



## Original Article

# Managing frailty in an Irish primary care setting: A qualitative study of perspectives of healthcare professionals and frail older patients

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## Abstract

**Objectives:** Little is known about the views of key stakeholders on frailty in Primary Care in Ireland. The aim of this study was to explore the views of Irish healthcare professionals and patients on frailty and its management in Primary Care. **Methods:** A qualitative descriptive design was used. Seventeen healthcare professionals and three patients were recruited using purposive sampling. Data were collected using semi-structured interviews which were analysed thematically. **Results:** Three themes were identified: (i) Perceptions of Frailty (ii) Current Management of Frailty and (iii) Comprehensive Geriatric Assessment in Primary Care. The results demonstrated variability in perspectives on frailty. Healthcare professionals described a fragmented service often delivering substandard care to frail older patients. The general consensus was that frailty management required an adequately resourced Primary Care service. Support for frailty screening and Comprehensive Geriatric Assessment was evident while the suitability of the current pathway for patients requiring assessment was questioned. **Conclusion:** This study highlights an absence of a shared and complete understanding of frailty among healthcare professionals and a fragmented model of care for community-dwelling frail older patients. Based on these findings, inter-professional training, investment in Primary Care, the development of a frailty pathway and an interface service is recommended.

**Keywords:** Comprehensive Geriatric Assessment, Frailty, Ireland, Primary Care, Screening

## Introduction

Frailty is a complex, multi-dimensional, age-related condition which confers a risk of serious and costly adverse outcomes<sup>1</sup>. Its prevalence in community-dwelling older people in Ireland was found to be 24%<sup>2</sup>. The predicted trend in ageing demographics places frailty management as a key public health priority as the Irish healthcare system struggles to meet its demands<sup>3</sup>. Primary Care, often the first point of contact for patients, is the appropriate setting to address the majority of the healthcare needs of the population and in Ireland the Health Service Executive (HSE) advocates reform and transition from hospital-based care to community-based Primary Care, to provide accessible and timely care for patients closer to their home<sup>3,4</sup>. The Irish Longitudinal Study on Ageing has highlighted the impact of frailty in Irish society<sup>2</sup>. Findings from their study

on healthcare utilisation in Ireland demonstrated a strong association between frailty and unplanned hospital care. Homecare support and general practice were cited as the most commonly used services, elucidating the importance of a responsive Primary Care service to address the needs

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of its ageing population. In the Irish Primary Care setting core healthcare services are provided by Primary Care Teams, consisting primarily of public health nursing (PHN), physiotherapy, occupational therapy and social work services, as well as General Practitioners (GPs), who work independently and are self-employed.

Research has provided evidence of the effectiveness of frailty screening, Comprehensive Geriatric Assessment (CGA) and integrated care in many settings including Primary Care to meet the needs of older people with frailty<sup>5-10</sup>. However, there is no consensus, on a universal frailty screening tool and many different frailty tools have been proposed for use in Primary Care<sup>8</sup>. It is suggested that in order to be feasible in Primary Care settings, screening tools need to be simple, reliable and brief, yet of a multi-dimensional construct in order to identify risk and prioritise the most vulnerable<sup>11</sup>. Comprehensive Geriatric Assessment is the diagnostic and therapeutic gold standard approach for managing frailty and it is proposed that regardless of the setting, CGA should be accessible to older people<sup>6,8,12</sup>. There is no evidence, however, regarding the optimal setting in which to conduct CGA. Additionally, despite international evidence of a drive towards transforming healthcare systems for older people, Hendry et al (2019) highlighted limited evidence of integrated care models specifically on frailty management in community settings<sup>10,13</sup>.

Qualitative research addresses the views and experiences of stakeholders, assisting in the provision of patient-centred, evidenced-based recommendations, in order to improve the delivery of healthcare<sup>14</sup>. Although acknowledged as a healthcare priority, little is known about the perspectives of the key stakeholders on the management of frailty in Primary Care in Ireland. The aim of this study was to explore the views of Irish healthcare professionals (HCPs) and older patients on the concept of frailty, current management of frailty and the feasibility of introducing screening and CGA to Primary Care in Ireland.

