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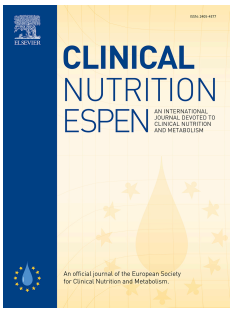

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Rachael Frost, Palak Bavishi, Nadia Kim, Nikoletta Mama, Adrian Slee

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Frailty Identification and Management by Dietitians: A Qualitative Study

Rachael Frost[1,2*], Palak Bavishi[3], Nadia Kim[3], Nikoletta Mama[4], Adrian Slee[3]

[1]School of Public and Allied Health, Liverpool John Moores University, Liverpool, UK.

[2]Department of Primary Care and Population Health, University College London, London, UK.

[3]Division of Medicine, University College London, London, UK.

[4]Students Union, Sport & Fitness department, Queen Mary University of London.

*Corresponding author: Dr Rachael Frost, School of Public and Allied Health, Liverpool John Moores University, Titherbarn Building, Tithebarn Street, Liverpool, UK, L2 2ER.

Rachael Frost ORCID 0000-0003-3523-0052

Nadia Kim ORCID 0009-0002-7269-4200

Adrian Slee: 0009-0007-2652-643X

No ORCID for other authors

Abstract

Background and aims: Frailty is common in later life and chronic conditions. It is associated with reduced quality of life, and increased disability and mortality. The large overlap with malnutrition means that dietitians can play a key role in frailty identification and management, however, few studies have explored their experiences of this. We aimed to explore the perceptions of dietitians on the identification and management of frailty in older people.

Methods: We carried out virtual interviews and focus groups with 13 United Kingdom registered dietitians working with older people in a range of acute and community settings. Data were analysed using reflexive thematic analysis.

Results: Dietitians felt they had an important role in managing the nutritional aspects of frailty and were confident in this. They reported a need to engage and educate patients and carers to overcome misconceptions about later life nutrition and weight loss. Dietitians were often part of a multidisciplinary team, which was considered a holistic approach that facilitated interprofessional learning. However, they reported that other healthcare professionals had variable understanding of their frailty role. Dietitians were unsure regarding their role in frailty identification and lacked confidence and experience in using assessment tools. They felt there were few formal frailty training opportunities available and that they needed to actively seek these out.

Conclusion: Guidance needs to be developed to strengthen dietitians' role in frailty care and provide clarity regarding frailty identification. More formal training opportunities need to be provided by key regulating organisations.

Word count: 4160

Keywords: Qualitative research, dietetics, frailty, nutrition, ageing

1 Introduction

Frailty is characterised by loss of biological reserves, failure of physiological mechanisms and vulnerability to a range of adverse outcomes, such as hospitalisation, falls, and transitions to long-term care, following stressor events such as falls or infections [1–3]. Frailty is linked to lower quality of life, a heightened risk of depression, and greater health care usage and expenses compared to healthier older individuals [4–6]. Globally, frailty affects approximately 12% of individuals aged 50 years and older [7]. In the United Kingdom (UK), the prevalence rises with age, from 6% in those aged 65-69 to 40.8% in those aged over 90 years [8]. Due to its widespread prevalence and potential negative impact, it is crucial to identify, diagnose, and manage frailty effectively. Frailty identification is the process of recognising frailty in older people. This may include brief or detailed assessments using structured tools as well as clinical judgement [9].

