PCRS Position Statement

Frailty and respiratory disease in primary care (Update)

April 2026

Respiratory disease and frailty should be considered jointly when caring for this vulnerable group of patients. Respiratory disease contributes to frailty and frailty must be considered when managing respiratory disease, in conjunction with other comorbidities, psychological and social issues.

Primary care should proactively identify and support people living with frailty and respiratory diseases. Use population case finding combined with individual assessments to grade frailty and tailor care. Whenever possible and appropriate, involve other healthcare professionals in the process (e.g. occupational therapists, physiotherapists, pharmacists, dieticians).

Assessments should be undertaken with the patient and their usual carer(s) to agree a shared plan, optimise medicines, address nutrition and physical activity, support independence with activities of daily living and consider other non-pharmacological interventions (e.g. pulmonary rehabilitation and smoking cessation).

Appropriateness of medications should be reviewed in the context of self-administration and available care package, dexterity, dysphagia/aspiration risk and cognitive impairment.

It is important when caring for this vulnerable group of patients that all the primary and community health team are utilised. This may mean community pharmacists not only delivering medication but ensuring that medications are appropriate and administered, using therapy teams to optimise the patient's ability to remain in their usual place of residence, and social care to support patients with activities of daily living where needed. Patients should have a clear, concise management plan that is available to and understood by all those providing care including, where appropriate, ceiling of care and end-of-life discussions.

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Background

Frailty is a health state in which a person's body systems gradually lose their in-built reserves.[1] Frailty is often associated with the following:

- Slow walking speed
- Impaired grip strength
- Declining physical activity levels
- Exhaustion
- Unintended weight loss.

Frailty is a dynamic clinical state and its modifiable factors, when identified, can be addressed to prevent, reverse or slow down deterioration. Around 10% of those over 65 years of age are thought to be living with moderate to severe frailty, a figure that rises to up to half of those aged >85 years.[2] Frailty impairs an individual's ability to cope with apparently minor health-related events. As a result, even a minor illness or event like a change in living circumstances may progress into serious threats to their overall health and well-being in frail patients. These vulnerabilities extend to pharmacotherapy, making frail patients more susceptible to the effects and side effects of medications they take. People with respiratory conditions who are frail are at increased risk of exacerbations of their conditions, and frailty contributes to the increased risk associated with a variety of respiratory viral infections such as influenza, respiratory syncytial virus (RSV) and COVID-19, among others.

Caring for the frail elderly patient

While a small proportion of frail elderly respiratory patients will be under specialist secondary care or integrated teams, many will be cared for in the community setting, including in residential/care homes or in their own homes. The ongoing respiratory health care of these patients therefore should be reviewed by a clinician in the primary care setting with appropriate expertise.

People living with frailty should not be excluded from respiratory research or best-practice interventions, and evidence generation in this group should be prioritised.

Evaluating frailty in the elderly patient

Not all elderly patients are frail. However, for those who are, a holistic approach is necessary to understand the full range of their medical and psychosocial needs, ensuring all treatments and interventions are harmonised. Controlling respiratory symptoms and maintaining quality of life with independence should be a priority.

Repeated falls and incontinence are red flags for the possibility of frailty in elderly patients, as are delirium, memory loss, prolonged immobility and significant polypharmacy.

Consider frailty among elderly patients with respiratory disease, especially those with multiple chronic physical and mental health problems and those with poor concordance with respiratory medication. When frailty is suspected it should be carefully evaluated and documented. This may often require several consultations and potentially involve a number of people including the patient's usual carer and other healthcare professionals. The key to success lies in the coordination between all healthcare professionals involved in the patient's care and social care. Multi-professional teams (MPTs) are ideal for addressing these issues but are often difficult to achieve. Having a single healthcare professional as the patient's key contact and advocate may be the solution, and primary care is ideally placed for this. During and following the review, further pharmacological prescribing or indeed deprescribing redundant or medications of limited benefit that might worsen symptoms may be needed. Psychological, social and physical therapy or secondary care interventions should be assessed, communicated and documented. Particular attention should be focused on medications with anticholinergic side effects which are commonly prescribed and can have significant side effects such as constipation, urinary retention and infections, falls, etc. Many commonly prescribed drugs have minimal anticholinergic side effects but, when prescribed in combination, can lead to significant adverse events.