## Materials and Methods

This study was a qualitative descriptive design, providing a comprehensive narration of views, events and experiences from its participants, while applying low-inference interpretation<sup>15</sup>. The study was conducted in a Primary Care area in one largely populated county in Ireland. This Primary Care service was linked to a local hospital, the only facility to conduct frailty screening and CGA for this population. This occurred when patients became acutely unwell and were admitted to the acute service. All patients over 75 years of age were screened for frailty by the Frailty Intervention Team (FIT) in the Emergency Department. Frail older patients subsequently received a CGA and were referred to Primary Care as indicated. Combined purposive and snowball sampling was adopted to target HCPs with experience and interest in the research topic. Participants from five

specialities in Primary Care, namely general practice, PHN, physiotherapy, occupational therapy and social work were recruited, thus providing source triangulation<sup>16</sup>. The physiotherapy participants were known professionally to the primary researcher (FK). FK was a senior clinical physiotherapist with a special interest in the research topic. The inclusion criteria for the patients selected were frail older patients accessing Primary Care Services following referral from the FIT. The sole exclusion criterion was any patient with cognitive impairment and this was determined in the initial CGA by the FIT.

A gatekeeper sent an e-mail invitation to all potential HCP participants who then contacted the researcher directly to express their interest in participation. Potential patient participants were invited to participate by their Primary Care physiotherapist. The researcher contacted these participants once they had consented to participate with their treating physiotherapist. Participation was voluntary and written informed consent was obtained from all participants included in the study.

Two pilot interviews were conducted in September 2019. Data were collected by FK in individual face-to-face semi-structured interviews conducted between October 2019 and January 2020. Interviews took place in the workplace of HCPs and in patients' homes. A family member was present for two of the patient interviews. An interview guide was adopted, using pre-determined, open-ended questions to facilitate ease and flexibility<sup>17</sup>. Professional questions related to the concept of frailty, current practice and how it addressed frailty, as well as views on frailty screening, CGA and integrated care. Patients provided initial data relating to their living situation and medical history. They were invited to express their views on frailty from their own perspective, its potential reversibility and its impact on them. They were then invited to discuss their recent experiences in the acute service and in Primary Care. Prompts were provided and probing questions were used when deeper meaning was sought<sup>17</sup>. Data were audio-recorded, anonymised and transcribed verbatim by FK. A reflexive diary was kept following each interview. Data saturation was reached following 20 interviews. All participants were offered a copy of their transcript for member checking. Five participants reviewed their transcripts.

Data were analysed using Braun and Clarke's six-step thematic analysis methodology<sup>18</sup>. No software was used in the analysis process. FK independently generated the codes throughout the entire data set. Codes were reviewed and agreed with an external validator, after which themes and subthemes were identified, refined, defined and named. The codes, themes and subthemes were inductively derived from the data. Finally, the data were presented using a descriptive summary and illustrative data extracts.

This research was approved by the HSE Northeast Area Regional Ethics Committee in September 2019.

Stakeholder UIN	Sex	Profession	Experience (years)	Experience with OP (years)	Frailty Training (NFEP)
HCP1	F	Physiotherapist	19	6	Y
HCP2	F	Physiotherapist	19	19	Y
HCP3	M	Manager	14	14	N
HCP4	F	Physiotherapist	39	39	N
HCP5	F	Physiotherapist	22	17	N
HCP6	F	Manager	30	30	Y
HCP7	F	Public Health Nurse	31	31	N
HCP8	F	Public Health Nurse	17	17	Y
HCP9	F	Public Health Nurse	15	15	N
HCP10	F	General Practitioner	16	13	N
HCP11	F	General Practitioner	28	28	N
HCP12	F	Social Worker	15	8	N
HCP13	F	Occupational Therapist	22	18	N
HCP14	F	Manager	23	15	N
HCP15	F	Social Worker	10	10	N
HCP16	F	Occupational Therapist	6	6	N
HCP17	M	Manager	17	14	N

**Table 1.** Profile of Professional Stakeholders (n=17).

Stakeholder UIN	Sex	Age	Living Arrangements	No of Chronic Diseases	No of Medications
P1	M	84	Lives with wife	1	8
P2	M	85	Lives with son	1	5
P3	F	93	Lives alone	1	4

F=Female, M=Male, OP=Older People, NFEP=National Frailty Education Programme

**Table 2.** Profile of Patient Stakeholders (n=3).

1 Perceptions of Frailty	2 Current Management of Frailty	3 CGA in Primary Care
Frailty as a State Frailty as a Medical Condition Frailty as Multi-dimensional Frailty Recognition Frailty Terminology	Organisational Structure of Primary Care Primary Care Teams and Team Working Clinical Interventions Integrated Care	Professional Perceptions of CGA Feasibility of Implementing CGA CGA in Acute and Primary Care Reform in Healthcare

