The older patient and medical admissions

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Clinical scenario

- Elsie: 87 year old lady, frail
  - Hypertension, on three anti-hypertensives
- Fall at home, left hip pain
- Brought to ED, fall noted, x-ray showed no fracture
- Urine dip
  - ++ leucocytes
  - ++ nitrates
  - No blood

Is this a UTI?

1. Yes
2. No
3. Don’t know

UTI and falls

- UTI can be cause of falls, but…
  - If LUTS, then urine dip only helpful if negative as may be other cause; if positive then treat and send MSU
  - If no history (e.g. cognitively impaired) then ONLY consider UTI if other features (e.g. abdominal pain, haematuria, fever)
  - If no LUTS then why testing urine?

What is the prevalence of asymptomatic bacturia in community dwelling older people?

1. 0.5%
2. 5%
3. 15%
4. 25%

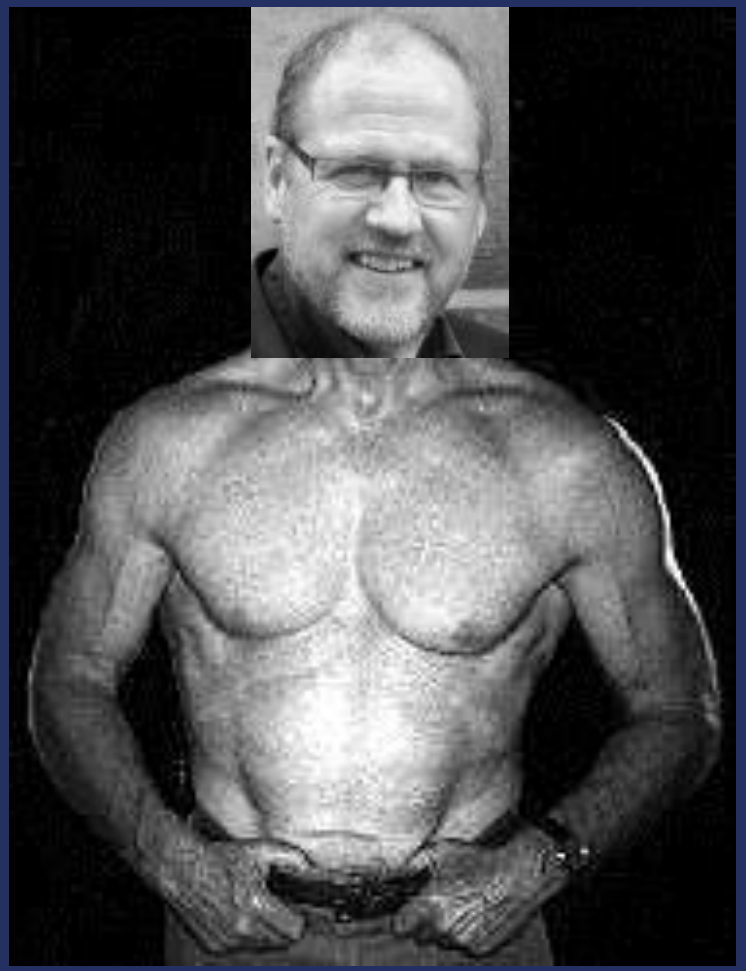
Elsie..

- Treated for urosepsis
  - Catheter
  - iv fluids, antibiotics
  - Stabilised
- Geriatric liaison service missed her on their round
- Outlied, failed TWOC
- LoS 14 days as care package lost…

So what's so different about Elsie?

