The geriatrician and the front door

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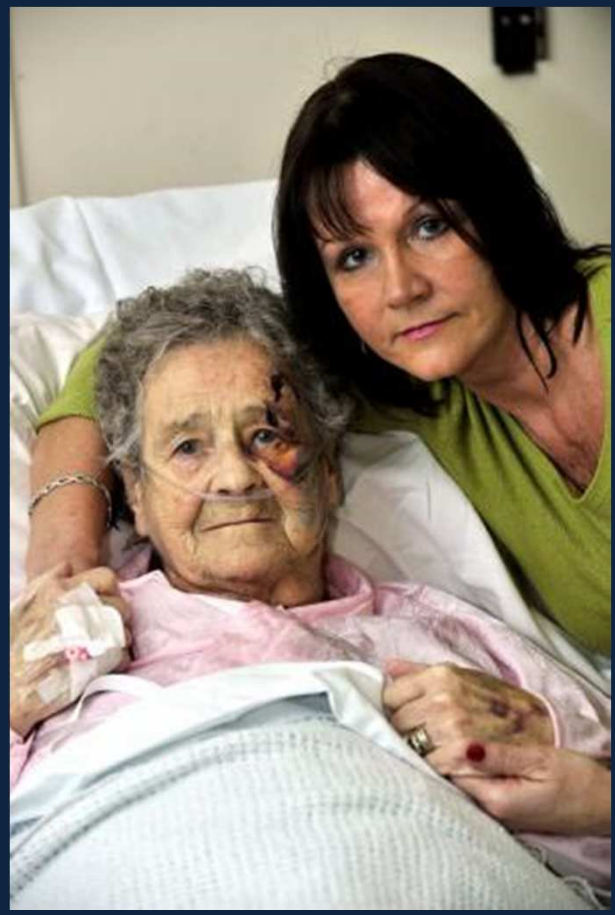
Edinburgh, June 2013

About Doris…

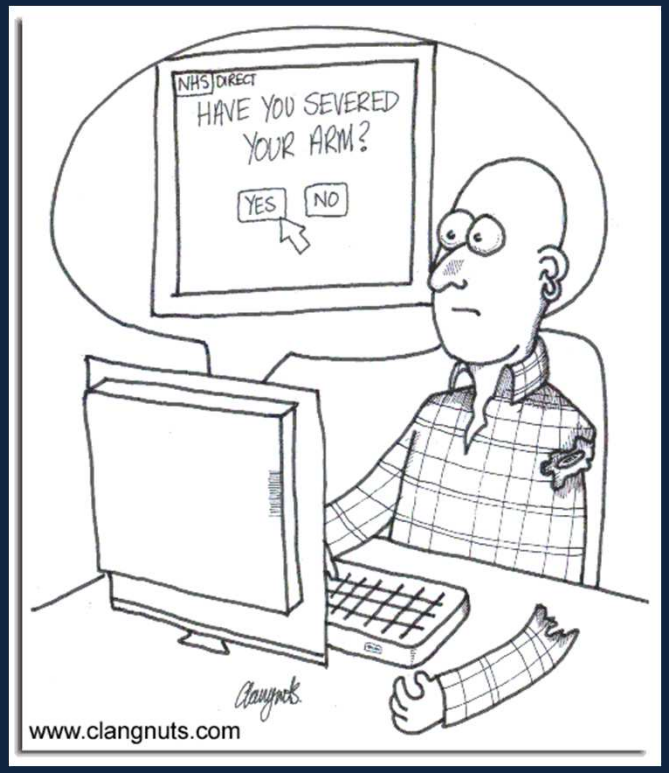
- Doris lives in her farm with her daughter and son-in-law, who farm her land in Belton

- 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



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

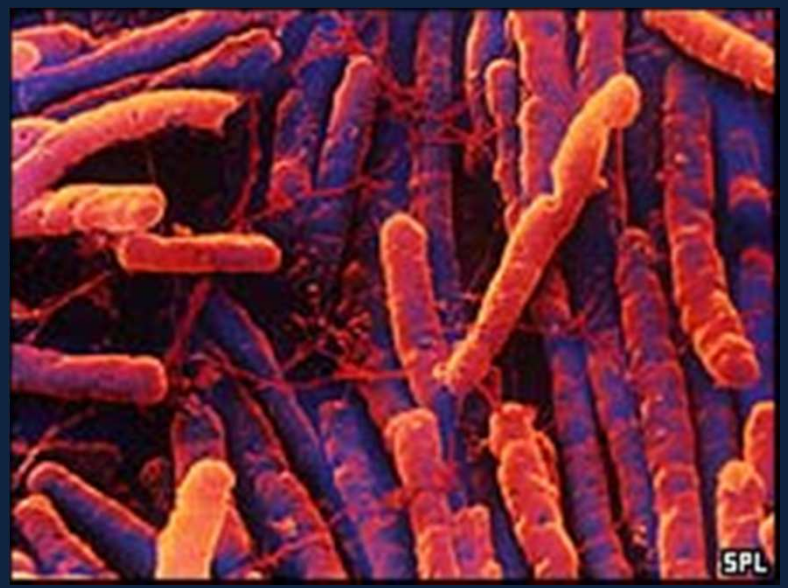
- Medications
  - Aspirin
  - Bendroflumethazide
  - Atenolol
  - Simvastatin
  - (Trimethoprim)