**Table 3.** Themes and Subthemes.

## Results

A total of 20 participants were interviewed, including 17 HCPs and three patients. The duration of the interviews varied from 23 to 47 minutes for HCPs and from 14 to 17 minutes for the patients. The characteristics of the participants are

presented in Tables 1 and 2. Healthcare professionals had extensive experience of working with older patients but few had attended frailty training. The three patients who participated had a mean age of 87.3 years (SD=4) and had one chronic medical condition. Two patients accessed homecare support and two took five or more medications.

One patient declined to participate due to illness. The three main themes and subthemes which were identified following analysis of the data are presented in Table 3.

## Theme 1: Perceptions of Frailty

### Healthcare Professional perspectives

Healthcare professionals viewed frailty as a blanket term encompassing multiple interacting factors.

#### Frailty as a State

They viewed frailty as an age-associated state of weakness, decline and risk where the body's resources are less able to cope with adverse outcomes:

*HCP5: "they are just about coping ... anything could easily knock them over the edge ... it just conjures up this image of a china cup, sitting on the edge of a table ...".*

Two participants felt age was not a factor in determining frailty status but conceded that advancing age heightened the risk of frailty. When prompted, most participants agreed that frailty is a malleable state, which may change in either direction. However, some felt that frailty could not change for the better. Participants commented that sudden changes in frailty may be attributed to trigger events, such as an acute illness, a fall, a bereavement, a change in medication or a change in support services.

*HCP1: "a big part of it would be that if they sustain a kind of a shock ... even a minor one even like a urinary tract infection (UTI) or a greater one, that they have a harder time in recovering from that."*

#### Frailty as a Medical Condition

Many participants commented on how targeted interventions may positively impact levels of frailty. Frailty was conceptualised by a minority as a medical condition, similar to many chronic medical conditions, whereby if managed early and comprehensively, better outcomes could be achieved.

*HCP3: "it's trying to get a focus on recognising something that up to now wasn't universally recognised as a condition on its own, that carries with it its' own risks and problems and the need for a comprehensive intervention."*

#### Frailty as Multi-dimensional

In general, professionals described frailty as a multi-dimensional state, encompassing physical, functional, cognitive, medical, psychological, social and environmental domains. All considered frailty as a physical state, while some focused more specifically on certain dimensions considered relevant to their own speciality, for example social workers and PHNs emphasised the impact of social circumstances and social supports on frailty. Four participants referred to sarcopenia as a factor in frailty. Some required prompts to consider more than one domain, while one participant saw frailty as purely physical.

### Frailty Recognition

A minority of HCPs had attended frailty training and agreed that training increased their awareness and recognition of frailty. Characteristics like delirium and polypharmacy, not as well understood prior to training were better understood and considered markers for frailty. Discourse and knowledge of the concept of frailty appeared to be greater in those who had attended frailty training. All participants reported using clinical intuition to identify frailty and were mostly confident in their judgement of frailty, citing experience and knowledge of their patients to guide this. One participant felt that this is where staff working in acute services would have difficulty in identifying frailty.

*HCP10: "in the acute setting it might be more difficult to identify frailty if you don't know their (patient) baseline".*

When probed further, clinicians believed that frailty screening tools would increase the accuracy of assessing frailty and supported the introduction of formal screening in Primary Care. They cited various discipline-specific tools which they felt measured frailty. However, they were not familiar with suitable or valid frailty screening tools for use in Primary Care.

### Frailty Terminology

The majority of participants disliked the language of frailty which was considered as having mostly negative connotations, an "unfortunate" word (HCP3), even "insulting" to patients (HCP14) and many stated that they would not like their relatives or themselves to be labelled as frail. However, some did not consider the terms used as stigmatising. The majority agreed that a common language was useful for HCPs but should be used with care and sensitivity.

### Patient Perspectives

Patients also discussed their understanding of frailty and they viewed frailty simply as a physical state, a state of slowness, weakness, immobility and decline. One patient felt that when frailty reached a certain point, its trajectory could not be reversed. When asked if they considered themselves as frail, two out of the three identified themselves as frail.

