Acute care toolkit 3: Acute medical care for frail older people March 2012

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One of the challenges is that of non-specific presentations, such as delirium, that can mask serious underlying issues. Given the holistic nature of acute care, this article focuses on acute hospital care; broader aspects of frailty* are discussed in Acute care toolkit 1: Handover.

The oldest patients attending hospitals are often physically cognitively, or socially frail; they are prone to significant deterioration, and are high risk of hospitalisation, and potentially reduce the need for long-term care after discharge. Thus, if effective medical treatment and care can be provided, some additional measures may be required. Older patients, hospital at home can be safe and effective, and has the potential to ward off and decompress reducing the risk of health and social care facilities. The addition of acute care to frail older people (aged 65+) comprises a relatively small proportion of patients to see quickly. Geriatric liaison teams, which are familiar with frail older people with communication barriers (cognitive or social), can intervene within the first hours of an admission by identifying a focused population who may benefit from an interdisciplinary team of experts. Geriatric liaison teams provide value-added input, especially in setting goals and in assessing frail older people. Perhaps most importantly, clinicians in the AMU can model the behaviour necessary to ensure geriatric expertise. For example, not attributing immobility to age alone; not ascribing every confusional state to urosepsis; demonstrating patience and consideration when assessing older people; having patience when accessing frail older people with communication barriers (cognitive or social). If these are attributable to a specific specific incident, this can be addressed accurately and comprehensively, will improve patient outcomes.

Acute care toolkit 1: Handover

Older people are major users of acute care (the AMU), so intellectually, socially and physically frail, and the presence of frailty in the AMU is a justification for clinical care based on the AMU to focus solely on these issues.

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Challenges

Assessment

The clinical assessment of frail older people is challenging, as they often present non-specifically (with falls, immobility or delirium), which can make the immediate diagnosis difficult. History taking may be complicated by the presence of sensory impairment, dementia or delirium. Other, additional information and collateral history may be needed, which may not be readily accessible in the acute setting. Time pressures may prevent junior staff from focussing on anything other than immediate problems.

Recommendations:

1) Do delay, delegate or delegate the collected history – a 10 minute consultation with a care co-ordinator might be more effective.
2) Ensure that staff working in the AMU can readily delegate duties from dementia patients, for example through using the delirium toolkit (RCP guidelines).
3) Ensure that adults who communicate are readily accessible (eg hearing aid facilities, visual aids).
4) Do not risk the death of older people who communicate barriers – consider using an exchangeable scale as your measure.

The presence of one or more frailty syndromes (see Box 1) should prompt consideration of the need for a fuller assessment, as it is more likely to be ongoing, than immediate problem.

While the assessment and initial management may be stable in the acute setting, it does not follow that all ongoing management needs to be stable. It is a growing only too apparent that navigating these services can be difficult, especially for staff who are new to working in these domains. Dedicated liaison nurses or local doctors for discharge in the AMU can be effective recommendations.

Consideration of other approaches can deliver early comprehensive geriatric assessment (CGA) for frail older people. CGA is a multidimensional, comprehensive assessment of all aspects of an individual's situation and of the needs arising. It is aimed at identifying problems that may need to be addressed and is a useful tool in both hospital and community settings for improving the health and well-being of frail older people. CGA involves a range of domains for comprehensive geriatric assessment, including physical, social and mental health.

Delirium may be a marker for comorbidity and a sign of serious underlying medical conditions, which might require urgent investigation. Delirium can be severe and is associated with increased risk of mortality, falls and delirium-related adverse drug events. Delirium in older people is a significant public health issue. It is associated with decreased quality of life and increased risk of subsequent dementia. Delirium can be caused by a variety of factors, including infections, metabolic disorders, medications and alcohol withdrawal. Delirium can also occur in the elderly due to a variety of factors, including infections, metabolic disorders, medications and alcohol withdrawal. Delirium can also occur in the elderly due to a variety of factors, including infections, metabolic disorders, medications and alcohol withdrawal.

Immobility

Recent immobility may be a marker for comorbidity and serious underlying medical conditions. Immobile older people may have underlying medical conditions that need to be assessed and managed. Immobility can be a sign of serious underlying medical conditions, which might require urgent investigation. Immobility can also occur in the elderly due to a variety of factors, including infections, metabolic disorders, medications and alcohol withdrawal. Immobility can also occur in the elderly due to a variety of factors, including infections, metabolic disorders, medications and alcohol withdrawal.

Polypharmacy

Polypharmacy is a common problem in elderly patients, and it can lead to adverse drug events. Polypharmacy is defined as the use of multiple medications by a patient. Polypharmacy can be a sign of serious underlying medical conditions, which might require urgent investigation. Polypharmacy can also occur in the elderly due to a variety of factors, including infections, metabolic disorders, medications and alcohol withdrawal. Polypharmacy can also occur in the elderly due to a variety of factors, including infections, metabolic disorders, medications and alcohol withdrawal.

