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The Clinical Frailty Scale version 2.0: Translation and defining reliability in Vietnamese older patients

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Abstract

Introduction: The Clinical Frailty Scale (CFS) is a practical, reliable, and judgment-based tool among many instruments used for detecting frailty in older adults. However, the CFS has not yet been culturally adapted or validated in the Vietnamese language. This study aimed to translate the CFS into Vietnamese and evaluate the reliability of the Vietnamese CFS version in older adults.

Methods: The prospective study recruited outpatients aged 60 years and older at a geriatric outpatient clinic of a public hospital in Vietnam between September 2022 and January 2023. The CFS version 2.0 was translated into Vietnamese following the guidelines of the International Society for Pharmacoeconomics and Outcome Research Task Force for Translation and Cultural Adaptation. Weighted kappa was used to assess for agreement of inter-rater and test-retest reliability, while Kendall's tau was applied to evaluate the correlation with other geriatric assessment-related characteristics.

Results: A total of 324 older participants were enrolled (mean age: 76±9 years) in the study. The CFS was successfully translated and culturally adapted into Vietnamese (CFS-VN). Overall, the CFS-VN demonstrated good inter-rater and test-retest reliability, with a weighted kappa of 0.808 ($p<0.001$) and 0.869 ($p<0.001$), respectively. The CFS-VN also showed a significant correlation with various geriatric assessments, including multimorbidity, polypharmacy, activities of daily living impairment, and instrumental activities of daily living impairment impairment.

Conclusions: The Vietnamese version of CFS demonstrated satisfactory reliability for evaluating frailty in older patients. This tool has the potential to enhave the quality of care for rapidly aging population in Vietnam.

Keywords: frailty; geriatrics; Vietnam

1. INTRODUCTION

Vietnam is among the Asian countries experiencing one of the fastest rates of population aging. In 2015, Vietnam officially entered the category of an aging society. Notably, by 2035, it is projected to become aged society with approximately one-fifth of its population expected to be aged over 60 years [1], In 2019, 12 million people in Vietnam were aged

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over 60 years, representing 11.9% of the total population. The rapidly aging population presents significant challenges to the healthcare system in Vietnam in delivering care for older adults [1], who often suffer from multimorbidity, polypharmacy, and geriatric syndromes [2]. Frailty is a common geriatric syndrome that increases the vulnerability of older adults to falls, infections, surgery, and hospitalization [3].

However, frailty is a preventable condition when recognized at an early stage [4]. Therefore, screening and early management of frailty are essential for preventing functional dependence, hospitalization, and mortality [5]. Additionally, recognizing frailty has significant implications for older adults, particularly for those who are moderately to severely frail. A range of tools is avilable for evaluating frailty [6,7]. Among them, the Clinical Frailty Scale (CFS), which relies on the clinician's judgment, is widely used to its validity, simplicity, and convenience [8]. In 2005, Rockwood et al. developed the CFS, which initially included items rated on a seven-point scale, ranging from very fit to severely frail, with brief descriptors and pictographs [9]. Subsequently, the scale was expanded to nine points, with addition of very severely frail and the terminally ill categories. In 2020, the CFS version 2.0 was revised, incorporating minor adjustments to the level descriptions [10]. This version has been translated and adapted into various languages such as Greek [11] and Korean [12]. The CFS has demonstrated high feasibility and accuracy when applied in clinical practice [13]. This instrument has been utilized in the evaluation of patients in intensive care units, hospital admissions, and preoperative monitoring [14].

In Vietnam, the prevalence of frailty is relatively high (18.1%) among older adults living in the community [15] and significantly increases in older inpatients (35%) [16]. Although the CFS has been widely used for evaluating frailty in geriatric clinical practice and research, no studies have yet translated nad validated the CFS into Vietnamese. For that reason, the aim of our study was to translate the CFS into Vietnamese (CFS-VN) and assess its reliability. This will provide a simple and convenient tool for Vietnamese clinicians and researchers to evaluate, manage frailty, thereby improving the quality of care for older adults.