*P2: "I know I am. I'm frail."*

*P3: "I do consider myself as frail. Very much so".*

## Theme 2: Current Management of Frailty

### Organisational Structure of Primary Care

Professionals described a disperse and densely populated county in which their Primary Care service was based, where the healthcare needs for frail older patients arose mainly from three of the five Primary Care networks in the county. Staffing and resources were considered as inadequate.

*HCP3: "It is incredibly low staff for the population that it serves ... it would compare very poorly with any other area in the country".*

Most clinicians were at a senior grade, many held part-time posts and the majority carried a mixed paediatric, adult and older persons caseload, “*from cradle to the grave*” (HCP4). The core Primary Care Team consisted of GP, PHN, physiotherapy, occupational therapy and social work clinicians. Many of these clinicians, including GPs were co-located in Primary Care centres and this was perceived as enhancing multi-disciplinary team (MDT) working. However, allied health professionals (AHPs) viewed GPs as being mostly removed from the Primary Care Teams, despite being vital to overall effectiveness of care. GPs had similar views of their place on the Primary Care Team.

*HCP10: “I would say we (GP’s) are loosely linked to Primary Care Teams”.*

Managers discussed governance and organisational structure within Primary Care. They felt that the current organisation and fragmentation within the pillars of care, namely Primary Care, Social Care and Acute Care, made it very challenging for frail older people to navigate the healthcare system and this in turn had a negative impact on service development and innovation.

*HCP3: “They regularly go from Primary Care into Older Persons Services or Disability Services to the Acute ... having them all fractured and separated makes that journey a little bit harder”.*

The underlying consensus by those in management was that all the pillars of care should be working cohesively under one division.

### **Primary Care Teams and Team Working**

When managing frail older patients, clinicians valued multi-disciplinary joint-working. Primary Care team meetings facilitated integration of Primary Care Teams and an opportunity for the multi-disciplinary team to discuss complex frail patients. However, overall the effectiveness of Primary Care Team meetings was questionable. It was reported that they had lost momentum and they lacked leadership.

*HCP2: “they (Primary Care Team meetings) tend to be cancelled on a regular basis”.*

*HCP3: “Primary Care meetings, they don’t seem to be beneficial in my personal opinion”*

GPs acknowledged that face-to-face Primary Care Team meetings enhanced communication and care, yet for the main part they did not have the time to attend. Allied health professionals considered this a big loss. Case management rarely occurred and was mostly assigned to the PHN, which was perceived as unfair. GP and AHP communication presented problems bidirectionally as GPs felt written communication was often delayed and seven out of 11 AHPs cited difficulties making contact with GPs.

Overall, participants portrayed a uni-disciplinary working environment which created barriers to effective communication. Nine participants, including all managers

and GPs, discussed the urgent need for a robust integrated electronic health record.

*HCP3: “there’s an absolute, paramount need for an integrated, electronic healthcare record system”.*

### **Clinical Interventions for Frailty**

Clinical interventions for frail older patients were clinic or domiciliary-based and this was dependent on patient need and availability of resources. Some interventions were viewed by clinicians as better managed in a clinic setting, while PHNs and social workers highlighted the value of home-based interventions.

*HCP6: “five minutes inside the house will tell you more than if you get a patient in the clinic”.*

Physiotherapists reported their limited service capacity enabled them to conduct at most one-to-two home visits and these served to primarily maintain patient safety rather than improve a situation and manage frailty effectively.

*HCP1: “You see people twice and then they are discharged and that really isn’t effective in trying to change anything”.*

Participants described inconsistent levels of access to therapies and services resulting in frail older patients receiving services at different times thus impacting on the effectiveness of their care. Frailty was not a criterion for prioritisation policies. However, the majority of HCPs agreed that if frailty had a score it would assist in prioritising frail older patients more accurately.

Clinicians were asked about the specific interventions they used for managing frail older patients. Referral for home support was integral to PHN assessment. Public Health Nurses reported that a recent embargo on home support services had an extremely negative impact on clinicians and patients as the absence of this vital service threatened the ability of frail older patients to continue to live independently and safely at home.

*HCP6: “that’s having a huge effect on our staff ... they’re dealing with a lot of anger”*

*HCP13: “you can sense people’s fears ... you can see the stress in the family, they’re trying to fill in gaps or people are doing things that they probably wouldn’t normally do”.*

Two participants also commented that even a small amount of home support could make a significant difference in managing frailty more effectively. However, these cases were often deemed as being of lower priority.

Exercise and educational interventions, considered integral to frailty management, were reported by physiotherapy and occupational therapy as being ad hoc and resource dependent. The absence of any psychology service for older people was cited as a major service gap.

