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Frailty screening in the emergency department: why does it matter?

Among acutely unwell older people, frailty changes everything. Older people living with frailty have higher mortality, longer admissions, and more frequent readmissions than people without [1]. Their outcome goals may be more oriented around empowerment and security than survival and longevity [2]. During acute crises, such goals are often not attained, and experiences are poor as emergency departments are often not set up to accommodate the care needs inherent with frailty [3].

Older people living with frailty need a different approach to emergency care. By definition, they have multiple and often compounding functional, medical, psychological, and social problems [4]. Streaming protocols and treatment pathways designed to encourage rapid flow of single-issue presentations therefore poorly serve people with frailty, missing their bigger picture and restricting the focus of care. Instead, frailty demands wider appraisal of the person and their situation through a more holistic lens [5]. Such comprehensive attention to needs is the cornerstone of geriatric emergency medicine, the practice of which requires assimilated competences of the parent specialties including prognostication, tolerance of uncertainty, and goal-oriented evaluation [6]. These skills are a limited resource and as such we must identify those people living with frailty so that they can be prioritised for targeted geriatric emergency care.

Acute hospitals are areas of high frailty concentration, as the 12-24% of communities' older population living with frailty are more likely to require emergency care and be admitted. Across Europe, 40% of older attenders to emergency care have frailty (representing one seventh of all adult attenders) [FEED study, accepted Eur Geriatr Med]. However, approaches to identifying and acting upon frailty are highly variable. Even in the UK National Health Service where emergency care administration of the Clinical Frailty Scale is mandated, access to acute geriatrics services is often operationalised using site-specific definitions based on age thresholds, receipt of community care, manifestation of 'geriatric giants', or alternative frailty scores.

The Delphi study by Moloney et al aimed to identify key features of a frailty score for use in the emergency department. The study included a range of international participants from relevant backgrounds including emergency medicine, geriatric medicine, nursing, and social care. The unique setting of the emergency department presents challenges to assessing older patients for frailty including limitations on times, space, and resource and this study was conducted with participants having fundamental understanding of these. The research provides credible guidance for the components, timing, and practicalities of emergency department frailty screening. Firm consensus was reached on statements recommending that frailty be screened early during attendance, that screening consider the person's baseline before the current illness, and that the finding be acted upon within the emergency department to trigger individualised interventions.

Actions following identification of frailty might include broadening the ED assessment with multidisciplinary involvement, perhaps engaging relatives, therapists, and pharmacy perspectives in consultation and decision-making with the person [7]. Frailty recognition might initiate entirely different care routes within the hospital, availing the resources of geriatrics services for those most likely to benefit. Awareness of frailty could prompt realistic discussions about health trajectory and inform honest conversations about goals of care [8]. This, in turn, may enable more cognisant decisions about anticipated benefits and risks of investigation and hospitalisation, leading to reductions in overdiagnosis and admission and perhaps avoiding hospital-associated harms foreseeably affecting older people [9]. For this to happen, professionals of all seniority must be educated and engaged in recognising and acting upon frailty, so that screening is not just implemented but actively embedded into good care.

Controversy remains over the optimal frailty score or measure for use in emergency departments. The five domains of the comprehensive geriatric assessment model were all found to warrant inclusion in frailty screening instruments. The Clinical Frailty Scale (CFS) is well-validated and very widely used but considers the overall impact on the person of their domain deficits rather than seeking to quantify, for example, the number of medications they use [10, 11]. By these standards, the CFS could be considered imperfect, yet Moloney et al also found agreement with the pragmatic notion that having something feasible trumps seeking something ideal. Research to date has generally aimed to validate the CFS using service metrics such as mortality and admission rates [12]. This Delphi study, though, reiterated rejection of the view that these are the most important outcomes. There is only limited emergency care evidence for poorer patient-reported measures with more severe frailty [13]; further person-centred validation of the CFS seems necessary.

So, we now have good guidance regarding the principles, logistics, and domains of frailty screening. Conventionally this has been directed at older people, and indeed the validity of the CFS is in people aged 65+. However, post-implementation studies have typically reported screening concordance of only around 50%, and with researchers increasingly using routinely entered data there is a need to understand and improve that figure. Further exploratory research is also needed on approaches to identifying younger people with frailty. As well as who to *screen*, what about who to *tell*? Frailty is not a short-term situation, and its implications extend beyond the emergency department. We need administration and communication solutions that can communicate new identification of frailty to community and hospital specialists and care teams so that the need for a more individualised approach can be appreciated.

Early emergency department frailty screening changes everything. If implemented at the triage stage, then people without frailty can be confidently streamed through rapid flow pathways for management of their current problem. People with frailty can receive prompt goal-oriented assessment and management of their wider situation and may be protected from unnecessary and unwanted intervention. The processes followed and the outcomes influenced should be different for these groups. Healthcare services need to adapt accordingly in perspective and stance.

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