2. MATERIALS AND METHODS

2.1. Study design and participants

This study involved two processes: 1) translation and cultural adaptation of the CFS and 2) the validation of the reproducibility of the translated instrument. The validation phase was conduted as prospective study among male and female outpatients, who consecutively visited the Geriatric outpatient clinic at Gia-Dinh People's Hospital, Ho Chi Minh City, Vietnam, from September 2022 to January 2023. The inclusion criteria were individuals aged 60 years and older, able to communicate, and consenting to particiapte in the study. Participants with acute conditions such as infections, respiratory failure, acute coronary syndrome, or other conditions requiring hospital admission were excluded. Thus, a total of 324 participants (out of the 330 participants) were included in the study.

2.2. Sample size and sampling

The calculated sample size to detect acceptable kappa (κ_0) of 0.60 and expected kappa (κ_1) of 0.75, with 90% power and accounting for a 5% dropout rate, was at least 315 patients. A convenience sampling method was employed for participants selection.

2.3. Translation and cultural adaptation

The original CFS is a pictographic scale derived from the accumulated deficit model of frailty including comorbidity, disability, and cognitive impairment, which was used in this study. The English CFS version 2.0 (Appendix 1), which classifies nine distinct levels frailty on a 1–9 scale, was translated into Vietnamese in accordance with the guidelines set by the International Society for Pharmacoeconomics and Outcome Research (ISPOR) Task Force for Translation and Cultural Adaptation [17–19] (Fig. 1).

The authorization for the translation of the CFS was obtained from Dalhousie University, Canada, in February 2022. After receiving permission, two independent translations of the CFS from English to Vietnamese were completed: carried out by a medical doctor with a certified knowledge of the English language (International English Language Testing System-IELTS score of 7.5) and a translation agency,