- 'Frail'
  - Non-specific presentations
  - Multiple comorbidities & polypharmacy
  - Impaired homeostasis
  - Differential challenge
- 'Vulnerability'

It’s not just ageing…



‘Freidologists’

Panel 2: The five phenotype model indicators of frailty and their associated measures

Weight loss
Self-reported weight loss of more than 4·5 kg or recorded weight loss of ≥5% per year

Self-reported exhaustion
Self-reported exhaustion on US Center for Epidemiological Studies depression scale[73]
(3–4 days per week or most of the time)

Low energy expenditure
Energy expenditure <383 kcal/week (men) or <270 kcal/week (women)

Slow gait speed
Standardised cutoff times to walk 4·57 m, stratified by sex and height

Weak grip strength
Grip strength, stratified by sex and body-mass index

Rockwoodologists

- Accumulation of deficits model
- Frailty Index
  - n/30 (was 92!)
  - ɣ distribution, >0.67 = BAD
- Construction
  - Must be associated with health status
  - Prevalence must generally increase with age
  - Must not have a ceiling-effect e.g. presbyopia
  - Deficits must cover a range of systems
  - Internally consistent

1. **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. **Well** – 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.

3. **Managing Well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. **Vulnerable** – 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.

5. **Mildly Frail** – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. **Moderately Frail** – People 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.

7. **Severely Frail** – 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).

8. **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** – Approaching the end of life. This category applies to people with a life expectancy < 6 months, who are not otherwise evidently frail.

Where dementia is present, the degree of frailty usually corresponds to the degree of dementia:

- **Mild dementia** – includes forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.
- **Moderate dementia** – recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.
- **Severe dementia** – they cannot do personal care without help.

K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495

Identification of frailty in acute care

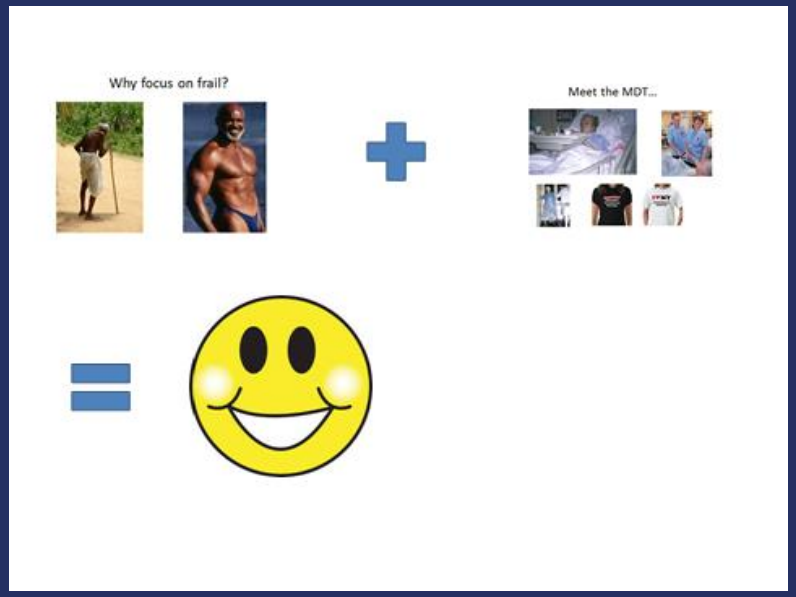
- 85+
- OR
- People aged 65+ with one or more of the following presenting features:
  - Cognitive impairment (delirium or dementia)
  - Care home residents (nursing or residential)
  - People with fragility fractures
  - People with Parkinson's disease
  - People with recurrent falls

Adverse outcomes associated with frailty

- Falls
- Delirium
- Restricted function (disability)
- Hospitalisation
- Institutionalisation
- Death

Why frail older people?

- Evidence based solutions
  - Comprehensive Geriatric Assessment (CGA)



Evidence:

- Fox 2012: ACE units better than usual care
- Ellis 2011: wards better than teams; frail better than age-specific
- Baztan 2010: acute geriatric units better than conventional care
- Deschodt 2013: teams reduce mortality but not function or service outcomes
- Lessons from stroke care & orthogeriatric care

So what is CGA?