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)

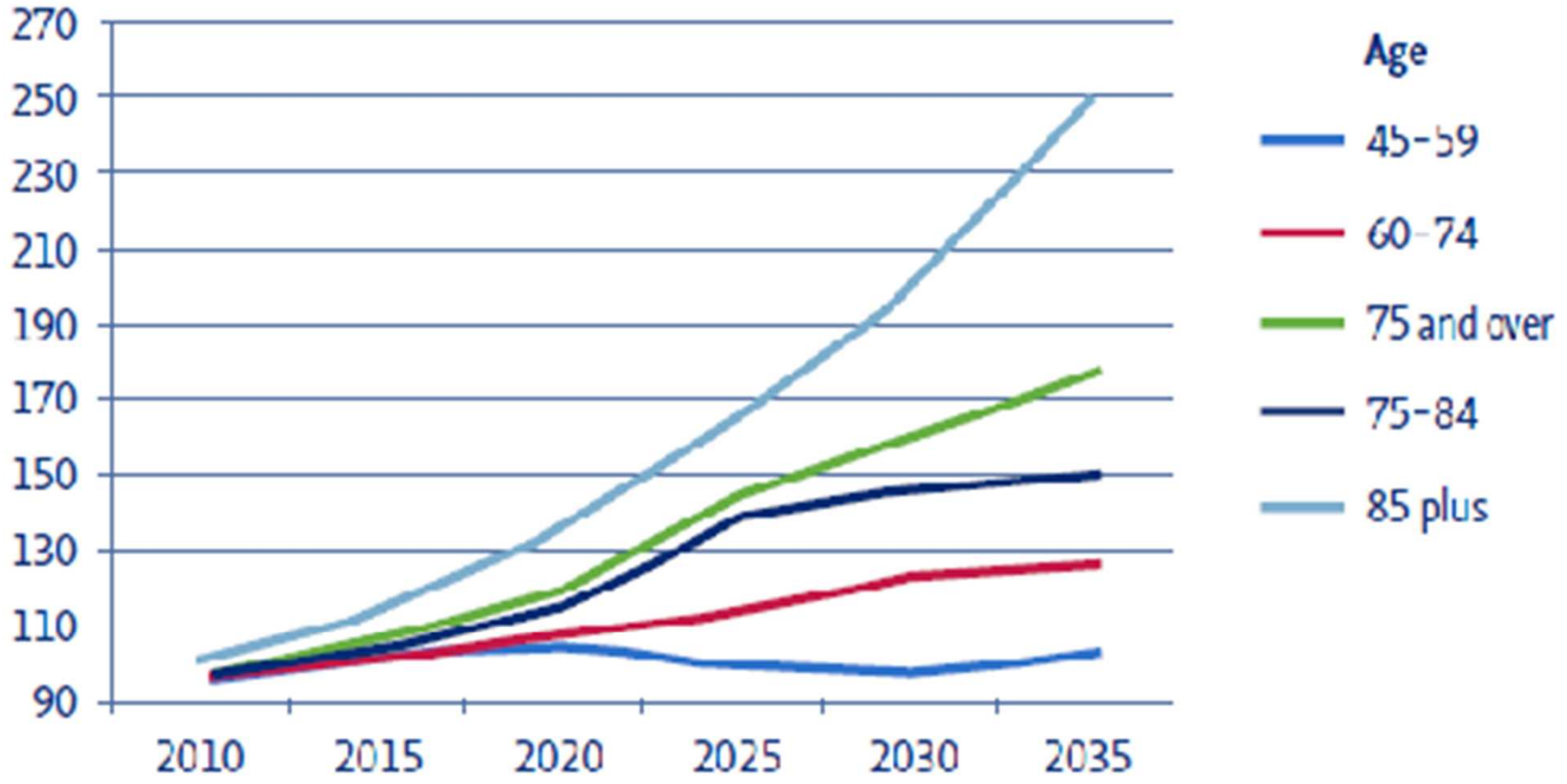
What could have been different?