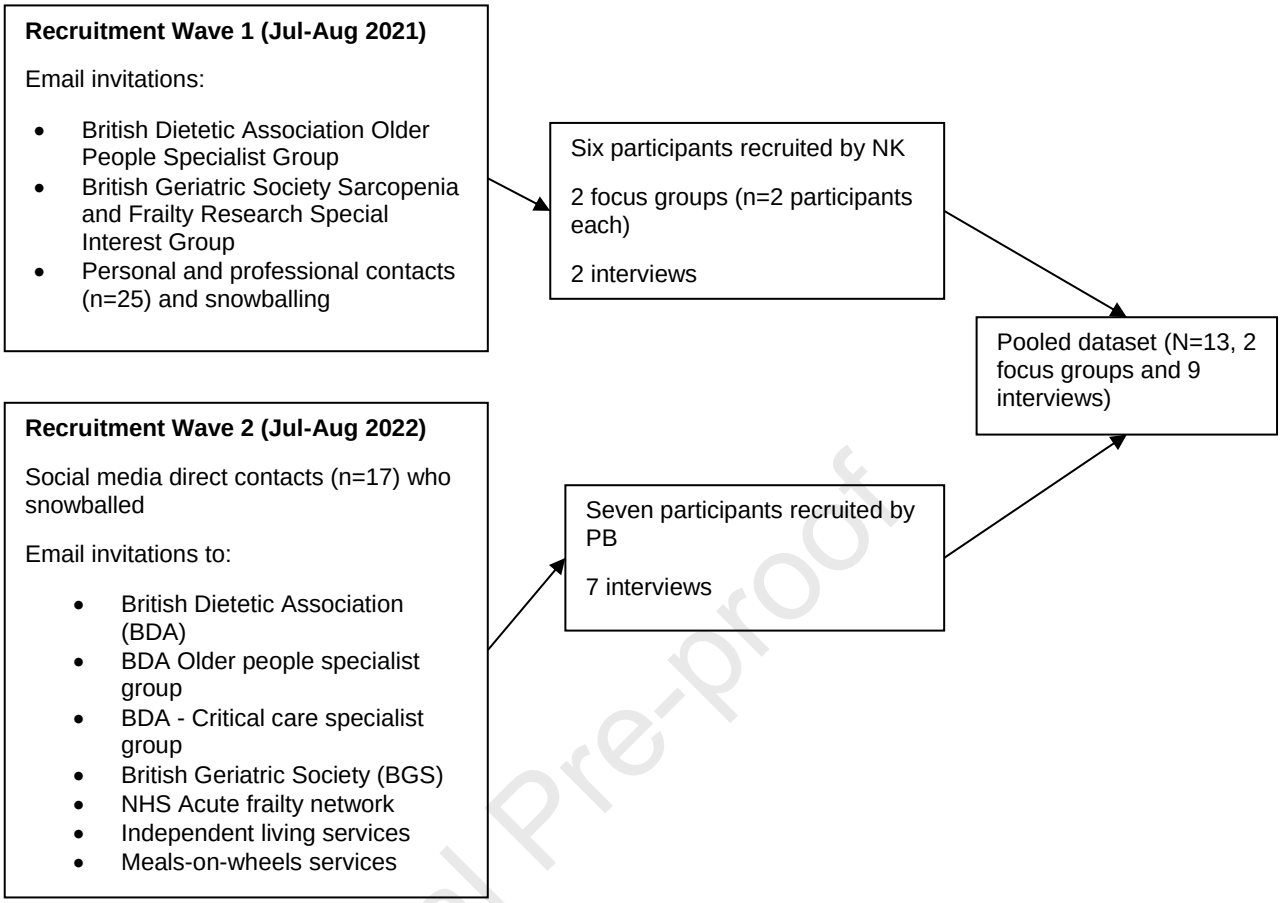
Malnutrition is a state arising from reduced intake/uptake of nutrition, leading to decreased fat free mass and body cell mass, consequently affecting physical and mental function and impairing clinical disease outcomes [10]. Weight loss is a key component of the physical frailty phenotype, with malnutrition being a clear part of the negative cycle of frailty, in addition to sarcopenia and lower energy expenditure [11]. Hence, the identification and management of malnutrition and frailty have some overlap [12]. Dietary interventions are a key mechanism for frailty intervention alongside exercise. Currently, the International Conference of Frailty and Sarcopenia

Research (ICFSR) group global guidelines for frailty management recommend that protein and/or caloric supplementation is provided to older people with frailty with weight loss or diagnosed undernutrition, or alongside a physical activity prescription to improve frailty [13].

