

MCOP discussion paper: The role of the interface geriatrician

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The role of the interface geriatrician across the acute medical unit / community interface

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Workstream 1: towards improving the care of people with mental health problems in general hospitals.
Development and evaluation of a medical and mental health unit.

Workstream 2: Development and evaluation of interface geriatrics for older people attending an AMU

Workstream 3: Development and evaluation of improvements to health care in care homes

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Summary

Many older people discharged from Acute Medical Units have poor outcomes. We proposed that their outcomes might be improved by “interface geriatricians” – geriatricians working across the hospital – community interface. We tested this hypothesis in the AMIGOS study, a RCT comparing the health outcomes and resource use of frail older people discharged from Acute Medical Units who were seen by an interface geriatrician to those who were not. This paper provides a clinical description and summary of the interventions delivered by the interface geriatricians in the AMIGOS study, and reflects upon the potential of these interventions to improve outcomes.

This paper was written by a team of interface geriatricians who met regularly throughout the AMIGOS study to discuss cases as part of their clinical and professional development. The paper is based upon themes drawn from review of the structured reflective case reports the interface geriatricians used in their meetings.

The interventions undertaken were typical of geriatric medical practice in any other setting. They comprised a comprehensive medical assessment which, alongside a general medical review, included enquiry into mental health issues and cognition, into geriatric syndromes, and into issues of polypharmacy – often employing the use of collateral history taking. A particular feature was that the initial assessment on the Acute Medical Unit was usually followed by assessment at the patient’s home, which often revealed important diagnostic facts undetected on the Acute Medical Unit. These assessments led to a range of actions such as changes to medication and also communication of the geriatrician’s assessment findings to patients and primary care staff. Whilst interface geriatricians often identified clear potential benefits arising from their actions, they were aware that in some cases they were unable to prevent poor outcomes, and in other patients they had little to offer.

Interface geriatrics as described here is a feasible option with the potential to benefit patients. The results of the AMIGOS study (in progress at the time of writing this paper) will examine the cost effectiveness of this approach.





Introduction

Frail older people who attend acute medical units (AMU) but who do not require hospital admission have high rates of re-attendance to acute hospital services and a high risk of mortality over the following year (1). Many of these patients present with geriatric syndromes, which usually have a background of multiple complex long-term conditions. In addition to the standard medical assessment offered by AMUs, many older people will require specialist assessment and support from other disciplines (geriatric medicine, physiotherapy, occupational therapy, nursing, social care and others) in order to deliver a comprehensive assessment and arrange on-going treatment, whether in hospital or in the community. Delivering such an assessment in a pressured acute environment is not easy and requires, staff, time, coordination and high quality communication. The conflict between these needs and the pressure of patient flow is self-evident.

Instead, this group of patients may be better served by a process that delivers "Comprehensive Geriatric Assessment" (CGA) across the primary-secondary care interface. For example, a specialist geriatric opinion could be given in the AMU, with follow-up and liaison with primary care resources as required until the medical crisis that led to the AMU attendance is properly resolved. We have coined the term "interface geriatrics" delivered by an "interface geriatrician" to describe this (2).

Whereas CGA in general is effective (3), there is no clear benefit of CGA for frail older adults specifically at the interface between the acute hospital and community care (4). In view of this uncertainty and the considerable costs of providing a service in this setting, we conducted a multi-centre randomised controlled trial to compare the outcomes and resource use of high risk older patients attending but discharged from an AMU managed in the usual way, with the outcomes of those whose management was augmented by an interface geriatrician. Full details of the trial protocol for the acute medical unit comprehensive geriatric assessment intervention study (acronym AMIGOS) have been published elsewhere (5).

The purpose of this report is to describe in clinical detail the nature of the interventions made by the interface geriatricians in AMIGOS. This will augment the description of the intervention in other published reports of AMIGOS, assist the interpretation of the





AMIGOS results, and facilitate implementation of the findings. This paper was written while AMIGOS was in progress and before the results were analysed.