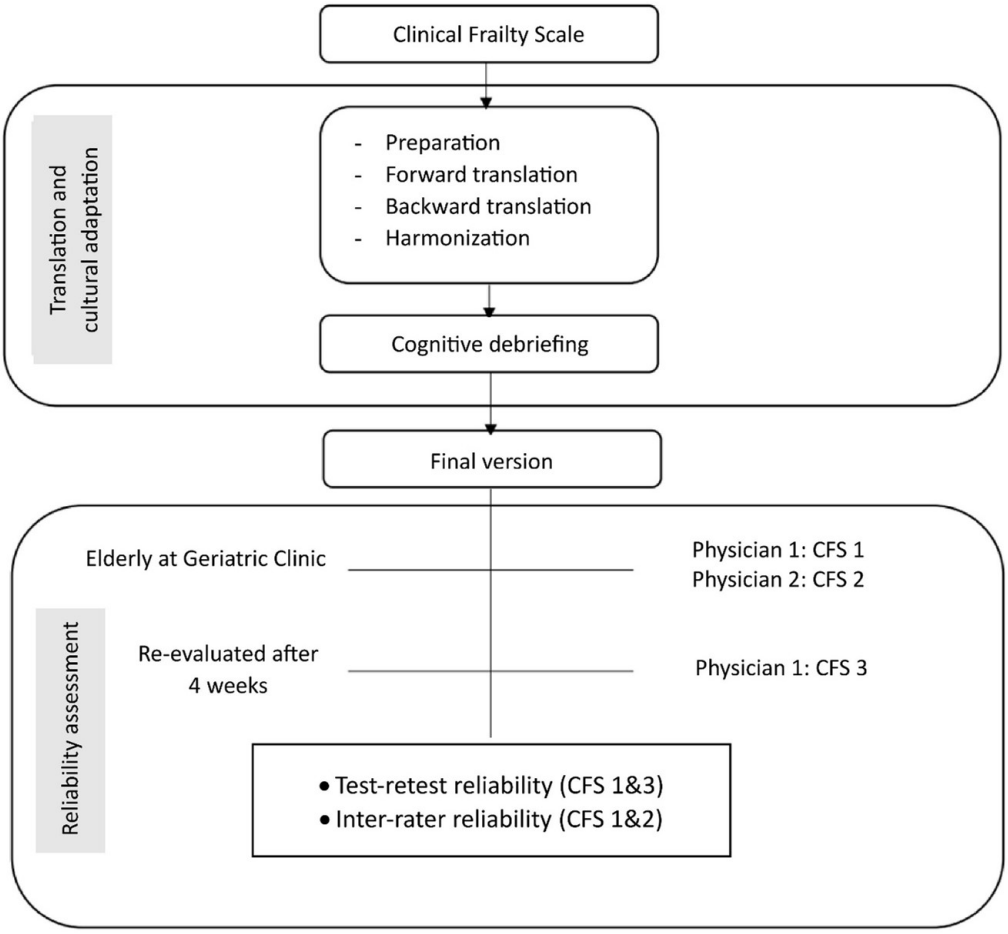

Fig. 1. Steps of translation, cultural adaptation and reliability assessment of the CFS-VN. CFS-VN, Clinical Frailty Scale into Vietnamese.

as part of steps 2–3. The two versions were compared, and the authors, along with the geriatrics specialists reached a consensus-based decision on most appropriate translation. Step 4–5: the Vietnamese version of CFS was subsequently back-translated into English by a professional translator and a medical doctor, both native Vietnamese speakers residing in the United States. The two back-translators were blinded to the original scale. The authors compared the two back-translated versions to the original scale, resolving any discrepancies thorugh agreement between the authors and the geriatrics specialists, with the goal of refining the Vietnamese-translated version. After that, the pre-final CFS-VN version was further assessed by 10 medical doctors who had at least 10 years of experience in their specialties with the native language is Vietnamese, in steps 7–8. The scale was revised according to the suggestions of the Vietnamese doctors until the final CFS-VN version was completed in steps 9–10. Finally, the CFS-VN version was published (Appendix 1). The translated instrument was evaluated for conceptual coherence, interpretation, and cultural relevance by testing it on 10 medical doctors from various specialties: geriatrics (three persons), cardiology (two persons), pulmonology (two persons), family medicine (two persons), and neurology (one person).

2.4. Reliability of the Clinical Frailty Scale into Vietnamese (CFS-VN) version

Before the study was conducted, the two examiners were trained in the use of the CFS-VN for frailty assessment. After the initial assessment, the CFS-VN scores for each patient (CFS-VN1) were obtained by a geriatrician, and a second CFS-VN assessment (CFS-VN2) was performed by another geriatrician who was blinded to the patient's initial

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scores to evaluate inter-rater reliability. Four weeks later, the CFS scores were re-assessed by the initial examiner, after reviewing the patients' entire records (CFS-VN3) to evaluate the test-retest reliability. For both CFS-VN1 and CFS-VN2, the scoring was based on participants's bseline function two weeks before visiting the geriatric clinic. Participants who scored 1–3 in the CFS-VN were grouped as non-frail, whereas those who scored ≥4 were grouped as frail.

Other information including the patient's demographics (age, sex, weight, height, previous occupation, educational level, and marital status) and health-related characteristics (comorbidities, medication use, and functional status including activities of daily living [ADL] and instrumental activities of daily living [IADL]) were also obtained. The ADLs and IADLs were evaluated using the Katz [20] and Lawton & Brody [21] scale. The ADLs include six activities: feeding, toileting, bathing, dressing, transferring, and incontinence. The IADLs include eight activities: the ability to use the telephone, shopping, food preparation, laundry, modes of transportation, housekeeping, ability to handle finances, and responsibility for own medications. ADL impairment was defined as a total score of less than six, and IADL impairment was defined as a total score of less than eight. We collected data on participants' chronic diseases based on their medical records. Multimorbidity was defined as having two or more chronic conditions [22]. Polypharmacy was defined as the concurrent use of five or more medications [23].

2.5. Statistical method

All statistical analyses were performed using the Stata version 14.0 software (STATA, College Station, TX, USA). A p-value of <0.05 was considered significant. All tests were two-tailed. Continuous variables were expressed as means and standard deviations, whereas the categorical variables were presented as numbers and percentages. The test-retest reliability and inter-rater reliability were assessed using weighted kappa (κ). The κ value was interpreted as no agreement (κ=0), poor agreement (κ=0.01−0.20), slight agreement (κ=0.21−0.40), fair agreement (κ=0.41−0.60), good agreement (κ=0.61−0.80), very good agreement (κ=0.81−0.92), and excellent agreement (κ=0.93–1) according to standard practice [24]. The correlation of CFS score with health-related characteristics (total medication number, polypharmacy, and multimorbidity) and functional status (ADL impairment and IADL impairment) were assessed using Kendall's tau.

