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CONSENSUS STATEMENT OPEN ACCESS

Australian Consensus Statement on the Prevention and Management of Frailty Among Community-Dwelling Older Adults: A Modified Delphi Study

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ABSTRACT

Introduction: This consensus statement from multidisciplinary experts and consumers across Australia provides comprehensive recommendations on the prevention and management of frailty in community-dwelling older adults.

Methods: The study uses a modified Delphi design. Phase I involved iterative discussion among six frailty care working groups, based on current evidence and expert opinion, to draft the statements. Phase II involved validation of each statement across two Delphi rounds conducted to determine level of agreement.

Main Recommendations:

- A lifelong approach to health promotion for frailty prevention should focus on raising awareness, annual screening (65+ years) and personalised counselling around accessible health behaviours to manage chronic comorbidities.
- An individualised, balanced, protein-rich diet is likely to be effective in delaying the onset of frailty. Protein–energy malnutrition and nutritional deficiencies should be identified and treated. A nutrition care plan that considers the relaxation of dietary restrictions aligned with goals of care should be planned for older adults with severe frailty.
- Progressive, individualised and ongoing exercise should be a combination of aerobic and resistance exercise, and balance and functional training tailored to frailty level and supervised by professionals.
- Social prescribing for older adults should be co-designed with a link worker to support meaningful, accessible and culturally appropriate activities that foster social engagement, with plans customised to the individual's frailty level.

- A comprehensive, multidisciplinary medication review tailored to the older adult's health status, preferences and frailty degree helps optimise medication use, minimise harm and support functional independence across all stages of frailty.
- Older adults with severe frailty need a regularly reviewed, personalised care plan, which involves carers in decision-making, supports advance care planning and ensures high-quality end-of-life care.

Changes in Management Informed by This Statement: The consensus statements introduce an integrated, evidence-informed and consumer-focused framework to guide healthcare professionals in delivering personalised and effective care for community-dwelling older adults living with or at risk of frailty.

JEL Classification: Gerontology, Health occupations, Health services administration, Nutritional and metabolic diseases

1 | Background

Frailty is a common and complex clinical syndrome characterised by reduced physiological reserve and increased vulnerability to adverse health outcomes. In Australia, frailty represents a growing public health challenge [1]. More than 20% of older adults are estimated to be living with frailty [2], experiencing declines in physical function, cognition and nutritional status, and facing a heightened risk of hospitalisation, loss of independence and entry into residential aged care [3]. As the population ages and the prevalence of multimorbidity increases, the prevalence of frailty is expected to rise substantially [4–6].

Importantly, frailty is a dynamic and potentially modifiable condition. With timely identification and appropriate intervention, frailty can often be prevented, delayed or even reversed [7]. Evidence supports the effectiveness of multicomponent interventions—such as nutrition, physical activity and medication optimisation—in reducing frailty and improving health outcomes for older adults [8].

Despite its significance, there remains considerable variation in how frailty is understood, assessed and managed across health and community care settings in Australia [9]. This variation is compounded by systemic challenges, including fragmented care pathways, limited access to multidisciplinary services and inconsistent use of frailty screening tools [10].

These issues are pronounced in community settings, where early intervention has the greatest potential to support healthy ageing, maintain independence and reduce avoidable hospitalisations. Limited emphasis on implementing community-driven frailty care has significantly increased strain on healthcare systems, which is evidenced by higher healthcare service usage, more frequent hospitalisation and longer recovery durations [11].

Current recommendations and policy documents pay limited attention to unified, integrated multidisciplinary approaches in community health settings. These multidisciplinary approaches are essential for an optimal response from healthcare systems and policy stakeholders. Without them, the growing burden of frailty and its complications remains inadequately addressed [12]. The lack of an integrated framework with multidisciplinary approaches contributes to substantial variations in the management of frailty among community-dwelling individuals, particularly across the degrees of frailty (such as mild, moderate and severe frailty) and discipline-specific approaches. To mitigate these variations and establish unified guidance, the aim of the study was to use a consensus-based approach to develop evidence-informed and consumer-focused national consensus statements to guide clinicians and healthcare professionals in delivering consistent, proactive and person-centred frailty care across community settings in Australia.

2 | Methods

2.1 | Expert Panel and Scope

Queensland Health and the Australian Frailty Network (The University of Queensland) collaborated to oversee the development of these consensus statements. A steering committee of 8 members was convened for the implementation of the project (Section S1). The steering committee invited multidisciplinary experts from across Australia to a consultative stakeholder meeting to determine the scope, methodology, consensus statement domains (health promotion and screening, nutrition, exercise, social prescribing, optimisation of medicines and management of severe frailty) and identify experts to lead these domains. The domains were identified based on previous literature and expert opinions. For the nutrition, exercise and social prescribing domains, statements were drafted for different degrees of frailty (mild, moderate and severe). The definitions for mild, moderate and severe frailty are given in Box 1 [13]. The stakeholders approved the modified Delphi method being conducted in two phases: Phase I (drafting statements) and Phase II (refining statements via Delphi rounds) [13]. For each domain, a working group was convened comprising members with expertise in research, academia, health services and community partnerships identified through professional connections and network recommendations. A national, multidisciplinary expert panel was assembled for the modified Delphi method, comprising all members from the expert working groups (including the consumer working group, described below) and an extended panel of 39 experts (Section S1). The additional members were identified through expression of interest calls and selection by the steering committee based on expertise and experience. This study was not prospectively registered. Ethics approval was obtained from the University of Queensland Research Ethics Committee (Project ID: 2024/HE002571) for the Delphi Survey. We report this study in accordance with the Accurate Consensus Reporting Document (ACCORD) guideline (https://www.ismpp.org/accord) with the checklist provided in Section S2.

