# Developing the use of the Clinical Frailty Scale in the Emergency Department as a triage tool for the Frailty Intervention Team

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## Introduction

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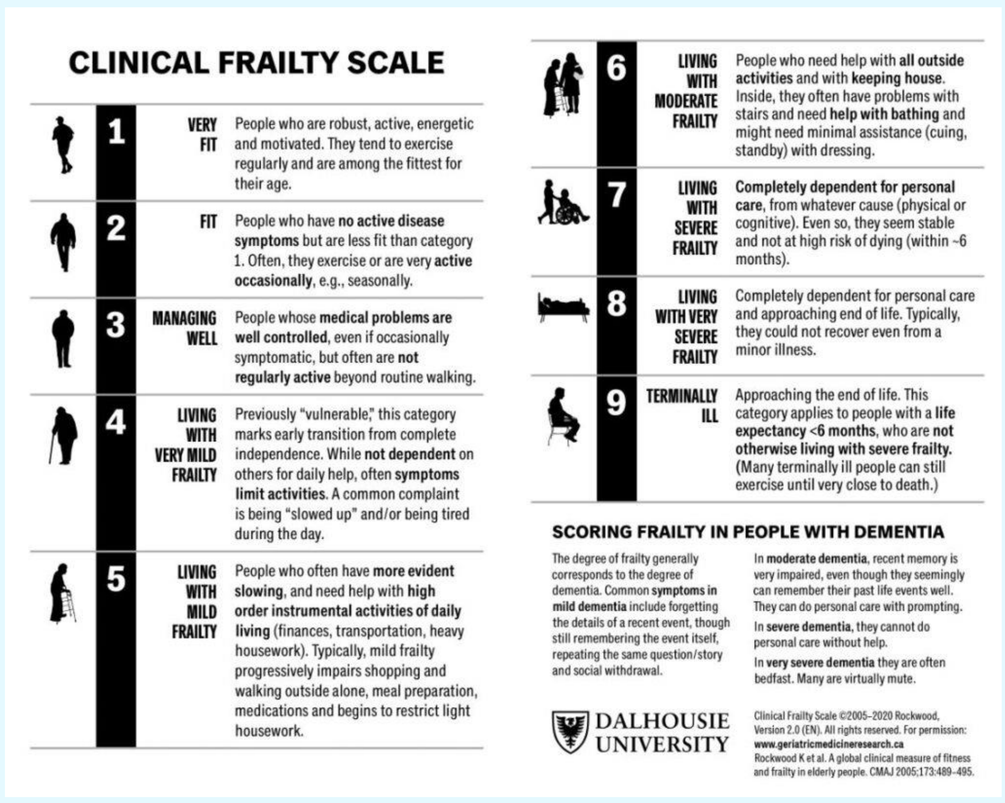
"Getting it Right First Time – Geriatric Medicine"[1] recommends the Clinical Frailty Scale (CFS)[2] (Figure 1)should be completed in patients aged 75+ on arrival in the Emergency Department (ED). Frailty services should focus on patients with a score of 5 or 6. The CFS has been shown to be easily completed in ED, however completion was variable. Completion rates range from 2.2%-100%[3]. Audits and studies suggest that CFS completed at triage under score patients by around 42%[4], with only 45-51% of patients living with moderate frailty or worse being identified as such[5]

Figure 1 – The Clinical Frailty Scale




## Service Development

The CFS was embedded into the Electronic Patient Record (EPR), as part of the Manchester Triage Tool (MTT) at the Royal Lancaster Infirmary in 2020. At about the same time a 4 week trial of an Emergency Department based acute frailty service took place, called the Frailty Intervention Team (FIT). During the trial it was noted that the completion of the MTT CFS was often not filled in, and when completed was often inaccurate.

In December 2021 FIT began formally and it was decided that rather than use the CFS for identifying appropriate patients that it would be based on age (75+) and a review of the ED notes to see if there was a possibility of same day discharge.

At the same time the FIT Advanced Care Practitioners (ACP) liaised with the ED triage nurses to train them how to use the CFS.