Dietitians can, therefore, play an important role in reducing and managing frailty alongside malnutrition. The involvement of dietitians in the care of older people is widespread in various settings such as the community, primary care, care homes, acute care, and outpatient clinics. In the UK National Health Service (NHS), dietitians are usually accessed through a primary care or outpatient referral, or may be members of multi-disciplinary ward-based teams. However, few previous studies have explored their role and confidence in frailty care. One survey, one mixed-methods study and one qualitative study have been carried out exploring dietitians' experiences of frailty in Australia, New Zealand and the USA [14–16], and one Brazilian frailty survey of healthcare professionals (HCPs) included 11% dietitian respondents [17]. UK-based work has explored dietitians' views regarding working with care homes and in addressing malnutrition in primary care [18,19], but limited frailty studies exist. A recent UK frailty survey only recruited three dietitians [20]. There remains a gap in understanding UK dietitians' perspectives on frailty. Consequently, the aim of this study was to examine the views and perceptions of registered dietitians in the UK on the identification and management of frailty in older people.

2 Methods

We carried out a qualitative research study using semi-structured virtual interviews and focus groups. We recruited participants aged 18+ years who were Health and Care Professions Council registered dietitians working in the UK within geriatrics or frailty-related care in any setting and with access to a personal computer and the internet. We aimed to purposively sample dietitians practising across a range of settings. Participants were recruited and interviews and focus groups carried out by two MSc students ([authors 2 and 3]) over two consecutive academic years (July-August 2021 and July-August 2022), supervised by [authors 1 and 5]. Participants were recruited through email invitations to relevant professional groups and through personal contacts and snowballing (see Fig. 1 for a summary of recruitment). We originally intended to use focus groups to explore shared understanding and experiences, however, there were scheduling and recruitment issues due to the Covid-19 pandemic and summer annual leave. Most were consequently carried out as individual interviews.



106

107 **Fig. 1. Recruitment process for interviews and focus groups**

108 A topic guide with questions and probes was developed by [author 3], [author 1] and
109 [author 5] based on the research aim and an informal literature review of other
110 similar studies by the authors. Topics covered included dietitians' perceptions of their
111 role in frailty care, challenges in caring for frail older people, the role of nutrition in
112 frailty, experiences of working in multidisciplinary teams (MDTs), confidence in frailty
113 management and the impact of the pandemic on frailty management. Written field
114 notes were taken after each interview/focus group. Focus groups lasted 50-60 min
115 and interviews lasted up to 47 min.

116 Microsoft teams was used as the videoconferencing platform and to record and auto-
117 transcribe the data, with unclear sections manually checked back to the recording.

Transcripts were inductively coded in NVivo 14 by [author 1] using reflexive thematic analysis [21], taking an iterative approach and combining codes and recoding where needed. We focussed mainly on manifest rather than latent content, taking a post-positivist approach. After developing an initial framework of codes and categories, an analytical framework was developed to produce four key themes summarising and explaining the data. The first draft of themes was reviewed by [author 5], and the second draft reviewed by all co-authors, with feedback incorporated.

The study was reviewed and approved by the [university] Research Ethics Committee (19821/001) and all procedures were performed in compliance with relevant laws and institutional guidelines. Informed consent was gained from all participants prior to interview/focus group participation.

3 Results

Participants (N=13) included six community dietitians (one specifically as a frailty dietitian, one working in an enhanced meals on wheels service), two acute care dietitians (one in oncology and hematology, and one in head and neck cancer), two prescribing support dietitians, one care home dietitian, one specialist primary care network dietitian (also with experience as an older person specialist clinician) and one hospital at home dietitian. We developed four themes: 1) dietitians' role in frailty identification and management, 2) working with patients and carers, 3) working with other healthcare professionals, and 4) training.

3.1 Dietitians' role in frailty identification and management

Whilst dietitians reported working with many frail patients, frailty identification and assessment was rarely an explicit part of their role. Malnutrition and weight assessment were prioritised as clearer dietetics tasks.

I do not think we are assessing frailty still, we are just looking at weight loss. But obviously I see a lot of people who are frail. (Community dietitian 4)

Even when frailty assessment was part of their role, it was one of multiple assessments. Participants discussed using measures such as the Rockwood Clinical Frailty Scale (CFS), Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA), Comprehensive Geriatric Assessment (CGA), Falls Risk Assessment Tool (FRAT), handgrip strength and bioelectrical impedance analysis (BIA). Some reported limited availability of assessment equipment. In some cases, frailty assessment focussed on muscle strength or mass rather than a multidomain approach. Where services did identify frailty, it was often as a criterion for receiving the service or for a specific project. As such, there was a general lack of confidence as to the process of frailty identification and whether it was in the scope of their practice.