Method

Participants for AMIGOS were recruited from the acute medical units of two independent teaching hospitals, Nottingham University Hospitals NHS Trust and University Hospitals of Leicester NHS Trust.

In both AMUs, patients were seen by a consultant physician and medical team, with additional input sought from members of a multidisciplinary team as deemed appropriate. Patients were eligible for AMIGOS if the AMU team had declared them suitable for discharge, they were aged over 70 years, and at risk of future health problems as evidenced by a score of $\geq 2/6$ on the Identification of Seniors at Risk (ISAR) tool (6). Informed consent was required for those with capacity, and those lacking capacity were included after discussion and with agreement by a carer or professional consultee (under the provisions of Section 32 of the Mental Capacity Act 2005). Patients were excluded if they lived outside hospital catchment area, if they lacked mental capacity to provide informed consent and had no available consultee, if there were exceptional reason for exclusion cited by AMU staff (e.g. dangerous), or if they were already participating in another intervention research project. Participants in the control group did not receive additional intervention over and above usual care after randomisation.

The AMIGOS protocol expected all participants randomised to the intervention to be seen by a geriatrician with community experience on the AMU before returning home. The geriatrician then took whatever steps he or she thought were required on the basis of this assessment. This could include changing management decisions on the AMU (reversing, altering or adding to them), communication with the general practitioner or other professionals, and arranging follow-up assessment or other actions. Follow-up could be by telephone, to an out-patient clinic or a home assessment. The nature, number and timing of any follow up was not pre-specified, but was to be as clinically indicated. It was anticipated that most patients would require some sort of additional input from the interface geriatrician on the acute medical unit leading to some further





intervention, and that most would also require follow-up for more detailed assessment, or monitoring the compliance with and response to the advice given.

The interface geriatricians contributing to AMIGOS from both centres met monthly to discuss their experiences and cases. The purposes of these meetings were to ensure that the interventions given by interface geriatricians remained compliant with the AMIGOS protocol, to support clinical and professional development (CPD), and for clinical governance. Interface geriatricians prepared and presented reflective case reports, which required a brief summary of the clinical details of the patient, what was done, and an estimate by the clinician of the likely impact, positive or negative or none, of the intervention.

This paper draws upon the findings of the experience of discussing these case reports. Common themes drawn from the case discussions were identified by group discussions. Case reports were selected that illustrated these themes.

Results

Five illustrated case reports are provided. The following discussion describes the actions of the interface geriatricians, first describing the assessment and actions made on the AMU and then those made at follow-up.

Actions in the Acute Medical Unit

In some cases, interface geriatricians reported that patients had gone home before they had been able to assess them: in these cases the patients' notes could be inspected. In other cases the patient had been moved to a "discharge lounge" pending collection by a family member or hospital transport: in these cases assessment was limited due to lack of privacy or equipment. In all such cases, this was reportedly not because the interface geriatrician was tardy in responding to the referral (reportedly responding in <30 minutes to the referral), but because of the frantic pace of the AMUs which were often in desperate need of beds due to large numbers of attendees. Thus, the delivery of interface geriatrics would be expected to extend the length of stay on an AMU by a few





minutes, but this might be operationally difficult in very busy units. Furthermore, the effect of interface geriatrics could be limited by service pressures.

In some cases, even after assessment, interface geriatricians found little to add to existing management. An example would be a patient with chest pain for whom the correct management was given and planned. In such cases, the specificity of the ISAR tool in identifying a complex patient in need of interface geriatrics is shown to be questionable. Cost-effective targeting of interface geriatrician time may be difficult if a standard tool such as the ISAR is used.

The assessment of the patient on the AMU by the interface geriatricians and the actions that followed were mainly: reviewing the diagnosis and actions already made; further attention to the mental health of the patient; taking a collateral history; assessment of the social network; specialist assessment of geriatric conditions; undertaking a medication review; and communication with the GP and other primary care professionals.

