— patients with pressure sores
— the presence of one or more frailty syndromes should trigger a more detailed comprehensive geriatric assessment.

Education and training

Much of the training in the AMU is directed towards nurse training; after the AMU training, handover and managing acute medical conditions. These are all inclusion criteria for: opportunity to augment knowledge and skills in assessing frail older people. It is a comprehensive geriatric assessment. The last two assessments are focused on frail older people.

Older people may have complex needs and are often managed by multiple healthcare professionals. They are likely to have underlying health conditions, and the need for care can be complex. The AMU provides a key role in identifying the important and urgent issues which, if addressed accurately and comprehensively, will improve patient outcomes. Accordingly, acute medical teams need to possess the knowledge and skills, and demonstrate the appropriate behaviours, for managing frail older people.

The AMU cares for patients with a wide range of conditions, but a large proportion of patients are frail older people. Frailty* is a complex condition that is associated with increased risk of adverse outcomes and mortality. The AMU has the potential to improve outcomes, reduce inappropriate hospitalisation, and potentially reduce the need for long-term care.

The AMU can provide care for frail older people in the community, and can be a bridge between hospital and community care. The AMU can also provide care for patients who are not frail older people.

One of the challenges is that of non-specific presentations, such as decompensation, that can mask serious problems. The silver book: Comprehensive assessment of the frail older patient March 2012

Another challenge is that of frailty, which is beyond the scope of this toolkit.
People will require assessment and support from professionals. The presence of one or more frailty syndromes (see Box 1) might better be achieved in the community setting.

Pain can be difficult to assess in older people who have hearing aid batteries, visual aids). Delirium and dementia

Delirium and dementia

End-of-life care

Box 1 Fractured synomy – a 30-second guide

Box 2 Comprehensive geriatric assessment

Table 1 Main domains of comprehensive geriatric assessment

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


Decisional: CGA is a diagnostic test. It can be used to help make decisions about treatment options (e.g. illness). 

Models of care

There are various models of service provision for older people with acute care needs in the community. All share these same strategic aims, i.e. to ensure that older people have access to CGA. Models of care in the community are designed to provide older patients with immediate access to investigations and treatment by appropriately trained medical, nursing and allied health professionals.

Age-related models

The Royal College of Physicians does not support age-segregated services, which risk discrimination. Instead, integrated units that care for all age groups are favoured. There are three kinds of advantage of systems against age-specific models. The evidence base for which advocates discrete units with a sequential rather than a simultaneous approach. There are examples of successful age-related models that deliver high-quality care for older people, but these require a clear understanding of the purpose of the service, and equitable access to support and investigations.

Recommendations

- Older people coming into contact with a healthcare provider or service following fall - whether in hospital or hospital. Self-harm, and to detect and initiate management for any mental health problems.

- Older people should not be routinely catheterised unless there is a clear indication.

- Ambulatory emergency pathways with access to multidisciplinary teams should be available, with a maximum time of less than four hours for an emergency overnight assessment for older people who do not require admission but need resettlement treatment.

- Models of care

There are various models of service provision for older people with acute care needs in the community. All share these same strategic aims, i.e. to ensure that older people have access to CGA. Models of care in the community are designed to provide older patients with immediate access to investigations and treatment by appropriately trained medical, nursing and allied health professionals.

Age-related models

The Royal College of Physicians does not support age-segregated services, which risk discrimination. Instead, integrated units that care for all age groups are favoured. There are examples of successful age-related models that deliver high-quality care for older people, but these require clear understanding of the purpose of the service, and equitable access to support and investigations.

Recommendations

- Older people coming into contact with a healthcare provider or service following fall - whether in hospital or hospital. Self-harm, and to detect and initiate management for any mental health problems.

- Older people should not be routinely catheterised unless there is a clear indication.

- Ambulatory emergency pathways with access to multidisciplinary teams should be available, with a maximum time of less than four hours for an emergency overnight assessment for older people who do not require admission but need resettlement treatment.

