Clinical Frailty Scale Assessment in Urology Emergency Patients: How Are We Doing?

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INTRODUCTION

Frailty affects at least 1.5 million people aged over 65 years in the UK[1] with 44% of all acute hospital admissions over 65 years living with a degree of frailty pre-admission.[2] The Clinical Frailty Scale (CFS) is a validated frailty assessment tool (see Figure 1), that is recommended nationally by the GIRFT guidelines for all emergency admissions over 65.[3]

Admission frailty assessment is important for surgical patients as a CFS ≥4 is independently associated with increased post-operative complications, delirium and mortality.[5] However, from personal observation, CFS assessment on admission is not always incorporated into routine clinical practice.

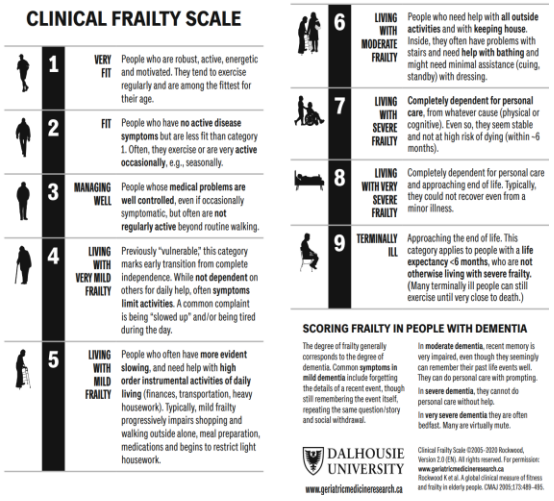

Figure 1: Rockwood Clinical Frailty Score (CFS) recommended for frailty assessment in all acute admissions over 65 by the GIRFT guideline[4]

METHODS

- Registered with clinical governance.
- Baseline audit conducted for January 2026
  - Inclusion criteria: All Emergency urology admissions aged over 65 years
  - Electronic clerking documentation was retrospectively reviewed for age, CFS score and social history documentation.
- Intervention:
  - Teaching programme with sessions on frailty assessment and post-operative medical complications
  - Given to surgical resident doctors
  - Case-based training on how to use the free Clinical Frailty Score smartphone app.
  - Re-audited in March 2026 using the same methodology

RESULTS

In January 2026, there were 54 of admissions over the age of 65 which represented 53% of total admissions for the month. Six (11%) of the admissions over 65 years had a documented CFS score and 20 (37%) had a documented social history. Of the 6 patients with a documented CFS score, 4 (67%) had a CFS score ≥4. The median frailty score was 5.5 (Interquartile Range 2-6).

Post-intervention in March 2026, there were 80 admissions over 65 years. CFS documentation on admission increased to 30 (38%). Social history documentation increased to 42 (53%) of admissions. Of the 30 patients with a documented CFS, 17 (57%) had a CFS ≥4, with a median CFS score of 4 (Interquartile Range 3-5).

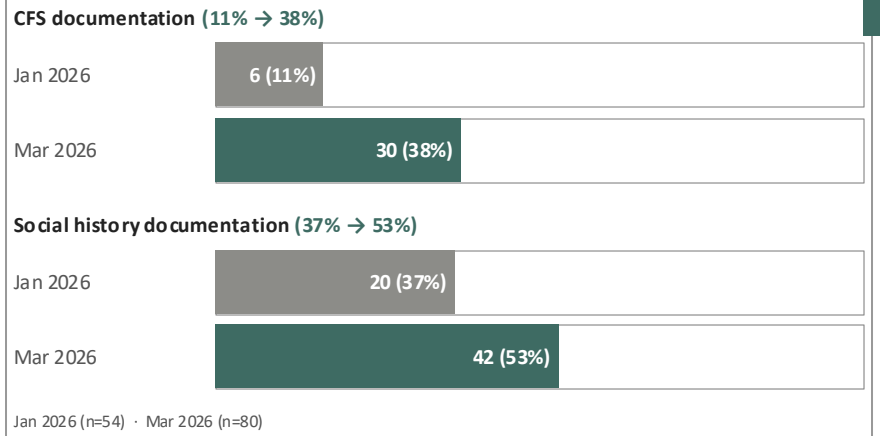

Figure 2: Bar chart showing rates of CFS documentation and social history documentation on admission in January 2026 and post-intervention in March 2026.

DISCUSSION

A departmental teaching programme increased CFS documentation on admission three-fold. The results of this QIP add to the evidence that departmental teaching can improve CFS documentation for surgical patients.[6] Additionally, social history documentation increased to over 53% post-intervention. The majority of both cohorts when assessed for frailty had a CFS score ≥4, suggesting that emergency urology patients are a frail population. Despite this improvement, CFS documentation still remained well below the 100% target and did not become part of routine clinical practice, meaning that current CFS data is likely affected by selection bias, and further improvement in CFS documentation is required in order to ensure these conclusions are accurate.

One limitation of a teaching programme is that attendance can be limited due to leave and on-call commitments, and not every resident doctors was able to attend a session. Moreover, rotational training programmes for resident doctors meant the current cohort who attended the training rotated through after this re-audit, limiting its long-term effectiveness as a measure for increasing CFS documentation. This is why for a second cycle, the focus will shift to standardise the use of a newer clerking proforma that has a CFS score automatically included in the form.

CONCLUSION

- A departmental teaching programme more than tripled CFS documentation (11%→38%).
- Social history documentation improved post-intervention (37%→53%).
- A high proportion of those assessed had CFS ≥4, suggesting this cohort could be meaningfully frail
- Documentation remains well below the national target of 100%.[2]

LEARNING POINTS

- Teaching programme is a cost-effective method for improving CFS documentation
- Limited as part of a long-term strategy to improve CFS documentation due to rotational nature of resident doctor training
- Despite running multiple sessions, reality of on-call and ward commitments still limited the effectiveness of the project

FUTURE ACTIONS

Use of standardised clerking proforma that mandates CFS assessment on admission, to close the remaining gap to 100%.

1. National Audit Office. Primary and community healthcare support for people living with frailty. HC session 2024–2026. London: NAO; Dec 2025.
2. O'Caoimh, Rónán, Laura Morrison, Maria Costello, 2024. "Frailty in an Adult Acute Hospital Population : Predictors, Prevalence, and Outcomes" *International Journal of Environmental Research and Public Health* 21, no. 3: 273. https://doi.org/10.3390/ijerph21030273
3. NHS England & NHS Improvement. Same Day Emergency Care: Acute Frailty Services. London: NHS England; 2019 (updated 2021).
4. Dalhousie University. (2020). *Clinical Frailty Scale (CFS)*. Geriatric Medicine Research (Permission Granted). https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html
5. Youssef S, Chekroud A, Shukla A, Rao M. Frailty is Associated With Poor Outcomes Following Emergency Laparotomy: What's Next? Cureus. 2022;14(7):e27071
6. A Bennett, R Meakins, P Moseley et al. 2025. *Improving Clinical Frailty Scale documentation in surgical admissions of older patients: A Quality Improvement Project*. British Geriatrics Society. https://doi.org/10.83033/8616CBB3-2FF5-4ECD-9AA1-09FFBE22BC8B

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