Reviewing the diagnosis and actions already made.

An example of a review of the diagnosis was a patient with a transient visual disturbance in whom a diagnosis of a possible TIA was made by the AMU team and who referred her to a specialist out-patient clinic, arranged a host of investigations, and started a range of secondary prevention medications. The interface geriatrician re-examined the history and confidently diagnosed a migrainous aura, and later found records that a similar diagnosis had been made some years previously. He stopped the referrals, investigations and medication, presumably saving costs and possible side effects of medication. He explained this to the patient, including suggestions in the event of further events, and she was grateful for a consistent explanation. One advantage of an interface geriatrician service is their breadth of medical expertise, thereby increasing access to specialist general medical skills that can be lacking in existing AMU teams that rely on junior medical staff.





Attention to mental health, use of a collateral history, assessment of the social network

Further attention to the mental health of the patient had frequently been overlooked by the AMU medical team. The most common aspect was assessing the cognitive function of the patient. Frequently unexpected, unrecognised or unappreciated deficits were noted. As a result, the history previously obtained was often questionable, and the contribution of the mental health disorder to the presentation overlooked. For example, in one case of a lady with no diagnosis who was due to be discharged from the AMU, a collateral history obtained by the community geriatrician by telephone from a variety of informants revealed that the real reason why a patient was on the AMU was a dire social failure in a lady with dementia who lived alone and who was entirely without insight into her inability to feed herself or maintain safety, associated with collapse of her informal, reluctant, and inadequate social support. As a result, with no other immediate options, she was admitted to hospital as a place of safety pending further assessment. In another case, a pattern of repeat presentation at the AMU in a lady with dementia was explored by the interface geriatrician, whose enquiry revealed a clear link between AMU presentations and days when she had reduced social care. The solution, extra care on the week day in question, was discussed with her son who said he was able to adjust her care accordingly, and so she was discharged with a solution to a long running problem for which no usual medical solution had been forthcoming.

Specialist assessment of geriatric syndromes

As expected, many patients seen by the interface geriatricians had presented with, or had among their complaints, one or more non-specific presentations such as falls. The usual AMU approach to falls was to look for single, serious medical illnesses as underlying causes, or to look solely for serious complications. Patients were discharged when none was found. Interface geriatricians used the geriatric approach of assessing a range of falls risk factors and examining the scope to alter any of them, consideration of evidence based interventions such as strength and balance training, and a fracture risk





assessment. Interface geriatricians frequently referred to community based falls services, and so patients should benefit from this.

Medication review

A near uniform part of the interface geriatrician assessment and a frequent area of intervention related to medications. Patients were frequently unaware of drugs they were taking and the hospital's records were often incorrect. Major drug-related problems could be present and not be recognised. The usual geriatric process of detailed medication review had often not been undertaken. The geriatric process of medication review included ensuring that:

- there was a diagnosis for every medication (if not, drugs might be stopped)
- there was evidence that every medication was achieving its desired effect (if not, drugs might be stopped or changed)
- each diagnosis had the right treatment (drugs might need starting, such as for osteoporosis)
- the possibility was explored that the presenting problem or its underpinnings were due to adverse effects of drugs.

An example was a lady who was diagnosed with urinary retention by the AMU team and which resolved for the temporary use of a urinary catheter, but it was the interface geriatrician who noted that she had recently been prescribed an anti-muscarinic drug and later revealed a history of difficulty passing urine since it had been started.

Many potential benefits might accrue from this process of in-depth medication review: reduction of patient symptoms, prevention of further episodes of care, and a reduction in drug costs, as in most occasions drugs were stopped rather than started.

The vital importance of medication review at follow-up is described in the next section.