Primary care teams should adopt a comprehensive geriatric assessment (CGA)[3] approach to assessment and care planning, ensuring coordination across medical, functional and social domains. The NICE national guideline (NG56)[4] includes recommendations on how to identify, assess and care for people living with frailty in primary care and community settings. It advises considering one of the following frailty assessment approaches:

- An informal assessment of gait speed (e.g. time taken to answer the door, time taken to walk from the waiting room).
- Self-reported health status (i.e. "How would you rate your health status on a scale from 0 to 10?"), with scores of 6 or less indicating frailty.
- A formal assessment of gait speed, with more than 5 seconds to walk 4 metres indicating frailty.

- The PRISMA-7 questionnaire[5], with scores of 3 and above indicating frailty.

There are several assessment methods to identify and grade frailty levels, with the Rockwood Clinical Frailty Scale[6] being commonly used in the UK (Figure 1).

Frailty in the elderly is often accompanied by loneliness, social isolation, depression and poverty. Additionally, social security benefits for which the patient is eligible may not be claimed. Enlisting the support of family members, social services and local charities such as Age UK may help to address these problems. Consider social prescribing and referral to a local link worker.

It should be remembered that most patients will need appropriate reassessment as their condition changes over time – and this assessment is not a one-off intervention but should be reviewed at every opportunity, taking into account changes in the patient's physical, social and psychological circumstances.

Home visits are particularly valuable in assessing the problems of frail elderly patients with respiratory conditions. These visits often give an insight into how patients are coping on a day-to-day basis which may be missed when they are seen out of their own houses.

Respiratory care for the frail elderly patient

When caring for frail elderly patients with respiratory conditions it is essential that all available steps are undertaken to optimise their needs beyond the respiratory issues. Potential harm from overdiagnosis and overtreatment should also be considered. Patients with frailty and other comorbidities are at increased risk of not only poor concordance with prescribed treatments but also the medications' effects and interactions, due to pharmacokinetic and pharmacodynamic changes related to polypharmacy and frailty itself.

Figure 1. Clinical Frailty Scale*

1. **Very Fit -** People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. **Well -** People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3. **Managing Well -** People whose **medical problems are well controlled** but are **not regularly active** beyond routine walking.

4. **Vulnerable -** While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5. **Mildly Frail -** These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. **Moderately Frail -** People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7. **Severely Frail - Completely dependent for personal care,** from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within approximately 6 months).

8. **Very Severely Frail - Completely dependent** approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill -** Approaching the end of life. This category applies to people with a **life expectancy <6 months,** who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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So how do we approach a holistic evaluation of the frail elderly patient presenting with respiratory issues?