I'm not that confident in identifying, but I think that's probably because it's not well recognised for dietitians to do that (Specialist Primary Care Network dietitian)

The greater remote service provision during the Covid-19 pandemic was seen as beneficial for patients as they did not need to travel and it increased appointment capacity, but generated concerns regarding remote frailty assessment. Visual assessment was seen as vital to understand function, deterioration and weight loss:

They're telling you they're fine […] But then you go to see them and you know they've lost 10 kilos and they're not eating. (Community dietitian 5)

Within frailty management, nutritional support was considered essential and clearly evidence-based due to the close connection between frailty, nutrition, muscle mass and functioning.

Well, I think nutrition is a huge part of it [frailty] (FG Community dietitian 1 & 2)

Management strategies focussed on preventing and managing malnutrition and weight loss, increasing weight and increasing calories and protein. Dietitians prioritised a food first approach, prescribing supplements where patients were high risk or frailer.

The standard stepwise thing that we do you should be modifying the diet that they're having, so choosing the higher calorie, high protein food options, eating little and often, using nutritional supplements. (Clinical dietitian 1)

Supplements were believed to be helpful for regaining weight. However, a few dietitians expressed hesitation, feeling that reluctance to eat needed to be explored holistically first, and food prioritised over supplements.

Sometimes we prescribed oral nutritional supplements. They are [a] quick fix, there are [a] sticking plaster, but often they don't get to the underlying cause of what the problem is. (Prescribing support dietitian 1)

Certain supplements were also restricted by their organisation. Although there was general agreement on strategies and approaches, potential gaps highlighted by a small number of dietitians included insufficient focus on micronutrients and hydration,

and challenges in coordinating with physiotherapists to promote exercise alongside good nutrition. Barriers such as low staffing and a pressure to discharge patients from hospital were also discussed.

Some dietitians expressed a desire for a more preventative role, but usually only saw those with existing weight loss or malnutrition due to the referral criteria (e.g. minimum Malnutrition Universal Screening Tool (MUST) score) of their commissioned service. Preventative approaches were viewed as possible in community services such as meals on wheels, care homes or hospital at home, where dietitians could detect people at risk of weight loss and manage these, plus refer on in the case of broader frailty issues.

> *We work with individuals in the community who are receiving those meals to prevent them from becoming more frail than they already are, or becoming frail to begin with. (FG2: Clinical dietitian 2 and Community dietitian 2)*

3.2 Working with patients and carers

A key part of a dietitian's role was seen as engaging and educating patients. Dietitians felt patients held mixed views about their role – where people were clearly underweight or had eating difficulties (e.g. in cancer care, later frailty), they felt highly valued and their role well understood. However, for managing nutrition in the context of frailty without other conditions, some patients were seen as more reluctant to engage as they didn't understand the dietitian's purpose.

> *I think with prevention it can be more difficult to educate someone and have them accepted, but once someone is already experiencing those side effects and those symptoms of frailty, they can. They're*

more receptive to it 'cause they can see it for themselves.

(Community Dietitian 1)

In this way, dietitians found it important to clearly explain their role and the role of good nutrition and adequate weight in frailty and functioning. Dietitians reported needing to address patient misconceptions that weight loss was positive, that dietitians' role was to remove pleasant foods from their diet, or that fruit and vegetable intake was the main consideration for a healthy diet in later life.

they'll be talking to me about the importance of eating their fruit and vegetables, which I know is important. But actually, they're not getting the calories that they need. What they see as a healthy diet, they're not getting the protein that they need. (Community dietitian 4)

Once some of these perceptions had been addressed, dietitians found greater engagement and many reported building good relationships, as their role necessitated seeing patients regularly. Some dietitians felt older people engaged better than other age groups, appreciating preventative advice, and that food was a topic people liked to discuss. However, participants discussed challenges in patient motivation, changing lifelong eating habits and overcoming physical barriers such as gastrointestinal illness. Consequently, most dietitians advocated a holistic approach to nutrition, recognising that people needed individualised plans that accounted for factors such as bereavement, loneliness and finances. Working out what was important to the person could be a strong motivator.