Communication with primary care

Most patients seen by the interface geriatricians had not been referred by their GPs but had instead presented after making a 999 emergency call and passing through the emergency department. This meant that the AMU team were usually unaware of the patient's history known to the GP. Furthermore, although a letter from the AMU team about the AMU presentation was routinely sent the GP, it was often very brief and in keeping with the brevity of the usual medical assessment. Interface geriatricians often contacted the GP surgery, and provided more detailed letters, usually listing what further actions might be helpful, who needed to do them, and when. Prior experience in community geriatrics was drawn upon, making it easier to anticipate what GPs needed to know, and who in the community also needed to be informed, such as community matrons, or intermediate care staff.

Follow-up by interface geriatrician

Not all patients were followed up, as a proportion had no clinical need. However, most were followed up and most were seen at home. Assessments at home was felt to be hugely informative, it sometimes revealed new and critical diagnostic information, it enabled reassurance for the patient and family, and it was a suitable setting to initiate advance care planning. Some actions by interface geriatricians were simply to check that messages had been understood, referrals received, and acted upon. Frequent, minor but irritating and potentially inefficient communications were unearthed by interface geriatricians and corrected, such as referrals that the AMU team intended to make but overlooked.

Better assessment at home

Interface geriatricians were struck by the improvement in the assessment afforded by a home visit. Missing collateral history often became available. In one case a man with dementia and diabetes was discharged from the AMU having presented in the early morning with acute confusion which had resolved without any cause being found. On home assessment a collateral history revealed details that were not known on the AMU including a history of increasing shortness of breath on exertion, a recent myocardial





infarction, recent introduction of a beta-blocker, increased abdominal girth and, finally, increasingly stout legs. As the collateral history unfolded during the home assessment the diagnosis of congestive cardiac failure causing paroxysmal nocturnal dyspnoea became obvious, and at that point it was possible to confirm this by the observation of a raised jugular venous pressure and (previously overlooked) oedema to the level of the sacrum. Management at that point was simple. In another case, a lady who had been a repeat attender at the AMU was seen at home with her brother. Her first attendance had been with shortness of breath, attributed to fast atrial fibrillation. On the various subsequent visits she received digoxin, then a higher dose of digoxin, then a low dose beta-blocker, then two higher doses. On home assessment she and her brother were found to be eccentric, and she informed the interface geriatrician that after each attendance she had taken all 14 doses of medication she had been prescribed. She had never contacted her GP for more tablets, claiming that she felt that 14 days tablets were “quite enough”. At the home visit she displayed a bag of drugs prescribed by her GP, none of which tallied with any of those listed in the AMU assessment, and all of which she felt were doing her harm and which justified her decision not to take any more drugs. After some discussion, she decided to stop all her medication (going further than the geriatrician’s advice) and did not present to the AMU again.

Explanation, reassurance

Some visits seemed to be well received even if nothing specifically medical was done. Interface geriatricians were warmly thanked for simply reviewing the case, providing explanation and reassurance that their GPs (in whom most patients had great trust) were doing the right thing. There often seemed to be an opportunity for patients to ask trivial questions, to think about the prognosis, or simply to talk. These benefits might be hard to capture in the outcome measures in a trial and might be an expensive way of providing higher quality care.

Advance care planning

In many patients who were residents of care homes, the interface geriatrician used the AMU presentation to trigger a discussion about advance care planning. In many cases, this was well received and timely, leading (after a few tears) to the formation of end of





life plans and decisions to avoid hospitalisation for future, expected deteriorations and the use of end of life care pathways in serious episodes. It was not uniformly effective. In one case after a very long and detailed discussion and apparent agreement with one patient's sons that she was dying and wished to die at the home, the patient was admitted the next week, only to die in hospital shortly afterwards. In other occasions, the intervention by the interface geriatrician, coming on the heels of a presentation at the AMU, provided a timely nudge towards end of life care planning which had hitherto been put off for a later day.