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

Modern health and social care

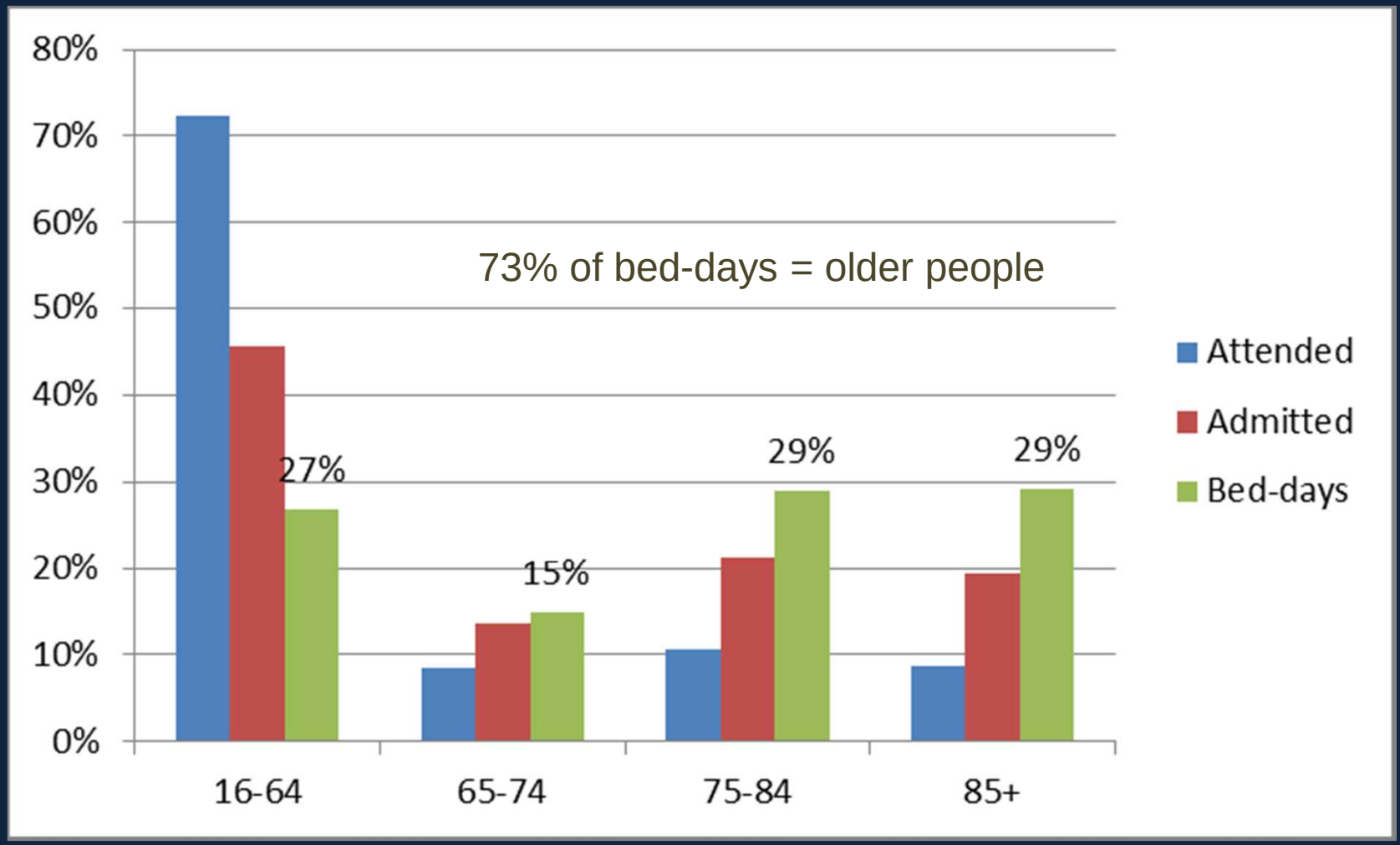
- Ageing population, increasingly complex care
- More attending emergency care
  - Despite intermediate care
  - Lower threshold for admissions
- Generalist vs. specialist care
- Coordinated care more challenging as ‘silo mentality’ sets in

Projected population by age, United Kingdom, 2010-35



Source: Office for National Statistics (Oct 2011) National Population Projections 2010-based Statistical Bulletin.

