

ClinicalEdu

Frailty & Clinical Frailty Scale

Learner Handbook - core reading for the ten-module ClinicalEdu course

Version	1.0 - Production Pass 1A
Status	Authoring baseline - not yet public release
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Evidence review date	16 September 2026
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About this handbook

This handbook supports the browser-based ClinicalEdu course. It contains the core reading but not every interactive case, formative question or assessment item. The website remains the primary learning environment because it records progress, delivers feedback and supports reflection.

Important: Frailty tools support clinical assessment; they do not replace diagnosis, Comprehensive Geriatric Assessment, consent, capacity assessment or individualised treatment decisions. Local policy and current authoritative guidance should be checked for time-sensitive decisions.

How to use it

- Read the corresponding chapter before or after each web module.
- Use the “Practice points” to prepare for module questions.
- Follow links to official tools rather than relying on screenshots or copied versions.
- Record questions and reflections in your ClinicalEdu CPD Diary.

Course overview

Module 1: Understanding frailty

Define frailty as a state of reduced reserve and increased vulnerability rather than as chronological age.

Module 2: Recognising frailty in clinical practice

Recognise common frailty syndromes and atypical presentations.

Module 3: Frailty identification tools: choosing the right instrument

Differentiate population case-finding, diagnostic confirmation, bedside judgement, physical performance and multidomain assessment.

Module 4: Clinical Frailty Scale: foundations, purpose and limits

Describe the intended role of the CFS as a judgement-based summary of overall fitness/frailty.

Module 5: CFS levels and clinical meaning: reasoning across the continuum

Understand that adjacent CFS levels reflect meaningful differences in usual function and dependence.

Module 6: Scoring the CFS correctly: baseline, collateral and acute illness

Anchor CFS scoring to the appropriate pre-acute baseline.

Module 7: CFS case laboratory: applying judgement under uncertainty

Apply CFS reasoning to realistic cases with incomplete or conflicting information.

Module 8: Managing frailty: from identification to intervention

Translate frailty recognition into an individualised management plan.

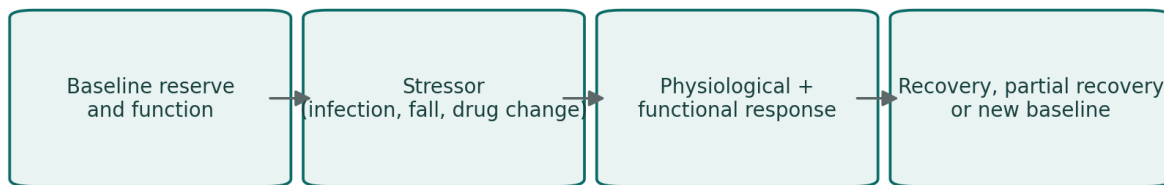
Module 9: Frailty services and pathways: designing care around the person

Describe core principles of effective frailty pathways across acute, community and care-home settings.

Module 10: Complex frailty and decision-making: proportionality, goals and uncertainty

Use frailty as one component of complex clinical decision-making rather than a deterministic rule.

1. Understanding frailty



Frailty becomes clinically visible when limited reserve meets a stressor. The response and recovery trajectory matter.

Learning outcomes

- Define frailty as a state of reduced reserve and increased vulnerability rather than as chronological age.
- Distinguish frailty from disability, multimorbidity, sarcopenia and ordinary ageing.
- Compare phenotype, deficit-accumulation and clinical-judgement approaches without treating them as interchangeable.
- Explain why apparently minor stressors can produce disproportionate deterioration in a person living with frailty.

Why this module matters

Frailty is often recognised only after a crisis, yet the word is easily misused. Calling every older person 'frail' strips the term of clinical meaning; refusing to use the concept because definitions differ loses a useful way of recognising vulnerability. The practical starting point is reserve. A person with substantial physiological and functional reserve can absorb infection, medication change, surgery or a fall with relatively little disruption. A person living with frailty may experience a much larger fall in function from the same stressor and may recover slowly or incompletely.

Frailty is not simply age

Age increases the prevalence of frailty but does not define it. People of the same chronological age can have very different mobility, cognition, independence, symptom burden and capacity to recover from stressors. The course therefore uses person-first language - 'a person living with frailty' - and asks what the person could do before the current problem, what has changed, and what matters to them.

