them so that they are utilized.

DISCUSSION

Identifying the key barriers and facilitators to care for frailty in LTC through collaborators' perspectives and understandings is a necessary step toward implementing a clinical care pathway for frailty and early palliative care. Proposed solutions for the described barriers are summarized in Table 3.

Overarching Barrier: Frailty Needs to be Recognized as a Clinical Issue & Objectively Measured

Frailty was not recognized or understood by many as a clinical issue warranting detection, diagnosis, or treatment. There are no standardized procedures in LTC to detect, document, or diagnostically confirm frailty in residents. To many, frailty was viewed as a descriptive adjective and not a clinical state that should inform or direct care decisions.

Participants widely assumed that most persons living in LTC were frail, which accurately reflects prevalence estimates of frailty and pre-frailty in LTC.[3] Even though frailty is prevalent in LTC, the assumption that all residents are frail

or severely frail, coupled with the lack of understanding of the clinical presentation and its implications, has led to a lack of active intervention for frailty in LTC. This generalized impression that all levels of frailty are equivalent argues for an objective measure of frailty. Mild, moderate, or severe frailty is associated with distinct prognoses and warrant distinct approaches to provide patient-centred care. The lack of consensus on how frailty is conceptualized, as well as the lack of objective frailty severity assessments, complicates the understanding of the importance of identifying frailty. It is necessary to have an approach specific to frailty that accounts for severity in LTC so that appropriate care can be triggered, including strategies to slow the progression of frailty. Choosing a single approach for frailty may be challenging given the complex population living in LTC.[26] Nevertheless, the use of any validated frailty tool will aid in objective measurement, documentation, and communication. There is a need for education on the clinical indicators of frailty and how it can be detected, an understanding of illness trajectory to manage expectations, and education on available interventions that may be appropriate given a spectrum of frailty severity.

Barrier: Frailty Needs to be Included in Care Conversations & Decisions

Frailty needs to be more explicitly linked to prognosis in LTC so that appropriate care and interventions can be delivered that maximize residents' quality of life.[27] When frailty is not linked to prognosis clinically, persons living in LTC may not receive care aligned with their needs, such as a palliative approach to care.

Reduced cognitive ability or decision-making capacity in residents at end-of-life complicates care conversations, stressing the importance of having care conversations that include frailty in relation to prognosis early and regularly.[28,29] Health-care providers need to include residents and care partners, based on their ability and desire to participate, in care conversations that address frailty so that potential outcomes can be better understood. To explicitly address frailty in care conversations, existing resources like the Palliative and Therapeutic Harmonization long-term care model or SeeMe™ care program for frailty can support the occurrence of conversations and the development of appropriate care plans.[30,31]

Barrier: Frailty Needs to be Treated Based on Severity

Frailty was identified by participants as not being directly or specifically treated. Treatment guidelines for frailty are lacking in LTC but proposed management strategies for populations outside of LTC operate under an assumption that frailty can be lessened and that treatments need to be individualized.[9,32] The goal of frailty management should be to improve quality of life and slow the progression of decline. Potential interventions for frailty that have been studied include exercise, nutritional interventions, multicomponent interventions, and individualized geriatric care models.[33] A review of exercise interventions for frail older adults found that residents of LTC benefited from a variety of exercise programs.[34]

The lack of formal frailty identification via frailty detection in LTC precludes the formal treatment of frailty. It is critical to identify and assess frailty severity in order to deliver

TABLE 3.
Barriers identified and proposed solutions

Barrier	*Proposed Solutions*
Frailty needs to be recognized as a clinical issue	Need for an approach that identifies frailty and accounts for severity. Appropriate care strategies that slow the progression of frailty should be triggered based on the identification and severity of frailty. Education is required on the clinical indicators of frailty as well as the available interventions to address the spectrum of frailty severity.
Frailty needs to be included in care conversations and decisions	Advance care planning conversations must occur early and regularly. Frailty needs to be linked to prognosis in care conversations so that prognostic outcomes and health trajectory can be better understood and timely, appropriate (e.g., interventions that enhance quality of life) care decisions can be made. Look to existing resources like the Palliative and Therapeutic Harmonization LTC model or SeeMe™ care program.
Frailty needs to be treated	Once frailty is identified and the severity is assessed, individualized, needs-based care that is suited to the resident's goals and preferences needs to be documented in the care plan, delivered by care providers, and followed up on. Treatments such as exercise, nutritional interventions, multicomponent interventions, and individualized geriatric care models that have previously been studied should be considered.
Palliative care needs to be utilized for frailty	Care providers without palliative care expertise need an understanding of what palliative care is, what resources are available, and how to utilize palliative resources. Look to existing approaches like telemedicine and Learning Essential Approaches to Palliative and End-of-Life Care (LEAP) in LTC for care providers to have access to consultation services from palliative care experts and develop palliative care competencies, respectively. Needs-based assessments should occur to determine when to integrate a palliative approach to care for residents.