I've had this with people where they've said well I don't want my grandchild to hug me and feel disgusted because all they're hugging is bones[…] Another person might be, well, actually what I'd really

love to do is be able to get to the toilet in good time, you know, because they had significant continence issues. And actually, you know, so they might not recognise that nutrition can play a good part in that. (Prescribing support dietitian 1)

The setting also made a difference – dietitians reported being constrained by the food available in a hospital or care home and needing to work closely with care home staff and provide lots of education about food first approaches in order to be able to implement their recommendations. However, a couple of dietitians felt that a major gap was domiciliary care organisations, where closer relationships were needed.

We're currently developing training packages for our care homes, and we're hoping to extend them out to perhaps care agencies. (FG1 - Community Dietitians 1 and 2)

Family carers were viewed as vital for care. In a hospital setting, carers could support patients' diets by bringing in preferred foods they were more motivated to eat. However, in care home and community settings, dietitians reported tensions when carers wanted inappropriate feeding towards the end of life or held similar misconceptions to older people about a healthy diet in later life and reinforced these.

I spend a lot of my time having to unpick bad habits that have been created by next of kin or even educating the next of kin themselves that actually this is not a good idea and we're causing more harm than good and the protective nature of a higher BMI for an older adult as well. (FG Clinical dietitian 2 and Community dietitian 2)

Communication was also discussed as a challenge when working with people with dementia, stroke, or post-laryngectomy who had difficulties communicating verbally. Those with dementia also had difficulty understanding why they were there. This necessitated working closely with carers, or careful detective work to understand the causes of not eating, such as disliking texture modified food or gastrointestinal problems that needed medication changes.

3.3 Working with other healthcare professionals (HCPs)

Dietitians worked within different systems that could enhance practice or pose barriers. Multidisciplinary team (MDT) working was considered vital for good frailty management in order to address complex interacting factors requiring different professional expertise. Most dietitians attended MDT meetings, whether in hospitals, care homes or the community.

> *you're never looking at just one aspect of care and having other health professionals around to support your interventions or understanding or whatever is really important. (Hospital at home Dietitian)*

A few dietitians were not part of MDTs, but worked closely with local professional teams, for example, if they were based outside the NHS. Furthermore, some dietitians felt MDTs provided valuable interdisciplinary experience and learning regarding frailty:

> *lot of it's [training] just been again within my job role within this multidisciplinary team. (Hospital at home dietitian)*

However, dietitians reported mixed experiences of other HCPs' understanding of their role in treating frailty. This varied according to individual professionals/teams

and their interest in and understanding of frailty. The small size of the dietetics profession was felt to reduce their visibility and other HCPs' awareness of their role. Many dietitians felt that it was their personal responsibility to demonstrate their contribution in MDT working and raise the profile of dietetics in frailty care, and some felt they had achieved positive change through this. However, low awareness was compounded by the lack of specific frailty dietetics roles available, with perceptions that often older people's care was allocated to dietetic assistants and not valued as something requiring specialist skills and knowledge.

> *[frailty] tended to be looked upon as what the lower grade dietitians do when it's not specialist area. And I think it's really important that becomes more in the limelight for dietitians and we make ourselves more visible. (Community dietitian 4)*

However, some dietitians felt positive that this was changing for the better, with more frailty-related roles available and greater focus on setting up frailty teams. Primary care network (PCN)-level roles were considered a positive new opportunity by a few dietitians.

Participants reported that some HCPs they worked with had little awareness of the formal definition of frailty, which could lead to inappropriate referrals and a lack of awareness of the potential impact of nutritional support.

> *It's just awareness of how important frailty is and that it's not just about assessing someone's nutritional status and giving them a supplement. (Community dietitian 5)*

Again, this was felt to be changing somewhat, with dietitians reporting seeing frailty more frequently on referral forms than previously, although still not often. A couple

of dietitians highlighted a particular lack of awareness around obesity and the potential for sarcopenia and malnourishment that was not often recognised by other professions.