Three useful conceptual lenses

The physical frailty phenotype describes a syndrome using observable characteristics such as weakness, slowness, low activity and exhaustion. Deficit-accumulation models quantify the proportion of health deficits present across many domains. Clinical judgement tools summarise the

overall picture after history and assessment. These approaches overlap but answer different questions. ClinicalEdu will teach learners to identify the task before choosing a tool.

Frailty, disability and multimorbidity

Disability describes difficulty or dependence in activities. Multimorbidity describes the coexistence of health conditions. Frailty describes vulnerability arising from reduced reserve across systems. They frequently coexist, but none is an automatic synonym for another. A person may have multiple stable conditions yet remain independent and resilient; another may have relatively few diagnoses but marked vulnerability and slow recovery.

The stressor-response model

Frailty becomes especially visible when a stressor occurs. Infection, dehydration, constipation, pain, a new sedative, a move of environment, or a minor procedure can trigger delirium, falls, immobility or loss of independence. The clinical task is not only to treat the trigger but to understand the pre-illness baseline, prevent avoidable deconditioning and support recovery toward meaningful goals.

Clinical reasoning checkpoint

Before using any frailty score, ask: What decision am I trying to inform? What was the person's baseline? Is the person acutely unwell? Am I measuring vulnerability, function, prognosis, or service need? What additional assessment will follow the label?

Practice point: Equating frailty with old age, disability or a long problem list. The course should repeatedly correct this because it leads to stereotyping and poor tool selection.

Pause and reflect

Think of a recent clinical encounter in which baseline function, collateral history or treatment burden mattered. What information would you collect differently after this module? Do not record identifiable patient information.

2. Recognising frailty in clinical practice

Learning outcomes

- Recognise common frailty syndromes and atypical presentations.
- Use baseline function and trajectory to distinguish chronic vulnerability from acute deterioration.
- Identify reversible contributors that may masquerade as “just frailty”.
- Know when recognition of frailty should trigger broader assessment or CGA.

Frailty often presents indirectly

People living with frailty may not present with a neat disease-specific symptom. Falls, sudden immobility, delirium, incontinence, reduced oral intake, medication problems or an unexplained loss of confidence can be the first visible sign of an acute illness superimposed on limited reserve. These syndromes should prompt a search for triggers as well as an assessment of baseline function.

Think in trajectories, not snapshots

A single observation can mislead. A person who needs two staff to transfer during pneumonia may normally walk independently. Another person who appears comfortable in bed may already have severe baseline dependence. Recognition therefore depends on change over time: what could the person do two weeks ago, three months ago, and a year ago; what has changed; and is the current change potentially reversible?

Reversible contributors

Pain, constipation, urinary retention, dehydration, infection, hypoxia, medication adverse effects, sleep disruption, sensory impairment and environmental change can all worsen mobility or cognition. Frailty increases vulnerability to these factors; it does not make them untreatable or inevitable. 'Frail' must never become a diagnostic stop sign.

Collateral history

When cognition, delirium, fatigue or communication difficulty limit self-report, collateral information becomes part of good clinical assessment. Family, carers, community teams, previous therapy notes, primary-care records and medication histories can clarify usual mobility, personal care, instrumental activities, cognition and recent trajectory.

Frailty syndromes as prompts

Falls, delirium, immobility, incontinence and susceptibility to medication adverse effects are often described as frailty syndromes. The educational value is not the label itself but the recognition that apparently separate problems may share underlying vulnerability and require multidomain assessment.