Mortality rates for frail older people in the year following discharge are significantly higher than the mortality rates for younger people. Mortality rates for frail older people in the year following discharge are significantly higher than the mortality rates for younger people.

The challenge for services is to design a system that facilitates the early identification of those people who could benefit from a multidisciplinary approach in hospital, and also benefits discharge, which reflects the established evidence base for CGA (see Box 2).

Domains for comprehensive geriatric assessment

Assessment of frailty for CGA are detailed in broad terms in Table 1. The precise nature of the assessment will vary between individuals. All members of the acute care team will make contributions. For CGA, the acute factors will address the acute medical problems, nursing and therapy staff assess home circumstances and physical abilities. But it requires an individual to possess the information in an overview and advise on next steps. It will typically be a geriatrician or a nurse with an acute nursing experience.

Recommendations:

1) Do ensure that the hospital staff are well-trained in delirium.
2) Consider carefully what needs to be done in hospital and what might better be achieved in the community setting.

Whole systems approach

Multidisciplinary assessment and management of elderly people leads to better outcomes. Frail elderly people often require more than one professional to treat them. It is therefore important to assess the whole person and co-ordinate care planning. But it requires an individual to possess the information in an overview and advise on next steps. It will typically be a geriatrician or a nurse with an acute nursing experience.

Recommendations:

1) Engage with GPs commissioners about whole systems of care in frail elderly care. Frail older people, social care and community services will be key partners.
2) Align engagement with appropriate acute and specialist services to deliver high quality care for elderly people at the widest possible time following contact with acute service.

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Box 1 Frailty syndromes – a 30-second guide

Falls

Distinguish between syncopal (eg cardiac, polypharmacy), or non-syncopal (eg neurological, trauma or delirium) falls. Assess for appropriate disposition to a specialist department.

Delirium

Identify delirium in the elderly, which may be masked by dementia, using the delirium toolkit (RCP guidelines). Once identified, refer to a geriatrician or psychiatrist.

Dementia

Identify dementia in the elderly, using the delirium toolkit (RCP guidelines). Once identified, refer to a geriatrician or psychiatrist.

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Domain classification:

- Physical
- Social
- Mental

Box 2 Comprehensive geriatric assessment

Evidence: CGA leads to better outcomes, including reduced morbidity, reduced length of stay, greater patient satisfaction and lower costs.

Definitive: a multidisciplinary, interdisciplinary diagnostic approach that encompasses physical, social, mental and psychological domains (a ‘whole systems’ approach); and engagement of all relevant stakeholders (eg primary care, acute, community, patient and carers) in decision making. CGA provides a structured approach to assessment and management of frail older people that can be used to improve service delivery for this population (courtesy of Jay Banerjee, the Silver Book).

What is different about CGA: While integrating geriatric assessment into usual care is key, patients with frailty and comorbidity may have particular needs that require specific targeted assessment and management. A typical CGA team comprises geriatrician, nurse specialist, occupational therapist, physiotherapist, pharmacist and others (see Table 1) (courtesy of Jay Banerjee, the Silver Book).

Table 1 Main domains of comprehensive geriatric assessment

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The clinical assessment of frail older people is challenging, which may not be readily accessible in the acute setting. Time spent on history taking, social information, and palliative rather than curative approach may be required. For example, patients with high risk of falls are admitted to hospital on a ‘place of safety’, although being in hospital actually increases the risk of falling. In acute care environment, increased risk of delirium, falls and stools that get in the way, high bed heights. Care at home is often a safer alternative.

Recommendations:
- Consider socialising through community services or having ‘staff swap’ services, to provide a better understanding of the role of each sector and pressures.
- The duration to discharge (or indeed admission) is always subject to risks. Risk assessment is especially complicated in the case of older people, as there are usually multiple competing priorities. Treatment goals may differ for some, some prefer palliative rather than curative approach may be required. It’s easy to get in the way, high bed heights. Care at home is often a safer alternative.
- The challenge for services is to design a system that facilitates the early identification of those people who can really benefit from being managed outside acute care, but also provide community care where necessary, reflecting the established evidence base for CGA (Box 2).

Domains for comprehensive geriatric assessment

Assessment required for CGA are detailed in broad terms in Table 1. For the present nature of the assessment will vary between individuals.

All members of the acute care team will make contributions. For CGA, the acute nurse will address the acute medical problems, nursing and therapy staff will assess home environments and physical abilities. But it requires an individualized assessment of the information in an interview and on advice on next steps. It will be a geriatrician or a nurse specialist for geriatric care.

Recommendations:
- Engage with GP commissioners about whole systems of care to facilitate acute elderly care. For frail older people, social care and community services will be key partners.
- Align emergency, acute medical and geriatric services to ensure effective information-sharing with acute services.
- Acute medical care should only be considered in patients with unexplained symptoms. It is important for those with a recent history of falls to manage patients with lower urinary tract symptoms, and caring for the patient groups.

Domestic support

- Older people coming into contact with healthcare providers on services following fall—without a holistic approach—should be offered a tailored multidisciplinary intervention to assess all elements of ongoing support. This can be achieved effectively by engaging with GP commissioners about whole systems of care and facilitating effective information-sharing with acute services.