*HCP12: “no adult psychology, that’s a big, big gap in the service, massive gap”.*

Public Health Nurses considered health promotion as a significant part of their remit, however, they reported that practice had moved away from this in recent years. Six participants considered patient empowerment and self-management as important in managing frail older patients. Nine participants discussed the importance of early intervention and how this was currently lacking.

*HCP14: “we’re probably missing the whole early intervention piece ... it’s a sad day that we’re missing that piece, because that’s actually where we could actually be impacting and sorting out a lot”.*

### **Integrated Care**

There were mixed views among participants on the integration between the PCTs. Thirteen participants cited communication and working together as critical to effective integration within Primary Care. However, the reality differed from this aspiration.

*HCP11: “we’re all working separately” and HCP2: “we are a team but we’re not a team”.*

Other barriers to integrated frailty management and care were reduced staffing, excessive waiting lists, infrastructure, keeping separate documentation, inadequate information sharing and inadequate resources. All of this affected staff morale and work satisfaction. However, the main barrier to integrated care for frail older people was reported by clinicians as inadequate communication between the Acute and Primary Care settings. Those in management felt that governance was the most critical factor to integrated care and common governance structure between Acute and Primary Care would greatly enhance integration.

Participants illustrated how substandard care had at times adversely affected patient outcomes. Increased disability and dependency, carer burnout, avoidable hospital admissions, prolonged hospitalisation and long-term care admission were reported in their narratives. The majority of participants described a fragmented service, which was not effective at managing frailty and was failing the patient. Care was viewed as reactive and in constant fire-fighting, crisis management mode.

*HCP4: “purely sticking plaster, it really is putting the finger in the dike and hoping that it works out alright”.*

### **Patient Perspectives**

All patients reported satisfaction with the care they received from HCPs in the acute service and in Primary Care. Two patients felt very restricted in their activities within the home and all three reported that their social connections were very limited. One patient who was awaiting home support services described her struggle of living alone without adequate support.

*P3: “I’m very disappointed ... I get it very, very difficult to get up in the morning, to dress myself. It’s a nightmare”.*

## **Theme 3: CGA in Primary Care**

### **Professional Perceptions of CGA**

There was limited knowledge of CGA among HCPs, which they linked to a lack of training. Those who had attended frailty training understood it precisely as a holistic assessment involving a diagnostic and therapeutic process to manage frailty. There was strong support for screening and CGA in Primary Care. However, four HCPs highlighted that the generalist nature of Primary Care working hindered dedicated and comprehensive management of frailty and pointed towards the effectiveness of specialist reablement and FITs to optimally manage older people with frailty.

### **CGA in Acute and Primary Care**

As part of a quality initiative public health nursing were planning to implement CGA to a selected Primary Care network through the merging of CGA and their home support assessment and highlighted many similarities between these two assessments.

*HCP14: “we can integrate the CGA into our home support assessment, ... let’s go for the first visit, the first time someone comes in contact with the service ... we can actually hit frailty at that stage”.*

One participant questioned the suitability of the current pathway for patients requiring CGA, which was only accessible to patients who were admitted to Acute Care:

*HCP11: “The problem with the current model is you’re actually saying they need acute unscheduled care to get a CGA, they have to be unwell enough to go to ED which is the only option for the unwell elderly”.*

This participant suggested an intermediate ‘interface service’ which Acute and Primary Care clinicians could access to comprehensively address the needs of frail older patients.

### **Feasibility of Implementing CGA**

The facilitators to initiating CGA in Primary Care were cited by HCPs as a willingness, existing expertise in Primary Care and a desire by HCPs to maintain people at home. Barriers included time, staffing, resources, ownership and the fragmented nature of current service delivery. One participant emphasised that interprofessional flexibility was required.

*HCP6: “I think everybody is a facilitator of a CGA ... we need to blur our roles a little bit”.*

Additional factors required to facilitate the implementation of CGA to Primary Care were cited as commitment and support from management, adequate funding, leadership, protected time and training.

### **Reform in Healthcare**

Professionals reflected on the need for reform and a shift in focus from the Acute to Primary Care setting. The

general consensus was that frailty management required an adequately resourced Primary Care service.

