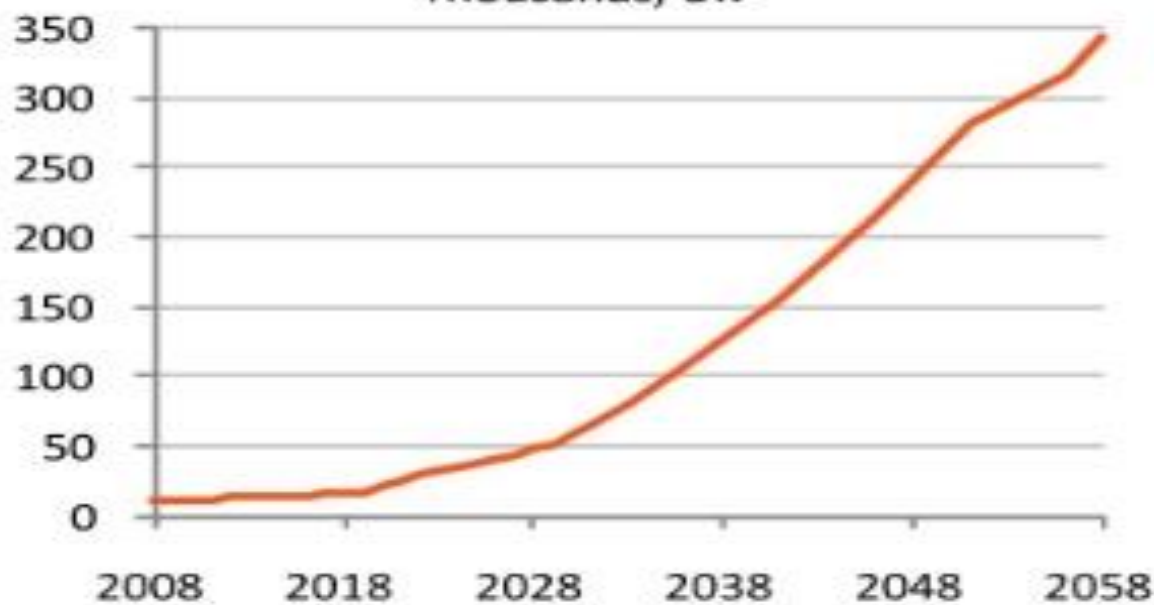


Liaison Services for Older People at the “Front Door”



Telegram overload - centenarians will continue to be the fastest growing age group