appropriate care and better understand or predict a resident's future health course.[8,28] Care plans were identified as being generic with a lack of individualized, needs-based care being outlined. To emphasize person-oriented care and ensure it occurs, participants suggested that care plans need to reflect person-oriented care so that staff would be given the time to deliver care that is specific to a resident's individual needs, preferences, and goals.

Barrier: Palliative Care Needs to be Utilized for Frailty

Earlier access to palliative care in LTC recognizes that frailty may have a prolonged disease trajectory and that it is difficult to prognosticate progressive frailty.[35,36] Palliative resources are known to be available, but those without palliative expertise may lack an understanding of what these resources are and how or when they are accessed. The need for continuing education, increased staffing, and access to specialized equipment have previously been identified as barriers to providing palliative care in LTC.[37]

In the LTC setting, palliative care is generally provided by non-palliative care clinicians, with palliative experts providing educational support and sometimes clinical consultative services for complex cases.[28] Other work has found methods like telemedicine for palliative care consultation effectively integrated an early palliative approach to care and improved health-care providers' confidence in care delivery.[38] There is a need for palliative care to be initiated earlier in residents' care trajectories so that more residents may have access to this care outside of times of crisis and end-of-life. Training programs, like Learning Essential Approaches to Palliative and End-of-Life Care (LEAP), exist for all health-care providers in LTC with competencies that include understanding a palliative approach to care; developing and providing holistic, person-centred care; as well as developing skills in communication, documentation, and care partner support.[39]

Families, residents, and health-care providers may be unaware of palliative care resources that are available or may lack an understanding of the benefits.[28] Palliative care being utilized primarily as end-of-life care was attributed to residents experiencing quick declines, and a potential lack of understanding of what palliative care resources were available and when they could be accessed. Admission to LTC should likely be a sufficient criterion for eligible access to palliative care as all residents have some combination of significant support needs, symptoms, or chronic illness.[28] The lack of early access to palliative care may lead to residents receiving inappropriate interventions (e.g., lifesaving interventions, hospital transfers) given their frailty status, or residents going without interventions targeting symptom or pain management. To understand when palliative care should be initiated in the care trajectory, assessments that are needs-based and consider symptoms, psychosocial needs, and functional dependence are needed to better incorporate a palliative approach to care within care planning.[28]

Strengths and Limitations

We included perspectives from a range of LTC collaborators including those delivering various aspects of care, care partners, and residents. Limitations of the present study include being unable to recruit any health-care aides who play an important role in care delivery in LTC. Although we were unable to recruit any health-care aides, we were able to hear from other nursing staff, allied health-care providers, physicians, and nurse practitioners who provided a broad outlook on how care is delivered in LTC. Participant accounts are based on experiences in the Canadian LTC context. Findings are likely transferable across Canada and beyond, but may be limited by provincial differences in LTC delivery and variable models of LTC delivery internationally.

CONCLUSION

Understanding the barriers and facilitators to frailty and early palliative care in LTC from the perspective of diverse LTC collaborators is the first step toward clinical care pathway implementation. Future studies must be undertaken to develop and evaluate the behavioural interventions that target the identified barriers.

ACKNOWLEDGEMENTS

Not applicable

CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal*'s policy on disclosing conflicts of interest and declare that we have none.

FUNDING

Funding was provided by the Canadian Institutes of Health Research, Canadian Foundation for Healthcare Improvement, and Canadian Patient Safety Institute.