*HCP6: “they want to flip most of the care into the Primary Care setting and that’s really good and we’re all for that but they have to resource it”.*

Professional development through frailty training was strongly supported by all participants. Enhancing information technology was advocated by eight participants. Many also viewed governance, ownership, leadership and communication as key components to optimise frailty management. Overall, support for change was evident but it was expected this would take time.

*HCP3: “it’s quite complex changing the ways things are done, the way services are designed, from an upper management level, decision maker level ... it makes it hard to just change the way things are being done.”*

## Discussion

The perceptions of frailty among HCPs are consistent with literature findings describing a dynamic, multi-dimensional geriatric condition, often triggered by illness or an acute event and which has the potential to be improved<sup>19-21</sup>. However, dissent was evident in views regarding specific markers for frailty and its’ reversibility. In this study multi-morbidity, physical and social frailty dominated the discourse on the concept of frailty. In this study, formal frailty screening was not practiced by HCPs in Primary Care. This may be attributed to an apparent lack of knowledge on screening and CGA. A similar knowledge gap was cited in a qualitative study of HCPs and frailty in the UK<sup>21</sup>. While mixed views were expressed about frailty terminology among HCPs and patients, in agreement with the literature, the majority of participants expressed a strong aversion to the dialogue of frailty<sup>22-23</sup>. One participant suggested that frailty terminology may be misjudged by clinicians if not universally understood. These aforementioned findings in addition to the uni-disciplinary and generalist nature of Primary Care working described in this study highlight an absence of a shared and complete understanding of frailty among HCPs.

In accordance with recent evidence, Primary Care services provided by PCTs in this study were described as fragmented, reactive and limited despite a strong desire and drive to deliver patient-centred MDT-based care<sup>24-26</sup>. This fractured nature of care delivery for older frail patients was reported to hinder effective integration within Primary Care and across care sectors. Managers viewed governance as paramount to the integration and reform of older persons and frailty services and felt that a common governance structure would deliver superior care rather than the current three pillars of care that older patients are often compelled to access. The GP, considered as crucial to effective management of frailty, yet this speciality was frequently disconnected from the rest of the PCT<sup>27</sup>. In agreement with Giguere et al (2018), HCPs proposed that frailty management was dependent

on good social networks and formal homecare support for community-dwelling older patients<sup>24</sup>. The general consensus was that homecare support is vital to frailty management.

Overall, patients in this study were very satisfied with the care they received from Primary Care HCPs. Social isolation, loss of mobility and independence and above all the lack of home support were cited as barriers to managing their frailty and living contently at home.

Implementing frailty screening and CGA in Primary Care was welcomed and considered feasible by HCPs. Comprehensive Geriatric Assessment in Primary Care was being explored. Additionally, an alternative pathway was proposed in the form of an interface service where Acute and Primary Care services could refer frail older patients for appropriate and comprehensive care.

Extensive inter-professional frailty training and education was advocated to narrow the frailty knowledge-gap, thus facilitating a mutual understanding of frailty and developing an integrated approach to its’ management. It is proposed that a suitable universal frailty screening tool, understood by all HCPs involved in managing frailty, is introduced to Primary Care practice. The development and implementation of a frailty pathway within Primary Care is also recommended, commencing with early recognition of frailty to targeted evidence-based interventions and appropriate onward referral by the PCT when further CGA is required. In support of this, investment of funding into Primary Care for essential services including psychology and home support is advocated to improve the quality of care for older patients with frailty. Additionally, robust integrated IT services, critical to comprehensive interprofessional management of frailty across care sectors are considered essential. Finally, an intermediate interface service with a dedicated frailty management team is proposed as the optimal solution to comprehensively manage frail older patients as they traverse care sectors. This hospital-avoidance proposal would prevent the duplication of time and labour-intensive interventions while supporting the ethos of community-based care for frail older patients.

The strength of this study lies in the rigor used throughout the research process. The sample size facilitated extensive perspectives from experienced HCPs in Primary Care, as well as including a small sample of frail older patients, thus providing a patient-centred, comprehensive view of frailty and its management. However, it must be acknowledged that the small number of patients interviewed limits the generalisability to all community-dwelling patients with frailty. Further research exploring the views of a heterogenous cohort of older adults with varying degrees of frailty is recommended. Despite similarities in PCTs nationally caution is advised in the generalisation of the findings of this study.

This study is the first of its kind to explore perceptions of frailty and its’ management in an Irish Primary Care setting. Its findings provide useful information for policy makers and

clinicians within the context of managing frailty in Primary Care in Ireland and identify several areas which warrant further research.

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