University of Leicester

Leicester Medical School

The clinical challenge of an acutely ill older person

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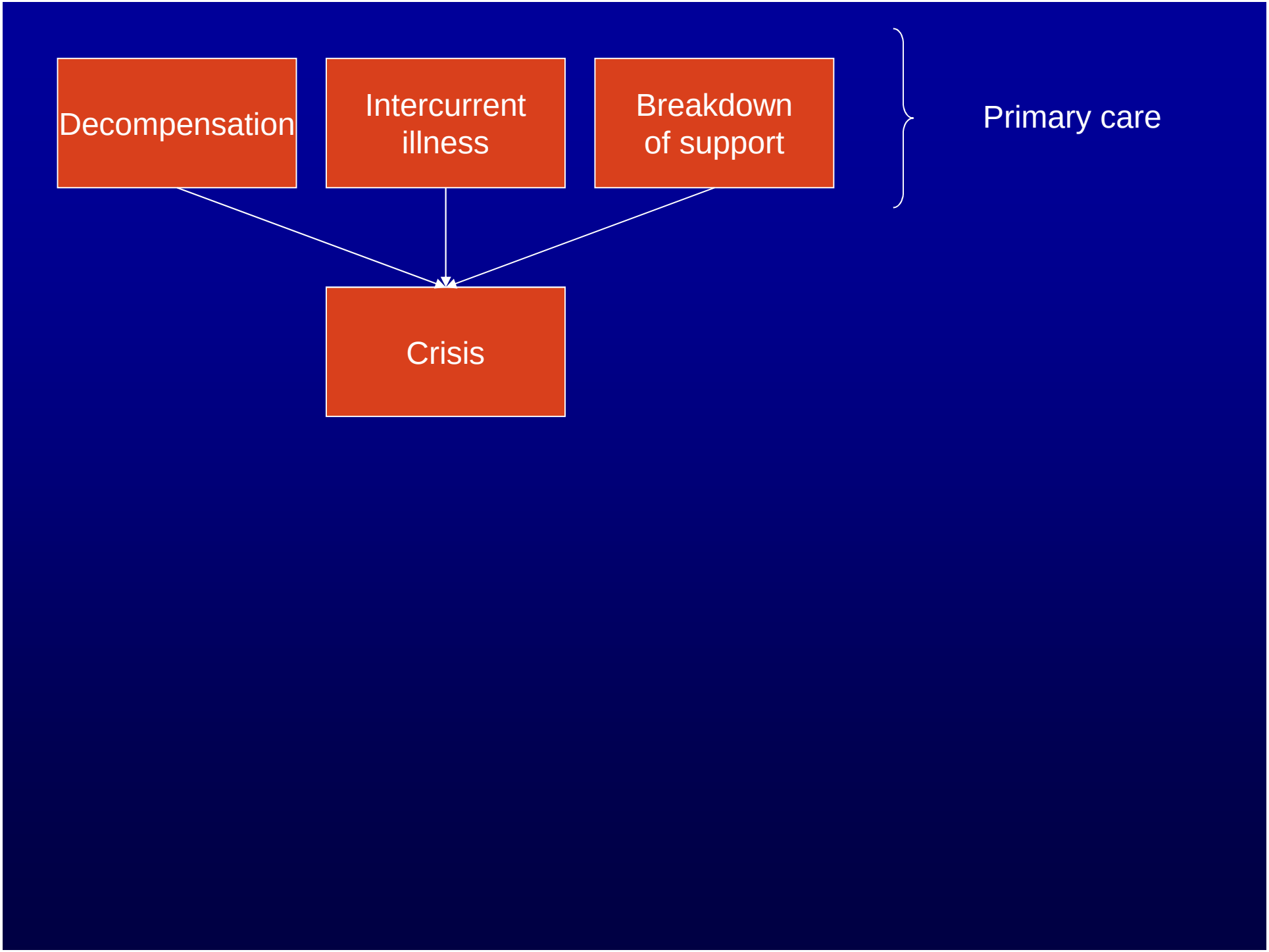
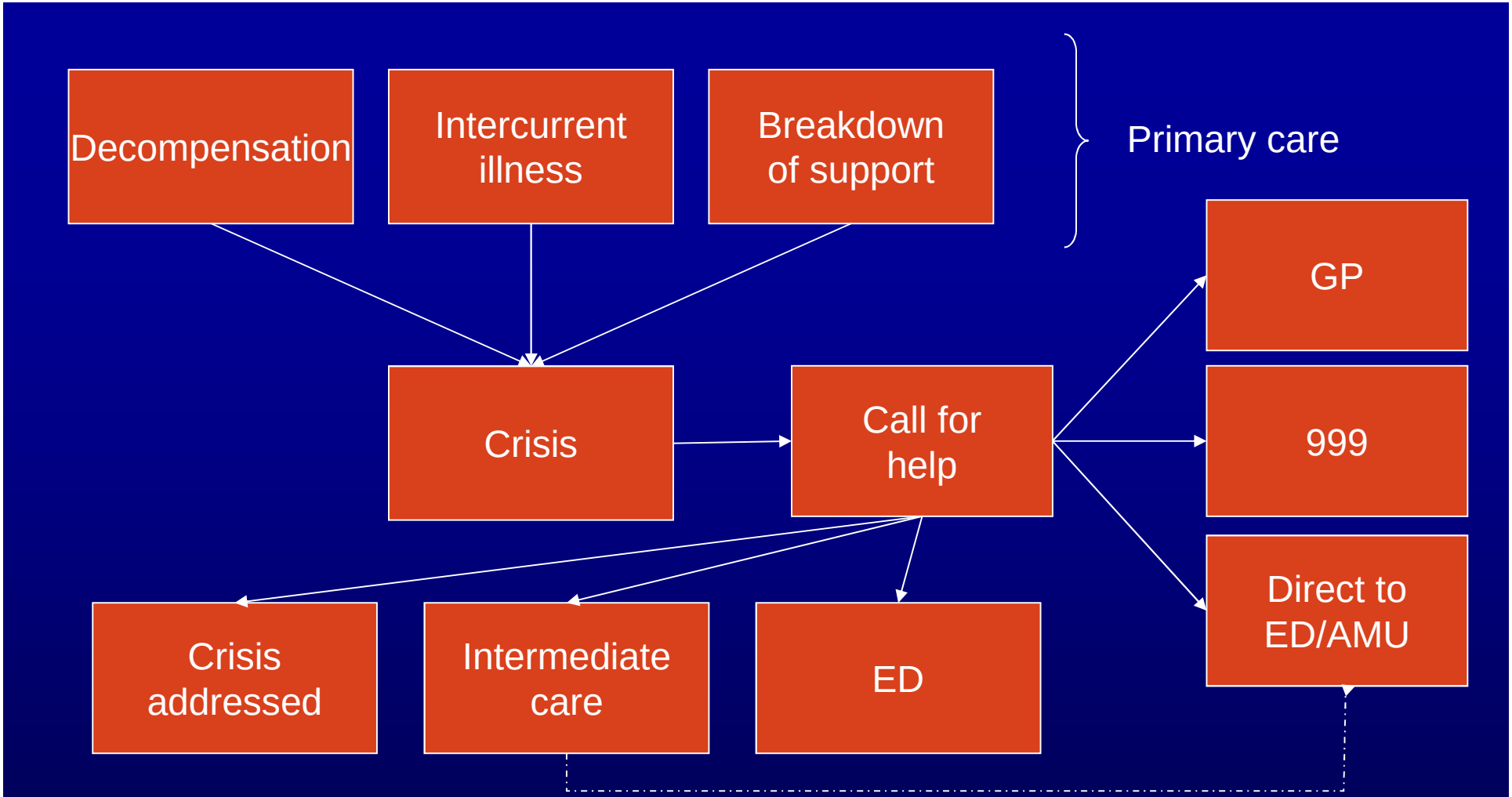
Admission Avoidance
London March 3rd 2011