3. RESULTS

3.1. Translation and adaptation of the Clinical Frailty Scale (CFS)

Following the ISPOR guidelines, the CFS was successfully translated into Vietnamese and its reliability was assessed. The process of translation is illustrated in Fig. 1 and can be outlined as follows: During the forward translation steps, there was a high level of agreement in both meaning and wording. The minor discrepancies observed primarily revolved around the use of synonyms for specific terms, which were carefully discussed and resolved during a reconciliation meeting. The back translation aligned well with the forward translation versions, with only a few discrepancies identified. Only slight modifications in some items were made. Despite the thorough evaluation, all the items received a "very good" or "excellent" rating, and only minor changes were made in the Vietnamese terms used in the scale. The adjusted words included: (1) Category 1. Very Fit _ "một trong những người khỏe nhất" was revised to "những người khỏe nhất"; (2) Category 4. Living with Very Mild Frailty_ "giai đoạn đánh dấu sớm" was changed into "giai đoạn chuyển biến sớm"; and (3) in mild dementia _ "tách biệt với xã hội" was revised to "cô lập với xã hội". In the final steps, the translation underwent proofreading, and subsequently, the CFS-VN version was established (Appendix 1).

3.2. Reliability of the Clinical Frailty Scale into Vietnamese (CFS-VN)

A total of 324 outpatient participants were analyzed in the validation cohort; 25.2% were between 60 and 69 years, 37.1% were aged between 70 and 79 years, and 36.7% were aged ≥80 years. Approximately 65% of the participants were women. The mean body mass index was 20.6±2.9 kg/m^2, with 25.6% classified as having ADL impairment and 63.9% IADL impairment. Approximately 79% of the participants

had hypertension, 31.5% had diabetes, 15.1% had a history of stroke, 17.9% had chronic kidney disease, and 4.6% had cancer. The mean total number of medications was 4.5±3.0 with 60.2% classified as having polypharmacy. Further participant characteristics are presented in Table 1.

For the frailty assessment, none of the participants were

Table 1. Baseline characteristics of the study population (n=324)

Characteristics	Mean±SD (range) or n (%)	Characteristics	Mean±SD (range) or n (%)
Age, years old, mean±SD (range)	76±9 (60–102)	Polypharmacy (n [%])	195 (60.2)
Age group (n [%])		ADL impairment (n [%])	83 (25.6)
60–69	85 (25.2)	ADL score (n [%])	
70–79	120 (37.1)	0	20 (6.2)
≥80	119 (36.7)	1	18 (5.5)
Gender (n [%])		2	7 (2.2)
Female	208 (64.2)	3	9 (2.8)
Male	116 (35.8)	4	11 (3.4)
Education (n [%])		5	18 (5.5)
Preschool	47 (14.5)	6	241 (74.4)
Primary	121 (37.3)	IADL impairment (n [%])	205 (63.3)
Secondary	72 (22.2)	IADL score (n [%])	
Higher education	19 (5.9)	0	35 (10.8)
Occupation (n [%])		1	24 (7.4)
Famer	43 (13.3)	2	26 (8.0)
Employee	47 (14.5)	3	21 (6.5)
Officer	38 (11.7)	4	23 (7.1)
Merchant	95 (29.3)	5	19 (5.9)
Other	101 (31.2)	6	25 (7.7)
Marital status (n [%])		7	32 (9.9)
Never married / widowed / divorced	178 (54.9)	8	119 (36.7)
Married	146 (45.1)	CFS score (mean±SD)	4.8±1.4
Living status (n [%])		Frailty group (n [%])	
Living alone	15 (4.6)	Frail	197 (39.2)
With family	298 (92.0)	Non-frail	127 (60.8)
Other	11 (3.4)		
BMI (kg/m^2, mean±SD)	20.6±2.9		
Multimorbidity (n [%])	272 (84.0)		
Comorbidities (n [%])			
Hypertension	256 (79.0)		
Chronic kidney disease	58 (17.9)		
History of stroke	49 (15.1)		
Osteoarthritis	91 (28.1)		
Anemia	27 (8.3)		
Diabetes	102 (31.5)		
Peripheral arterial disease	12 (3.7)		
Ischemic heart disease	91 (28.1)		
Heart failure	28 (8.6)		
Cancer	15 (4.6)		

SD, standard deviation; BMI, body mass index; ADL, activities of daily living; IADL, instrumental activities of daily living; CFS, Clinical Frailty Scale.