2.2 | Consumer Working Group

We collaborated with six consumers (individuals with lived and living experiences of frailty) and caregivers (individuals

BOX 1 | Definition of degrees of frailty.

Mild frailty: Mild frailty is a condition where an individual experiences a slight reduction in their physical and mental resilience, making them more vulnerable to stressors such as illness or injury. People with mild frailty might notice some fatigue, slight muscle weakness or slower movement, but they can still manage most daily activities independently. This is represented as a score of 4 or 5 on the Clinical Frailty Scale [13].

Moderate frailty: Moderate frailty is characterised by a noticeable decline in physical and cognitive abilities, making it more challenging for individuals to manage daily activities independently. People with moderate frailty often need help with tasks such as housework, shopping and sometimes personal care such as bathing and dressing. They might also experience significant fatigue, a slower walking speed and reduced strength. This is represented as a score of 6 on the Clinical Frailty Scale [13].

Severe frailty: Older adults with severe frailty, represented by a score of 7 or 8 on the Clinical Frailty Scale, are completely dependent on others for personal care [13]. In Australia, many people living with severe frailty are unable to reside in the community, oftentimes due to lack of available support.

informally caring/having cared for people with frailty), throughout the development process to meaningfully incorporate their insights. At the planning stage, the consumer working group reviewed the scope, domains and methodology. They expressed a preference to participate collectively at the review and consultation stage, rather than being dispersed as individual consumer representatives across the working groups. The draft statements were presented to the consumers for discussion in a series of meetings, and their suggestions and edits were integrated by working groups into the final statements presented in the Delphi survey. All consumers participated in two consecutive Delphi rounds.

2.3 | Literature Review

Rapid systematic reviews were conducted for each domain to provide overview of the existing literature to the working groups to facilitate discussion. We searched for original English literature (guidelines/systematic reviews/independent studies) published in PubMed, Embase and Scopus from 2014 to 2024. The preliminary search strategy was sent out to the domain working group leads for approval. The identified relevant literature was tabulated and summarised for review, and working group experts nominated additional relevant articles [13].

2.4 | Modified Delphi Method

For drafting the statements in Phase I, the working group members drew on the summary of identified literature to develop a draft set of statements through iterative rounds of discussions via online meetings and email feedback. In the absence of evidence, the experts' judgement and experience was used to guide the discussion. A representative from each working group presented the draft statements to consumers in online consumer consultations to review and further refine the statements. Consumer feedback was provided to the working group to revise the statements.

To refine the statements in Phase II, the final draft statements were further examined in two anonymous survey rounds, developed and distributed using the Qualtrics XM platform (a web-based platform designed to securely collect and store responses). The surveys were piloted among external experts before dissemination to the expert panel. In round 1 ($n = 77$, response rate = 96.2%), the Delphi survey contained 40 draft statements to capture the level of agreement via an 11-point Likert scale (0 = strongly disagree, 5 = neither agree nor disagree, 10 = strongly agree; with an option for 'no opinion'). Qualitative feedback was collected via free text entry responses on content, clarity and comprehensiveness. Consensus was defined a priori as agreement by at least 80% of panellists, with scores ranging from 7 to 10. Quantitative data were analysed using descriptive statistics and presented as counts and percentages. Qualitative data (free-text entry) were organised through inductive thematic analysis to categorise into themes and subthemes [14]. Data (rating and comments from the Delphi panel) from round 1 were analysed and interim results were circulated to panel members. The statements with consensus were revised into 19 statements with the aim to design concise and easy to understand statements and presented in round 2 ($n = 70$, response rate = 90.9%) in an anonymised survey. The strength of the recommendations was assessed based on the Appraisal of Guidelines for Research and Evaluation II (AGREE II) checklist [15].

3 | Consensus Statement: Recommendations

The statements presented in round 1 are shown in Section S3. Demographics (discipline, location and years of experience) of the Delphi panel experts and the level of agreement in rounds 1 and 2 are presented in Sections S4 and S5. Consensus was reached for 19 statements with results from the Delphi round and level of agreement summarised in Table 1 [16]. The appraisal of the consensus statements using the AGREE II checklist is provided in Section S6. The level of evidence for each statement is provided in Section S7. Figure 1 presents the integrated framework of recommendations across the six domains.

The consensus statements, along with relevant literature and expert opinion for each of the six domains, are detailed in the following sections.