In September 2024 FIT were given dedicated space to work and so developed this as a FIT Same Day Emergency Care (FIT SDEC) zone. This was seen as an opportunity to align the service with GIRFT and see patients based on a combination of age and MTT-CFS of 4+

## References

(1)Hopper A (2021) Geriatric Medicine: Getting it Right First Time. GIRFT

(2) Rockwood K, Song X, Macknight C, Bergman H et al (2005) A global clinical measure of fitness and frailty in elderly people, CMJA 173(5) pp489-495

(3) Hörlin, E., Munir Ehrlington, S., Toll John, R. *et al.* Is the clinical frailty scale feasible to use in an emergency department setting? A mixed methods study. *BMC Emerg Med* 23, 124 (2023).

(4) Ghaffari E, Collier A, Carrick J, Brebnchley C et al (2023) Frailty Score (CFS) documentation at the Emergency Department of a tertiary NHS hospital. Poster BGS Autumn Conference

(5) Cosimetti A, Zhang Y, Montagu A (2024) Improving the identification of frailty in the emergency department. BGS Poster, Frailty and Urgent care Meeting

## Further Information

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## Methods

The numbers of patients assessed by ED between 1/4/2024 and 8/9/2024 were analysed along with whether they had the CFS measured and what the MTT-CFS was.

The change of service to FIT-SDEC commenced on 9/9/20 and so the same data were assessed between 9/9/2024 and 29/1/2025.

All patients who were seen by FIT in July 2024 were reviewed and the MMT-CFS recorded alongside the CFS as assessed by FIT (FIT-CFS) and the scores assessed by contingency tables and the Mann Whitney U test

A similar assessment was carried out for patients seen by FIT between 1/12/2024 and 15/12/2024

## Results

In the period of 1/4/2024-8/9/24 there were an average of 35.64 patients aged 75+ seen in the ED. Each day a mean of 32.41 MTT-CFS forms were completed (91% completion rate). Of these 11.24 a day scored 1-3 (35%) and 21.2 a day scoring 4+ (65%)

For the period 9/9/2024-29/1/2025 the ,mean daily attendance to ED for patients aged 75+ was 38.06, with 36.51 having the MTT-CFS completed (96%). Of those assessed for MTT-CFS 8.97 had a score of 1-3 (25%), and 27.57 scoring 4+ (75%)

In both the pre FIT-SDEC samples and the post FIT-SDEC samples both the rate of completion of MMT-CFS and the proportion scoring 4+ increased following FIT-SDEC commencing ($p<0.001$ by Chi square in both cases)

In July the MTT-CFS were compared to FIT-CFS using Mann Whitney U, which showed a strongly significant difference between the 2 populations ($p<0.00001$), with FIT-CFS being scored higher, Comparing the MTT-CFS scores with the FIT-CFS scores in the December sample once again showed a significant difference (*p*-value is .00014) with the FIT-CFS scoring higher.

In the detailed July sample there were 235 patients reviewed by FIT, however only 210 had both MTT-CFS and FIT CFS together. 21.9% of the time the MTT-CFS and FIT-CFS were equal. 67.1% of patients had a higher FIT-CFS than MTT-CFS. 11% of patients had a higher MTT-CFS than FIT-CFS.

To assess whether the MTTCFS could be used to identy patients with CFS 5+ for FIT-SDEC we carried our a Chi suqred test and found that both for CFS 4+ and CFS5+ the MTT and FIT scores were statistically different ($p<0.0001$ in both cases) with FIT-CFS scores being higher. It was then decided to compare MMT-CFS 4+ with the FIT-CFS 5+ group. Here there was no statistical difference ($p=0.2465$)

## Conclusions

- Initial comparisons of the CFS scores in ED and by frailty specialists showed that ED tend to score lower
- A combination of education and probably a perceived need to score more accurately to feed patients appropriately into frailty services improved both the rate of CFS completion and the numbers being rated as frail
- Despite the Triage scores and frailty scores for CFS being statistically different the comparison of MMT-CFS 4+ with the FIT-CFS 5+ samples suggests that a pragmatic approach to capturing most CFS 5+ by the frailty services is to accept MTT-CFS of 4+
- Further work is needed to assess the MTT-CFS scores of patients that FIT do not see