Decompensation
Intercurrent illness
Breakdown of support
Primary care
Crisis

Acute care starts in primary care

- 269,000 admissions (all ages) from 144 general practices in Leicester/Leicestershire
- 1 admission per person per 10 years
- Practice level predictors of hospital admission
  - Age>access>deprivation>distance

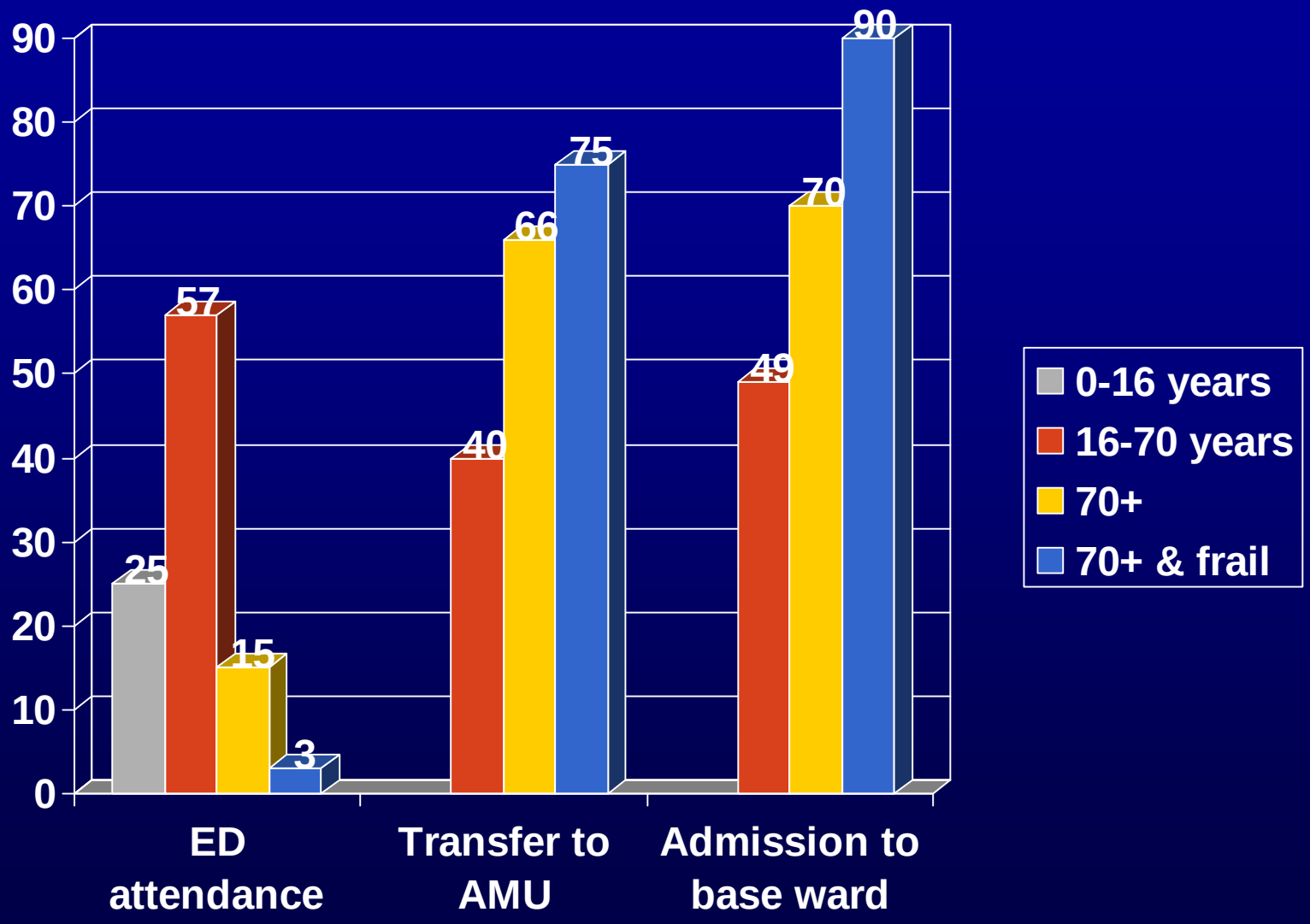


The number of emergency admissions in England rose by 11.8 per cent over the five-year period 2004/05 to 2008/09 (Nuffield Trust, 2010)