3.1 | Health Promotion and Screening

3.1.1 | The Case for a Lifelong Approach to Frailty

A life-course approach is fundamental to addressing frailty in ageing populations, and such strategies would strongly align with World Health Organization (WHO) initiatives to support

TABLE 1 | Final consensus statements with level of agreement.

No.	Statements	Level of agreement[a]
Health promotion and screening		
1.1	A lifelong approach to health promotion for frailty prevention should be adopted, and personalised counselling around accessible health behaviours initiated well before an individual develops multiple chronic conditions or experiences a health crisis (e.g., chronic disease-related hospital admission). Raising awareness of frailty and its consequences, as well as prevention and management strategies, should be prioritised for both consumers and health practitioners	A
1.2	Frailty prevention strategies include (but are not limited to) exercise, nutrition, screening programmes, vaccinations, advice on smoking and alcohol use, oral care, comprehensive medication review and social engagement, with a focus on supporting early self-management	A
1.3	Frailty screening for older adults (65+ years) should be done annually using a validated, reliable screening tool that is easy to apply, leads to treatment recommendations and allows any progression in frailty to be tracked over time. Broader population-based screening should inform health policy and enable risk stratification, further evaluation and diagnosis of frailty, and health planning at scale	C
Nutrition		
2.1	*Robust and mild frailty* A balanced diet, rich in vegetables, fruit, whole grains, dairy, lean meats and other animal and plant-based protein sources to meet the older adult's requirements and prevent/manage chronic disease is likely to be effective in delaying the onset of frailty among older adults. Older adults with frailty will typically benefit from higher dietary protein intake	A
2.2	*Moderate frailty* Protein–energy malnutrition, dehydration and other nutritional deficiencies (e.g., vitamin D, B12, iron, calcium) should be identified and treated by a multidisciplinary team of qualified healthcare professionals (including an accredited practising dietitian) according to evidence-based guidelines	B
2.3	*Severe frailty* An individualised nutrition care plan should be developed in partnership with the older person to align with their goals of care and maximise their quality of life. This should consider relaxing previous dietary restrictions to allow the person to eat what they wish. Older adults with cognitive decline may require support to address complex nutrition care needs. Families and caregivers should also be included in all steps of the nutrition care process.	B
Exercise		
3.1	*Robust and mild frailty* Progressive, ongoing exercise involving a combination of aerobic (most days per week) and resistance (2–3 days per week) exercise and balance training undertaken independently or under the supervision of an exercise professional can prevent or delay the development and/or progression, of mild frailty. Older adults should remain physically active in their daily life through a combination of recreational, vocational and incidental movements	A
3.2	*Moderate frailty* An individualised, progressive, ongoing exercise programme involving a combination of aerobic and resistance exercise, balance and functional training, by an exercise professional, can prevent or delay the progression of moderate frailty. Older adults who are moderately frail should remain as physically active as their condition allows	A
3.3	*Severe frailty* A safe, individualised, progressive, ongoing exercise programme for older adults with severe frailty should be prescribed by an exercise professional and should involve a combination of function and balance training and aerobic and resistance exercise, that is commensurate with the person's capabilities and aligned with goals of care. The exercise programme should be supervised and complemented by supplementary exercises that can be performed independently. Older adults who are severely frail should remain as physically active as their condition allows	A

(Continues)

TABLE 1 | (Continued)

No.	Statements	Level of agreement[a]
Social prescribing		
4.1	*Robust and mild frailty* Social prescribing to support social engagement, stimulation and creativity should be co-designed with the older adult and a link worker to identify activities that are relevant and meaningful. These activities should align with their personal preferences, interests and values, be culturally acceptable and make use of existing community resources (like gardens and walking groups) to make them affordable and accessible. Consider activities that bring people together with different levels of frailty and life experiences to create connections across the community	B
4.2	*Moderate frailty* A personalised and coordinated plan should be co-designed with the older adult and link worker to accommodate the older adult's health needs and cognitive and functional capacity, while considering their personal preferences, transportation needs, technology assistance requirements and other barriers. This plan should help maximise the older adult's ability to access and participate in socially engaging activities (especially group-based programmes) made available across different delivery modes (in person, online or by phone)	B
4.3	*Severe frailty* The social prescribing of activities should be co-designed with the link worker to meet the older adult's practical, social and well-being needs. The activities should be regularly monitored and modified by a relevant healthcare professional in accordance with any change in their prognosis, preferences, health needs and functional capacity. The plan should consider engaging family and carers, delivery at an accessible venue (like older adult's home), supplementation with digital and telephonic options, supporting carer education and utilising safety equipment to facilitate older adult's continuous access and participation in prescribed social activities	B
Optimisation of medicines		
5.1	A regular, comprehensive and multidisciplinary medication review can help to optimise medication use by older adults with frailty by aligning medication use with the older adult's overall therapeutic and medication management goals, providing strategies that promote their functional independence and limiting the risk of unintended harm from medications	A
5.2	A medication review needs to involve the older adult, all direct carers, substitute decision makers and relevant healthcare professionals and service providers (especially during care transitions). It also needs to be informed by knowledge of the older adult including their values and preferences, all their previous and current diagnoses, geriatric syndromes, reconciled medication use history, goals of care, nutrition and physical activity status	U
5.3	A medication review should address non-pharmacological management, under-treatment, over-treatment, the cumulative impact of all the person's medications, adherence and communication. Consider pharmacological changes with frailty; applicability of evidence for medication efficacy and safety, time to benefit, and increased susceptibility to severe adverse drug reactions. Accommodate any limitations in swallowing, vision, hearing, hand function or cognition	B
5.4	Many medications can impair physical, cognitive or social function, increase the risk of falls and affect exercise tolerance or nutrition, particularly when used in combination. It is important to recognise and manage these effects using the medication optimisation strategies described in Statements 5.1, 5.2 and 5.3. Failure to recognise adverse drug reactions can result in an inappropriate prescribing cascade (where one drug is used to treat the adverse effects of another) or perpetuation of unnecessary medication-related harm. This recommendation is applicable to older adults with all stages of frailty and to those living with dementia. It is particularly important for older adults with severe frailty or dementia, who may be more susceptible to medication-related harm and in whom medication-related harm can be more difficult to identify	A