> *it's not just under nutrition in the sense of a low BMI or clinically significant weight loss, the muscle part and that happens with obesity needs to be recognized as well. (Prescribing support dietitian 1)*

3.4 Training

Dietitians' confidence in managing frailty and malnutrition was mainly built through years of workplace experience, with few reporting formal training. Most stated that their university training had little frailty content and focussed upon malnutrition only. A small number of participants had completed a Masters degree level course and focussed on older people or frailty as part of this. Most participants reported self-study or actively seeking training courses.

> *I've only learned through working. Yeah, working with the physios, working with the consultant and the reading that I've done. And obviously I'm interested in this area, for research as well. So I guess it's what I've picked up as I've gone along. It's not been training that's been offered to me. (Community dietitian 4)*

The lack of frailty content was felt to arise from the perception that it required a general approach without specialist skills (see Theme 3). Most felt there was a gap in formal frailty-related continuing professional development (CPD) for dietitians. Frailty-specific training was sporadic and depended on the organisation, with some reporting brief frailty training on joining a meals on wheels organisation, specific

Rockwood CFS assessment training for a care home project, or virtual reality frailty training by their Sustainability and Transformation Partnership. Others were actively involved in a frailty network or older people's special interest groups. As a result, participants felt their knowledge was likely to be better than the average dietitian.

> *if you asked a large proportion of dietitians, they would probably give overlapping definition of what all of them [e.g. frailty, malnutrition, sarcopenia] were and they'd have trouble identifying what exactly frailty was. (Clinical dietitian 1)*

Key areas for further training included: carrying out and interpreting frailty assessments, learning from dietitians in other settings, and the clinical topics of distress, dementia and use of physical exercise for reducing frailty.

> *What you do around gait speed or stand up to sit down, stand up, sit down tests and looking at sarcopenia and let's bring it all together so that for me is what's missing. (Prescribing support dietitian 1)*

A few dietitians also emphasised the need for frailty guidelines or protocols for dietitians in different settings and to develop consistent processes in this area.

4 Discussion

4.1 Key findings

Dietitians reported feeling confident in frailty management, through assessing malnutrition, focusing on increasing weight through food first approaches, using oral nutritional supplements where needed and taking a holistic approach to overcome patient barriers. They had a particularly important role in educating patients and

carers on misconceptions about nutrition in later life. They felt MDT working was important for addressing frailty, but that other HCPs had mixed perceptions of their role, leading to a need to make dietetics visible and demonstrate dietitians' value. They felt there was little formal training available and most of their expertise arose from experience and self-study. Areas of low confidence related to their role in identification, particularly carrying out and interpreting frailty assessments.

4.2 Comparison with prior work

Confidence in frailty management despite a lack of training has been reported in other UK healthcare professions [20], but contrasts to the Brazilian setting where dietitians were much less confident than doctors, nurses, physiotherapists and gerontologists [17]. The importance of multidisciplinary working was supported by two other studies of dietitians [16,19]. Romano et al [19] also reported mixed understanding from other HCPs on dietitians' role in UK care homes and the need to advocate for the role of the dietitian.

Focussing on malnutrition and taking a food first approach to addressing weight loss through increasing calories and protein concurs with dietitians' approaches from the USA, Australia and New Zealand [15,16]. Although nutritional supplements are recommended for weight loss and malnutrition in frailty guidelines, dietitians expressed reservations about using these unless there was presence of severe weight loss or other difficulties with consuming food. This concurs with other studies [16,18,19], in which food based approaches were perceived to be a unique selling point for dietitians' contributions to frailty management and part of a holistic approach. However, the role of goal setting and motivational interviewing had much greater emphasis within Australian and New Zealand dietitians' practices, with 93%

379 respondents reported using goal setting in practice [16], but few UK dietitians
380 mentioned this in our study.

