Using the Clinical Frailty Scale to
Rapidly Assay Grades of Fitness and Frailty in Long Term Care

The Clinical Frailty Scale (CFS) is an inclusive 9-point scale introduced to summarize the overall level of fitness or frailty of an older adult after they have been evaluated by a clinician. The CFS is scored so that higher scores mean greater risk. It is not a questionnaire, but a judgement-based tool to screen for frailty and to broadly stratify degrees of fitness and frailty.

The CFS focuses on a few items that can be readily observed without special training. The items should be stable to not become confused with features of health that have changed recently and that might be rehabilitated. This is especially true in clinical settings where changes in how healthy someone appears can change dramatically. For example, when older people are ill enough to come to the Emergency Department, even people who have been fit can appear frail.

The CFS can be used in community-dwelling older adults or in those in long term care. **It is not designed for young people, whose disabilities often reflect single-system problems, not a gradual accumulation of many health deficits with age**. Another important distinction in long term care is that for the great majority of residents, the care staff already a have a good understanding of that person's typical (baseline) health. It is appropriate to ask residents how they feel, but the CFS is not a questionnaire about an individual's opinion of their health. It is based on the clinical judgment of health care professionals about the health state of the person for whom they are caring. (Here a health care professional is defined as anyone with a license or registration – e.g. MD, RN, LPN, OT, PT, SW, psychologist.) Like care of older adults in general, it's a team game. Even so, as many aspects of care are best known by the care staff, wherever possible information from them should be gathered. Clinical judgment appropriate to the rater's background and training is expected.

Wherever it is used, the focus is on establishing the baseline health state - what the person was like before they were ill (i.e. two weeks ago). Understanding their baseline is essential for planning for their care. In those cases where the resident is new to the team, you can ask an informant so as to gain the best understanding to supplement what you are observing. The CFS is introduced by saying something like: "I'd like to know about how you are [your dad is] doing overall." We then ask about four features: *how the person moved, functioned, thought and felt about their health over the last two weeks*. In nursing homes, the full range of the scale would not be used. The lowest level indicates the greatest fitness / least frailty. To get the full picture of the scale, and perhaps for some residents in Residential Care Facilities, the CFS score for people who regularly do vigorous physical activity would be **Level 1 – Very Fit**. The same profile, with regular but less frequent or less vigorous activity would be scored as **Level 2 - Well**. Another person who fits the broad description, but who uses few medications (less than seven) and is otherwise asymptomatic, would also be scored based on their degree of physical activity. If their symptoms were mostly controlled, but not entirely so, they would be scored as **Level 3 – Managing Well**. Likewise, a person who required treatment as part of ongoing symptomatic management would be scored as **Level 3 - Managing Well**, as long as their symptoms did not limit activities, in which case they would be scored as **Level 4 - Vulnerable**.

For levels 4 to 7, **mobility**, **function** and **cognition** are key. Each reflect high-order aspects of health: they integrate a lot of information. This means that there are many ways to have mobility problems, for example: a sprained ankle, diabetic nerve damage, dehydration, heart failure, kidney damage or pneumonia. In consequence, these key domains are sensitive signs of health but are not very specific. It is the combination of impaired function and impaired mobility, which are commonly accompanied by several illnesses, that make it likely that someone is frail.

Level 4 - Vulnerable is characterized by the person who, although not totally dependent, seems at risk. Incomplete symptom control and a reduction in demanding activities, such as heavy housework, lifting, or climbing more than a flight of stairs are useful signs. Although these activities might still be attempted, often they are not done as well or as often. Many people at this stage simply do not feel all that well, and might complain of being "slowed up". When asked, "Compared to others of your own age, how would you rate your health?", they will usually rate their health as fair or poor.

Levels 5 to 8 relate to changes in function**. Almost all nursing home residents will have a score of at least 5**. Varying degrees of dependence in instrumental ADLs define **Level 5 – Mildly Frail**. At this level, typically, there is no more pretence of doing heavy housework or the like – items that began to be impaired in Level 4. A person doesn't need to be dependent in all demanding activities to qualify as Level 4, nor in all aspects of Instrumental ADLs to qualify as Level 5. We are interested in change: someone who never did the banking would not now be scored as dependent in that. With **Level 6 – Moderately Frail**, dependence now extends past instrumental ADLs to intermediate ones, notably including bathing. Often at this level, minimal assistance with personal care might be needed. In **Level 7 – Severely Frail** there is progressive dependence in personal ADLs. People do not need to be dependent in every aspect of personal care to be scored as Level 7. When assessing functional dependence in intermediate (Level 6) and personal (Level 7) ADLs, lifelong habit is a less relevant consideration: most everyone needs to bathe, groom and use the toilet.

Level 8 – Very Severe Frailty is the not uncommon state in which a frail person takes to bed, often for weeks, prior to dying. This is either heralded by an identifiable episode, such as an infection, or the person just slips away, commonly after some days of reduced oral intake. Very severely frail people who die without a single apparent cause typically follow such a trajectory, commonly without much pain or even distress; often with the exception of impaired bowel function, even without opiates. **Level 9 – Terminally Ill** is the only level in which the current state trumps the baseline state, in that the terminally ill person might have been operating at various frailty levels at baseline. The person is pictured seated in a chair. Many older adults who are dying with single system illness – notably cancer – have a reasonable level of function until about the very end, and that is why we portray the situation in that way. Even so, if a terminally ill person was bedfast, they would still be scored as Level 9.

Within each level, individuals will vary. About 80% or more of people will fit the description offered for a given level. If they fit two categories equally well, it is best to score the scale at the higher or more dependent level.