(Continues)

TABLE 1 | (Continued)

No.	Statements	Level of agreement[a]
Management of severe frailty		
6.1	Older adults with severe frailty require a holistic assessment and personalised management plan that is reviewed and updated regularly and considers the older adult's values, preferences, goals of care, medical and functional needs, social circumstances and available carer support. Referral for a comprehensive geriatric assessment (CGA) should be considered in the context of the older adult's preferences, needs and availability of healthcare resources	U
6.2	Older adults and carers should be actively involved and supported in decision-making during care transitions and dignity of risk should be afforded. Care transitions should provide an opportunity to perform a CGA, re-evaluate existing care plans, recommend care pathways and ecosystems of care that recognise and minimise risk, provide access to rehabilitative and supportive care and be facilitated by clear communication among all stakeholders	A
6.3	Older adults should be supported by clinicians involved in their care to engage with advance care planning to ensure their wishes are upheld and avoid inappropriate or futile care that does not align with their personal goals. Older adults with severe frailty deserve high-quality end-of-life care, delivered by experienced clinicians at a place of their choosing	A

[a]Level of agreement: U = 100%; A = 99%–95%; B = 94%–90%; C = 89%–85%; D = 84%–80%.

'Good Health and Well-being' (e.g., Sustainable Development Goal 3) [17]. Although frailty is often associated with older adults, evidence shows that it can begin much earlier. UK Biobank data have shown how early-life adversity, including poor nutrition, poor maternal health and socio-economic disadvantage, has been linked to increased frailty risk in adulthood [18]. Childhood and adolescence are especially critical, as development during these stages shapes long-term health outcomes.

Despite this, awareness of frailty remains limited among both consumers and healthcare professionals [18], and many healthcare professionals lack training in its early identification and management [19]. Raising awareness and embedding frailty education into primary care, community health and public health messaging can empower both professionals and the public to recognise early signs and take timely action. Early intervention can delay or prevent frailty, thereby improving outcomes and reducing healthcare burden [20].

3.1.2 | Evidence for Frailty Prevention Strategies

Frailty is increasingly recognised as a dynamic and potentially reversible condition, rather than an inevitable consequence of ageing [21]. Even modest improvements across a few domains can yield meaningful reductions in frailty incidence, with one study suggesting up to 86% of frailty cases could be prevented through improvements in modifiable behaviours and life circumstances, particularly in physical activity, psychosocial health and lifestyle [22]. Lifestyle behaviours, such as physical activity, nutrition, sleep, smoking, alcohol use, loneliness and mood, are independently associated with frailty risk [6]. Physical activity, particularly progressive resistance training, has the strongest protective effect [23]. Despite robust evidence, real-world practice often falls short of national lifestyle guidelines, particularly for physical activity and nutrition. This gap underscores the need for behaviour change strategies and early personalised counselling on modifiable behaviours to empower individuals to build physiological and psychological reserves, protecting against functional decline and promoting healthy ageing [24].

3.1.3 | Frailty Screening

Our recommendations for frailty screening are consistent with several guidelines [24–26]. These guidelines collectively emphasise the importance of regular screening using validated frailty measures that are feasible for integration into routine clinical care. However, screening must be meaningfully linked to intervention pathways. Evidence from stakeholder engagement cautions against using frailty screening tools as standalone diagnostic instruments [26]. Rather, they should serve as a trigger for comprehensive assessment and/or tailored care planning to facilitate early identification and proactive management [27].

Qualitative research highlights challenges in frailty screening and communication [28]. Clinicians often question the utility of screening tools, preferring clinical judgement based on appearance and history. There is reluctance to use the term 'frailty' due to its perceived stigma and the belief that it is irreversible [29]. Furthermore, systemic issues such as poor integration of care between hospitals and primary care, and limited community resources hinder effective management [30]. Older adults are sceptical about objective frailty measures unless these measures lead to actionable outcomes and are sensitively communicated to avoid psychological harms from frailty labelling [29]. To address these barriers, frailty screening must be embedded within a broader framework of early engagement and personalised intervention that is best practice and evidence-based—a summary of which is provided in these consensus statements. Primary care offers an ideal setting to screen for risk of frailty, track frailty over time and support a tailored approach to prevention and management.