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classified as "very fit" (1) or "terminally Ill" (9). The more prevalent CFS phenotype was "mildly frail" (5) (94 patients), followed by "managing well" (3) or "moderately frailty" (6) (62 patients). The distribution of the participants by CSF scores is illustrated in Figs. 2 and 3.

Table 2 shows the results of the validation tests of the

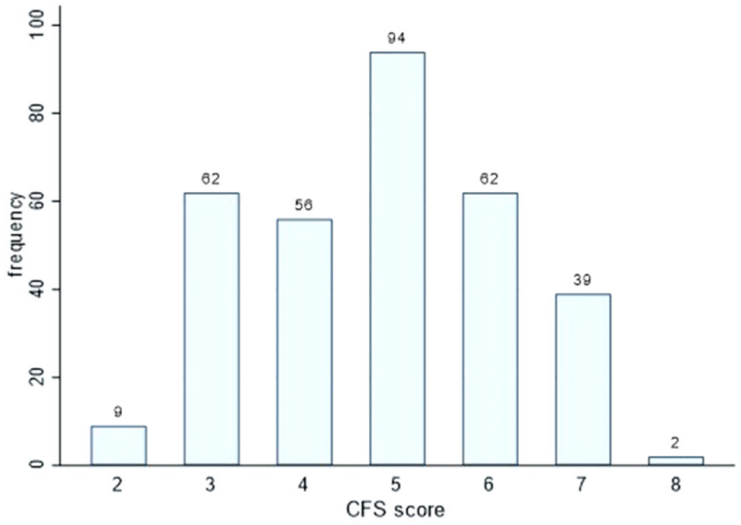

Fig. 2. Number of patients across the clinical frailty scale.