REFERENCES

1. Clegg A, Young J, Iliffe S, Rikkert MO, Rockwood K. Frailty in elderly people. *Lancet.* 2013 May 2;381(9868):752–62.
2. Kojima G, Iliffe S, Walters K. Frailty index as a predictor of mortality: a systematic review and meta-analysis. *Age Ageing*. 2018;47(2):193–200.
3. Kojima G. Prevalence of frailty in nursing homes: a systematic review and meta-analysis. *J Am Med Dir Assoc*. 2015 Nov 1; 16(11):940–45.
4. Fried LP, Tangen CM, Walston J, Newman AB, Hirsch C, Gottdiener J, *et al*. Frailty in older adults: evidence for a phenotype. *J Gerontol Series A*. 2001 Mar 1;56(3):M146–M157.
5. Rockwood K, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, *et al*. A global clinical measure of fitness and frailty in elderly people. *CMAJ*. 2005 Aug 30;173(5):489–95.
6. Muscedere J, Andrew MK, Bagshaw SM, Estabrooks C, Hogan D, Holroyd-Leduc J, *et al*. Screening for frailty in Canada's health care system: a time for action. *Can J Aging*. 2016 Sep; 35(3):281–97.

7. Rasiah J, Gruneir A, Oelke ND, Estabrooks C, Holroyd-Leduc J, Cummings GG. Instruments to assess frailty in community dwelling older adults: a systematic review. *Int J Nurs Stud*. 2022 Oct 1;134:104316.
8. Hoogendijk EO, Afilalo J, Ensrud KE, Kowal P, Onder G, Fried LP. Frailty: implications for clinical practice and public health. *The Lancet.* 2019 Oct 12;394(10206):1365–75.
9. Dent E, Martin FC, Bergman H, Woo J, Romero-Ortuno R, Walston JD. Management of frailty: opportunities, challenges, and future directions. *The Lancet*. 2019 Oct 12;394(10206):1376–86.
10. Lorbergs A, Prorok J, Holroyd-Leduc J, Bouchard D, Giguere A, Gramlich L, *et al*. Nutrition and physical activity clinical practice guidelines for older adults living with frailty. *J Frailty Aging*. 2022 Jan 1;11(1):3–11.
11. Apóstolo J, Cooke R, Bobrowicz-Campos E, Santana S, Marcucci M, Cano A, *et al*. Effectiveness of interventions to prevent pre-frailty and frailty progression in older adults: a systematic review. *JBI Evid Synthesis*. 2018 Jan 1;16(1):140–232.
12. World Health Organization. Palliative care [Health Topics] Geneva: n.d. Available from: https://www.who.int/health-topics/palliative-care
13. Stow D, Spiers G, Matthews FE, Hanratty B. What is the evidence that people with frailty have needs for palliative care at the end of life? A systematic review and narrative synthesis. *Palliat Med*. 2019 Apr;33(4):399–414.
14. Kaasalainen S, Sussman T, McCleary L, Thompson G, Hunter PV, Wickson-Griffiths A, *et al*. Palliative care models in long-term care: a scoping review. *Nurs Leadersh*. 2019 Jul 1; 32(3):8–26.
15. Canadian Frailty Network. Assessing frailty: how screening for frailty helps. Kingston, ON; 2022 Available from: https://www.cfn-nce.ca/frailty-matters/how-screening-for-frailty-helps/
16. Walston JD, Bandeen-Roche K. Frailty: a tale of two concepts. *BMC Med*. 2015 Dec;13(1):1–3.
17. de Nooijer K, Van Den Noortgate N, Pype P, Van den Block L, Pivodic L. Palliative care symptoms, concerns and well-being of older people with frailty and complex care needs upon hospital discharge: a cross-sectional study. *BMC Palliat Care*. 2022 Oct 6;21(1):1–7.
18. de Nooijer K, Penders YW, Pivodic L, Van Den Noortgate NJ, Pype P, Van den Block L. Specialist palliative care services for older people in primary care: a systematic review using narrative synthesis. *Palliat Med*. 2020 Jan;34(1):32–48.
19. Polak L, Hopkins S, Barclay S, Hoare S. The difference an end-of-life diagnosis makes: qualitative interviews with providers of community health care for frail older people. *Br J Gen Pract*. 2020 Sep 21;70(699):e757–e764.
