Editorial

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Frailty screening should be nursing business: Planning care, not just predicting outcomes

As the surgical population ages, perioperative nurses are increasingly caring for older adults with complex needs. Among this group, the presence of frailty is common, yet it is often not formally identified.

While many nurses recognise frailty intuitively, it may not consistently shape clinical decision-making, and opportunities to address its social, psychological, emotional and environmental dimensions are frequently missed. This matters because frailty significantly increases the risk of complications, functional decline and delayed recovery. While perioperative care is often focused on technical procedures and short-term recovery goals, frailty introduces a need for a broader, more holistic approach to nursing assessment and planning. Recognising and responding to frailty is not just a matter of predicting poor outcomes – it is central to improving them.

Frailty: A nursing-relevant syndrome hiding in plain sight

Frailty is a clinical syndrome characterised by diminished physiological reserve and reduced capacity to recover from acute stressors. It reflects cumulative deficits across physical, cognitive and social domains and leads to an increased risk of functional decline, complications and mortality[1,2]. Despite its impact, frailty is rarely routinely documented in in-patient settings. This omission is especially concerning given that hospitalisation alone presents risk to older adults, and surgery imposes an additional layer of harm through anaesthesia, fasting, physiological insult and sensory overload. While we hope the benefits of surgery outweigh the risks, for frail older adults this balance is fragile. Nurses are at the forefront of identifying and managing this vulnerability, yet frailty screening remains underutilised in perioperative nursing practice.

One of the most widely used tools for screening is the clinical frailty scale (CFS)[3], which provides a baseline measure of a patient's functional capacity prior to hospitalisation. This baseline score is essential for differentiating between long-standing vulnerability and acute changes, and for planning care that is realistic, appropriate and patient-centred.

Nurses know frailty when they see it, but that's not enough

Nurses often recognise frailty through experience and intuition. For example, a patient who is slow to mobilise, uses a mobility aid or shows signs of cognitive impairment might be informally labelled as 'frail'. However, this reliance on subjective informal recognition contributes to variability and missed opportunities to intervene early. Recent qualitative work has shown that nurses' understanding of frailty is mixed and often shaped by task-based thinking rather than functional trajectory[4]. Without a standardised framework or tool, frailty remains a soft label rather than a clinical cue that informs practice.

Frailty screening in action – from prioritisation to planning

Frailty screening offers more than a risk score – it informs care decisions in real time. It helps nurses identify who may need more support with mobility, eating or cognition; who is at greater risk of developing delirium; and who may not follow the usual recovery path. Frailty screening allows for proactive, tailored

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nursing care that supports patient function and prevents avoidable decline. Based on the patient's needs, this may include early mobilisation, environmental modifications, engagement of family or carers, assistance during meals, regular orientation prompts, referrals to allied health or medical escalation if subtle deterioration is observed. These actions align with recognised domains of frailty care – nutrition, falls prevention, medication management, physical activity and cognitive support – which are shown to reduce the impact of frailty and improve outcomes[5,6].

These actions align with core nursing responsibilities such as nutrition support, pressure injury prevention, continence management and the promotion of mobility[7]. Nurses also play a key role in escalation and delegation, referring early to physiotherapy, occupational therapy, dietetics and geriatric services, when frailty risk is identified. In doing so, they help coordinate care that is proactive rather than reactive. Frailty screening, particularly when using the CFS, provides a snapshot of a patient's pre-hospital baseline. This information supports meaningful goal setting with patients and families, clarifying what recovery might look like, what level of independence is realistic and what supports are needed to achieve it. Tools alone are not enough – it is the translation of frailty into action that determines whether a patient maintains independence or loses it.

Reframing the patient – language, workload systems and clinical clarity

Too often, we reduce complexity to shorthand. Terms such as 'heavy', '2 assist' and 'confused' have become common but they tell us little about a person's trajectory or baseline. The term '2 assist' originates from nursing workload allocation systems, such as TrendCare[8], which categorise patients based on acuity and physical care needs for the purposes of staff resource allocation. Instead of describing someone as '2 assist' we should use frailty screening to help us consider and articulate a patient's baseline function and their potential ceiling of recovery. This is essential for safe handover, team planning and coordination.

By understanding the origins of this terminology, we can appreciate the importance of shifting towards more holistic descriptors that encompass a patient's pre-hospital function and potential for recovery. This approach aligns with the principles of frailty screening, which aims to provide a comprehensive view of an older adult's health status, thereby informing more individualised and effective care plans. Recognising frailty is not about labelling patients – it's about equipping nurses to provide care that is anticipatory, respectful and person-centred.

From scoring to systems – integrating frailty into surgical pathways

The work by Orkaby and Callahan[9] is an important example of moving from identification to intervention. Their team developed a geriatric surgical pathway that operationalises frailty scores into clinical actions, tailoring perioperative care to the needs of mildly, moderately or severely frail patients. This work reinforces the opportunity for frailty screening to inform real-time, tiered responses. It is also aligned with the newly established age-friendly hospital measure[10], where frailty screening and intervention is one of five core domains. Perioperative nurses, with their central role in assessment, planning and interdisciplinary communication, are essential to embedding these systems into daily practice.

Conclusion

Frailty screening belongs in the perioperative nursing toolkit. But to realise its potential, we must move beyond recognising it informally and advocate for systems that translate frailty into action. Perioperative nurses are not only ready to lead this change, they are also essential to its success.

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