Confirm the respiratory diagnosis/diagnoses

1. Review the respiratory conditions ensuring the initial diagnosis was correct and factor in the effect of any comorbidities (e.g. ensuring that heart failure is not missed as a potential worsening of breathlessness). This review should be undertaken by a clinician with the expertise and training to complete in a holistic fashion.[7]
2. Provide a holistic review incorporating non-pharmacological interventions and therapy assessments at home (e.g. occupational, dietary, speech and language and physiotherapy). Ensure that referrals to pulmonary rehabilitation, smoking cessation and other services are timely made where appropriate and consider local initiatives supporting activity in comorbid patients, including Asthma & Lung UK Breathe Easy and similar groups.
    a) Pulmonary rehabilitation, including home-based and digitally supported models, should be considered a core intervention to improve physical function and potentially reverse frailty.
    b) Support and facilitate smoking cessation at every opportunity, given its clear benefits for respiratory health and potential to slow or reverse frailty.
    c) Nutrition should be assessed and optimised early, with attention to protein intake, muscle strength and food access.
    d) Psychological wellbeing and social support should be addressed proactively, recognising their strong influence on outcomes and engagement with care.
3. Conduct a comprehensive medication review, ensuring that all prescribed and over-the-counter medications are reviewed in the context of:
    a) Patients, carers and relevant healthcare professionals ideas, concerns and expectations (ICE)[8] and their carers.
    b) Expected treatment benefits versus potential harms, e.g. from repeated oral corticosteroid courses for poorly managed airways diseases (avoid prescribing 'rescue packs' on repeat prescriptions).
    c) Interactions and potential prescribing cascades.
    d) Individual treatment targets, e.g. blood pressure or glucose control in frail/elderly patients, considering the 'start low – go-slow' approach where appropriate.[9]
    e) Ability to use medications: assess patients' swallowing ability, dexterity and inspiratory capacity (ability to use inhalers), cognition, eyesight and other relevant capabilities when designing a treatment regime. Community pharmacists are often best placed to undertake inhaler checks with patients, and clinicians who visit housebound patients should be undertaking these reviews at home.
    f) Ease of concordance: whenever possible the medication regime should fit into the patient's routine and availability of carers, e.g. a once-daily regime (including inhalers) may be preferred in patients with a once-daily package of care; the timing of newer high-intensity statins can be safely changed to morning to align with other medications.
4. Document a clear plan that can be easily accessed, understood and followed by the patient, their carers and healthcare professionals involved in their care.

Medication review tools:

- Quality prescribing strategy for respiratory (Scottish)
- PrescQIPP IMPACT tool (UK)
- STOPP/START criteria
- Deprescribing.org (Canadian)
- Medstopper.org (Canadian)
- Beers Criteria (American)
- BRAN tool (Scotland)

Conclusion

Primary care teams play a central role in supporting people living with both frailty and respiratory disease. Their continuity of care, holistic assessment and understanding of each patient's social and clinical context enable tailored management that goes beyond symptom control.

Recognising frailty early allows clinicians to coordinate medical, psychological and social support, ensuring that interventions are appropriate, proportionate and person-centred. Regularly reviewing respiratory and non-respiratory treatments, optimising nutrition and physical activity, and involving carers and relevant healthcare professionals are all essential to maintaining quality of life and independence.

A structured, yet flexible approach focused on what matters to the individual can reduce treatment burden, minimise harm from polypharmacy and improve outcomes.

PCRS position

In line with national guidance and emerging evidence, the PCRS believes primary care teams are ideally placed to support people living with both frailty and respiratory disease. Primary care practitioners should:

1. Identify and proactively support people living with frailty:
- Systematically identify people living with frailty and respiratory disease using validated tools and population case-finding approaches.
- Anticipate and prevent deterioration through regular monitoring and early intervention.

2. Undertake comprehensive person-centred reviews:
- Confirm respiratory and comorbid diagnoses and establish the patient's goals and priorities for care.
- Involve the patient's usual carer and, where possible, multidisciplinary input (e.g. pharmacist, physiotherapist, occupational therapist, dietitian).

3. Optimise medication and minimise harm:
- Review all medications for indication, benefit and potential harm.
- Consider dexterity, cognition, swallowing ability and inspiratory capacity when selecting or continuing pharmacological treatments.

4. Promote function, independence and wellbeing:
- Encourage physical activity and participation in pulmonary rehabilitation where appropriate.
- Support self-management, nutrition and engagement with community and voluntary sector resources such as Asthma + Lung UK and local social prescribing schemes.

5. Coordinate and communicate care:
- Ensure plans for ongoing care, escalation and end-of-life preferences are documented and shared across the care network.
- Facilitate continuity and integration across health and social care boundaries.

Any unanswered questions/potential research priorities this statement has highlighted?

- Training, particularly in generalists and being able to look at the patient as a whole, rather than just their respiratory issues.

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