

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.

Always record score on paper documentation and on computer based systems. Record Clinical Frailty Scale on admission and discharge and communicate with GP

Suggested actions for patients with frailty score 1-4

- Referral to local Wellbeing Services

Suggested actions for patients with frailty score 5-6

Clinical Assessments:

- Undertake a medication review.
- Aspirin, warfarin, opiates, anti-cholinergics, antidepressants, ACE inhibitors and anti-hypertensives should be used with caution Stop medications if indicated.
- Start any new medication at low dose with very gradual increments
- Consider need for calcium/vitamin D if housebound
- Avoid over treating hypertension and diabetes

Risk Assessment and Care Planning:

- Use advanced care plan when applying disease-based guidelines e.g. for diabetes, hypertension and CKD, dementia etc. outlining treatment goals/wishes with supporting anticipatory care plans for urgent care
- Consider the patient’s preference for end of life and complete a DNACPR from if appropriate.
- Screen for falls, check for postural hypotension and reduce medications accordingly. Refer to NCH&C if required.
- Assess nutritional status and skin integrity

Ongoing referral:

- Refer to community matron if 3 or more long-term conditions
- Discuss with HCP or at next planned MDT or as part of yearly review
- Consider referral to geriatric medicine if significant complexity, diagnostic uncertainty or challenging symptom control
- Consider referral to Old Age Psychiatry if complex cognitive or behavioural problems
- Consider whether the right social care is in place considering carers support, signposting to other support services
- Ensure good network and carer support



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 ~ 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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Suggested actions for patients with frailty score 7-9

Clinical Assessments:

- Undertake a medication review.
- Aspirin, warfarin, opiates, anti-cholinergics, antidepressants, ACE inhibitors and anti-hypertensives should be used with caution Stop medications if indicated.
- Start any new medication at low dose with very gradual increments
- Consider need for calcium/vitamin D if housebound
- Avoid over treating hypertension and diabetes

Risk Assessment and Care Planning:

- Use advanced care plan when applying disease-based guidelines e.g. for diabetes, hypertension and CKD, dementia etc. outlining treatment goals/wishes with supporting anticipatory care plans for urgent care
- Discuss the patient’s preference for end of life and complete a DNACPR from if appropriate. Anticipatory care plans as part of advanced care planning
- Screen for falls and refer to NCH&C if required
- Check for postural hypotension if falling
- Ask about memory problems and refer on if indicated

Ongoing referral:

- Consider whether the right social care is in place considering carers support, signposting
- Refer to community matron if 3 or more long-term conditions
- Consider referral to geriatric medicine if significant complexity, diagnostic uncertainty or challenging symptom control
- Consider referral to Old Age Psychiatry if complex cognitive or behavioural problems
- Consider entering patient onto the GSF register
- GP practice to deliver a clinical review providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions.