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Using the Clinical Frailty Scale (CFS) in geriatric emergency medicine

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The Clinical Frailty Scale (CFS) uses clinician judgement to quantify the functional impacts of multidimensional health deficits ¹. The CFS has become widely adopted in research and clinical settings and has been recommended in the UK for routine administration with adults aged 65+ with unscheduled hospital attendances.

Frailty screening at ED triage has been recommended for its potential to alter downstream processes and attune care to the individual. The study by Munir Ehrlington et al yields post-implementation evidence for CFS concordance and patient outcomes in typical clinical emergency care ². Pragmatically, the methods and ethics approvals allowed for analysis of anonymous routine data without consent, thus widening the representation of older people living with frailty who are so often excluded from the very research vital to improve their care. It is notable that only approximately half of patients attending during the study period had CFS recorded, reflecting expectedly moderate staff adherence and competing tasks ³. Little is known of the missed attenders, who perhaps had different presentation patterns or who had obviously more or less severe frailty than the included cohort. A sub-study of the Frailty in European Emergency Departments (FEED) project is shortly due to provide such insights on the characteristics of people missed by screening ⁴.

Consideration of frailty alongside physiological vital signs has potential to reduce the underperformance of risk-stratification tools in older people ⁵. While active intervention may seem an appropriate response to an acute problem, having severe underlying frailty remains, for now at least, a largely irreversible situation and consequently there is a need for honed prognostication and decision-making through application of person-centred care principles. If universal prevention of death were to be health services' only aim, then all people with at least severe frailty (CFS 7+) would require resuscitation room care as their in-hospital mortality observed by Munir Ehrlington et al approximated that of sufficiently pathological vital signs (15% in-hospital mortality when NEWS2 \geq 5) to warrant urgent response ⁶. Instead, it serves to identify and orientate care processes around realistic individualised healthcare goals.

Recognition of frailty and the appropriate corresponding enactment of person-centred management might indirectly be reflected in this study through the variability in outcomes observed among people living with terminal illness (CFS 9). These people had mean lengths of stay that were both the shortest in the emergency department and longest in the hospital, while also having the broadest interquartile ranges in these outcomes of any CFS level. While there were perhaps relatively few people with this frailty score, they likely received more person-attuned assessment and decision-making due to identification of their terminal illness, thereby influencing more variable decision-making concerning admission and discharge. Similar variability in CFS 9 outcomes compared to other frailty categories was observed in the FEED study⁴. Perhaps this suggests clinicians are better equipped to deliver person-centred care to people with palliative care sensitive conditions such as metastatic cancer than people living with other frailty trajectories. To confirm or reject the assumption that outcome variability in CFS 9 patients is a proxy for more patient-centred care, exploratory research seems necessary.

These observations expose a current limitation in evidence for the CFS in emergency care. Although in frequent use, the predominant justification for CFS remains its validity for higher mortality, admission rates, and lengths of stay with progressively severe frailty⁷. These outcomes, however, have been shown to lack comprehensive meaningfulness among people living with frailty. This group additionally (or indeed preferentially) seek more personalised healthcare outcomes such as prognostic knowledge and situational security⁸. We now have the situation of using a score to identify people at higher risk of mortality, to then target those individuals with interventions which have low probability to change the risk of mortality⁹. Adopting this altered stance when caring for people living with frailty seems entirely appropriate, but how should we determine the impact on patients of using such a score? There has been only minimal evaluation of the CFS in emergency care with such patient-reported outcome measures (PROMs)¹⁰. Further CFS validation against meaningful outcomes using PROMs now seems necessary.

A strong evidence base has been accumulated for initial applications of the CFS in emergency care settings. The resulting experiences and learning must now be shared and explored further to understand how to use the measure for ensuring optimal patient-centred care. A first important reflection in this endeavour would be that pre-morbid vulnerability, as quantified by the CFS, remains a feature already present before the need for emergency care. This implies responsibility upon not only receiving but also referring clinicians to assess frailty and determine the values and aims of emergency care.

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