When to move to CGA

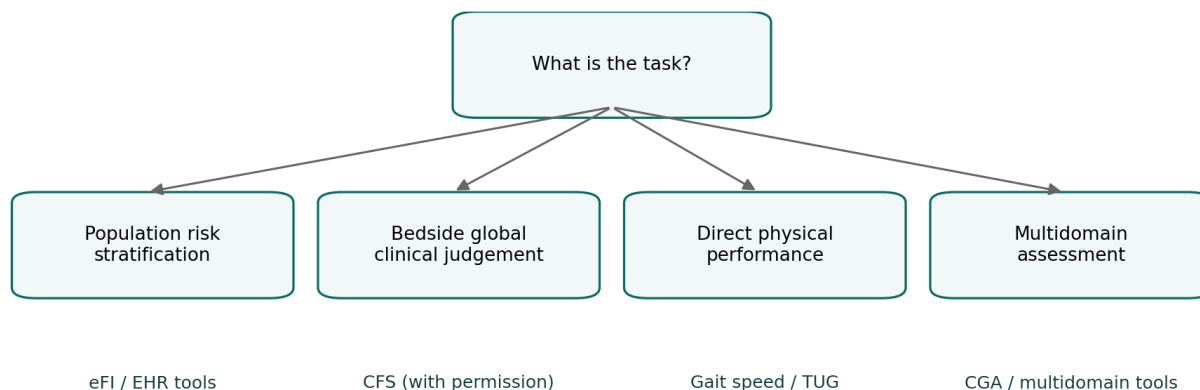
Frailty recognition should lower the threshold for comprehensive assessment when there is multimorbidity, recurrent crisis, functional decline, complex medicines, cognitive change, carer strain, uncertain goals or difficulty coordinating services. CGA is explored in the companion course; here the learner should understand that frailty identification is the beginning of a care process, not its endpoint.

Practice point: Writing “frailty” as the explanation for deterioration without looking for acute illness or reversible causes.

Pause and reflect

Think of a recent clinical encounter in which baseline function, collateral history or treatment burden mattered. What information would you collect differently after this module? Do not record identifiable patient information.

3. Frailty identification tools: choosing the right instrument



Choose a tool because it answers the clinical task - not because it is familiar or available.

Learning outcomes

- Differentiate population case-finding, diagnostic confirmation, bedside judgement, physical performance and multidomain assessment.
- Explain the appropriate role and limitations of the eFI.
- Recognise why performance tests may be misleading during acute illness.
- Select a tool that matches the clinical question and setting.

Start with the task

The most common tool error is choosing an instrument because it is available rather than because it answers the question. Population risk stratification, bedside global judgement, physical performance, rehabilitation tracking and multidomain assessment are different tasks. ClinicalEdu therefore teaches tool selection before tool scoring.

Electronic Frailty Index

The eFI uses routinely coded primary-care data and a cumulative-deficit approach to identify populations at increased risk. NHS England explicitly describes it as a risk-stratification tool rather than an individual diagnostic tool. A high eFI should trigger clinical validation; it should not be batch-translated into a bedside diagnosis without assessment.

Physical performance tools

Gait speed and Timed Up and Go can provide useful functional information in suitable settings. NICE advises caution when assessing frailty in someone who is acutely unwell and specifically advises against physical performance tools for frailty assessment during acute illness. A poor result during pneumonia may measure the pneumonia as much as baseline vulnerability.

Global clinical judgement tools

The CFS is a judgement-based global scale intended to summarise overall fitness/frailty after assessment. It is not a questionnaire and should not be reverse-engineered from age or a diagnosis list. Modules 4-7 provide detailed training while permission for direct reproduction of the tool is pending.

Multidomain and complementary tools

The PFFS offers a multidomain pictorial approach and HABAM focuses directly on balance and mobility. These can complement rather than compete with a global frailty judgement. Their role depends on the question: a rehabilitation team may need repeated mobility measurement even when a frailty category is already known.

Tool selection as clinical reasoning

Ask five questions: What is the decision? Is the person acutely unwell? Is the task population-level or individual? Is the outcome a frailty construct or a direct domain such as mobility? What action follows the result? If the final question has no answer, collecting the score may add documentation without adding care.

Practice point: Treating eFI categories as diagnoses or treating every poor mobility result during acute illness as baseline frailty.

Pause and reflect

Think of a recent clinical encounter in which baseline function, collateral history or treatment burden mattered. What information would you collect differently after this module? Do not record identifiable patient information.

4. Clinical Frailty Scale: foundations, purpose and limits

Learning outcomes

- Describe the intended role of the CFS as a judgement-based summary of overall fitness/frailty.
- Explain why the current official tool and training resources should control scoring practice.
- Recognise populations and circumstances in which the CFS may be inappropriate or require caution.
- Avoid using CFS as a standalone treatment-allocation or prognostic decision rule.

