Royal College of Physicians

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Acute care toolkit 3 addendum

COVID-19 and acute care for older people living with frailty December 2020

The principles of managing frail older patients acutely in urgent care settings remain unchanged. However, it is worth drawing attention to some COVID-19-specific issues.

Identification

As discussed in this toolkit, early identification of frailty should take place within 30 minutes of older people presenting to urgent care settings;[1] there are growing data on the ability of the Clinical Frailty Scale (CFS) at triage to predict outcome in the short and longer terms[2,3] and to prompt an individualised, holistic assessment. It is important to remember that the CFS is only appropriate for patients over the age of 65 without stable long-term disabilities, learning difficulties or autism and should not be used as a determinant of frailty in isolation.[4] Frailty assessment, accompanied by person-centred discussions, can aid decision making with regards to appropriateness for critical care escalation.

Frailty syndromes

Atypical presentation of clinical conditions is common in frail older patients. Patients often present with a 'frailty syndrome', eg delirium and falls, which may mask an underlying illness. Data are emerging that COVID-19 infection can also present atypically, without the well-documented symptoms and signs of cough, breathlessness and fever,[5] for example with delirium.[6] Patients with dementia and/or hyperactive delirium, who may be agitated and wandering, present an additional challenge. Careful identification of suspected and confirmed cases of COVID-19 is essential to try to prevent hospital-acquired infection. Presentation with a frailty syndrome should lower thresholds for COVID-19 testing and early isolation according to local protocols.

Rehabilitation and post-acute care?

COVID-19 appears to result in accelerated frailty,[7] and given its multi-system effects, there will be substantial implications for rehabilitation and recovery services. Similarly, the reported neurological manifestation of COVID-19, such as stroke and delirium,[8] may lead to accelerated cognitive ageing, with important implications for health and social care systems.

End-of-life care

As discussed in the toolkit, in-hospital mortality is high for frail older patients, increasing from 3% in CFS 1 to 31% in CFS 9 cohorts. It is estimated that 44% of COVID-19 deaths have occurred among people who would have been in their last year of life despite the pandemic.[9] Advance care planning allows a patient to express their future wishes and priorities of care.[10] Despite the challenges presented by the COVID-19 pandemic (including hampered communication with patients, communication with carers limited to telephone or remote video conversations and, in some cases, a reduced community palliative care service), urgent care attendances provide an important opportunity to consider advance care planning discussions.

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Royal College of Physicians
11 St Andrews Place
Regent's Park, London NW1 4LE

Tel: +44 (0)20 3075 1649
Fax: +44 (0)20 7487 5218

www.rcplondon.ac.uk

Royal College of Physicians