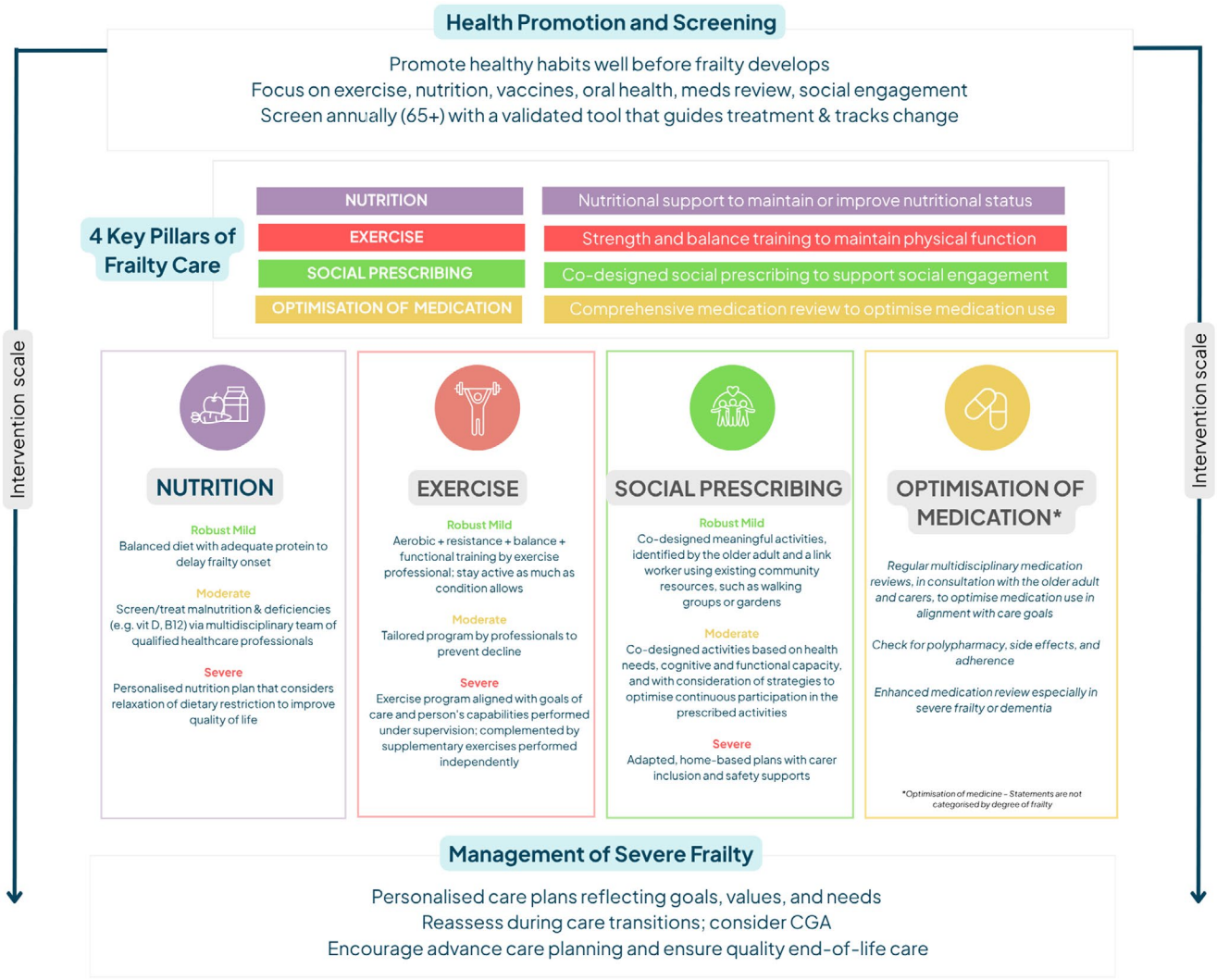

FIGURE 1 | Integrated framework of recommendations across six domains. CGA, comprehensive geriatric assessment.

3.2 | Nutrition

3.2.1 | Diet and Nutrition in Frailty Prevention

There is evidence from systematic reviews and meta-analyses that adherence to healthier dietary patterns characterised by a greater consumption of fruit, vegetables, whole grains, lean animal and plant-based proteins is associated with lower frailty risk [31]. Similar findings have also been observed with adherence to a Mediterranean-style diet [32]. This diet is characterised by a higher consumption of plant-based foods, extra-virgin olive oil, fermented dairy products and a lower consumption of red and processed meats and ultra-processed foods. This diet is rich in micronutrients, antioxidants such as polyphenols, carotenoids and other bioactive compounds [33]. In contrast, consumption of ultra-processed foods is associated with greater risk of frailty [34]. The provision of person-centred medical nutrition therapy and dietary counselling delivered by an accredited practising dietitian (APD) is essential to deliver culturally appropriate, sustainable and tailored dietary interventions.