What the CFS is

The Clinical Frailty Scale originated as a way to summarise overall fitness/frailty after clinical assessment in the Canadian Study of Health and Aging. It evolved from seven to nine levels and the current English version is Version 2.0. The official Dalhousie resource remains the controlling source for the instrument, descriptors, training and permissions.

What the CFS is not

It is not a substitute for history, examination, CGA, diagnosis or discussion of goals. It is not an automatic treatment ceiling. It is not a standalone mortality calculator. A recent emergency-department systematic review found useful prognostic association but insufficient performance for screening tools to stand alone as predictors of adverse outcomes.

Judgement-based means evidence-based judgement

The score should emerge from a coherent account of usual mobility, instrumental and personal activities, cognition, symptoms and dependence. The assessor integrates what the person says, what collateral sources say, what is observed and what the clinical context means. 'Judgement-based' does not mean intuitive guessing.

Population boundaries

Official guidance states that CFS is not validated for people under 65 and is not designed for stable single-system disability or developmental delay where dependence does not reflect age-related accumulation of deficits. This boundary is educationally important because a visually similar level of dependence can have a different meaning.

CFS and treatment decisions

Frailty can inform conversations about vulnerability, likely recovery, treatment burden and the need for CGA. It should sit alongside diagnosis, reversibility, patient goals, capacity, values, physiological severity and available treatment. A numerical threshold should not silently become a decision that the scale was not designed to make.

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ClinicalEdu has requested non-commercial educational permission to reproduce the official CFS. Until executed permission is held, the website production version should link to the official scale and training resources rather than embed the copyrighted graphic or full descriptors.

Practice point: Turning a useful global judgement into a deterministic treatment rule.

Pause and reflect

Think of a recent clinical encounter in which baseline function, collateral history or treatment burden mattered. What information would you collect differently after this module? Do not record identifiable patient information.

5. CFS levels and clinical meaning: reasoning across the continuum

Learning outcomes

- Understand that adjacent CFS levels reflect meaningful differences in usual function and dependence.
- Use change in instrumental and personal activities to structure a judgement.
- Recognise the special role of terminal illness within the scale.
- Explain a score in clinical language rather than documenting a number alone.

Learning the continuum without memorising a poster

Direct reproduction of the official level descriptors is permission-dependent. The educational task is nevertheless clear: learners must understand the continuum from robust independence through increasing vulnerability and dependence to very severe frailty and terminal illness. The scale becomes clinically useful when the assessor can explain what functional evidence places a person on one side of an adjacent boundary.

Instrumental activities first

Subtle decline often becomes visible first in complex activities: shopping, transport, finances, cooking, medication organisation, housework or navigating unfamiliar tasks. The key question is change. A person who has never performed a particular household role should not automatically be labelled dependent because someone else has always done it.

Personal activities and mobility

As frailty becomes more severe, assistance is increasingly required with mobility and personal care. The assessor should identify exactly what help is needed, how often, and whether it is supervision, prompting, physical assistance or complete dependence. Vague words such as 'needs help' are not sufficiently discriminating.

Cognition and dementia

Cognitive impairment can contribute to dependence and therefore to the overall frailty judgement. The assessor should describe functional consequences rather than infer a frailty category from a diagnostic label alone. Dementia severity, prompting needs, personal-care dependence and mobility should be established from history and collateral information.

Terminal illness is conceptually different

The highest CFS category is designed for people approaching the end of life who are not necessarily otherwise severely frail. That distinction prevents terminal disease from being forced into a dependence-only hierarchy. Prognostic estimates remain uncertain and should not be presented as mathematical certainty.

Document the evidence, not just the score

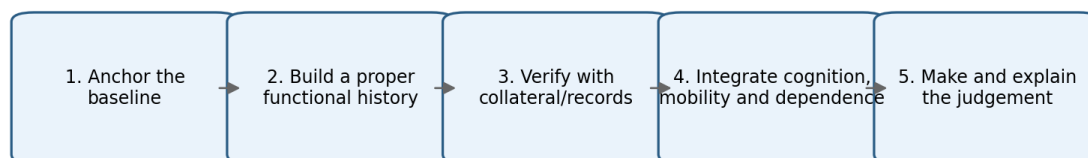
A useful note records the CFS and the evidence underpinning it: baseline mobility, instrumental activities, personal care, cognition, recent trajectory and collateral source. This makes the judgement auditable and allows another clinician to understand why adjacent categories were considered and rejected.