Thousands, UK



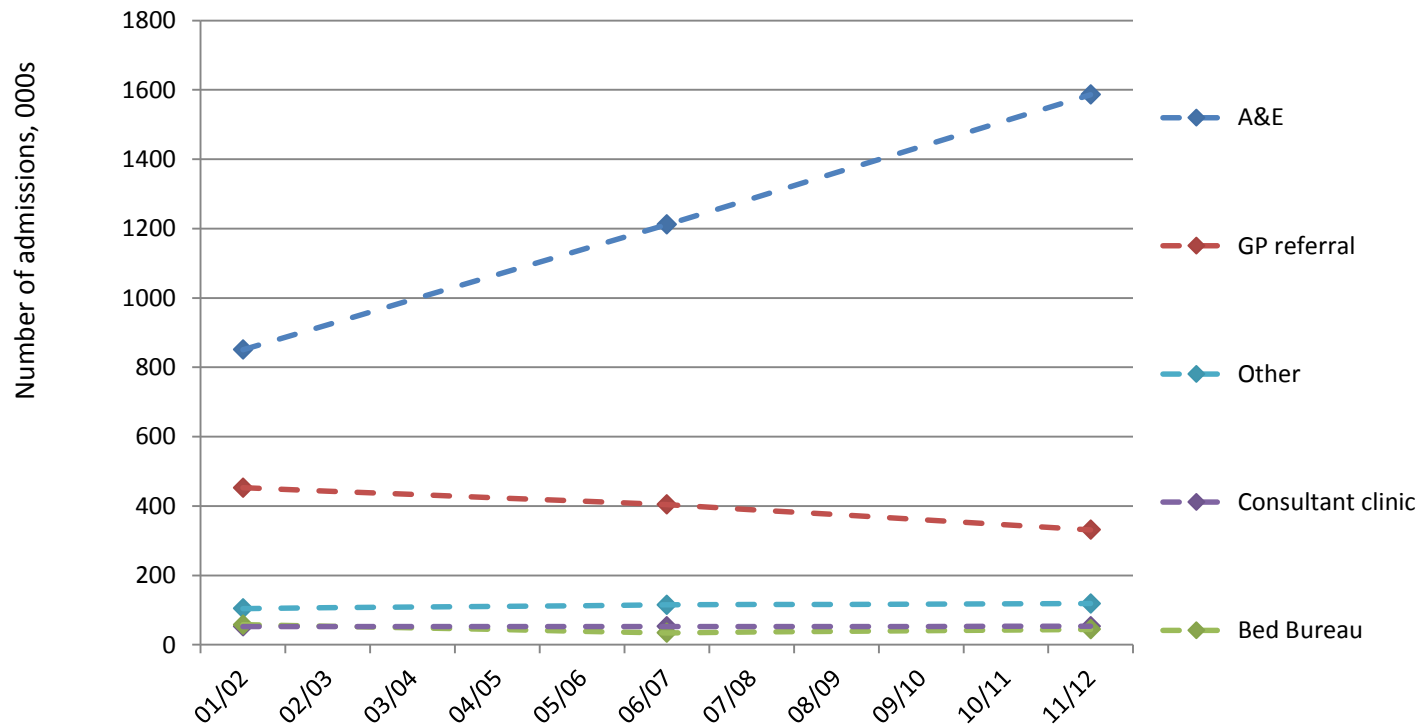
Government Actuary's Department

Which older people?