Discussion

A simple (if tautological) summary of the nature of interface geriatrics is that it is geriatric medicine across the hospital-community interface. The features of practice displayed by the interface geriatricians will be familiar to geriatricians working in any other setting or disease group. These features include a thorough medical assessment, with particular emphasis upon a mental health assessment, the use of a collateral history, identifying geriatric syndromes and issues of polypharmacy. They also included close attention to communication across the secondary/primary care interface, both acquiring and passing on vital diagnostic and management information. The relatively unusual aspects of the interface geriatrician role was that it was provided on the AMU rather than in an in-patient setting with a full MDT, and that it involved community follow up – although community geriatricians are becoming more common.

The degree to which this way of working is cost-effective will be examined by AMIGOS. Such evaluation is warranted because the interface geriatrician did not work in a typical MDT setting. The experience listed here raises concerns about the degree to which AMIGOS will be able to detect such benefits. First, the use of the ISAR tool to select patients for intervention may not have sufficient specificity, resulting in individuals who are not at risk of future adverse events being assessed. The observed effect of the interface geriatrician intervention might be attenuated in AMIGOS because of the "dilution" of any effect in some patients by the inclusion of patients who could not benefit. Second, interface geriatricians felt that their interventions might be too little or too late to make a significant difference. Third, the differences they might make were





difficult to measure using standard outcome measures. For example, benefits of interventions by interface geriatricians might include reduction of minor medication side-effects, patient or carer reassurance, reduction of specific symptoms, reduction in readmissions, or reduction in drug costs. The AMIGOS primary outcome measure, days spent at home, is sensitive only to reductions in readmissions and deaths, and some secondary measures such as institutionalisation, are also likely to be insensitive to such benefits.

In both Leicester and Nottingham, the original notion of an interface geriatrician as tested in AMIGOS appeared to be developing while AMIGOS was in recruitment. In Leicester, a Frail Older People Advice and Liaison service (FOPAL) developed on its AMU. Its roles extended beyond frail older people being discharged, as in AMIGOS, into the management of ill frail patients on the AMU and directing skilled subsequent hospital care. In Nottingham, an Acute Medical Unit geriatrician was commissioned whose role it was to support the AMU teams in deciding who might be discharged home rather than admitted, and to guide the in-patient care of frail older people being admitted. In both these cases, the interface geriatrician role extended beyond the primary/secondary care interface to the AMU/in-patient interface. This illustrates that AMIGOS only tested one aspect of interface geriatrics and further studies are likely to be required irrespective of the result of AMIGOS.

In summary, we have described the key features of the intervention delivered by interface geriatricians, as shown to be feasible and tested in the AMIGOS study. The potential benefits to patients included a range of improved health outcomes, stemming from a comprehensive geriatric medical assessment enhanced by home assessment. Limitations to the effectiveness of such ways of working included problems in the identification of the patients most likely to benefit, and making such an assessment in a busy Acute Medical Unit where time and space were short. The benefits of such an intervention may be difficult to detect in a RCT because of dilution of any benefits by the inclusion of patients who could not benefit from interface geriatrics, and because of the difficulties of capturing the wide range of potential health benefits using conventional





health outcome measures. The model of interface geriatrics tested in AMIGOS (assessing and advising on patients discharged from an Acute Medical Unit) did not examine the wider roles of geriatricians in Acute Medical Units.





Abbreviations

AMIGOS: Acute Medical Unit Comprehensive Geriatric Assessment Intervention Study; AMU: Acute Medical Unit; CGA: Comprehensive Geriatric Assessment; CPD: Continued professional development; GP: General Practitioner; IG: Interface geriatrician; ISAR: Identification of Seniors At Risk; MMSE: Mini Mental State Examination.

