

Paper Category:	COVID 19 and Sarcopenia and Frailty
Paper Title: (Arial Font; 14 Pt Size)	Comparison of CFS and HFRS to a modified HFRS allowing a “live screening tool” to identify frailty in hospitalised older adults without a clinical assessment
Abstract Body: (Arial Font; 12Pt Size)	<ul style="list-style-type: none"> • Background • Objectives • Method • Results • Discussions and Conclusions

(Maximum word limit - 300 words)

Background

Frailty is purported to be the largest global problem associated with an ageing population. Frailty is challenging to identify during an acute hospital admission and current frailty screening tools require manpower resources and a face-to-face assessment.

Objective: Comparison of a new methodology to identify frail hospitalised older patients using a modified Hospital Frailty Risk Score (mHFRS) and comparing this to the current gold standard Clinical Frailty Scale (CFS) and standard HFRS methodology.

Methods: retrospective review of electronic health records in patients admitted from the Emergency department (ED) to a tertiary hospital in Singapore, between July 2022 and 31st March 2023. This included patients aged 65 years and above, whose CFS had been undertaken at ED triage. The standard HFRS and mHFRS were identified using ICD codes but the modified methodology has not been previously described in the literature and permits a “live scoring” during hospitalisation. Patients were categorised into high risk (>15), intermediate risk (5-15) and low risk (<5) of frailty.

Results: 3042 patients were identified using CFS, of whom, 49.8% were male, mean age of 78.3 years. CFS, HFRS and modified HFRS were all predictive of long length of stay (defined as ≥ 7 days, AUC 0.68, 0.73 and 0.67 respectively. CFS, HFRS and modified HFRS were all predictive of 30-day unplanned hospital re-admission, AUC 0.68, 0.68 and 0.70 respectively. CFS, HFRS and modified HFRS were all predictive of mortality at 30-days, AUC 0.78, 0.76 and 0.74 respectively and was also predictive of 90 day mortality, AUC 0.80, 0.73 and 0.72 respectively.

Discussion:

Frail patients can be identified using a mHFRS without clinical assessment during an acute hospital admission, however, there is some loss of sensitivity but mHFRS remains predictive of long LOS, 30-day re-admission and mortality. This offers potential to improve frailty screening in the acute hospital setting.

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