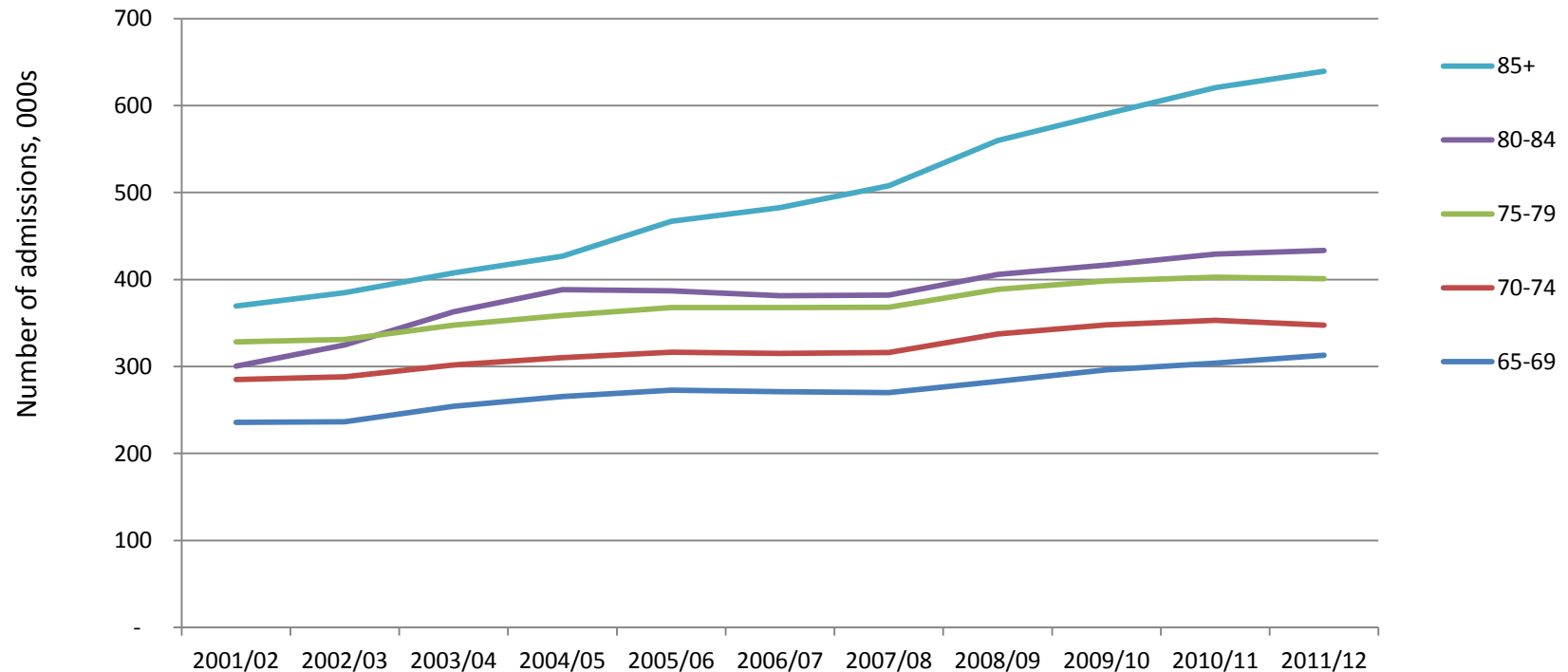


Emergency hospital admissions, older people (85 yrs or more), by source of admission, thousands

Emergency hospital admissions



Emergency hospital admissions by age band, thousands, 2001/02 – 2011/12



Is there a problem?

- Older people are disproportionately represented in ED attenders (the very elderly more so)
- “Sicker”, require more investigations, more likely to be admitted
- More likely to arrive by ambulance
- Spend longer in the ED

Risk of adverse outcomes

- “environment prone to errors”
- High volume patients
- High acuity
- High complexity
- Incomplete information
- Frequent interruptions

- Older people at higher risk of errors

Patient Safety in the Emergency Department: far reaching implications

- 43% increase in mortality at ten days after admission through an overcrowded emergency department (ED) (Richardson 2006)
- Length of stay in an ED is a predictor of inpatient length of stay (Liew et al 2003)
 - An ED stay of 4-8 hours increases inpatient length of stay by 1.3 days and an ED stay of more than 12 hours increases length of stay by 2.35 days
- For patients who are seen and discharged from ED, the longer they have waited to be seen, the higher the chance that they will die during the following seven days (Guttman et al 2011)

For older people discharged...

- After ED attendance older people more likely:
 - to re-attend (probably),
 - be (re-) admitted,
 - suffer functional decline,
 - be admitted to long term care or
 - to die

- Frailty associated with worse outcomes

Commonest presentations

- Older (UK) literature identifies falls as commonest reason for attendance
- more recent paper (USA) cite cardiac conditions
- Frailty syndromes (falls, off legs, delirium, continence problems) common
- Often unrecognised
- Eg only 10% patients with dementia, delirium or depression were identified by the attending doctor

- 20% older people sent home from A&E reported new difficulty with self care (vs 10% young)
- Few recalled doctor asking them about how they would care post discharge
- More problems in very elderly (ie 85+ yrs)
- 1/3 lived alone

Two problems!

- Older people who are discharged under current arrangements often have sub-optimal outcomes
- More and more older people are being admitted to hospital- is this always the best or only way of managing their problem?

Comprehensive Geriatric Assessment (CGA) in the ED

- We know CGA evidence for benefit –
 - fewer (re-)admissions,
 - people more likely to be alive and living at home
- Could CGA commence in the ED?
- Requires specialist medical assessment and appropriate access to PAM

What works in preventing decline post ED discharge?

- Health visitors found 50% had increased dependence post discharge from A&E
- 92% seen given advice or referral for support or equipment
- Intervention group sig more independent at 4 weeks
- Interventions tested included telephone contact or home visiting

Interface Geriatrics

- Assessment by a specialist in medicine for the elderly
- Access to PAM (as required- usually physio/ OT/ social worker)
- Targeted investigations
- Rapid discharge planning
- Close liaison with families/ GPs/ community health and social care

Liaison across health and social care boundaries

- Information gathering and giving
- Links with primary care- telephone, electronic, hand written
- Links with local neighbourhood integrated teams (community matrons, district nurses, social workers)
- Links with intermediate care teams