Box 2 Comprehensive geriatric assessment

Evidence: CGA leads to better outcomes, including reduced readmissions, reduced long-term care, greater patient satisfaction, and reduced hospital stay.

Deﬁnition: Multidisciplinary, interdisciplinary diagnostic approach that integrates assessment of physical, mental, social, and functional capacities of a frail older person in order to facilitate appropriate discharge planning and long-term follow-up.

What is different about CGA? While integrating geriatric medicine into acute medical practice, it also emphasizes the holistic assessment of an older person and their environment to achieve better outcomes and the ability to transfer care to the most appropriate setting at the earliest point.

CGA usually includes a geriatrician, nurse, pharmacist, occupational therapist, physiotherapist, and social worker. It often occurs at the time of discharge planning and is strongly connected with primary care and community services. It also emphasizes the holistic assessment of an older person and their environment to achieve better outcomes and the ability to transfer care to the most appropriate setting at the earliest point.
The clinical assessment of frail older people is challenging, as they may present with multiple concurrent conditions and factors that require a comprehensive geriatric approach. The Geriatric Assessment Tool (GAT) is a framework that guides the evaluation of frail older people in acute care settings. It aims to predict adverse outcomes and provide a basis for effective management. The GAT uses a multidisciplinary approach to assess the patient and includes the following sections:

1. Initial assessment
2. Risk assessment
3. Clinical assessment
4. Functional assessment
5. Social assessment
6. Psychological assessment
7. Medication review
8. Discharge planning

The GAT helps healthcare professionals to identify and address the needs of frail older patients, ensuring that they receive appropriate care and support. This approach is essential in improving patient outcomes and reducing hospital stays.

Challenges

Assessment

The presence of one or more frailty syndromes (see Box 1) can make the clinical assessment of frail older people in acute care settings challenging, as it requires a comprehensive geriatric approach. The GAT is a framework that guides the evaluation of frail older people in acute care settings. It aims to predict adverse outcomes and provide a basis for effective management. The GAT uses a multidisciplinary approach to assess the patient and includes the following sections:

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Education and training

Much of the training in the AMU is directed towards improving nutrition, falls prevention, the AMU drug clinic, handwashing, and managing acute medical conditions. These are all directly relevant to the specific role of the AMU as an ideal opportunity to augment training and education in geriatric medicine. Patients with frailty syndromes can be a valuable resource for geriatricians, as important, and have generic relevance. The AMU is also a clinician based in the AMU to focus solely on these issues.

Older people are major users of acute care (the AMU is a key setting for decision-making, and education and training relevant to older people). Different models will be suited to different hospitals, but all need to be able to devise CSGs within the AMU and have strong links with community health and social services. Geriatricians supporting the AMU can help to facilitate identification of older people who may be safely managed in the community, improving patient outcomes and reducing bed days.

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One of the challenges is that of non-specific presentations, such as confusion, that can mask serious underlying pathology – ensuring a holistic assessment in the AMU is difficult for acute teams, with large numbers of patients. Geriatricians support the AMU, which hone the skills and time to focus on frail older people, can be helpful. Better integration between primary care, emergency departments, AMUs and geriatrics services, all working towards achieving high standards of urgent care, should reduce duplication and improve outcomes.

Background

Older people (aged ≥65) comprise a relatively small proportion of all patients admitted during the emergency department (ED), but forms a much higher proportion of patients in the AMU, with substantial proportion (60–70%) of overall hospital inpatients. The oldest patients attending hospitals are often physically, cognitively or socially frail to provide significant deterioration after admission or perioperatively. Frailty and vulnerability contribute to the oldest patients having the longest lengths of stay, highest rates of re-attendance and long term care after discharge. Admission to hospital also adds the risk of harm from cross-infection, pain, disorientation etc. Thus, appropriate medical treatment and care can be provided at home; these additional measures may be needed for selected patients. Hospital at home can be safe and effective, and has the potential to avoid functional deceleration, reducing the need for rehabilitation and long term care. But selecting the patients who can be safely treated at home is not straightforward.

Getting the assessment of older people right in the AMU has the potential to improve outcomes, reduce inappropriate hospitalisation, and potentially reduce the need for long term care. The increasing number of acute care beds on existing beds for urgent care for older people was covered in the Silver Book, due to be published in early 2012.
Integrated models

Integrated models are complex and require the collaboration of different professionals, often over a long period. The themes for this toolkit are designed to help people look beyond the most obvious and traditional ideas of models. Models that are based on real evidence and that are relevant to the specific context are needed. The models should be flexible, adaptable, and able to evolve over time.

Older people are major users of acute care (the AMU) is a key area for decision-making, education, and care that is relevant to older people. Different models will suit different hospitals, but all will need to be able to create CAs within the AMU and have strong links with community health and social services. Care models that are successful in the AMU will help to identify the frail elderly patient who may be best managed in the hospital, probably improving patient outcomes and reducing bed days.

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