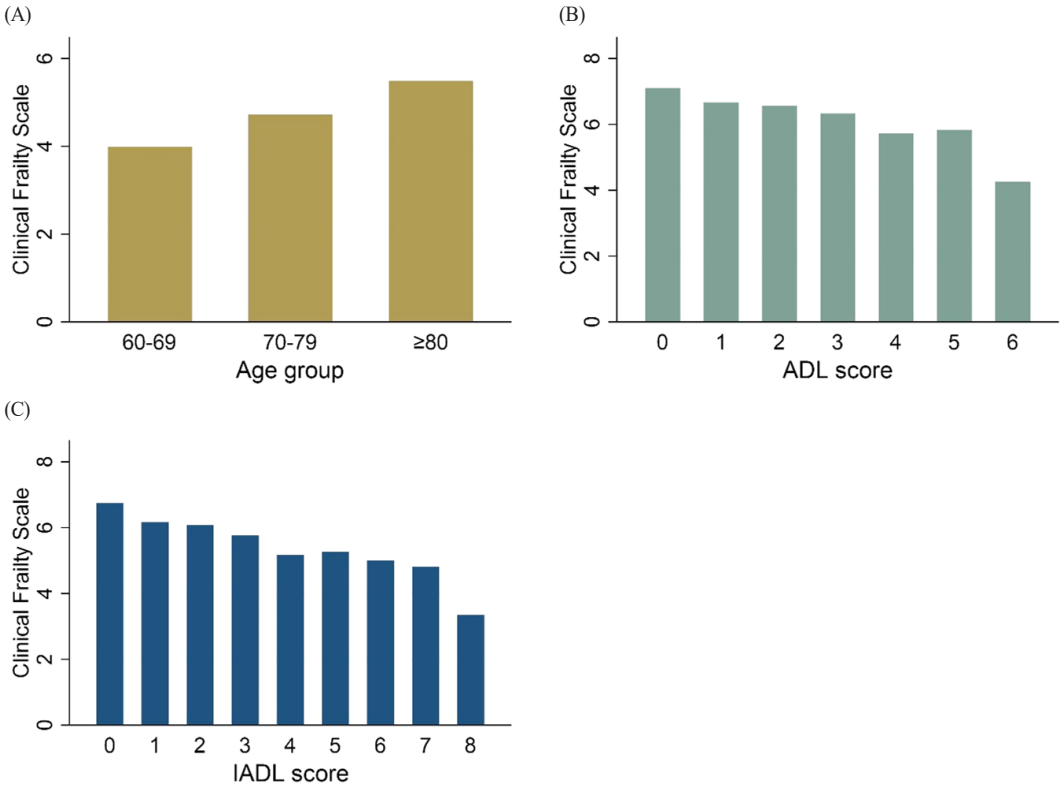

Fig. 3. CFS scores across subgroups of the participants based on (A) age groups, (B) activities of daily living, and (C) instrumental activities of daily living scores. ADL, activities of daily living; IADL, instrumental activities of daily living; CFS, Clinical Frailty Scale.

Table 2. Results of the CFS-VN reliability tests

Tests	Weighted kappa (p-value)		
	Total (n=324)	Male (n=116)	Female (n=208)
Inter-rater reliability	0.808 (p<0.001)	0.7784 (p<0.001)	0.8216 (p<0.001)
Test-retest reliability	0.869 (p<0.001)	0.8594 (p<0.001)	0.8722 (p<0.001)

CFS-VN, Clinical Frailty Scale into Vietnamese.

Table 3. Correlation of the CFS-VN with health-related and geriatric assessment-related characteristics

	Kendall's τ coefficient	p-value
Total medication number	0.0665	0.124
Polypharmacy	0.1151	0.021
Multimorbidity	0.1810	<0.001
ADL score	–0.6307	<0.001
IADL score	–0.8159	<0.001

CFS-VN, Clinical Frailty Scale into Vietnamese; ADL, activities of daily living; IADL, instrumental activities of daily living.

CFS-VN. Inter-rater reliability was achieved with a weighted kappa of 0.808 (p<0.001). Test-retest reliability was achieved with a weighted kappa of 0.869 (p<0.001). The CFS-VN scores significantly positively correlated with polypharmacy, multimorbidity, ADL impairment, and IADL impairment; however, they did not correlate positively with the medication number (Table 3).

4. DISCUSSION

A cultural adaptation process is conducted to determine whether a measurement tool remains effective when applied in a culture different from that in which the original scale was developed. In this study, we successfully translated and adapted the CFS version 2.0 into Vietnamese (CFS-VN), with minor changes in some of the terms used, following the comments of the 10 senior medical doctors from various specialties. Furthermore, the translation and review steps based on highly cited, expert consensus guidance [17,18] were significantly followed, thus contributing to the high quality of the revised scale.

The Vietnamese version of the CFS demonstrated satisfactory inter-rater (weighted kappa: 0.808) and test-retest (weighted kappa of 0.869) reliabilities, with good agreements between raters. These outcomes were similar to those reported in French study, where the inter-rater variability of the CFS-French version was 0.73, whereas the test-retest variability was 0.86 [25]. Interestingly, none of the participants in the study were rated as "very fit" (category 1). This may be reflect the context in Vietnam where population is aging rapidly, but overall health status has not improved correspondingly. Moreover, as noted in a previous study [26], older adults in Vietnam typically develop multiple chronic conditions, with an average of seven types of diseases, which serves as significant risk factors for frailty. Therefore, the CFS-VN may allow frailty assessment, imporoving the quality of care and preventive strategies among Vietnamese older adults. In our study, the proportion of females was nearly double that of males (64.2% vs. 35.8%), which is different from the result of the Korean study [12]. Indeed, according to the results of the Population and Housing Census 2019 in Vietnam [27], a widening gender gap was observed in older population , with more females than males at advanced ages. The participants in our study were outpatient, which may reflect the gender disparity among older people living in the community in Vietnam. A similar gender ratio was reported in the previous study on frailty in Vietnam [15]. Otherwise, the Korean study included outpatients and inpatients, which may account for the difference in the gender ratio in the Korean study compared to ours.

