Screening for Frailty: Instructions for using the FACT

Frailty is a robust marker of vulnerability. Appropriate care planning and care delivery with frailty is entirely contingent upon the critical first step of recognizing the presence and degree of frailty. The Clinical Frailty Scale (CFS) provides a practical approach to measuring frailty that is both quantitative and feasible when health care providers are experienced in the process of comprehensive geriatric assessment and are able to gather information about cognition, mobility, and function. But how can we maximize the objectivity and interpretability of the Clinical Frailty Scale in the hands of a non-expert? This document introduces an adaptation of the CFS called FACT (or Frailty Assessment for Care planning Tool) that can be used in busy “non-geriatrics” clinical settings, and provide instructions for its use.

Why this tool? We believe that any screening tool used for the purpose of recognizing frailty must be easy to administer and easy to interpret. The FACT (Frailty Assessment for Care planning Tool) can be used to rapidly identify frailty through routine assessment (as performed by nurses or other health care professionals) to detect patients that may benefit from a more detailed assessment of frailty and individualized care planning.

The FACT is innovative in its methodology in that: (1) it has brief cognitive tests embedded in the assessment; (2) involves both patients and their caregivers in the frailty assessment; and (3) takes less than 6 minutes to complete once a caregiver is identified. Data from outpatient settings suggests that a patient/caregiver self-report of frailty level (using the same ordinal scale) shows good correlation with the healthcare professional assigned frailty level [Goldstein 2013].

You will recognize the FACT as an adaptation of the validated Clinical Frailty Scale [Rockwood]. There are three major modifications (Table 1), each based on user feedback and designed to improve the feasibility and interpretability of the tool.
Table 1. Modifications of the Clinical Frailty Scale for the FACT

<table>
<thead>
<tr>
<th>Modification</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>Separation of the original ordinal scale into four domains</td>
<td>Allows for easier determination of scale score when one domain is driving frailty Suggests areas of focus for further assessment (PLAN tool)</td>
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<tr>
<td>Addition of validated screening tools for cognitive assessment</td>
<td>Improves objectivity/reliability of score</td>
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<tr>
<td>Reliance on collateral history instead of self-report</td>
<td>Improves objectivity/reliability of score May help identify poor insight</td>
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<tr>
<td>Combination of levels 1 and 2</td>
<td>Allows for more ease of administration without losing information that is instrumental to decision making</td>
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How to administer the FACT

Step 1: Identify the collateral informant

Dementia is common in frailty. People with dementia commonly over-estimate their functional abilities. Therefore, in order to achieve an accurate measure of baseline function, we need a collateral history. The collateral informant should be someone who is in regular communication with the patient, or provides care for the patient, and can therefore speak to the patient’s circumstances and abilities.

Step 2: Provide the collateral informant with the ‘Collateral Informant’ page of the FACT

The purpose of the collateral Informant page is to streamline the screening process by providing the assessor with some preliminary information with which to work. If this step takes extra time in your clinical setting (e.g., the collateral historian is only available by phone), you can proceed to Step 4.
Instructions are provided on the Collateral Informant form, but you can also remind the collateral to first check the two yes/no boxes in the top row and then, for each column, check the one box that BEST describes the person’s abilities at their baseline (i.e., in the past 1-2 weeks or before any recent acute illness developed). Ideally, this step can be done while the patient and collateral historian are in the waiting room, or (for inpatients) while the collateral historian and patient are completing admission paperwork.

Step 3: Review the results of the Collateral Informant page

Look at the responses in each column. This will give you a sense of the degree of deficits the patient may have in each of these domains and will tell you where to start when validating the information provided.

Step 4: Validate (reconcile) the information

Briefly interview the collateral historian with the Collateral Informant page and the Final Scoring Sheet in front of you. For each column, use the level of deficit indicated by the Collateral Informant page to frame your question. For example, in the mobility column, you might say, “You’ve indicated that your husband uses or needs to use a cane or walker. Has he had any falls in the last 6 months?” This will allow you to ensure that the level indicated reflects a true report of the patient’s abilities, and isn’t off by a level up or down. Repeat this process for each of the first three columns. The “Memory” column will be scored after directly testing the patient.

Step 5: Evaluate cognition

For this step, you will interview the patient (with or without the collateral historian present). If your clinic setting permits, you may decide to have one person administer the cognitive screen while another speaks with the collateral historian (in person or over the phone) in order to complete the screen in less time. Start by administering the Mini-Cog on page 3/5. Provide the optional explanation on page 3/5 if desired: “Part of my role is to look at your overall health, so I’m going to ask you some questions which may not seem to be related to the reason why you’re here today.”
After completing the Mini-Cog, look at page 2/5 and follow the flow chart which provides prompts and instructions on how to score the results of this part of the screen. The frailty descriptions on the stop signs refer to the level you should assign in the “Cognition” column of the Assessor page.

**Step 6: Interpret the results**

Now that you’ve assigned a frailty level in each of the four columns, note the results: **The column with the worst score = the final score.** For example, if the patient scores “4” in mobility, “2” in social, “3” in function, and “2” in cognition, their final score would be 4.

**Case Example**

Now, let’s look at each completed page of a sample FACT tool, completed by Peggy Smith, caregiver for her father.

**Figure 1a. The collateral informant page of the FACT**
**Mobility:** In the mobility column (“Getting Around”), Peggy Smith indicates that her father is active and exercises occasionally, but also indicated that he’s slowing down. This will need clarification such as:

HCP: “You’ve indicated that your father is active, exercises occasionally, and doesn’t need a cane or walker, but also that he’s starting to slow down and often tired during the day. Tell me more about this.”