- ‘a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up’

A bit of detail…

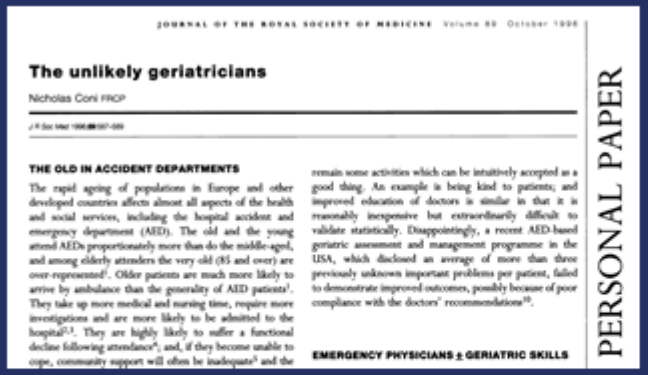
- *Multidimensional*
  - Not just troponin pathways for chest pain
- *Interdisciplinary diagnostic process*
  - Flattened hierarchy, mutual respect, constructive challenge
  - Iterative process
- *Coordinated and integrated plan for treatment*
  - Some understanding of each others roles and expertise
- *Follow-up*
  - Because bad things will happen

So what's different?

- Integrates standard medical diagnostic evaluation
- Problem solving
- Team working
- Patient centred approach

So what's the problem?

- Not enough CGA & too much specialism
- 'Integrated care'



JOURNAL OF THE ROYAL SOCIETY OF MEDICINE Volume 89 October 1996

The unlikely geriatricians

Nicholas Coni FRCP

PERSONAL PAPER

THE OLD IN ACCIDENT DEPARTMENTS

The rapid ageing of populations in Europe and other developed countries affects almost all aspects of the health and social services, including the hospital accident and emergency department (AED). The old and the young attend AEDs proportionately more than do the middle-aged, and among elderly attenders the very old (85 and over) are over-represented[1]. Older patients are much more likely to arrive by ambulance than the generality of AED patients[1]. They take up more medical and nursing time, require more investigations and are more likely to be admitted to the hospital[2,3]. They are highly likely to suffer a functional decline following attendance[4], and, if they become unable to cope, community support will often be inadequate[5] and the remain some activities which can be intuitively accepted as a good thing. An example is being kind to patients; and improved education of doctors is similar in that it is reasonably inexpensive but extraordinarily difficult to validate statistically. Disappointingly, a recent AED-based geriatric assessment and management programme in the USA, which disclosed an average of more than three previously unknown important problems per patient, failed to demonstrate improved outcomes, possibly because of poor compliance with the doctors' recommendations[10].

EMERGENCY PHYSICIANS ± GERIATRIC SKILLS

'Geriatrics is too important to be left to geriatricians. We are all geriatricians now, and geriatric medicine should be like a caretaker government-self-appointed to instruct others how to do it, and then to preside over its own demise.'

Sheffield AFU

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Timely care for frail older people referred to hospital improves efficiency and reduces mortality without the need for extra resources