- Models of care

There are various models of service provision for older people with acute care needs in the community. All share these same strategic aims, i.e. to ensure that older people have access to CGA. Models of care in the community are designed to provide older patients with immediate access to investigations and treatment by appropriately trained medical, nursing and allied health professionals.

Age-related models

The Royal College of Physicians does not support age-segregated services, which risk discrimination. Instead, integrated units that care for all age groups are favoured. There are examples of successful age-related models that deliver high-quality care for older people, but these require clear understanding of the purpose of the service, and equitable access to support and investigations.

Recommendations

- Older people coming into contact with a healthcare provider or service following fall - whether in hospital or hospital. Self-harm, and to detect and initiate management for any mental health problems.

- Older people should not be routinely catheterised unless there is a clear indication.

- Ambulatory emergency pathways with access to multidisciplinary teams should be available, with a maximum time of less than four hours for an emergency overnight assessment for older people who do not require admission but need resettlement treatment.

- Models of care

There are various models of service provision for older people with acute care needs in the community. All share these same strategic aims, i.e. to ensure that older people have access to CGA. Models of care in the community are designed to provide older patients with immediate access to investigations and treatment by appropriately trained medical, nursing and allied health professionals.

Age-related models

The Royal College of Physicians does not support age-segregated services, which risk discrimination. Instead, integrated units that care for all age groups are favoured. There are examples of successful age-related models that deliver high-quality care for older people, but these require clear understanding of the purpose of the service, and equitable access to support and investigations.

Recommendations

- Older people coming into contact with a healthcare provider or service following fall - whether in hospital or hospital. Self-harm, and to detect and initiate management for any mental health problems.

- Older people should not be routinely catheterised unless there is a clear indication.

- Ambulatory emergency pathways with access to multidisciplinary teams should be available, with a maximum time of less than four hours for an emergency overnight assessment for older people who do not require admission but need resettlement treatment.

- Models of care

There are various models of service provision for older people with acute care needs in the community. All share these same strategic aims, i.e. to ensure that older people have access to CGA. Models of care in the community are designed to provide older patients with immediate access to investigations and treatment by appropriately trained medical, nursing and allied health professionals.

Age-related models

The Royal College of Physicians does not support age-segregated services, which risk discrimination. Instead, integrated units that care for all age groups are favoured. There are examples of successful age-related models that deliver high-quality care for older people, but these require clear understanding of the purpose of the service, and equitable access to support and investigations.

Recommendations

- Older people coming into contact with a healthcare provider or service following fall - whether in hospital or hospital. Self-harm, and to detect and initiate management for any mental health problems.

- Older people should not be routinely catheterised unless there is a clear indication.

- Ambulatory emergency pathways with access to multidisciplinary teams should be available, with a maximum time of less than four hours for an emergency overnight assessment for older people who do not require admission but need resettlement treatment.

- Models of care

There are various models of service provision for older people with acute care needs in the community. All share these same strategic aims, i.e. to ensure that older people have access to CGA. Models of care in the community are designed to provide older patients with immediate access to investigations and treatment by appropriately trained medical, nursing and allied health professionals.

Age-related models

The Royal College of Physicians does not support age-segregated services, which risk discrimination. Instead, integrated units that care for all age groups are favoured. There are examples of successful age-related models that deliver high-quality care for older people, but these require clear understanding of the purpose of the service, and equitable access to support and investigations.

Recommendations

- Older people coming into contact with a healthcare provider or service following fall - whether in hospital or hospital. Self-harm, and to detect and initiate management for any mental health problems.

- Older people should not be routinely catheterised unless there is a clear indication.

- Ambulatory emergency pathways with access to multidisciplinary teams should be available, with a maximum time of less than four hours for an emergency overnight assessment for older people who do not require admission but need resettlement treatment.

- Models of care

There are various models of service provision for older people with acute care needs in the community. All share these same strategic aims, i.e. to ensure that older people have access to CGA. Models of care in the community are designed to provide older patients with immediate access to investigations and treatment by appropriately trained medical, nursing and allied health professionals.