Peggy: “Well, he used to have lots of energy, but in the last few months he’s complaining of being tired, and is napping more. His doctor suggested he uses a cane, but he absolutely refuses.”

Peggy’s further history indicates that on the Assessor page, you should check box 4 in the mobility domain (Figure 1b).

**Social Health:** In the column marked “Social”, Peggy has indicated that her father rarely engages in social activity and might find someone to help if daily help was needed. You can also reconcile/validate this information by saying:

HCP: “You’ve indicated that your father rarely socializes. Is he mostly confined to the house?”

Peggy: “No, he just seems to have less get up and go. Over the last few months, he’s stopped his weekly bowling.”

Peggy’s further history indicates that on the assessor page, you can keep his score as is and check box 5 (Figure 1b).

**Figure 1b. The assessor page of the FACT:**

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*Note: Figure 1b is an image of the Frailty Assessment for Care-planning Tool (FACT) assessor page.*
**Function:** In the function column, Peggy has indicated that her father needs help with all IADLs and perhaps BADLs. You can confirm this by saying:

**HCP:** “You’ve indicated that your father needs some help with activities inside the home such as dressing. Tell me more about this.”

**Peggy:** “Yes, I do the banking, shopping and cooking/cleaning, but lately I have to pick out his clothes or he’d wear the same dirty clothes every day.”

**HCP:** “Do you need to physically help him to be able to get his clothes on and off?”

**Peggy:** “No, it’s more that he doesn’t take the initiative to get dressed. Once I convince him to change, he can do it on his own.”

Peggy’s further history indicates that on the Assessor page, you can keep his score as is, and check box 6.

In the cognition column, Peggy has indicated that there may be some cognitive deficits but that these appear to be mild. Let’s see how Mr. Smith’s cognitive screen looks. (Figure 1c)

**Cognition:** Mr. Smith’s Mini-Cog (Figure 1c) shows 1/3 recall and he has problems with his clock drawing (number placement and hand placement). Now let’s look at the rest of his cognitive testing.

Because he had 1/3 recall, we move down the flowchart (Figure 1d) to ask about current events. Despite watching the news daily, he could not recall any specific details about current events (“There are lots of wars”). Therefore, we move on to asking Mr. Smith to name the President of the United States. He incorrectly named the US President, so we move on to asking Mr. Smith to name his children, which he was able to do correctly (Figure 1d). Now, return to the assessor page (on the reverse side of the flowchart) to record the cognitive score, which is 6 (Figure 1b.).
Figure 1c. Cognitive Screen

Fraility Assessment for Careplanning Tool (FACT)

Optional explanation for testing: “Part of my role is to look at your overall health, so I’m going to ask you some questions which may not seem to be related to the reason that you’re here today”

1. Ask the patient to, “Repeat the following 3 words and remember them for later:
   
   APPLE  PENNY  WATCH

2. Have the patient, “Draw a clock,” on a separate piece of blank paper (provided) “and place the hands of the clock at ten minutes after eleven.”

3. Ask the patient “What were those words I asked you to remember?” and record their answer in the space below:

   Apple  —  Clock

   Answers must be exact (e.g: “clock” is not acceptable).

4. Determine a cognitive score by following the Cognitive Flow Sheet

Clock Drawing Task

Have the patient draw a clock on the space below and place the hands of the clock at “ten minutes after eleven.”
Figure 1d. Cognitive Screen Flowchart

FACT Cognitive Screen

1. Word Recall
   - “What were those 3 words I told you earlier?”
   - Recall 0 to 1
   - Recall 2-3
   - Look at the clock drawing
   - Clock is normal
   - Clock is abnormal
   - Collateral not available
   - Normal Aging
   - Thriving
   - Normal Aging
   - Collateral says “impresses others with memory and thinking”
   - Patient is worried about memory but family is not concerned
   - Collateral has checked concerns in memory column (i.e., 4 possible responses)

2. “Do you watch TV or listen to the news?”
   - IF YES
     - “Tell me what is going on in the news these days, or about the television shows you watch.”
   - IF NO
     - “Tell me about some of your medical problems.”
   - Incorrect recall

3. “Who is the US President?”
   - Reagan
   - Normal recall
   - Mild
   - Moderate
   - Severe
   - Very Severe

4. “What are the names of your children?”
   - OR
     - “What is your spouse’s name?”
   - OR
     - “What are your sibling’s name?”
   - Incorrect recall
   - Speaks more than 10 words
   - No

Describe answers given to above questions:

"THERE ARE LOTS OF WARS"
Note: If no collateral historian was available when you did the cognitive screen, you would have to check the “no collateral present”, indicating that he has at least moderate deficits but that the cognitive screen is incomplete.

Now you’ve completed scores for all four domains. The results are telling:

1. Mr. Smith is moderately frail. The final score is the highest score in any domain. Mr. Smith’s final score = 6.
2. Mr. Smith’s cognition is driving this score. His cognitive and functional scores are the same, which suggests that his cognitive deficits may be having an effect on his function—you’ll need more information to confirm this, but Mr. Smith certainly needs further evaluation.
3. His daughter’s understanding and appreciation of the degree and impact of his cognitive deficits is an area for future focus and education

Conclusion
The FACT is a quick and powerful tool that can be used to screen for frailty in a busy office setting. It does not require expertise beyond these instructions and some practice. There are multiple approaches to gathering the information (in person, by phone, by a singular or multiple assessors).

References