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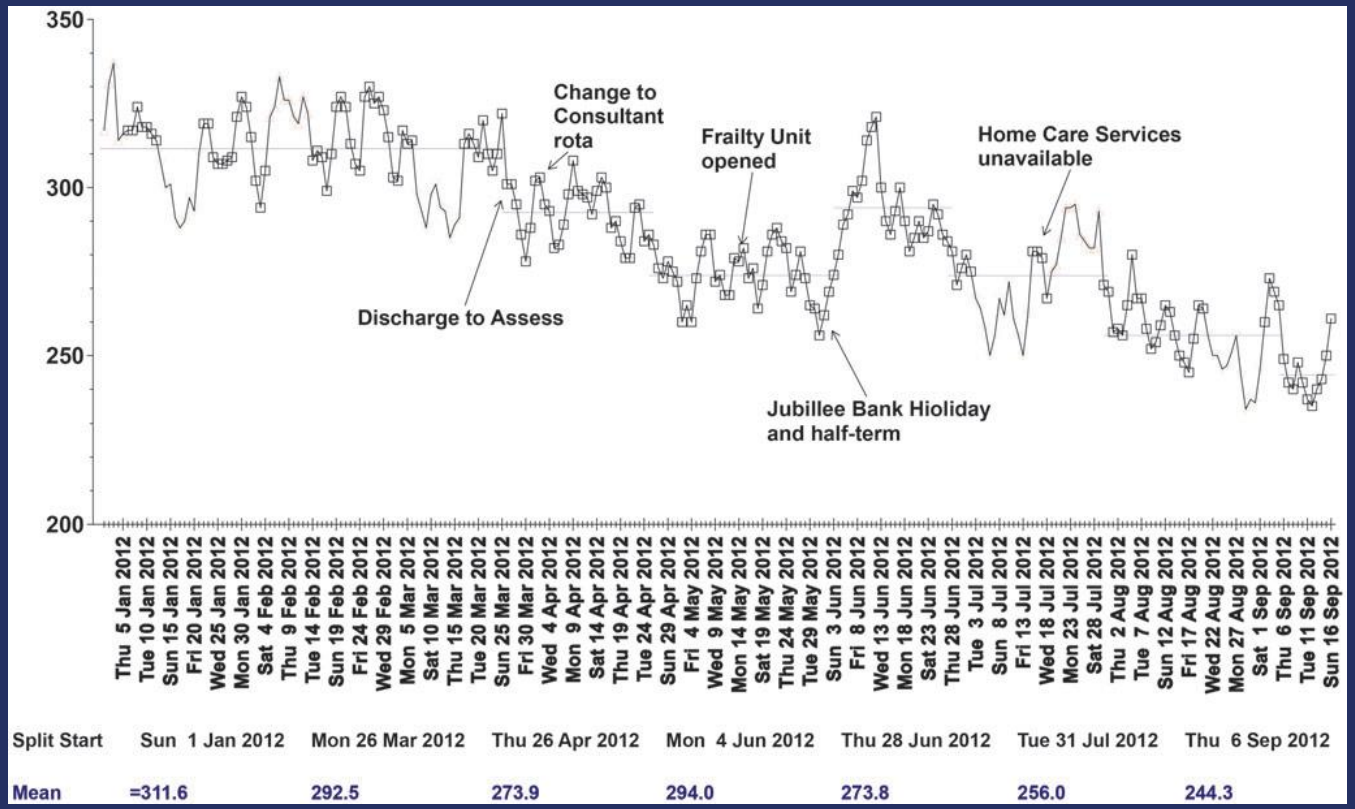

Split Start	Sun 1 Jan 2012	Mon 26 Mar 2012	Thu 26 Apr 2012	Mon 4 Jun 2012	Thu 28 Jun 2012	Tue 31 Jul 2012	Thu 6 Sep 2012
Mean	=311.6	292.5	273.9	294.0	273.8	256.0	244.3

Leicester EFU

Age and Ageing Advance Access published July 23, 2013

Age and Ageing 2013; 0: 1–6
doi: 10.1093/ageing/aft087

A controlled evaluation of comprehensive geriatric assessment in the emergency department: the 'Emergency Frailty Unit'

