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## LETTER TO THE EDITOR

### COVID-19 AND THE CHALLENGES OF FRAILTY SCREENING IN OLDER ADULTS

*Dear Editor,*

We read with interest the recent editorial examining the relationship between geriatric syndromes and severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the cause of Covid-19 (1), particularly the authors recognition of the need to identify frailty among older adults presenting with suspected symptoms and the importance of mobilising a range of healthcare professionals to tackle this disease (1). However, the identification of frailty and the utilisation of screening instruments by those without geriatric training and especially in acute care is challenging. Frailty is a complex condition. While age-associated, it is multi-dimensional and remains difficult to define (2). Although the Covid-19 pandemic has disproportionately affected older adults (1), data are lacking and pathophysiological mechanisms and the impact of differential management strategies on the course of the disease among older adults is uncertain (1). Further, the prevalence of frailty among those diagnosed, admitted or dying is not clearly reported at present. Nevertheless, the rationale for using frailty to identify those at risk and to allocate care has been correctly highlighted (1). We suggest however, that the use of instruments such as the Clinical Frailty Scale (CFS) (3) and particularly by non-specialised staff in this setting warrants more careful examination.

Prioritization in healthcare is challenging, both practically and ethically, particularly when health systems are stressed and prognostic uncertainty remains (4). Age-based cut-offs to determine access to limited intensive care treatments during this pandemic have been reported and while there is recognition that age should not be the predominant criterion (4), little guidance is available to help ration limited resources as countries continue to manage a surge in cases. Although older adults are the main users of healthcare, they are a heterogeneous group with variable potential to recover from acute illness (2). Frailty is therefore a useful risk-stratification paradigm to target limited resources to those most likely to benefit (2). The United Kingdom's National Institute for Health and Care Excellence (NICE) have recently published a COVID-19 Rapid Guideline (critical care) for patients requiring critical care during the pandemic. This, like the editorial, also suggests the CFS, a nine-point scale scored from one (very fit) to nine (terminally ill) (3), in a way such as those scored as non-frail (CFS less than five) should, if their condition deteriorates, be considered for critical care. The management of those scoring five or more (frail) is less well-defined but implies that many would receive best supportive care.

While guidance such as NICE's COVID-19 Rapid Guideline is welcome in navigating complex decisions, the use of the CFS or any short frailty instruments to ration access should be considered cautiously, particularly by those who have not received training in the assessment of frailty. Taking the example of the CFS, while it is the most widely-applied scale in critical care, as with other frailty measures, its reliability and validity needs to be more established in this setting (5). The CFS mixes items such as comorbidity, cognitive impairment and disability (3), and hence its administration requires familiarity with these concepts. The CFS includes illustrative pictures; however, the detailed text is what matters and there is a risk that untrained, overwhelmed clinicians just refer to these without taking these additional factors into account and without understanding the patients' recent baseline. In "Fit For Frailty", the British Geriatrics Society advised that it should be used to identify the level of frailty only after the completion of a geriatric assessment, which requires talking to patients and often taking a collateral history. Other instruments also require these details. Guidelines must also refer to important factors including illness severity, likelihood of survival and patient preferences otherwise, there is concern that this nuanced complexity may be minimised when units face a surge in cases.

In those with acute illness, assessment should consider patients' baseline rather than their current status as this can over-estimate frailty severity (5). Frailty scores might then be applied bluntly potentially denying suitable candidates appropriate escalation. To avoid therapeutic nihilism in the care of older people with Covid-19 during this pandemic, we urgently require epidemiological data to support decision-making algorithms before they or frailty scales are used to ration care. If it is to be of value, staff performing such assessments must have an adequate understanding of the concept of frailty and be familiar with the basic principles that underpin these scales. Geriatric teams can and should support this education in conjunction with online resources such as the CFS training module developed by the Aging Innovation in Perioperative Medicine and Surgery Research Group available at <https://rise.articulate.com/share/deb4rT02lvONbq4AfcMNRUudcd6QMts3#/>.

In the challenging environment presented by Covid-19, it is crucial that frailty screening assessment is not reduced to quick 'eyeball' examinations of the person because that risks frailty becoming a new form of ageism.

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