

The Clinical Frailty Scale – Overview for Training

Frailty is a state of increased risk. Like the risk of dying, on average, frailty increases with age. People are frail when they have more things wrong with them than do others of the same age. That might not seem like a big deal, but it's a real challenge for how we deliver health care now. Our tremendous success in treating one illness at a time makes us think that is how people should get ill. As our population ages though, because frailty and age go together, many of our patients have many things wrong, all at once. That's the challenge. By understanding frailty, and changing to meet the needs of people who live with it, we can face that challenge.

The key idea behind the **Clinical Frailty Scale (CFS)** is that as people age they are more likely to have things wrong with them. Those things they have wrong can erode their ability to do the high order functions which define their overall health. These high order functions are being able to: think and do as they please; look after themselves; interact with other people; and move about without falling. Each of those functions can become impaired due to a single cause – for example, someone who might not be able to walk could find themselves in that state because of a stroke, or a broken hip, or arthritis, or heart disease, or difficulty with their lungs. Many older people, though, have all of these things wrong. Treating just one, because it's the “real” cause, might fix that illness but it won't allow them to walk better again. To do this you need to treat everything that impairs their walking. As with problems walking, the older someone is, the more likely they are to have accumulated several health problems that can contribute to their not being able to move, think, care for themselves or engage with others. For that reason, we need to be able to bring that information together in one place. That's what the Clinical Frailty Scale is for.

The Clinical Frailty Scale was developed in Halifax, Nova Scotia in the 1990s and is now used in more than 20 countries. It is employed both in routine clinical care and in research. The CFS robustly predicts a variety of outcomes, including death. In a recent study of Emergency Department patients, we found that mortality rates were higher among people with higher levels of frailty, especially when their illness was severe. For example, among mildly frail patients (CFS 5), 9% of the patients with low illness severity and 14% of those with high illness severity died within 30 days. Among very severely frail patients (CFS 8), 33% of the patients with low illness severity and 53% of those with high illness severity died within 30 days. Of those who survived 30 days, half again were dead by six months. Compared to well patients (CFS 1-4) who were not severely ill, the chance of dying within 30 days was more than 20 times higher for severely frail patients (CFS 7-9) with high illness acuity.

For those interested in administering the CFS for clinical or research purposes, please see the accompanying 2-page CFS training guide entitled: “Using the Clinical Frailty Scale to Rapidly Assay Grades of Fitness and Frailty”.

In addition, the AIMS Research Group at the Ottawa Hospital has developed a [Clinical Frailty Scale \(CFS\) Training Module](#) that is freely accessible online that is useful in learning to administer the CFS.