Dietary protein intake is likely to play an important role, primarily due to its role in stimulating muscle protein synthesis and facilitating postprandial muscle protein accretion [35]. There is an inverse association between protein intake and frailty prevalence [36]. The need for adequate dietary protein in older adults is imperative and largely due to the blunted muscle protein synthetic response to an anabolic stimulus, a phenomenon termed anabolic resistance [35]. As such, several leading experts and consensus groups have emphasised the need for higher protein intakes for older adults than the current guidelines of 0.8–1.0 g/kg body weight per day [37]. Current evidence suggests intakes of at least 1.2–1.5 g/kg body weight per day of high-quality protein (e.g., lean meat, egg, dairy and soy) are a better target for the prevention of frailty [36].

3.2.2 | Protein–Energy Malnutrition and Frailty

There is a clear overlap between malnutrition and frailty in community-dwelling older adults, especially in moderate frailty [38]. Evidence-based guidelines recommend routine screening for malnutrition (with the use of validated and population-specific screening tools). This screening could facilitate timely and supportive person-centred dietary interventions targeting the provision of high-energy, high-protein dietary interventions,

ideally adopting a food-first approach [39]. However, when adequate energy, protein and nutrients cannot be achieved through a food-first approach or malnutrition is identified, patients should be referred to an APD for a comprehensive malnutrition assessment. The provision of medical nutrition therapy based on food fortification strategies and/or a multinutrient oral nutrition supplement, enriched with protein (including the essential amino acid leucine) and micronutrients to optimise nutritional status and prevent unintentional weight loss should be adopted [40].

3.2.3 | Individualised Dietary Prescription and Liberalised Diets

Competency standards for dietitians in Australia, Europe, USA and Canada encourage a person-centred approach, involving collaboration between clinicians and patients, patient involvement in decision-making and a responsiveness to each patient's unique values, personal needs and cultural preferences [41]. Historically, the provision of individualised medical nutrition therapy includes an assessment of nutritional status coupled with the prescription of an individualised nutrition intervention plan, often featuring a prescriptive dietary intervention for management of a disease or clinical symptoms. However, for severely frail older adults, overall health goals may not warrant the use of prescriptive dietary interventions due to their potential to be restrictive, and thus increasing the risk of unintentional weight loss, dehydration and malnutrition [42]. In contrast, a more liberalised nutrition approach that is less restrictive has been associated with increased food and fluid intake, improved appetite and patient satisfaction, and optimisation of nutritional status [43].

3.3 | Exercise

Regular physical activity is a public health priority, reflecting its many health benefits. Current guidelines recommend that all adults should undertake 150–300 min of moderate intensity aerobic activity and at least two sessions of resistance exercise per week [44]. These recommendations are consistent with the evidence for exercise in preventing or delaying the development and/or progression of mild frailty. A systematic review to inform the current WHO physical activity guidelines [45], found that interventions involving a combination of resistance, balance and endurance exercise were effective at improving frailty outcomes. Similarly, a recent meta-analysis of the effects of exercise interventions consistent with the American College of Sports Medicine (ACSM) guidelines, found that programmes that aligned with the ACSM recommendations were more effective at reducing the frailty phenotype than those that did not [46]. The ACSM recommendations can be achieved by undertaking moderate intensity aerobic activity (such as walking, cycling or swimming) on most days to accumulate at least 150 min over a week, or by undertaking at least three sessions of vigorous exercise totalling 75 min each week [46]. Older adults who are unable to meet the recommendations should be advised to be as active as their abilities or health conditions allow. While people with mild frailty can perform aerobic activity and strength and balance training independently, supervision and structure can improve adherence [47]. People experiencing moderate to severe frailty can benefit from closer supervision and guidance from an exercise professional to tailor an exercise programme to their specific needs. Low impact exercise, such as hydrotherapy, is particularly well suited to people with more severe frailty [48]. Balance training is important across all degrees of frailty to help maintain confidence and reduce the risk of falls [49].

Progressive resistance training is an effective strategy to delay and reduce frailty, with benefits evident at both early and late stages [50]. This reflects the positive impact that resistance training has on muscle mass and function to address sarcopenia, which often accompanies frailty. Resistance exercise programmes should be initiated at a low intensity, allowing 15–20 repetitions to be performed comfortably to facilitate the establishment of good technique, progressing to a moderate intensity that enables 8–12 repetitions to be performed with good technique, before volitional fatigue [51]. Exercises should be prescribed that target major muscle groups of the upper and lower body. Supervision of resistance exercise facilitates instruction in correct technique and tailoring intensity to individual fitness levels.

Exercise interventions as a component of a multidomain intervention incorporating exercise, nutritional, pharmacological, psychological or social interventions tend to be more effective than single domain interventions on frailty status, muscle mass, strength and physical functioning. More specifically, the combination of an exercise intervention and a nutritional intervention has a more positive impact on frailty than either exercise or nutritional intervention alone [52].

In addition to exercise, it is important for people experiencing frailty to minimise sedentary time and engage in a range of domestic and recreational activities, as their level of frailty allows. This not only helps maintain physical function and assists in the management of frailty, but also has a positive effect on quality of life, mental health and social engagement [53].