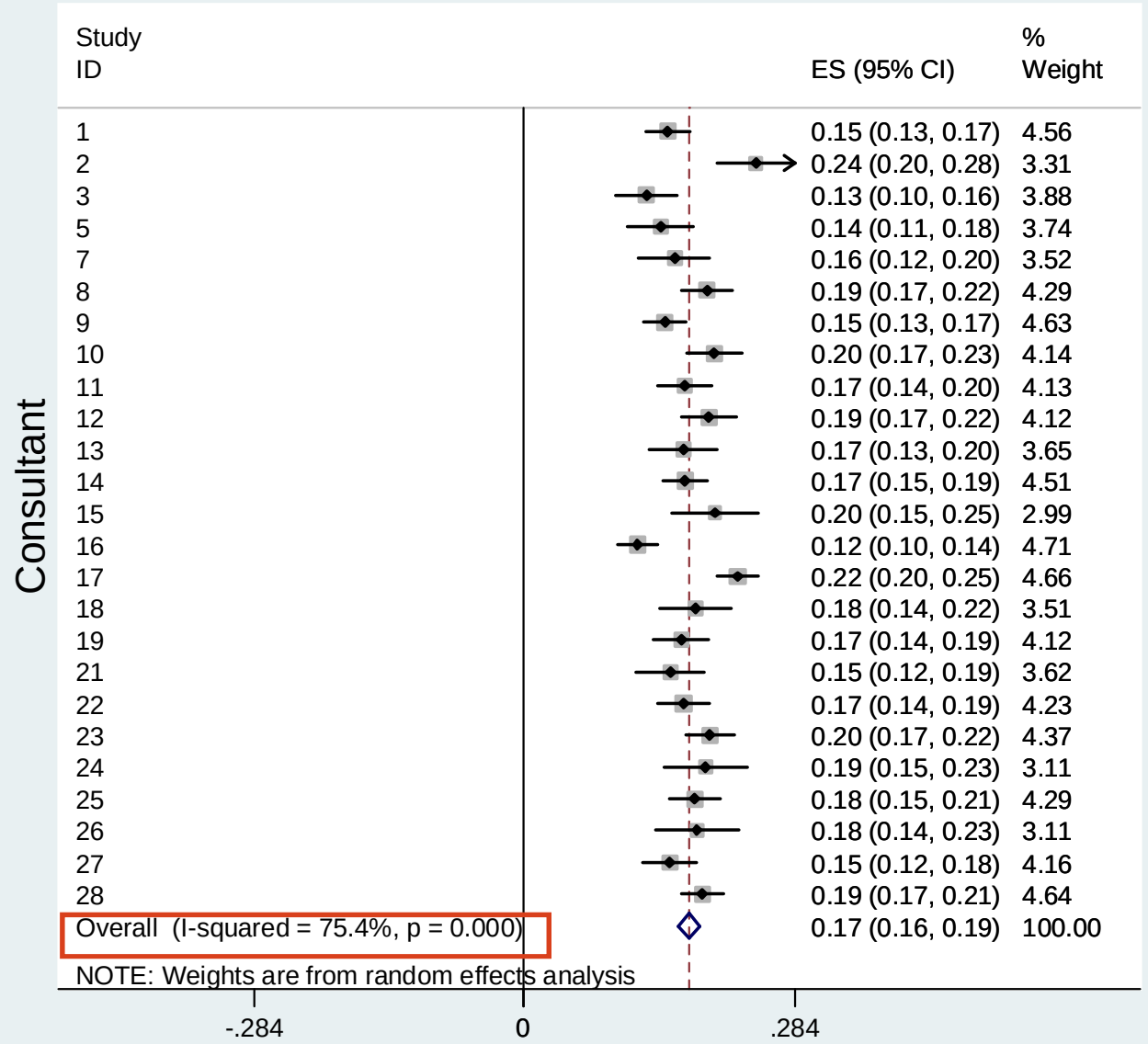
Frail older people and the ED

- The decision to admit to hospital
  - Increases the risk of complications (falls, urinary catheterisation, delirium, malnutrition, pressure ulcers, deconditioning)
  - Puts community services on hold (so discharge complicated)
  - Costs ~£1000-1500
- So is delegated to the most junior doctor in the hospital…

The ‘transfer of care’



Meta-analysis of consultant level discharge rates (AMU)



Older people

What is going wrong?

- Frail older people are different
- Managing frail older people is not taught very well
- Managing frail older people is not sexy (for some)