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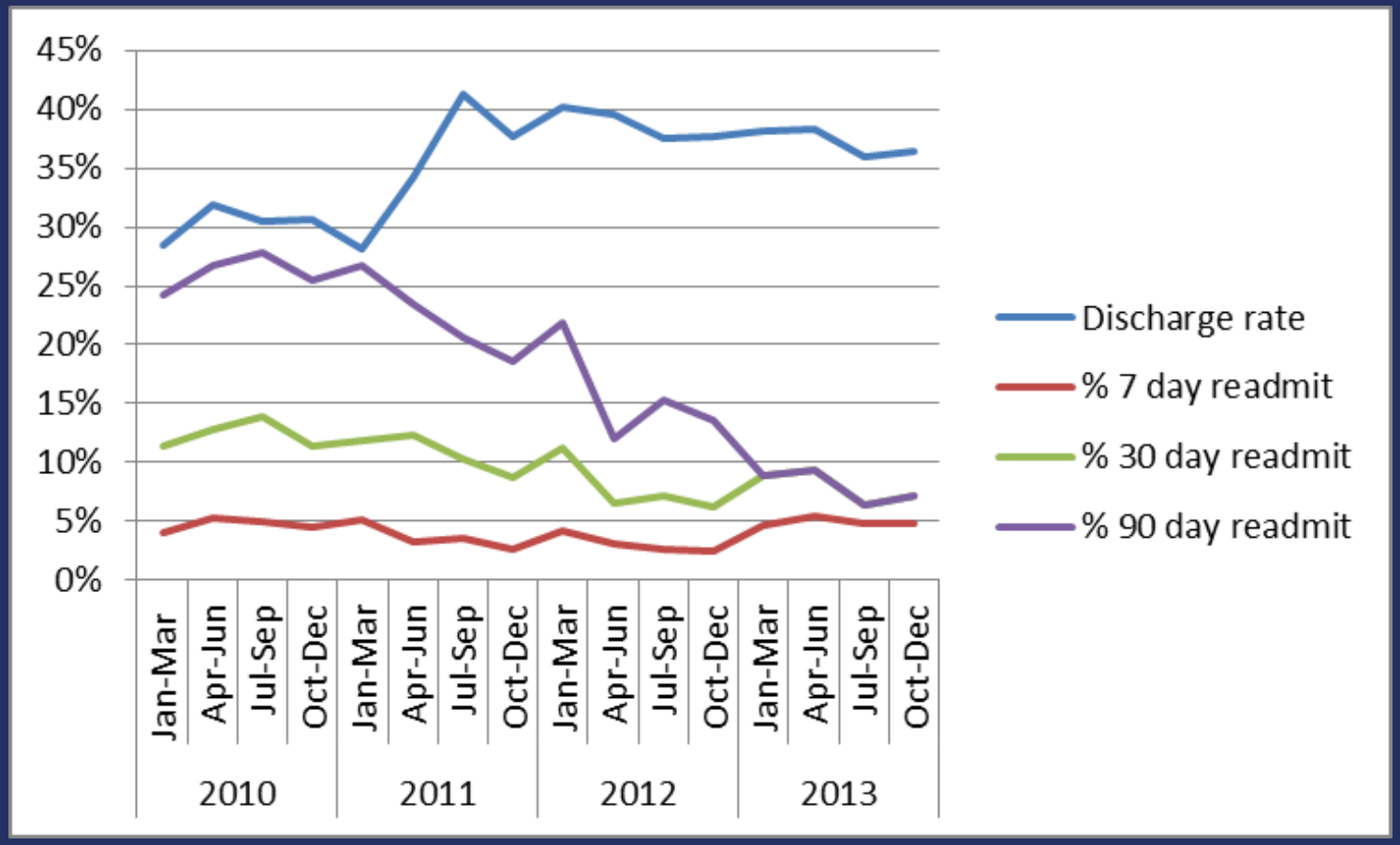


What do we mean by an ‘acute frailty unit’?

- An ACE Unit is a multidisciplinary approach to care for older hospitalised patients with four key elements:
  - specially designed environment (http://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-in-dementia-care)
  - patient-centred care
  - http://www.institute.nhs.uk/qipp/joined_up_care/patient_centred_care.html
  - planning for discharge
  - review of medical care

  Landefeld NEJM 1995

Why might an AFU work?

- Focus on problems
  - Falls, mobility
  - Cognition
  - Polypharmacy
  - Continence
  - End of life care