Practice point: Memorising category labels without being able to describe the functional evidence that supports them.

Pause and reflect

Think of a recent clinical encounter in which baseline function, collateral history or treatment burden mattered. What information would you collect differently after this module? Do not record identifiable patient information.

6. Scoring the CFS correctly: baseline, collateral and acute illness



Do not score the acute appearance alone. A defensible frailty judgement is a synthesis of pre-illness function and clinical context.

Learning outcomes

- Anchor CFS scoring to the appropriate pre-acute baseline.
- Take a structured functional history that supports scoring.
- Use collateral information and records to verify baseline.
- Recognise common scoring errors in dementia, acute illness and long-standing disability.

Anchor the baseline

Official CFS guidance emphasises the person's usual pre-illness state, commonly using approximately two weeks before the acute illness as the anchor. The purpose is to prevent pneumonia, delirium, pain or hospital immobility from being mistaken for chronic frailty. The baseline is a clinical anchor, not a magical date; use the best account of usual pre-acute health and function.

Build the history in layers

Start with mobility and community activity. Then ask about shopping, transport, finances, cooking, medication organisation and housework. Move to personal activities such as bathing, dressing, toileting, transfers and feeding. Ask about cognition, symptoms, falls and trajectory. Clarify what the person does independently, what requires prompting and what requires physical help.

Trust but verify

People may overestimate or underestimate their function; families may do the same. Delirium, memory impairment and social desirability add noise. Verification is therefore good practice, not distrust. Compare the account with carers, therapy notes, previous discharge summaries, community records and observed performance, while recognising that hospital performance may be below baseline.

Dementia and dependence

Do not assign a frailty level simply because dementia is present. Establish how cognition affects everyday activities and personal care. Similarly, do not assume that a person with a stable lifelong disability should be scored using the same logic as age-related deficit accumulation; official CFS guidance explicitly warns about stable single-system disability and developmental delay.

Acute deterioration

Acutely ill people can temporarily appear much more dependent. Record current dependency separately from baseline frailty. This distinction is vital for goals of rehabilitation, discharge planning, prognosis discussions and evaluation of recovery.

A structured scoring note

ClinicalEdu recommends documenting: baseline date/period; mobility; instrumental ADLs; personal ADLs; cognition; living situation; collateral source; current acute change; CFS judgement; and one-sentence rationale. The score should be reproducible from the narrative even if the original assessor is unavailable.

Practice point: Scoring how the person looks on the day of admission instead of their usual pre-illness state.

Pause and reflect

Think of a recent clinical encounter in which baseline function, collateral history or treatment burden mattered. What information would you collect differently after this module? Do not record identifiable patient information.

7. CFS case laboratory: applying judgement under uncertainty

Learning outcomes

- Apply CFS reasoning to realistic cases with incomplete or conflicting information.
- Identify what additional information is needed before scoring.
- Distinguish baseline frailty from acute deterioration and long-standing disability.
- Explain uncertainty and defend a provisional judgement without false precision.

Why a case laboratory

Real CFS scoring is rarely as tidy as a poster. The purpose of this module is to make uncertainty visible. Each case therefore withholds at least one important piece of information, introduces conflicting accounts, or includes an acute change. Learners are rewarded for asking the right next question as well as for selecting a defensible category.

Case 1 - acute pneumonia

An 86-year-old normally walks with a stick, manages medicines and finances, cooks simple meals and shops with her daughter because she no longer drives. During pneumonia she requires assistance to transfer. The first task is not to score the transfer dependency; it is to reconstruct usual function and determine whether shopping support reflects frailty, transport choice or another factor.

Case 2 - dementia with preserved mobility

An 82-year-old walks independently but needs prompting for medication and repeated reminders for appointments. A relative reports increasing difficulty with finances. Learners must describe the functional impact of cognition rather than equate the diagnostic label with a fixed CFS level.

Case 3 - lifelong disability

A 70-year-old with a long-standing spinal cord injury is dependent for several activities but has stable health, active work and no age-related decline. The case tests whether learners remember that the CFS is not designed for stable single-system disability.