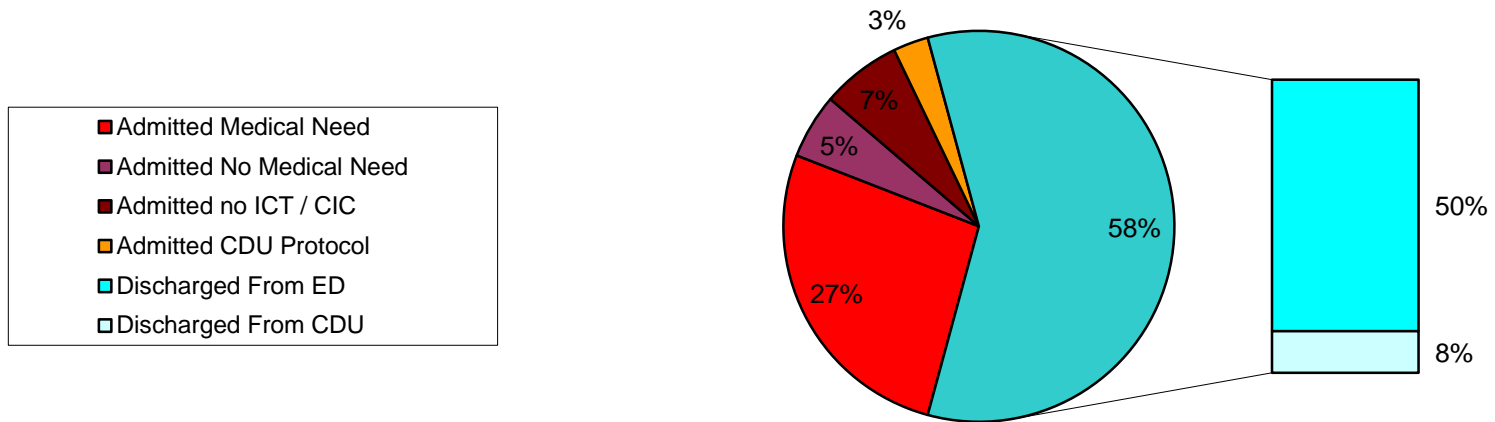
Interface Geriatrics

- Evidence from Leicester, Kings (London), Leeds:
- Fewer admissions- conversion rate lower
- Fewer re-attendances and admissions with in 30 and 90 days

- Average discharge rate from A&E without interface geriatrician role:
 - 75-85 yrs 28-33%
 - >85 yrs 22-25%
- 58% when interface geriatrician on duty (further 12% admitted because of lack of community services)
- Time to see doctor for elderly patients reduced by 17 minutes when interface geriatricians on duty

Impact

Patients seen in ED by IG



Patient Experience

- Starts at Front Door (Emergency Department)
 - CGA + decision-making
 - Facilitating discharge direct from ED
 - Rapid access outpatient reviews
 - Starting outpatient investigation
 - Liaising with Care Homes, GPs and community services
 - Advance care planning
 - Developing links with ED

Primary Care Access Line

- Initially set up as a route to a hospital bed
- Now used also to access specialist advice
- Calls taken by nurses with knowledge of other resources available
- Three way calls between GP, geriatrician and nurse allow exploration of possible options
- Admissions can be deferred in some cases- rapid access outpatient clinic appointment, community geriatrician visit, agreement on an end of life pathway

Part of a continuum of care for frail older people

- Preventive, care
- Supportive self management
- Focussed support for those considered to be at highest risk of hospital admission
- Crisis response in the community/ hospital
- Excellence in inpatient care (whether on an elderly care ward/ orthopaedics/ etc), including effective early discharge planning
- Ongoing case management, ultimately end of life care

Conclusion

The evidence base for effective care of older people indicates that we should offer Comprehensive Geriatric Assessment to Older People at their first point of contact with the acute hospital

- We need to define and measure quality indicators
- Use local data for action and improvement
- Use the available evidence to drive a change culture
- “Turn patients into people again”

Case Study 1

- 85 year old man been visiting his wife in a care home and had collapsed on leaving.
- 3rd attendance to ED with “collapse”- via 999, several short stay admissions
 - Medications reviewed previously-postural hypotension
 - appeared low in mood, tearful
- Referred to the community matron from ED
 - arranged for him to have a hot meal at the care home joint visit with social worker, subsequent telephone F/U
- better quality of life, improved mood and health, not presented again to the ED.

Case Study 2

- 91 year old female in Residential Home.
- End of life approaching
 - Community DNACPR in situ
 - Advance care planning being considered
- Presented to ED following a seizure
 - Excluded reversible causes
- Spoke to NOK, care home manager, GP, S/W
 - Identified ongoing care needs + concerns seizures, pain
- Discharged from ED with increased Anti-epileptics, analgesia, PRN rectal diazepam, advanced care plan