Practical examples of interdisciplinary working

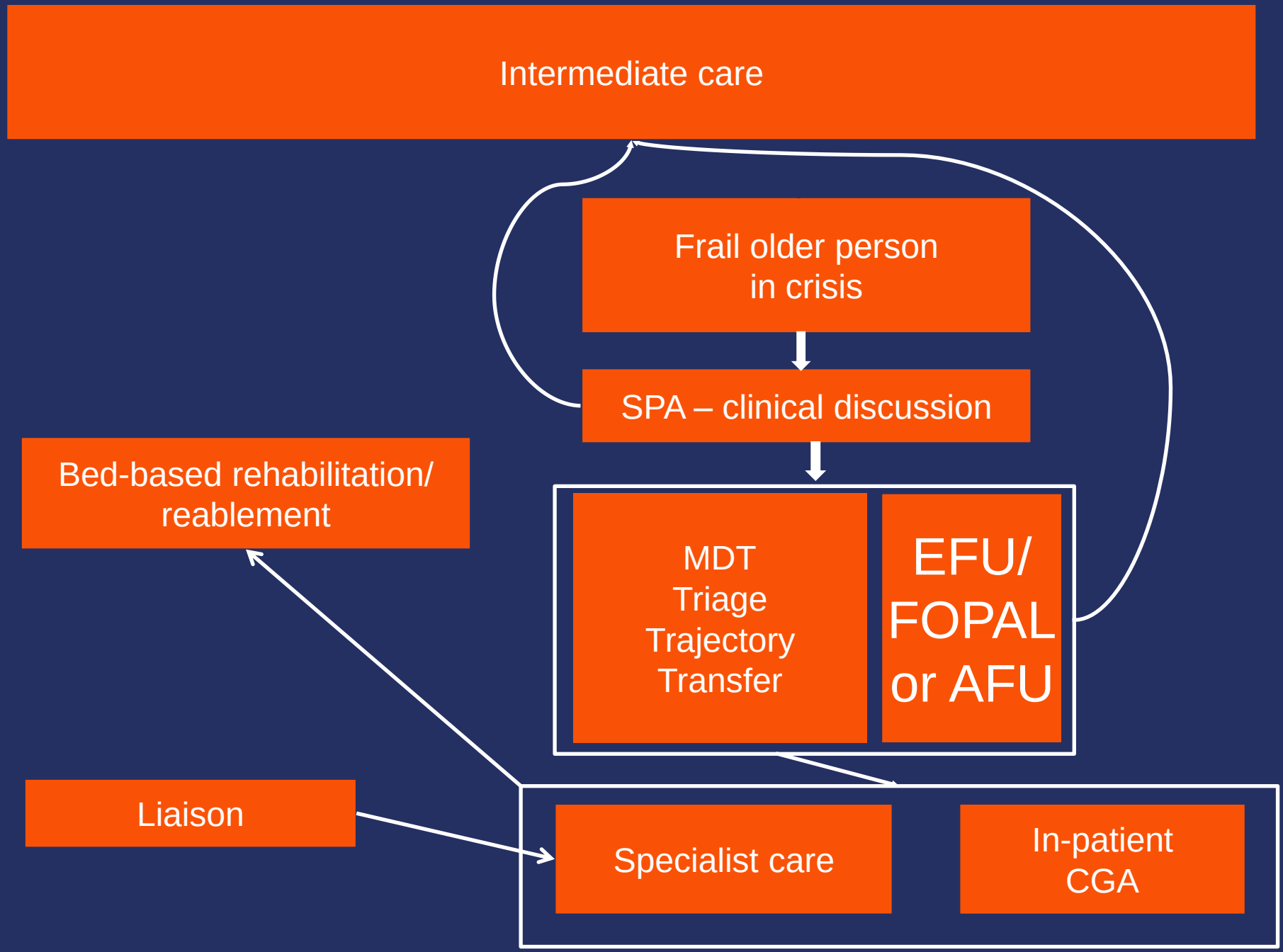
Care principles

- Patient centred
- Problems>diagnoses
- Holistic
- MDT focus with regular meetings
- Strong links with community
- Acute care when it is needed
- Structured assessment – shared clerking document

Take home messages

- Frail older people are an especially vulnerable population accessing urgent care
- They need a different approach from ‘standard’ acute medical care
- ACE units offering CGA are efficient and effective
  - Benefits for patients, staff and the system

Thank you!


Intermediate care
Frail older person in crisis
SPA – clinical discussion
Bed-based rehabilitation/ reablement
MDT
Triage
Trajectory
Transfer
EFU/ FOPAL or AFU
Liaison
Specialist care
In-patient CGA