People with chronic conditions may be eligible for a general practitioner-initiated chronic condition management plan, which provides limited Medicare rebates for referral to accredited exercise physiologists or physiotherapists for exercise prescription or supervision.

3.4 | Social Prescribing

3.4.1 | Co-Designed Social Prescribing to Support Social Engagement

International guidelines, including the International Conference of Frailty and Sarcopenia Research (ICFSR) clinical practice guidelines (2019), strongly recommend offering social support to all individuals with frailty to address unmet needs and promote adherence to a comprehensive management plan [54]. Effective frailty management in primary care requires a coordinated network of support integrating family, caregivers and community providers to ensure continuity and responsiveness of care [8]. In the Australian setting, social prescribing is increasingly recognised as a structured, relationship-based model that complements clinical care by addressing the social,

cultural and environmental determinants that shape frailty trajectories. Social prescribing interventions have been shown to reduce loneliness and have a positive impact on function outcomes; however, there remains a need for well-conducted longitudinal trials to determine the most effective social prescribing strategies.

Social engagement activities can include a wide range of activities, including joining hobby, cultural, recreational, volunteer or support groups, depending on local availability. When developing a social prescribing plan, co-designing interventions with older adults is important to ensure that activities are meaningful, accessible and aligned with personal values, preferences and capacities [55]. There is a role for local expertise to match available group activities to the needs of older adults living with frailty. Ideally, this role is performed by a new workforce of 'link workers' [56]. Link workers might have more knowledge of local resources and dedicate time to engage clients with community services, programmes and activities and can oversee follow-up of the older adults on health-related non-medical challenges.

The role of the link worker may be undertaken by general practitioner practice nurses or by the general practitioner supported by a directory of available community resources to assist in social prescribing. Community resources might be listed by local councils, primary health networks or hosted on the HealthPathways platform. For people in complex circumstances, including those living with frailty who are socially isolated, vulnerable, suffer mental health illness or housing challenges, referral to a social worker may be required. Health systems should consider integrating telehealth, mobile outreach and partnerships with community organisations to extend access to link workers and social engagement opportunities. These strategies are particularly important for older adults with severe frailty, who may be homebound or face significant mobility barriers.

For individuals living with frailty, there is a need for regular monitoring and adaptation of prescribed activities. The frequency of reassessment should be guided by clinical indicators such as recent hospitalisation, functional decline or changes in caregiver support.

The inclusion of family and carers is critical in supporting frail older adults, particularly those with complex needs. However, not all individuals have family members available or capable of providing support. In such cases, community volunteers, peer supporters or professional carers may serve as surrogates. Carer education should be tailored to the needs of the older adult and may include training in communication, assistive technology and safety practices.

3.5 | Optimisation of Medicines

3.5.1 | Comprehensive Medication Review to Optimise Medication Use

Our recommendations on medication optimisation align with the Asia–Pacific Clinical Practice Guidelines for the Management of Frailty [25] and with international consensus on medication management for people with frailty [57]. Among individuals living with frailty, although high-quality evidence on the effects of medication review alone is lacking [58], individualised care planning including medication optimisation and regular follow-up reviews has been demonstrated to sustain independence [59].

Under-treatment is also common in individuals living with frailty [60] and should be addressed as part of the comprehensive medication review for this population. This is particularly important due to the potential role of pharmacological management, including symptomatic management, in reducing frailty through prevention and management of diseases, although high-quality evidence supporting this role is lacking [61]. Non-pharmacological treatments are particularly important in disease prevention and management for individuals living with frailty, given the complexities of medication use in this population. Non-pharmacological management strategies can reduce the need for medications that are poorly tolerated by older people (e.g., sleep hygiene to reduce the use of sedative hypnotics) and may improve the tolerability of medications [62].

Frailty has significant impacts on medication use and response, including higher rates of polypharmacy and suboptimal prescribing, frailty-associated changes in pharmacokinetics and pharmacodynamics, and increased vulnerability to medication-related harm [62]. People living with frailty may therefore benefit from more frequent medication reviews than those without frailty. A comprehensive review of medications should occur on identification of frailty and when there is a significant change in the person's clinical condition or goals of care [62].

Multidisciplinary medication reviews may be undertaken by general practitioners, geriatricians, other specialists and pharmacists. Guidelines such as the New South Wales Agency for Clinical Innovation guide for Medication Review for People with Frailty [63] outline the key steps involved in conducting a comprehensive medication review. General practitioners can consider referral to community pharmacists for a home medicines review. International guidelines on medication management in patients with polypharmacy in primary care highlight the importance of patient and caregiver involvement during medication reviews [64].

3.6 | Management of Severe Frailty

3.6.1 | Holistic Assessment and Personalised Management Plans

The management of severe frailty in older adults requires a person-centred, multidisciplinary approach that takes account of an individual's values, preferences and goals of care [65]. This assessment should inform the development of a personalised management plan that is responsive to changes in the individual's condition, and might include exercise, optimisation of comorbid conditions, ways to address low mood and referral to appropriate aged care services [66]. International guidelines on frailty management also highlight the importance of personalised care planning [67]. However, guidelines to support the implementation of person-centred care in adults with severe

frailty, who have high levels of dependency and are nearing the end of life, are lacking.

