Clinical Practice Procedures:
Assessment/Clinical Frailty Scale©

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Date	February, 2021
Purpose	To ensure a consistent procedural approach to the Clinical Frailty Scale©.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
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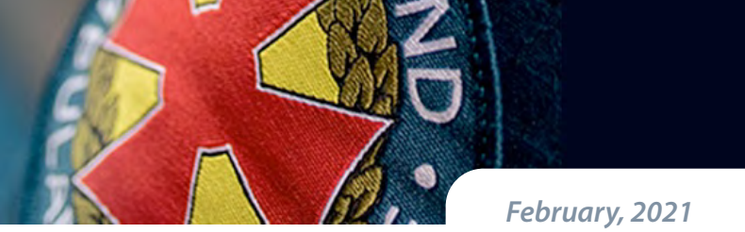
Clinical Frailty Scale©



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Frailty may be defined as a syndrome of physiological decline in later life with increased vulnerability to adverse health outcomes.[1] Frail patients are less able to cope with stressors such as acute illness or trauma compared with younger or non-frail older adults.[2]

Although frailty is associated with increasing age, aging itself does not define frailty. Some people remain vigorous and high functioning despite advanced age, while others experience a gradual, relentless functional decline in the absence of apparent disease or illness or may fail to rebound following illness or hospitalisation.[1,3]

The ability to accurately assess frailty in older adults can have important benefits for patients through better tailored and informed clinical practice and referral to the most appropriate clinical pathways. A variety of frailty measures have been developed and the prevalence of frailty varies with the tools used to define it.[1]

The Clinical Frailty Scale (CFS)© is a rapid screening tool that allows triage or resources to those most at risk of complications and allows the at-risk cohort to be predicted better than by age alone.[1,4] It enables clinicians to quantify frailty through clinical judgement to inform practice.[3] Additionally, it can be used to identify those who might need a more formal comprehensive geriatric assessment.

Clinical Frailty Scale© components:

- Level of **dependence**
- Presence of **terminal illness**
- Presence of **dementia**

Indications [3]

- Patients aged 65 years and over
- Aboriginal and Torres Strait Islander people aged 55 years and over
- Patients younger than 65 years for whom frailty is a potential concern, based on the clinician's observations and reports from patients and their caregivers (clinical judgement must be applied)

Contraindications

- Patients who obviously do not present with signs of frailty (clinical judgement must be applied)

Complications

- Application of the Clinical Frailty Scale© must not be allowed to delay clinical assessment and management of the acute patient.
- Assessment of clinical frailty must be undertaken with due sensitivity and respect for patients and family members at all times.

The CFS© is scored on a scale from 1 (very fit) to 9 (representative of a terminally ill patient). Each score on the CFS© corresponds with a written description of health status and level of functioning, with a visual chart to assist with classification.[3]

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 occassionally**, 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. **MILDY 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 outdoors alone, meal preparation.

6. **MODERATELY FRAIL** – People who 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 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 approx. 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 detail 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 2005:173489-495

Additional information

- Factors associated with increased prevalence of frailty include:[1]
  - Older age
  - Lower educational level
  - Current smokers
  - Unmarried
  - Depression, or use of antidepressants
  - Intellectual disability
- There is increased evidence that dysregulated immune, endocrine, stress, and energy response systems are important to the development of frailty.[1]
- Sarcopenia, the degenerative loss of skeletal muscle mass and strength is a key physiologic component of frailty.[1]
- Frailty is associated with an increased risk of mild cognitive impairment and an increased rate of cognitive decline with aging.