Several domains were incorporated into the CFS, including comorbidity, cognition, functional disability, and physical activities. A significant correlation was found between the CFS-VN and several geriatric conditions, such as polypharmacy, multimorbidity, ADL impairment, and IADL impairment, which aligns with these components. Among these components, the IADLs and ADLs showed the highest correlation with the CFS-VN, as the functional status is one of the most important criteria for classifying the CFS. This finding is consistent with previous studies [11,28].

In this study, the CFS successfully distinguish between age groups. As shown in Fig. 2, frailty severity increases with age. Participants in the age group ≥80 years had the highest

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level of frailty. These findings align with the literature and a large body of studies. Age is a strong predictor of frailty because older age is associated with several negative outcomes, including multimorbidity, impaired cognitive function, and poor physical status [29–31].

This study had some limitations. There is no validated Vietnamese frailty tool that can be compared to the CFS-VN, as a reference tool for assessing frailty. Although the Fried phenotype is widely used in research in Vietnam [15,32], it is not suitable for evaluating frailty in older patients due to the requirement of instruments and is time-consuming [33–35]. Additionally, the study only analyzed older outpatients; healthy older adults living in the community or severely ill people in the hospital were not included. As a result, this study lacked paricipants who are "very fit" with a CFS score of 1 and "severely frail" or "terminally ill" patients with a CFS score of 9, who might receive home care or hospice service. Older inpatients were not included in our study because frailty status in older inpatients could be influenced by acute conditions and during hospitalization [36]. However, our study developed the CFS-VN with good reliability, providing a translated and cultural-adapted tool for frailty assessment in older Vietnamese adults. Further studies should include community-dwelling older adults and outpatients as participants to further validate the efficacy of the frailty assessment, particularly in "very fit" and "terminally ill" patients.

5. CONCLUSION

Our study demonstrated that the Vietnamese version of the CFS version 2.0 (CFS-VN) is a reliable tool for evaluating frailty among older adults in Vietnam. The application of this tool can aid in developing preventive strategies, ensuring appropriate management, and ultimately inproving the quality of health care for Vietnamese elderly population.

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Conflict of interest

No potential conflict of interest relevant to this article was reported.

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Writing - original draft: TTT Nguyen, THK Pham.
Writing - review & editing: TV Nguyen, TTT Nguyen, TC Nguyen, THK Pham.

Availability of data and material

Upon reasonable request, the datasets of this study can be available from the corresponding author.

Ethics approval

This study was approved by the Institutional Review Board of the University of Medicine and Pharmacy at Ho Chi Minh City (approval number: 336/HĐĐĐ-ĐHYD; March 22, 2023).

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APPENDIX

Appendix 1. Clinical Frailty Scale (CFS) version 2.0 and its Vietnamese translation