About Doris…

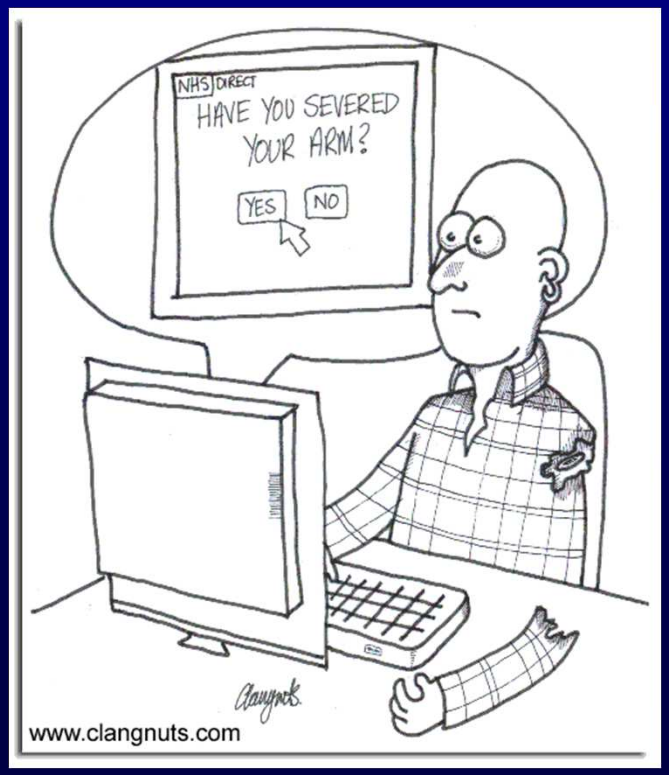
- Doris lives in her farm with her daughter and son-in-law, who farm her land in Belton

- Fall in the kitchen (Saturday)
  - Poor recall – doesn't remember hitting the floor
  - Rapid recovery – alert when found by daughter in law a few minutes later
  - Small cut at the back of her head, a bruise above her left eyebrow and a small skin flap on her left forearm

Bank holiday weekend

- Put too bed over bank holiday as no major injuries, daughter dressed the wounds
- Bruising worsened & swollen/bruised left clavicle
- Daughter took her to MIU in Loughborough

NHS Direct



Loughborough MIU

- Seen by nurse practitioner
- Noted extensive bruising and delayed presentation
- ?Abuse – contacted SS
- Sent to LRI as per vulnerable adult protocol – despite Doris's protestations
- Doris felt betrayed by the 'nice nurse'

LRI emergency department

- ‘Diagnosed’ syncopal falls
- Possible abuse
- No bony injury
- Hypotensive
- Urine dip positive
- Urosepsis diagnosed
- Catheter, fluids, antibiotics
- Admit medics

LRI acute medical unit

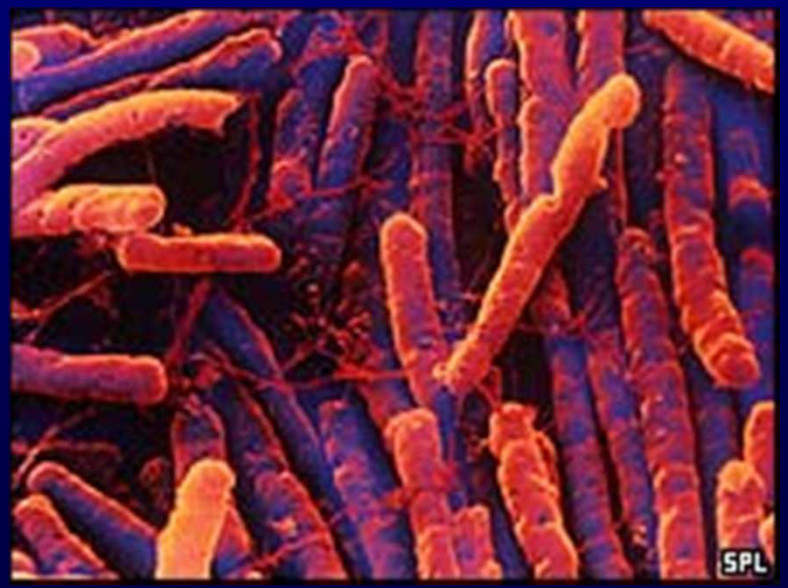
- Syncopal fall
- PMHx
  - AF
  - Previous hypertension
  - Previous stroke with residual dysarthria
- BP 100/50, wobbly on standing
- ECG AF, LAD
- Medications
  - Aspirin
  - Bendroflumethazide
  - Atenolol
  - Simvastatin
  - (Trimethoprim)

LRI - AMU

- Unable to contact SS
- Admit geriatrics – but no beds
- Outlied as ‘medically stable’ – needs ‘social sort out’

Outlying ward

- Developed catheter associated sepsis
- Given iv co-amoxiclav
- Developed clostridial diarrhoea
- Treated
- Slow recovery
- On list for Loughborough
- LoS 35 days
- Outcome?