Case 4 - terminal illness without severe baseline frailty

A 74-year-old with advanced progressive malignancy remains mobile around the house and manages personal care but is thought to be in the final months of life. Learners explore why end-of-life status is not identical to severe functional frailty and why prognosis remains uncertain.

Case 5 - conflicting collateral

A person reports full independence; a daughter says 'Dad does nothing now'; therapy notes show independent transfers but recent withdrawal from community activities. Learners must ask for specifics, avoid taking either account literally, and identify what evidence would discriminate between very mild and more established frailty.

Case 6 - recovery trajectory

An older person was independent before hip fracture, dependent at discharge and improving during rehabilitation. Learners record baseline frailty separately from current function and use direct mobility measures to track recovery rather than repeatedly changing baseline CFS with every therapy session.

How uncertainty should be documented

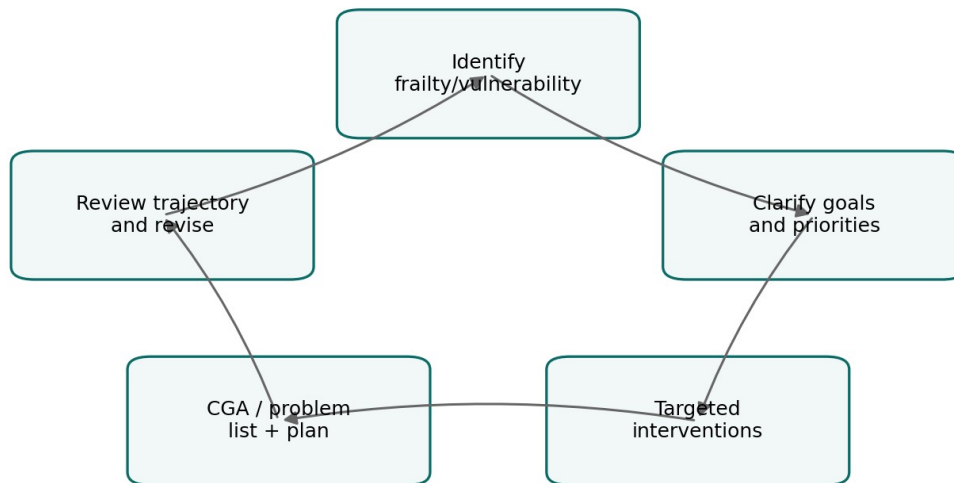
If evidence is incomplete, say so. A provisional score with a stated range or competing interpretation is safer than false precision. Record the missing information and who will obtain it. The score should become more certain as the history becomes better, not because time has passed.

Practice point: Treating uncertainty as failure. Skilled assessors often know what they still need to know.

Pause and reflect

Think of a recent clinical encounter in which baseline function, collateral history or treatment burden mattered. What information would you collect differently after this module? Do not record identifiable patient information.

8. Managing frailty: from identification to intervention



Frailty-informed care is iterative. Identification should lead to action, ownership and review - not to a label alone.

Learning outcomes

- Translate frailty recognition into an individualised management plan.
- Prioritise reversible contributors, function, medicines, nutrition, mobility and patient goals.
- Explain the role of multicomponent exercise and rehabilitation without overgeneralising trial protocols.
- Use CGA as the organising intervention for complex frailty.

Frailty is modifiable, but not with one treatment

Frailty is not a single disease with a single prescription. Management combines treatment of acute and chronic illness with rehabilitation, medicines optimisation, nutrition, falls prevention, sensory support, social intervention and goal-based care. The balance depends on the person's priorities and the drivers of vulnerability.

Treat the trigger and protect function

During acute illness, prevent avoidable secondary decline: unnecessary bed rest, poorly controlled pain, sleep disruption, constipation, dehydration, missed hearing aids, sedating medicines and fragmented handover can all worsen function. Early mobilisation and rehabilitation should be tailored to safety and baseline ability.

Exercise and rehabilitation evidence

Recent systematic reviews support multicomponent exercise for improving frailty-related and physical-function outcomes in selected older adults. The evidence does not justify one universal dose or programme. Assessment, contraindications, preferences, setting and professional input

matter. The teaching message is that physical function can improve and should be actively considered rather than assumed irreversible.