Clinical Frailty Scale v2.0*	Thang suy yếu lâm sàng phiên bản 2.0
1. **Very Fit** – People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.	1. **Rất khỏe**- Những người khỏe mạnh, năng động, nhiều năng lượng và tích cực. Họ tập thể dục đều đặn và là những người khỏe nhất trong độ tuổi của họ.
2. **Fit** – People who have **no active disease symptoms** but are less fit than category 1. Often they exercise or are very **active occasionally**, e.g. seasonally.	2. **Khỏe**- Những người **không có triệu chứng bệnh** tiến triển nhưng không khỏe bằng nhóm 1. Họ thường tập thể dục hoặc **đôi khi rất năng động**, Ví dụ tùy theo mùa trong năm.
3. **Managing Well** – People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.	3. **Sức khỏe ổn định**- Những người có bệnh lý **được kiểm soát tốt** dù thỉnh thoảng có triệu chứng, nhưng họ **thường không năng động** ngoài việc đi lại thông thường**.**
4. **Living with Very Mild Frailty** – Previously "vulnerable", this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up" and/or being tired during the day.	4. **Suy yếu rất nhẹ**- Trước đây là nhóm "dễ tổn thương", nhóm này là giai đoạn chuyển biến sớm sang không còn độc lập hoàn toàn các hoạt động chức năng nữa. Dù **không phụ thuộc** vào người khác trong sinh hoạt hàng ngày nhưng các **triệu chứng thường gây giới hạn hoạt động**. Than phiền thường gặp là cảm thấy "chậm chạp" và/hoặc mệt mỏi trong ngày.
5. **Living with Mild Frailty** – People who often have **more evident slowing**, and need help with **high order** instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.	5. **Suy yếu nhẹ**- Những người **có biểu hiện chậm chạp rõ**, và cần giúp đỡ trong các hoạt động sinh hoạt hàng ngày cấp cao (tài chính, sử dụng phương tiện giao thông, làm việc nhà nặng). Thông thường, suy yếu nhẹ làm giảm dần hoạt động mua sắm, đi ra khỏi nhà một mình, nấu ăn, quản lý thuốc và bắt đầu hạn chế các công việc nhà đơn giản.
6. **Living with Moderate Frailty** – People who need help **with all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.	6. **Suy yếu trung bình**- Những người cần giúp đỡ trong **mọi hoạt động bên ngoài** và **quản lý việc nhà**. Trong nhà, họ khó khăn khi leo cầu thang và **cần giúp đỡ khi tắm**, có thể cần sự hỗ trợ tối thiểu (gợi ý, đứng bên cạnh) khi mặc quần áo.
7. **Living with Severe Frailty** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).	7. **Suy yếu nặng- Hoàn toàn phụ thuộc người khác trong việc chăm sóc bản thân** do bất cứ nguyên nhân nào (thể chất hoặc nhận thức). Dù vậy, họ có vẻ ổn định và không có nguy cơ tử vong cao (trong vòng 6 tháng).
8. **Living with Very Severe Frailty** – Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.	8. **Suy yếu rất nặng**- Hoàn toàn phụ thuộc người khác trong việc chăm sóc bản thân và đang bước vào giai đoạn cuối đời. Thông thường, họ không thể phục hồi ngay cả khi có bệnh nhẹ.
9. **Terminally Ill** – Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty** (Many terminally ill people can still exercise until very close to death).	9. **Bệnh giai đoạn cuối**- Ở giai đoạn cuối đời. Nhóm này áp dụng đối với những người có **kỳ vọng sống < 6 tháng nhưng không hẳn là người suy yếu nặng** (Nhiều người giai đoạn cuối vẫn có thể vận động cho đến khi cận tử).
Scoring frailty in people with dementia	Đánh giá suy yếu ở người sa sút trí tuệ
The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.	Nhìn chung mức độ suy yếu thường tương ứng với mức độ sa sút trí tuệ. **Các triệu chứng thường gặp của sa sút trí tuệ nhẹ** gồm quên các chi tiết của sự kiện gần, dù vẫn nhớ sự kiện đó, thường lặp lại cùng một câu hỏi/ câu chuyện và cô lập với xã hội.
In **moderate dementia**, recent memory is very impaired, even though they can remember their past life events well. They can do personal care with prompting.	Trong **sa sút trí tuệ trung bình**, trí nhớ gần bị giảm nặng, mặc dù họ có thể nhớ rõ các sự kiện trong quá khứ. Họ có thể tự chăm sóc bản thân nếu được nhắc nhở.
In **severe dementia** they cannot do personal care without help.	Trong **sa sút trí tuệ nặng**, họ không thể tự chăm sóc bản thân nếu không có sự trợ giúp.
In **very severe dementia** they are often bedfast. Many are virtually mute.	Trong **sa sút trí tuệ rất nặng**, họ thường nằm liệt giường. Nhiều người hầu như không nói chuyện.
Clinical Frailty Scale © 2005-2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: www.geriatricmedicineresearch.ca Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005:173;489-495.	Thang điểm suy yếu lâm sàng © 2005-2020 Rockwood, Phiên bản 2.0 (VN). Mọi quyền được bảo lưu. Liên hệ xin phép: www.geriatricmedicineresearch.ca Rockwood K và cộng sự. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005:173;489-495. Translated with permission to Vietnamese by Tri Van Nguyen, Tran To Tran Nguyen, The Ha Ngoc Than,Tai Huy Kien Pham and Tuan Chau Nguyen in Ho Chi Minh City, Vietnam, 2022.

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