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**Case 1**

A 77 year old lady was referred the AMU by her GP when neighbours had raised concerns about her increasing confusion and the possibility that she had taken a week supply of medication over a two day period. Assessment by the attending medical team on the AMU found her medically stable with no evidence of a critical drug overdose and planned to send her home. Despite presenting with reported increased confusion, no formal assessment of cognition was made. When she was reviewed by the interface geriatrician, she scored 8/30 on MMSE and while able to engage well in conversation, there were inconsistencies in her history. There was no suggestion of depression or deliberate drug overdose. A collateral history was sought from her next of kin, a family friend, who detailed deteriorating memory and increasingly erratic behaviours. They expressed grave concerns for the patient's safety in her current environment. The patient lived alone in a first floor flat and had refused social supports in the past. Until recently her neighbours had been supportive, assisting with shopping and providing informal social support. In recent times the patient had started wandering out of her flat overnight, knocking on neighbours doors and phoning them up to twenty times per day, often in the middle of the night. Her medications were delivered on a weekly basis by the local pharmacy but the patient was either taking or discarding all the medications within a day of delivery. Her behaviour was described as pestering the neighbours and they had increasingly withdrawn their support. As the patient was keen to return home, but serious concerns regarding safety and lack of social supports had been raised, the interface geriatrician assessed mental capacity to make this decision. The geriatrician felt the patient lacked capacity to make an informed decision about discharge and that an urgent assessment of care needs was required. As there was no available intermediate care assessment bed, pending its availability, an acute hospital admission was advised for further assessment.



**Case 2**

A 90 year old lady presented to the AMU having been found wandering outside her home in a confused state by neighbours. She was treated for a urinary tract infection despite negative urinalysis and inflammatory markers. She was reviewed by the interface geriatrician who felt the presentation was suggestive of a delirium but without clear precipitant. There was evidence that the patient was cognitively impaired having scored 21/30 on Mini Mental State Examination (MMSE) that day, but the degree to which this score was attributable to delirium or an underlying dementia process was initially uncertain. The interface geriatrician also identified seven admissions in recent months with similar presentations. A collateral history was obtained from the patient's son who confirmed a diagnosis of mixed aetiology dementia had been made six months previously. He also confirmed that the patient lived in a warden-aided flat with carers calling twice daily to assist with activities of daily living. Her son felt social contact was important to his mother as she tended to repeatedly phone family and friends when she was alone. A friend also called daily except on Sundays and Wednesdays. On reviewing the admission history the IG identified that all recent admissions had occurred on either Sundays or Wednesdays, the days on which the additional social call did not occur. It suggested that these wandering events and associated increased confusion were prevented by a consistent routine and adequate social support. A plan was put in place for the patient's son to contact social services to arrange additional social supports, activities, or a day centre on the days in question so that the patient could be supported to remain in her current environment for as long as possible.



**Case 3**

A man was seen in the AMU having been sent as an emergency with a non-specific presentation of acute illness or confusion that morning. He was known to have a dementia and type II diabetes mellitus. By the time of initial assessment he not attended by a carer or family member, so there was little history of the presenting event, and he appeared in normal health and well being. This diabetes was well controlled and basic observations were normal. The interface geriatrician spoke by telephone to his son, with whom the patient lived, and who was at work. Time was short for the son and the patient was keen to return home. No diagnosis for the episode was made. The interface geriatrician saw the patient at home with his family and wider social network 3 days later. At that point the presenting episode was more clearly an episode of shortness of breath waking him in the early hours, leading to agitation. Without prompting, a number of previously unexplained symptoms were catalogued: increasing shortness of breath on exertion such as dressing, swollen feet requiring changes to his footwear, and increasing abdominal girth leading to a reduced number of pairs of trousers that fitted him. These symptoms all developed a few weeks after a presentation at another hospital where a diagnosis of an uncomplicated myocardial infarction had been made and a beta-blocker had been started. By this point the diagnosis was pretty clear and the geriatrician had already spotted the patient's mild tachypoea and JVP visibly pulsating above the patient's collar while seated. Sacral oedema was then detected. The patient was obese and so ascites was suspected but not detected clinically. The presenting condition was presumably paroxysmal nocturnal dyspnoea due to CCF, and this simple diagnosis was obscured because of the patient's dementia and means though which his health care was provided.