Age-related models

The Royal College of Physicians does not support age-segregated services, which risk discrimination. Instead, integrated units that care for all age groups are favoured. There are examples of successful age-related models that deliver high-quality care for older people, but these require clear understanding of the purpose of the service, and equitable access to support and investigations.

Recommendations

- Older people coming into contact with a healthcare provider or service following fall - whether in hospital or hospital. Self-harm, and to detect and initiate management for any mental health problems.

- Older people should not be routinely catheterised unless there is a clear indication.

- Ambulatory emergency pathways with access to multidisciplinary teams should be available, with a maximum time of less than four hours for an emergency overnight assessment for older people who do not require admission but need resettlement treatment.
### Challenges

**Assessment**

The clinical assessment of frail older people is challenging, as they often present non-specifically (for example with falls, immobility or delirium), which can make the immediate diagnosis difficult. History taking may be complicated by a series of sensory impairment, dementia or delirium. Often, additional information and collateral history needed, which may not be readily available in the acute setting. Time pressured teams often start from focusing on anything other than immediate problems.

**Recommendations:**

- Do not delay, defer or delegate the collateral history – a 10-minute conversation with a carer can rapidly reveal the story of the patient.
- Do not try to perform an exhaustive assessment in the acute setting. Delivering a holistic assessment in a series of small steps can improve accuracy, efficiency and protection against systematic errors.
- Ensure that staff working in the AMU can readily defer data from dementia, for example through using the delirium tick list (ICP guide).
- Ensure that all communication is readily available (eye level, written bullet points, visual aids).
- Pain can be difficult to assess in older people who have co-morbidities. Consider analgesia before obtaining a history.

**Management**

- The presence of one or more frailty syndromes (see Box 1) can make the immediate assessment and direct ongoing management.
- Do not delay, defer or delegate the collateral history – a 10-minute conversation with a carer can rapidly reveal the story of the patient.

**Recommendations:**

- Do not delay, defer or delegate the collateral history – a 10-minute conversation with a carer can rapidly reveal the story of the patient.

**Fig 1 Core clinical features of frail older people**

**Recommendations:**

- Multiple geriatric syndromes will be taken late, but is crucial to identify early and treat, as it can rapidly lead to delirium. Early discharge. Discharges should provide for provision for ongoing assessment to the AMU so that they are expected and tailored.

While the assessment and initial management may be stated in the acute setting, it does not follow that all ongoing management needs to be in hospital. There is growing only evidence for the benefits of navigating these services can be difficult, especially for staff who are relating through the AMU. Deliberate hidden services or local measures for discharge in the ACU can be recommended.

**Recommendations:**

- Convergni considers that it can help deliver early comprehensive geriatric assessment (CGA) for frail older people.
- Consider involving staff through community services or having ‘staff warps’, ways to promote a better understanding of the range of each sector and pressures.
- The decision to discharge (or indeed admission) is always critical. Discharge risk assessment is especially complicated in the case of older people, as they are usually multiple competing priorities. Treatment goals may be different for some; some marginally rather than carer approach may be required. For example, patient who have an acute condition admitted to hospital on a ‘place of safety’ although being in hospital actually increases the risk of losing autonomy. Managing delirium, increased risk of delirium, delirium and delirium cells that get in the way, high risk cells. Care at home is often a safer alternative.

The challenge for services is to design a system that facilitates the early identification of frail people, who commonly require community and primary care involvement. This requires the establishment of evidence base for CGA (See Box 2).

**Domains for comprehensive geriatric assessment**

The challenge for services is to design a system that facilitates the early identification of frail people, who commonly require community and primary care involvement. This requires the establishment of evidence base for CGA (See Box 2).

**Recommendations:**

- Older people coming into contact with a healthcare provider on services following falls in and without a fall history should be offered a（See Box 2）

### Acute care for frail older people

**Fig 1**

**Urgent care tasks – points for intervention**

**Recommendations:**

- Ambulatory emergency pathways with access to multidisciplinary teams should be available, with an expected time of less than four hours. Follow-up in the community overnight for older people who do not require admission but need ongoing treatment.

