Evaluating clinician compliance of the clinical frailty score tool for patients admitted with suspected or confirmed COVID-19: a quality improvement project

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Introduction
The COVID-19 pandemic has pushed healthcare services around the world beyond their limits. The National Institute for Health and Care Excellence (NICE) published COVID-19 rapid guideline: critical care in adults; NICE guideline [NG159] which advised clinicians on maximising efficiency and supporting critical care services; in these unprecedented times, the prompt identification of patients who would or would not benefit from escalated levels of care is essential. The guideline therefore recommends assessing the frailty status of all patients at admission, irrespective of their COVID-19 status. NICE recommends grading frailty using the Clinical Frailty Scale (CFS; Fig 1).

Fig 1. Clinical Frailty Scale.2

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COVID-19 who were admitted to a district general hospital’s acute medical unit.

**Methods**

Retrospective analysis of patient documentation collected from an electronic recording system was conducted. As per the CSF eligibility criteria, all patients under the age of 65 or with any learning / long-term disabilities were excluded from analysis. Data were collected over a 2-week period for the first audit cycle. Both initial clerking and post-take ward round (PTWR) documentation were analysed for a recorded functional status assessment and a CFS score. Data were also collected on patient age, resuscitation status and whether ITU were involved with the patient’s care at any point.

Interventions were implemented to improve compliance. Improving clinician awareness of the NICE guideline and the CFS was targeted through lectures, briefings at handover meetings and email reminders. Posters of the CFS were also placed in doctor offices. A second audit cycle was completed to assess if any improvement to compliance of CFS documentation could be observed.

**Results**

In the first audit cycle, 273 patient admission documentations were analysed. One-hundred and fifty-four patients met the criteria to be graded using the CFS. 74% had some form of functional status documented at clerking or PTWR and only 21% had a documented CFS.

Following the implementation of interventions, 260 patient records were analysed in a second audit cycle. One-hundred and fifty-six patients were eligible for CFS grading. Of these, 89% had functional status recorded in some capacity. 37% of clerking or PTWR documentation had a clearly noted CFS.

**Conclusions**

The CFS allows for a simplified and objective assessment of a patient’s frailty. The recommendation by NICE to grade patient frailty using the CFS aims to maximise efficiency and patient safety during a time when critical services are fully saturated. The results of this study show that although functional status is widely considered at admission, compliance of CFS grading is alarmingly poor.

Improving clinician awareness, through online tools and email reminders, of the NICE guideline and the CFS has been shown to increase compliance. Following the second audit cycle, interventions were put into place: stickers with a reminder to document a CFS were placed on every computer used for clerking and online reminder tools were set. To further improve this, clerking pro formas will be updated to include the CFS and educational worksheets will be distributed throughout the acute medical units within the trust.

**Conflicts of interest**

None declared.

**References**

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