**Case 4**

An 84 year old lady attended the AMU with delirium secondary to infective diarrhoea, further complicated by fast atrial fibrillation and acute kidney injury. She had a background history of dementia, scoring 16/30 on MMSE. Her medical issues were optimised and she was reviewed by an interface geriatrician who arranged a follow-up domiciliary visit due to the medical complexity of the case in the context of dementia. At the time of the domiciliary visit, the patient's nephew provided a collateral history which suggested the patient was experiencing paranoid delusions about her neighbours and had become increasingly socially isolated. She had also accused her niece of stealing her money when she had tried to assist with financial affairs. When repeated at this time, the MMSE was again 16/30 and there was no evidence of an ongoing delirium. The interface geriatrician contacted the community mental health team for an urgent assessment and communicated the events and plan to the GP. The geriatrician was contacted by the patient's niece shortly after the home visit with concerns about the follow up plan and supports as the patient had been removed from the GP's list due to abusive behaviour towards the staff of the practice. When the GP was unavailable to discuss the case further, the geriatrician again contacted the community mental health team to expedite their assessment. Before the assessment could take place the patient called an ambulance and attended the emergency department with symptoms and signs consistent with dermatitis. The geriatrician reviewed the patient in the emergency department and, with prior knowledge of the case, was quickly able to identify that although medically stable, there was an impending crisis from a mental health point of view. Rather than discharge the patient back to the community, potentially allowing the situation to escalate further, the geriatrician facilitated admission for urgent psychiatric assessment which resulted in transfer to aged care psychiatry unit for ongoing management.





Case 5

A 71 year old gentleman was referred to the emergency department (ED) following a fall with an associated head injury. He had a reduced level of consciousness with a Glasgow Coma Scale score of 13/15 on arrival. He was stabilised in the ED and underwent a CT head to rule out a traumatic cerebral bleed. There was no acute brain injury on this occasion but the scan revealed extensive chronic ischaemic changes with three mature infarcts and generalised cerebral and cerebellar atrophy. He had a raised alcohol level consistent with alcohol intoxication. He was referred to the AMU for ongoing management, where he was deemed stable and suitable for discharge. He was assessed by the interface geriatrician who noted that there had been multiple similar admissions in the preceding years with alcohol intoxication. The geriatrician also identified a number of ongoing issues. He had a right hemiparesis following a stroke which was associated with impaired mobility and was significantly contributing to his fall risk. He continued to mobilise around his flat using a walking frame. He lived alone in a flat, with no formal social supports in place. He had a pendant alarm that he would use when he fell. In conversation he displayed evidence of mild cognitive impairment and although he lacked insight into how his excessive alcohol intake was contributing to his ill health, he had capacity to make a decision about returning home. He scored 19/30 on Mini Mental State Examination. A collateral history was obtained from the patient's daughter who clearly differentiated the patient's functional abilities when he wasn't drinking alcohol compared to times when his consumption increased. During periods of heavy alcohol intake, he was at risk of repeated falls and episodes of increased confusion. His mobility deteriorated and he experienced episodes of urinary incontinence when he was drinking excessively. During times when he was drinking less, his functional capacity increased. He had refused social services input on a number of occasions in the past. The geriatrician reviewed medications, recommended discontinuation of a diuretic as there was no evidence of hypertension or heart failure. The patient was advised that he needed to dramatically cut down his alcohol intake and was encouraged to accept social services input. He had been assessed by the hospital alcohol liaison team and referred to the community alcohol services on many occasions, but he repeatedly declined their input. He was referred to the community falls prevention team and the GP was asked to refer to social services again. A domiciliary visit was arranged to assess the patient in his own environment, to reinforce the need for alcohol cessation, and to encourage the need for social support.



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