**Models of care**

There are various models of service provision for older people requiring hospital admission. While all these share the same strategic aim, it is clear that older people now access a care continuum; while the frail older patient has immediate access to investigations and treatment by appropriately trained, nursing and allied health professionals.

**Age-related models**

The frail older person does not support age- related models. The frail older person can deliver high-quality care for older people, but these require a clear understanding of the purpose of the service, and equitable access to support and investigations.

**Recommendations:**

- Older people coming into contact with a healthcare provider on services following falls in and without a fall history should be offered a（See Box 2）

### Box 2 Comprehensive geriatric assessment

**Evidence:** CGA leads to better outcomes, including reduced medication, reduced length of stay, greater patient satisfaction and lower re-admission rates.

**Definition:** A holistic, interdisciplinary diagnostic approach to frailty and medical and social factors. It focuses on a frail older person in order to plan a comprehensive care plan to meet needs (Box 2).

**Recommended diagnostic tools**

- Advance care planning and end-of-life care plans
- Special treatment by appropriately trained medical, nursing and related professional groups

**Table 1**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>cognition, mood and anxiety, sleep</td>
</tr>
<tr>
<td>Functional capacity</td>
<td>basic activities of daily living, light and balance, muscle strength, fatigue, instrumental activities of daily living</td>
</tr>
<tr>
<td>Social circumstances</td>
<td>informal and formal support available from family or friends, informal or formal support available from informal or formal support provider or services</td>
</tr>
<tr>
<td>Environment</td>
<td>home, comfort, facilities and safety, use or potential use of telehealth technology, etc, transport facilities, accessibility to local community services</td>
</tr>
</tbody>
</table>

**What is different about CGA?**

While integrating geriatric medicine into acute medical care, comprehensive geriatric assessment (CGA) goes beyond the measurement of life and functional status, prognosis, and outcome, and thus overcomes the conceptualised medical intervention tools to represent an evidence-based approach to frailty and frailty management.

A typical CGA tool comprises geriatrics, nurse specialist, occupational therapist, physiotherapist, pharmacist and others (nurse for home-based care planning, etc.).

**Box 2 Comprehensive geriatric assessment**

Evid: CGA leads to better outcomes, including reduced medication, reduced length of stay, greater patient satisfaction and lower re-admission rates.  

Method: A holistic, interdisciplinary diagnostic approach to frailty and medical and social factors.  

Domain: It focuses on a frail older person in order to plan a comprehensive care plan to meet needs (Box 2).

**Table 1** Main domains of comprehensive geriatric assessment

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>cognition, mood and anxiety, sleep</td>
</tr>
<tr>
<td>Functional capacity</td>
<td>basic activities of daily living, light and balance, muscle strength, fatigue, instrumental activities of daily living</td>
</tr>
<tr>
<td>Social circumstances</td>
<td>informal and formal support available from family or friends, informal or formal support available from informal or formal support provider or services</td>
</tr>
<tr>
<td>Environment</td>
<td>home, comfort, facilities and safety, use or potential use of telehealth technology, etc, transport facilities, accessibility to local community services</td>
</tr>
</tbody>
</table>
**Challenges**

**Assessment**

The clinical assessment of frail older people is challenging, as they often present non-specifically, and in a manner that is often slow to identify. Frail older people are at risk of life-threatening problems, including acute illness, delirium, and stroke. The importance of early recognition and appropriate management of acute problems in older people cannot be overstated.

**Recommendations**

1. **Early identification and diagnosis**
   - Staff should be trained to recognize the signs of acute illness, delirium, and stroke.
   - Early diagnosis and management can improve outcomes and reduce hospital stay.

2. **Multidisciplinary assessment**
   - The presence of one or more frailty syndromes (see Box 2) should prompt consideration of the need for a fuller assessment.
   - Multidisciplinary assessment is essential to identify the needs of frail older people and to plan appropriate care.

