

## **FRAILITY AND COVID-19: WHY, WHAT, HOW, WHERE AND WHEN?**

The information on this page is also available here as a downloadable PDF, including links.

**Key point:** clinicians should not place too much emphasis on frailty alone when discussing prognosis in older people with COVID-19 infection.

### **WHY IS THIS IMPORTANT?**

Rapid [NICE guidance](#) produced in response to the COVID-19 outbreak clearly outlined the importance of identifying and grading frailty using the Clinical Frailty Scale (CFS). At that time, there had been no studies examining the role of the CFS specifically in older people with COVID-19. Since, there have been many studies that have shown an association between an increased risk of COVID-19 related death and increasing frailty, but other studies demonstrate a more nuanced understanding of frailty and outcomes in COVID-19 is needed.

Analysis of all people aged 75+ years admitted with COVID-19 (whether PCR confirmed or clinically diagnosed) in England indicates that those with greater frailty risk may actually have lower all-cause mortality. This may relate to immunosenescence and a less marked cytokine storm, which is thought to underpin poor outcomes in COVID-19 infections.

### **WHAT SHOULD YOU BE DOING?**

You should always use a holistic assessment to guide clinical decision making – no one tool should be used in isolation. Frailty considerations, alongside other risk scores such as the 4C Mortality Score can form part of a holistic assessment to inform a shared decision making process. Frailty can be useful in identifying the risk of COVID-19 related complications such as delirium and deconditioning.

**Outwith** the context of COVID-19, frailty is associated with increased mortality, fewer people returning home and poorer quality of life following a critical care episode. These outcomes have not been studied in older people with COVID-19 to date.

### **HOW SHOULD I USE THE CFS?**

**DON'T** use the CFS in isolation to direct your clinical decision making.

**DO** remember that the CFS has only been validated in older people; it has not been widely validated in younger populations (below 65 years of age), or in those with learning disability. It may not perform as well in people with stable long term disability such as cerebral palsy, whose outcomes might be very different compared to older people with progressive disability.

- The CFS can be undertaken by any appropriately trained health or social care professional (doctor, nurse, health care assistant, therapist etc.) with training and support BUT decision makers using the CFS to inform clinical management MUST check the score themselves to ensure that it is accurate.
- Ask the patient, their carer/next of kin/paramedics/care home staff what their capability was TWO weeks ago.
- DO NOT base your assessment on how the patient appears before you today.
- DO be careful about differentiating between CFS 6 and 7:

- CFS 6 (need help with outdoor activities and some help with basic activities) – all cause mortality during admission to acute hospital = 6% (NOT COVID-19 specific data)
- CFS 7 (completely dependent for personal care) – all cause mortality during admission to acute hospital = 11% (NOT COVID-19 specific data)

## WHEN?

The CFS should be assessed in Emergency Department triage, or any first point of contact with acute care (including by paramedics), alongside National Early Warning Scores (NEWS). It should be reassessed after two weeks if clinically relevant in environments where stable patients are being observed for progress over a longer time-frame.

## RESOURCES

- A CFS app is now available for both [Apple](#) and [Android](#) devices
- Specific training on the use of the CFS in the urgent care context is available [here](#).
- A general overview of frailty with tips on using the CFS can be found [here](#).

## REFERENCES

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