381 The need for patient and carer education aligns with previous studies [16,18].
382 Norwegian older patients discharged from hospital viewed weight loss as positive
383 [22]. Likewise, a qualitative study with UK patients aged 75 and over with or at risk of
384 malnutrition and their carers found that older people did not recognise weight loss as
385 problematic and perceptions of a healthy diet related mainly to fruit and vegetable
386 consumption and low fat and sugar diets [23]. There was little awareness of needing
387 to increase protein or calorie intake, and carers also expressed concerns regarding
388 wanting to promote weight gain without consuming unhealthy food [23]. There was a
389 clear perceived need to raise awareness of healthy diets in later life through public
390 health. This would facilitate better nutritional conversations, promote the role of
391 dietitians in frailty and to prevent onset of frailty and malnutrition. Primary care may
392 be a potential vehicle for prevention. A new UK NHS service evaluated dietitian
393 frailty and malnutrition screening, with the provision of advice and setting goals [24].
394 It found improvements in weight, BMI, handgrip strength and upper arm
395 circumference, alongside lower ONS prescribing costs and high patient satisfaction
396 [24].

397 Frailty assessment was a key knowledge gap, aligning with previous studies.
398 Brazilian dietitians were three times less likely to use a frailty assessment tool than
399 other HCPs [17]. This may relate to limited frailty screening policies, with fewer
400 institutions having a frailty screening policy versus a malnutrition one across various
401 countries [15,16,25]. It is also likely to relate to a lack of training. The importance of
402 gaining confidence through on the job training found in our study has also been

found for Brazilian HCPs, as those who saw more older adults were more likely to be confident establishing a management plan [17].

Other UK HCPs have also reported moderate levels of frailty assessment training (57%), mainly in-house rather than external courses [20]. However, in Brazil formal training increased frailty assessment fifteen-fold and more than doubled confidence in developing a management plan [17], suggesting more formal training would effect change in this area. The challenge of assessing frailty remotely was also echoed by Australian and New Zealand dietitians, who felt that home visits allowed observation of people, the kitchen and food [16]. However, since the pandemic there has been wider availability of brief remote malnutrition and frailty screening tools, such as R-MAPP (Remote - Malnutrition in the Primary Practice) [26] (including MUST and SARC-F (Strength, assistance walking, rise from a chair, climb stairs and falls)) and the FRAIL (Fatigue, Resistance, Ambulation, Illness, Loss of weight) scale [27], and training in using these may be important where services still have some element of remote delivery.

Our study suggests that there is a need for systematic provision of frailty assessment and management training for dietitians working with older people to ensure consistency in practice, including greater focus within undergraduate courses and well-publicised CPD. Participants also wanted stronger guidelines and clearer multidisciplinary assessment and management protocols, taking into account resources available.

4.3 Strengths and limitations

This research project focussed on a novel topic with little focus to date. We included dietitians from a range of settings to gain multiple perspectives. Limitations of the

research include challenges in recruitment due to the Covid-19 pandemic at the time, leading to smaller focus groups and more interviews. Focus group participants informally reported enjoying learning from dietitians in other roles, so larger focus groups may have prompted further discussion and ideas. We did not assess data saturation; data collection stopped each year within the timeframe of data collection for Masters degree dissertations. This work therefore provides preliminary data upon which future projects can build. Although we are confident a range of experiences were sampled, we did not collect data on years in practice and formal data on qualifications or record recruitment source. Further recruitment across different settings and years in practice may detect greater nuance in views and experiences. Finally, it is likely that those taking part had an interest in frailty, so some results may not be transferable to those without frailty interests.

5 Conclusion

Dietitians working with older people generally feel confident in managing frailty, but lack clarity as to their role in identifying it. Further guidance needs to strengthen the role of the dietitian in frailty and advocate for their visibility and involvement in MDTs. There is a need to provide public health education to older people and carers on optimal diets, and to provide more formal opportunities for dietitians to train in frailty management, and particularly frailty assessment.

6 Statements and declarations

On behalf of all authors, the corresponding author states that there is no conflict of interest.

7 Acknowledgements

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9 Conflict of interest

The authors declare no conflicts of interest.

10 Author contributions

Rachael Frost: Conceptualisation, Formal analysis, Data curation, Methodology, Project administration, Supervision, Visualisation, Writing – original draft

Palak Bavishi: Data curation, Investigation, Writing – review and editing

Nadia Kim: Methodology, Data curation, Investigation, Writing – review and editing

Nikoletta Mama: Data curation, Writing – original draft, Writing - review and editing

Adrian Slee: Conceptualisation, Validation, Methodology, Supervision, Writing – review and editing, Project administration

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