20. Wu P, Holroyd-Leduc J, Simon J, Kaasalainen S, Sinnarajah A, Hogan DB, *et al*. Development and implementation of a clinical care pathway for frail older adults in long-term care: results of a modified Delphi procedure. *Can Geriatr J*. 2023 Jun 1;26(2):323–24.
21. Canadian Institute for Healthcare Information. Long-term care homes in Canada: How many and who owns them? Toronto: CIHI; 2021. Available from: https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them
22. Green J, Thorogood N. Qualitative methods for health research, 4th ed. Thousand Oaks, CA: Sage; 2018.
23. Cane J, O'Connor D, Michie S. Validation of the theoretical domains framework for use in behaviour change and implementation research. *Implement Sci*. 2012 Dec;7(1):37.
24. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res Method.* 2013 Dec;13(1):117.
25. Michie S, Van Stralen MM, West R. The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implement Sci*. 2011 Dec;6(1):42.
26. Sobhani A, Fadayevatan R, Sharifi F, Kamrani AA, Ejtahed H-S, Hosseini RS, *et al.* The conceptual and practical definitions of frailty in older adults: a systematic review. *J Diabetes & Metabol Disord*. 2021 Sep 28;20(2):1975–2013.
27. Koller K, Rockwood K. Frailty in older adults: implications for end-of-life care. *Cleve Clin J Med*. 2013 Mar 1;80(3):168–74.
28. Downar J, Moorhouse P, Goldman R, Grossman D, Sinha S, Sussman T, *et al*. Improving end-of-life care and advance care planning for frail older adults in Canada. *J Frailty Aging*. 2018 Oct;7(4):240–46.
29. Silveira MJ, Kim SY, Langa KM. Advance directives and outcomes of surrogate decision making before death. *New Eng J Med*. 2010 Apr 1;362(13):1211–18.
30. Mallery L, Moor-House P, editors. Palliative and therapeutic harmonization. Healthcare Management Forum. 2014 Spring; 27(1):37–45.
31. Liu A, Sinden D, Plant J, Norman M, Acosta D, Hsu A, *et al*. Program evaluation of SeeMe™: understanding frailty together. *Can Geriatr J*. 2022 Mar 2;25(1):1.
32. Fairhall N, Langron C, Sherrington C, Lord SR, Kurrle SE, Lockwood K, *et al*. Treating frailty-a practical guide. *BMC Med*. 2011 Dec;9(1):1–7.
33. Walston J, Buta B, Xue Q-L. Frailty screening and interventions: considerations for clinical practice. *Clin Geriatr Med*. 2018 Feb;34(1):25–38.
34. Theou O, Stathokostas L, Roland KP, Jakobi JM, Patterson C, Vandervoort AA, *et al.* The effectiveness of exercise interventions for the management of frailty: a systematic review. *J Aging Res*. 2011 Apr 4;2011(1):569194.
35. Covinsky KE, Eng C, Lui LY, Sands LP, Yaffe K. The last 2 years of life: functional trajectories of frail older people. *J Am Geriatr Soc*. 2003 Apr 5;51(4):492–98.
36. Hamaker M, van den Bos F, Rostoft S. Frailty and palliative care. British Medical Journal Support Pallativ Care. 2020 Sep 1; 10(3):262–64.
37. Brazil K, Bédard M, Krueger P, Taniguchi A, Kelley ML, McAiney C, *et al*. Barriers to providing palliative care in long-term care facilities. *Can Fam Physician*. 2006 Apr 1;52(4):472–73.
38. Perri G-A, Abdel-Malek N, Bandali A, Grosbein H, Gardner S. Early integration of palliative care in a long-term care home: a telemedicine feasibility pilot study. *Palliat Support Care*. 2020 Aug;18(4):460–67.
39. Kelley M, Pereina J, Marcella J, Downer K, Maddison G, Johnston J, *et al*. Learning essential approaches to palliative and end-of-life care (LEAP) in long-term care (LTC). Available from: https://www.pallium.ca/wp-content/uploads/2024/07/Learning-Essential-Approaches-to-Palliative-and-End-of-Life-Care-LEAP-in-Long-Term-Care-2016.pdf

Correspondence to: Zahra Goodarzi, MD, Department of Medicine, University of Calgary, South Tower, Room 1104, 1403–29 St NW, Calgary, AB, T2N 2T9
E-mail: zahra.goodarzi@albertahealthservices.ca