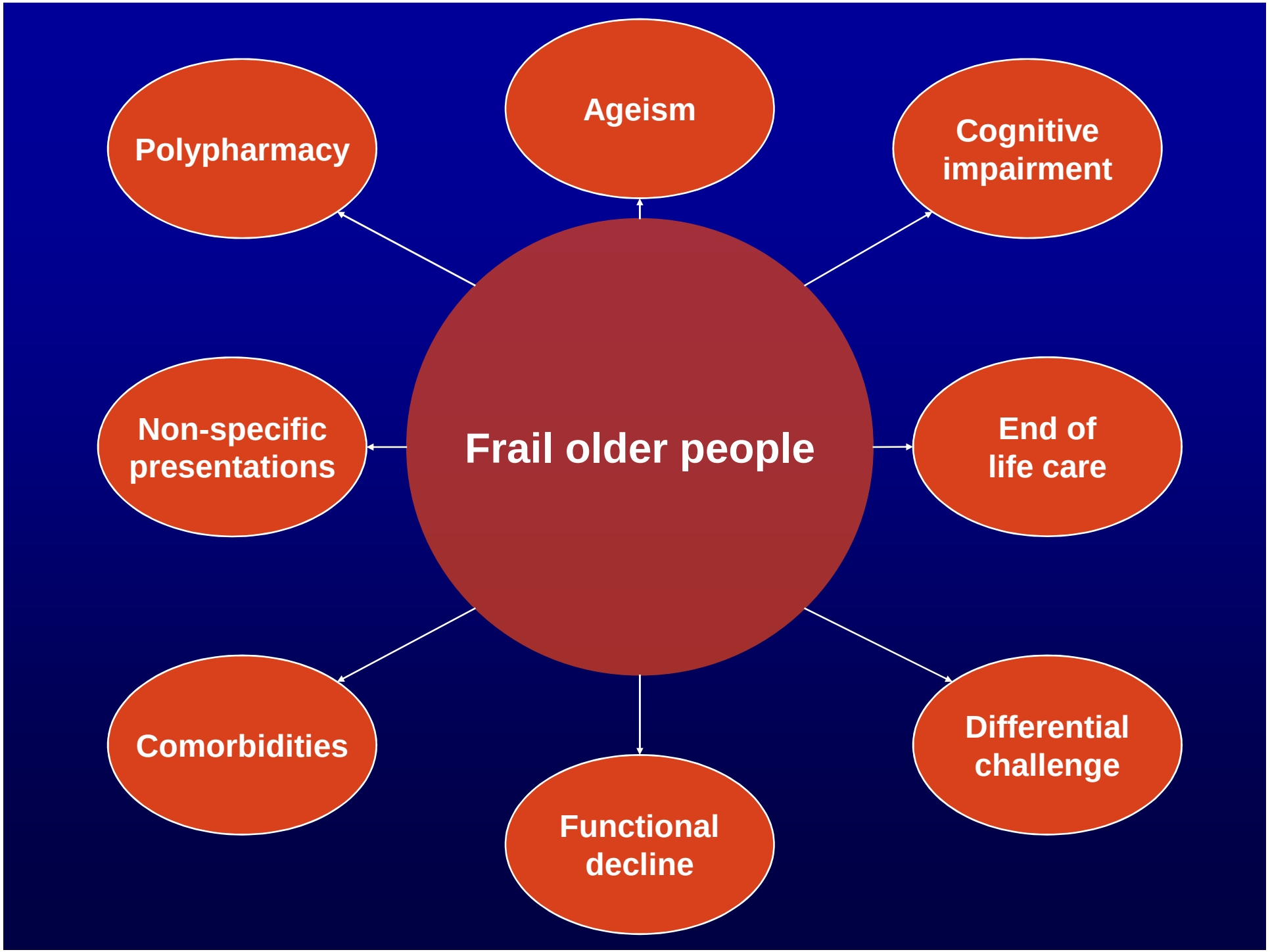


What could have been different?

1. GP review of medications
   - How long had she been hypotensive and at risk of falling?
2. Over-zealous response to ‘delayed presentation’
3. Do not diagnose syncope (find the cause and treat)

What could have been different?

4. Nonsense diagnosis of urosepsis
5. No catheter (infection, detrusor instability, mobility, dignity)
6. Better social services response
7. Do not admit – at least do not outlie


Polypharmacy
Ageism
Cognitive impairment
Non-specific presentations
Frail older people
End of life care
Comorbidities
Functional decline
Differential challenge

Summary

- Frail older people poorly served by acute care response
- Reverse of Marjory Warren’s era!
- Getting acute care right for frail older people requires an integrated whole systems approach