3. **Advanced care planning**
   - Advanced care planning is an important aspect of care for frail older people.
   - Advanced care planning should be considered for all frail older people.

**Functional capacity**

- **Basic activities of daily living**
  - Independence in basic activities of daily living (ADL) is an important indicator of functional capacity.
  - Independence in ADL is associated with lower mortality and improved quality of life.
- **Instrumental activities of daily living**
  - Instrumental activities of daily living (IADL) are more complex activities that require planning, organizing, and problem-solving skills.
  - Independence in IADL is also associated with lower mortality and improved quality of life.

**Mental health**

- **Cognition**
  - Cognition is an important aspect of functional capacity in older people.
  - Impaired cognition is associated with increased risk of falls and other adverse outcomes.
- **Mood and anxiety**
  - Mood and anxiety disorders are common in older people.
  - Depression and anxiety are associated with decreased quality of life and increased mortality.

**Whole systems approach**

- **Multidisciplinary assessment and management**
  - Multidisciplinary assessment and management of older people leads to better outcomes.
  - Multidisciplinary assessment is essential to identify the needs of frail older people.
- **Advanced care planning**
  - Advanced care planning is an important aspect of care for frail older people.
  - Advanced care planning should be considered for all frail older people.

**Models of care**

- **Acute care toolkit**
  - There are various models of service provision for older people in acute care settings.
  - These models include the acute medical unit (AMU), the acute medical ward, and the critical care unit.

**Box 1 Frailty syndromes – a 30-second guide**

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incontinence</td>
<td>Incontinence is a common problem in older people.</td>
</tr>
<tr>
<td>Mobility</td>
<td>Mobility is an important aspect of functional capacity.</td>
</tr>
<tr>
<td>Delirium</td>
<td>Delirium is a common complication in older people.</td>
</tr>
<tr>
<td>Depression</td>
<td>Depression is a common problem in older people.</td>
</tr>
</tbody>
</table>

**Box 2 Comprehensive geriatric assessment**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health</td>
<td>Physical health is an important aspect of functional capacity.</td>
</tr>
<tr>
<td>Social support</td>
<td>Social support is an important aspect of functional capacity.</td>
</tr>
<tr>
<td>Mental health</td>
<td>Mental health is an important aspect of functional capacity.</td>
</tr>
</tbody>
</table>

**Evidence**

CGA leads to better outcomes, including reduced mortality, reduced length of stay, greater patient satisfaction, and lower healthcare costs.

**Definitions**

- **Comprehensive geriatric assessment (CGA)**
  - A systematic, multidisciplinary evaluation of an older person to determine their functional capacity and to identify areas for improvement.

- **Multidisciplinary team**
  - A team of professionals including physicians, nurses, social workers, and other healthcare providers.

- **Advance care planning**
  - A process that aims to identify the preferences and decisions of older people about end-of-life care.

- **Frailty**
  - Frailty is a state of increased vulnerability to stressors that lead to an increased risk of adverse outcomes.

**Box 3 Urgent care – points for intervention**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>Clinical assessment is an important aspect of urgent care.</td>
</tr>
<tr>
<td>Communication</td>
<td>Communication is an important aspect of urgent care.</td>
</tr>
<tr>
<td>Decision-making</td>
<td>Decision-making is an important aspect of urgent care.</td>
</tr>
</tbody>
</table>

**Table 1 Main domains of comprehensive geriatric assessment**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health</td>
<td>Physical health is an important aspect of functional capacity.</td>
</tr>
<tr>
<td>Social support</td>
<td>Social support is an important aspect of functional capacity.</td>
</tr>
<tr>
<td>Mental health</td>
<td>Mental health is an important aspect of functional capacity.</td>
</tr>
</tbody>
</table>

**Conclusion**

CGA is an important aspect of urgent care. It is an effective way to identify frail older people, provide appropriate care, and improve outcomes.