Medicines and treatment burden

Medication review should ask not only whether each medicine has an indication but whether the overall regimen remains proportionate to goals, renal function, falls risk, cognition, adherence and treatment burden. Deprescribing is not simply reducing tablet count; it is structured optimisation with monitoring.

Nutrition and oral health

Weight loss, swallowing difficulty, poor dentition, depression, social isolation and acute illness can all reduce intake. Nutrition assessment belongs alongside function and goals. Supplements may be appropriate in selected circumstances, but the course should avoid implying that supplements alone reverse frailty.

CGA as the organising process

For complex frailty, CGA provides the structure to connect medical, psychological, functional, social, environmental and future-wishes domains into one prioritised plan. The companion CGA course teaches this in depth. Here the key principle is that intervention follows the person's problems and goals, not the frailty score itself.

Review trajectory

A plan needs a review question: what are we trying to improve, preserve or clarify, and by when? Function, symptom burden, falls, medication burden, carer strain and achievement of personal goals can all be meaningful outcomes.

Practice point: Assuming frailty means decline is inevitable or, conversely, promising that exercise or nutrition will “reverse” frailty in every person.

Pause and reflect

Think of a recent clinical encounter in which baseline function, collateral history or treatment burden mattered. What information would you collect differently after this module? Do not record identifiable patient information.

9. Frailty services and pathways: designing care around the person

Learning outcomes

- Describe core principles of effective frailty pathways across acute, community and care-home settings.
- Distinguish evidence-based service principles from locally variable operating models.
- Identify how continuity, rapid assessment, rehabilitation and CGA should connect across settings.
- Recognise common service-design failure modes.

Principles before structures

There is no single universal frailty-unit blueprint. Workforce, geography and commissioning differ. The more transferable principles are early recognition, timely senior assessment, CGA when complexity warrants it, preservation of function, access to rehabilitation, continuity, clear escalation, medication review, patient goals and communication across transitions.

Front-door and acute frailty

Acute frailty services aim to recognise vulnerability early, identify reversible illness, avoid unnecessary duplication and coordinate an appropriate pathway. A same-day or ambulatory model can be helpful for selected patients, but service design must match acuity, diagnostics, staffing and escalation capacity. A label of frailty should never be used to divert a sick person from appropriate acute care.

Community and virtual models

Community frailty services can support proactive assessment, rapid response, rehabilitation and coordination. Hospital-at-home and virtual-ward models vary widely. The educational focus should be on clinical selection, access to review, escalation, diagnostics, medicines and continuity rather than assuming the service name guarantees a particular capability.

Care homes

Care-home residents often have high frailty, multimorbidity and cognitive impairment. Good care requires anticipatory planning, access to clinical review, medicines support, rehabilitation where appropriate, recognition of deterioration and communication with residents and families. Avoiding hospital is not automatically a quality outcome; avoiding avoidable harm while providing care in the right place is.

Transitions are a high-risk point

Discharge, admission, temporary placement and changes of team can break medication lists, mobility plans and goals. A frailty pathway should transfer the problem list, baseline function, current trajectory, treatment plan, escalation plan and responsible contacts - not merely the score.

Service evaluation

A pathway should measure outcomes that reflect its purpose: time to assessment, unplanned admission, length of stay, functional outcome, readmission, place of care, patient/carer experience and balancing measures. A service can reduce hospital attendance by shifting burden elsewhere; evaluation should make that visible.

Practice point: Assuming every service called “frailty” provides the same clinical capability or that admission avoidance is always the desired outcome.

Pause and reflect

Think of a recent clinical encounter in which baseline function, collateral history or treatment burden mattered. What information would you collect differently after this module? Do not record identifiable patient information.

10. Complex frailty and decision-making: proportionality, goals and uncertainty

Learning outcomes

- Use frailty as one component of complex clinical decision-making rather than a deterministic rule.
- Integrate reversibility, treatment burden, patient goals, function and prognosis.
- Recognise when capacity, consent, escalation or palliative-care expertise is needed.
- Communicate uncertainty without therapeutic nihilism or false reassurance.

Frailty changes context, not rights

Frailty may alter treatment risk, recovery potential and burden, but it does not reduce a person's right to individualised assessment, consent, symptom relief or appropriate treatment. The clinical task is proportionality: what benefit is realistically achievable, what burden is involved, and how does that align with the person's values?