Referral for a Comprehensive Geriatric Assessment (CGA) should be considered when appropriate, based on individual preferences, clinical need and the availability of resources. The CGA is a holistic assessment, encompassing medical, functional, psychological, cognitive and social domains, which leads to a personalised care and management plan. Evidence supports the role of CGAs in reducing unplanned hospital admissions in older community dwellers living with frailty, although findings on mortality and nursing home admission remain mixed [68].

3.6.2 | Considerations During Transitions of Care

Care transitions represent both a risk and an opportunity for older adults living with severe frailty. Transitions between care settings are associated with adverse outcomes, including falls, delirium, functional decline and medication errors. However, severely frail adults are a vulnerable group and are likely even more at risk during transitions of care than less frail adults. Care transitions must therefore be facilitated by clear communication between individuals, their carers and healthcare teams, and pathways of care and physical environments should be optimised to mitigate these risks [69].

Despite the risks faced by adults with severe frailty during care transitions, it remains critical that they are afforded dignity of risk. This allows severely frail older adults to make informed choices about which risks are worth taking to honour their values and goals of care [70].

Access to rehabilitative and supportive care is essential during and after care transitions, where it is in keeping with an individual's needs and goals. Such services should aim to promote physical and emotional well-being, optimise functional capacity and support a return to home were consistent with the individual's goals. This recognises the preference of many older Australians to 'age in place' [71].

3.6.3 | Advance Care Planning

Clinicians often fail to recognise severe frailty, or its significance as an end-of-life condition. In turn, this acts as a barrier to advance care planning in this group [72]. The British Geriatrics Society clinical guide published in 2020 offers advice and support about end-of-life care in adults with severe frailty [73].

Individuals living with severe frailty often experience symptoms that are comparable to those faced by people with terminal malignancies. Advance care planning (ACP) offers a critical opportunity for older adults to articulate their values and preferences for future care, including decisions around hospitalisation and preferred place of death. These discussions should ideally be initiated by clinicians experienced in the person's care. There is strong evidence that ACP improves satisfaction with care and increases the likelihood that end-of-life care aligns with the person's preferences [74]. High-quality end-of-life care for older adults with severe frailty must be a priority. Where possible, this care should be delivered in their preferred setting by experienced clinicians, with access to specialist palliative care as required.

3.7 | Limitation

Although the statement development process was informed by the lived experiences of older adults across Australia, it did not include representation from key priority populations, including Aboriginal and Torres Strait Islander peoples and individuals from culturally and linguistically diverse backgrounds. The scope of the consensus statements has been limited to addressing individual-level recommendations to prevent and manage frailty and does not address the systemic implementation barriers and facilitators to ensure applicability of the statements. Addressing these limitations has been identified as a priority for future research efforts.

4 | Conclusion

The national consensus statements were developed through a collaborative process involving clinical experts, researchers, policy stakeholders and consumer representatives. The statements reflect a shared commitment to facilitating frailty-informed care and enhancing the quality of life and health outcomes for older adults in community settings. Clinicians and healthcare professionals should adopt and combine key recommendations such as raising awareness, personalised counselling on health behaviours, optimal protein intake coupled with exercise programmes, encouraging meaningful social engagement and customising care plans to the individual's values and goals of care, with a special focus on optimisation of medicines. Collectively, these recommendations aim to embed integrated, multidisciplinary frailty care delivered in community settings to optimise outcomes for older adults across all stages of frailty.

Author Contributions

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Conflicts of Interest

Members of the consumer group were offered an honorarium to participate in the consumer consultation and to review the statements via the modified survey. No other funding was provided. Elizabeth Whiting reports serving as the Clinical Lead for the Queensland Health Reform Office. Sarah N. Hilmer reports that she is active in a programme of research in clinical pharmacology for frailty and developed the Drug Burden Index, which is being considered for commercialisation. Anthony Villani reports receiving an honorarium from Abbott Australasia Pty Ltd. as an invited member of an advisory board for development of a muscle health algorithm to guide screening, assessment and management of poor muscle health in primary care. Mark Morgan reports receiving consultancy fees from the Department of Health and Aged Care, Gold Coast Primary Health Network, Primary Sense, MedCast and the Royal Australian College of General Practitioners and provides medical services to the general practitioner clinic, Eastbrooke Family Clinic, Burleigh Waters.

Data Availability Statement

The authors have nothing to report.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Section S1.** Consensus statement expert panel. **Section S2:** ACCORD checklist. **Section S3:** Draft consensus statements for Delphi Round 1 Survey. **Section S4:** Australian consensus statement on prevention and management of frailty among community dwelling older adults—Delphi Round 1 Survey. **Section S5:** Australian consensus statement on prevention and management of frailty among community-dwelling older adults—Delphi Round 2 Survey. **Section S6:** AGREE checklist. **Section S7:** Level of evidence for the consensus statements.