**Fig 1**

**Urgent care – points for intervention**

- **Clinical evaluation**
  - Clinical assessment is an important aspect of urgent care.
- **Communication**
  - Communication is an important aspect of urgent care.
- **Decision-making**
  - Decision-making is an important aspect of urgent care.

**References**

acute care toolkit 3
Acute Medical Care for Frail Older People
March 2012

Acute Medical Care for Frail Older People

All staff working in acute medical units (AMUs) will be familiar with the increasing number of frail older people requiring access to acute care. The AMU provides a key role in identifying the urgent and important issues which, if addressed accurately and comprehensively, will improve patient outcomes. Accordingly, acute medical teams need to possess the knowledge and skills, and demonstrate the appropriate behaviours, for managing these frail patients.

One of the challenges is that of non-specific presentations, such as sepsis, that can mask serious underlying causes, which require a holistic and multidisciplinary approach. AMUs, with access to dedicated staff and facilities, are highly effective in managing these frail patients.

The oldest patients attending hospitals are often physically, cognitively, or socially frail, and have the potential to avoid functional decompensation, reducing the need for residential care later in life.

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 Acute Medical Care for Frail Older People toolkit was developed by the Royal College of Physicians of the UK. The findings are intended to be relevant for those working in acute care. The change in perceptions of frail older people, and the need for acute intervention, is now well recognized and accepted, and it is hoped that the toolkit will help to inform the development of local policy in this area.

The toolkit is intended to: establish the rationale for appropriate care for frail older people who present with acute illness; and provide guidance for those involved in the care of frail older people, including medical practitioners, nurses, and allied health professionals.

The toolkit is divided into three sections, each covering a different aspect of the care of frail older people:

1. Education and training
2. Needs-related models
3. Integrated models

The toolkit is intended to be used as a guide for those involved in the care of frail older people, and to support local development and implementation of local policies.

The toolkit is available for download from the Royal College of Physicians' website, and is also available as a hard copy.
patients with pressure sores.

The presence of one or more frailty syndromes should trigger a more detailed comprehensive geriatric assessment.

Education and training

Much of the training in the AMU is directed towards improving acute and rehabilitation care, but there is also an ideal opportunity to augment training and education in a holistic fashion for patients with frailty syndromes. It involves identifying and understanding the presence of frailty and involving older people. Perhaps most importantly, clinicians in the AMU can model the behaviours necessary to implement geriatric expertise. For example, not attributing immobility to agealone; not ascribing every fall to sensory impairment; not ascribing every confusional state to urosepsis; and involving carers and others in the multidisciplinary team. The AMU is difficult for acute teams, with large numbers of frail patients, and hence it is important to demonstrate the appropriate behaviours, for managing frail older people.

Accordingly, acute medical teams need to possess the knowledge and skills, and the ability to augment knowledge and skills in assessing frail older people with communication barriers (cognitive or sensory impairment, dysphasia etc); and involving carers and others in the multidisciplinary team. The AMU is difficult for acute teams, with large numbers of frail patients, and hence it is important to demonstrate the appropriate behaviours, for managing frail older people.

Older people are major users of acute care (the AMU is a key area for AMU decision-making), and education and training relevant to older people. Different models will suit different hospitals, but all will need to be able to include CDA within the AMU, and have strong links with community health and social services. Geriatric care-support in the AMU will help to identify to older people who may be safely managed in the community, probably improving patient outcomes and reducing bed days. The oldest patients attending hospitals are often physically, cognitively or socially frail, and in the hospital environment, they have the time and space to have the full range of interventions. The links between the interface across the different models, probably improving patient outcomes and reducing bed days.

References


All staff working in acute medical units (AMUs) will be familiar with the interface between primary and secondary care. All staff have access to acute care. The AMU provides a key role in identifying the urgent and important issues which, if addressed accurately and comprehensively, will improve patient outcomes. Accordingly, acute medical teams need to possess the knowledge, and skills, and demonstrate the appropriate behaviours, for managing frail older people.