Separate four questions

Complex decisions are clearer when four questions are separated: What is the diagnosis and reversibility? What is the person's baseline vulnerability and likely recovery trajectory? What are the person's goals and preferences? What burdens and risks accompany each option? Frailty informs the second question strongly and may influence the fourth; it does not answer all four.

Prognosis without false precision

Frailty is associated with adverse outcomes, but prediction at individual level remains uncertain. Use ranges, scenarios and functional expectations rather than deterministic statements. A score should not be presented as though it predicts exactly who will survive an intervention.

Capacity and consent

A person living with frailty may have full decision-making capacity. Cognitive impairment may prompt a capacity assessment for a specific decision but does not automatically remove autonomy. Where capacity is lacking, the relevant legal framework and best-interests process apply. These topics are developed in later ClinicalEdu courses.

Treatment escalation and DNACPR

Frailty can be relevant to discussions about escalation, but it should not be used as a shortcut to a treatment ceiling. Decisions about CPR or other interventions require consideration of clinical effectiveness, burden, law, professional guidance and the person's wishes. This module deliberately signposts rather than duplicates the later End-of-Life and Consent courses.

Palliative care alongside active care

Palliative care is not synonymous with imminent death or cancer. Symptom control, communication and support can run alongside disease-modifying and rehabilitative treatment. In advanced frailty, goals may shift over time; good care makes those changes explicit rather than assuming them.

The final ClinicalEdu reasoning model

Use frailty to ask better questions: What was the baseline? What is reversible? What matters most? What is the likely functional consequence of each option? What support is available? Who needs to be involved? What will trigger review? This approach preserves individual judgement while keeping vulnerability visible.

Practice point: Using frailty as shorthand for “do not treat” or, at the opposite extreme, avoiding honest discussion of burden and limited recovery potential.

Pause and reflect

Think of a recent clinical encounter in which baseline function, collateral history or treatment burden mattered. What information would you collect differently after this module? Do not record identifiable patient information.

Course summary: ten principles to carry into practice

1. Frailty is vulnerability and reduced reserve, not an age label.
2. Use trajectory and baseline function rather than a single acute snapshot.
3. Look for reversible causes; “frailty” is not a diagnostic endpoint.
4. Choose a tool because it fits the task and setting.
5. Treat the eFI as population risk stratification that requires clinical validation.
6. Use the CFS as a judgement-based summary supported by a proper history and collateral information.
7. Do not let a frailty score become a standalone treatment ceiling or prognosis.
8. Link identification to intervention: function, medicines, nutrition, rehabilitation, goals and CGA.
9. Design services around continuity, capability and escalation rather than labels alone.
10. Document uncertainty, patient goals and review plans openly.

Selected references and official resources

1. **BGS Frailty Hub.** British Geriatrics Society. [Official/source link](#)
2. **BGS Frailty education and training.** British Geriatrics Society. [Official/source link](#)
3. **BGS CGA Hub.** British Geriatrics Society. [Official/source link](#)
4. **NHS England - Identifying frailty.** NHS England. [Official/source link](#)
5. **NICE NG56 Multimorbidity.** NICE. [Official/source link](#)
6. **Clinical Frailty Scale official page.** Dalhousie University Geriatric Medicine Research. [Official/source link](#)
7. **CFS guidance for use.** Dalhousie University Geriatric Medicine Research. [Official/source link](#)
8. **CFS Top Tips.** Dalhousie University Geriatric Medicine Research. [Official/source link](#)
9. **Rockwood et al. 2005.** CMAJ. [Official/source link](#)
10. **Fried et al. 2001.** J Gerontol A. [Official/source link](#)
11. **Clegg et al. 2016.** Age and Ageing. [Official/source link](#)
12. **Systematic review: frailty screening in ED.** Annals of Emergency Medicine, 2025. [Official/source link](#)
13. **Multicomponent exercise meta-analysis.** Experimental Gerontology, 2024. [Official/source link](#)
14. **BGS setting up frailty services.** British Geriatrics Society. [Official/source link](#)
15. **Pictorial Fit-Frail Scale official page.** Dalhousie University Geriatric Medicine Research. [Official/source link](#)

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