21st century urgent care



Non-specific presentations – urgent challenges

- Non-specific presentations
  - Falls, delirium, immobility
- Functional decline
- Multiple co-morbidities
- Polypharmacy
  - Also under-prescribing
- Differential challenge
  - Sensory impairment, dementia, delirium
  - Poor access to collateral history

The Silver Book

Urgent care - standards

- The Silver Book
  - http://www.bgs.org.uk/campaigns/silverb
- Membership
  - Age UK
  - National Ambulance Service Medical Directors
  - Association of Directors of Adult Social Services
  - British Geriatrics Society
  - Chartered Society of Physiotherapists
  - College of Emergency Medicine
  - College of Occupational Therapists
  - Society for Acute Medicine
  - Royal College of General Practitioners
  - Royal College of Nursing
  - Royal College of Physicians
  - Royal College of Psychiatrists
  - Community Hospitals Association

Underpinning principles

- All older people have a right to a health and social care assessment and should have access to treatments and care based on need, without an age-defined restriction to services
- A whole systems approach with integrated health and social care services strategically aligned within a joint regulatory and governance framework, delivered by interdisciplinary working with a patient centred approach provides the only means to achieve the best outcomes for frail older people with medical crises

Developing a frail friendly front door

Standards (some)

- All older people accessing urgent care should be routinely assessed for:
  - Pain
  - Depression
  - Skin integrity
  - Falls and mobility
  - Continence
  - Safeguarding issues
  - Delirium and dementia
  - Nutrition and hydration
  - Sensory loss
  - Activities of daily living
  - Vital signs
  - End of life care issues

Frailty syndromes & urgent care

- The presence of one or more frailty syndrome should trigger a more detailed comprehensive geriatric assessment, to start within 4 hours (14 hours overnight)
- Frailty syndromes
  - Falls & immobility
  - Functional decline
  - UTI & incontinence
  - Pressure sores
  - Delirium and dementia
  - Polypharmacy (>4 items)
  - Carer strain

Training & development

- Healthcare professionals managing older people, irrespective of clinical setting, need the following mandatory skills as minimum standards:
  - Communication skills
  - Clinical reasoning and assessment skills
  - Risk assessment/management skills
  - Multidisciplinary team working skills
  - Cultural awareness
  - An understanding of relevant mental health legislation and guidance
  - Training in safeguarding skills

Education and training in Emergency Geriatric Medicine

EMJ Supplement

Developing a frail friendly front door: a Fellowship in Geriatric Emergency Medicine

Patients over the age of 70 years currently make up 15% of emergency department attendances,[1] a figure that will increase significantly over the course of the next 20 years. High quality management of frail older people is challenging because they often present non-specifically (for example, with falls, immobility, delirium) which can make the immediate diagnosis obscure and management more challenging.

Emergency training of doctors, nurses and allied health professionals has not traditionally focused on the needs of older patients, thus there is a lack of confidence and expertise in managing older people and conditions associated with ageing.[2]

Aside from the knowledge of geriatric syndromes, there is a skill involved in geriatric medicine—history taking is challenging, for example, because of sensory impairment, dementia or delirium. Often a collateral history is needed which may

WHAT WAS INVOLVED?

The year was split into three parts: inpatient care, community care and emergency care of frail older people.

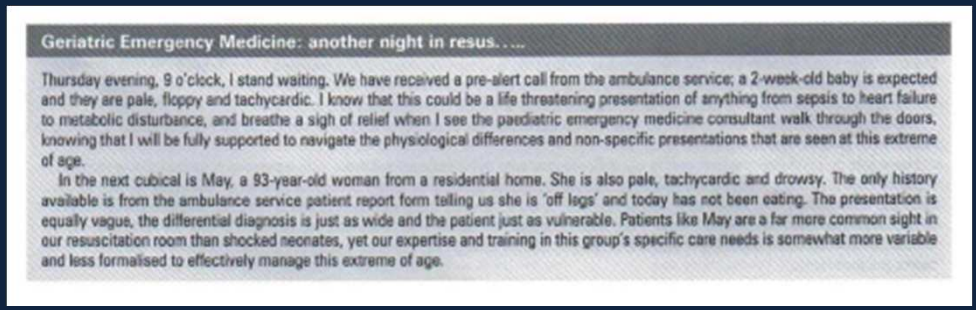
INPATIENT GERIATRIC MEDICINE

Four months was spent working on a geriatric base ward at the city's main teaching hospital joining a team led by two consultants. The purpose of this was to develop an understanding of 'comprehensive geriatric assessment' (CGA) and lay down the principles for investigating and managing the non-specific presentations that bring older people into hospital. CGA is a geriatrician's version of Advanced Trauma Life Support as it provides a common language and structured diagnostic assessment used by the whole multidisciplinary team (MDT). Medical, psychological and functional capabilities are evaluated to allow a coordinated and integrated treatment plan through to discharge from the rehabilitation ward. Half of TIA clinic referrals are found to have an alternative diagnosis, such as tumour or migraine, so this clinic was particularly useful in learning how to elicit the subtleties to narrow down the differential diagnosis.

COMMUNITY GERIATRICS

The next block of training focused on what was possible outside the acute hospital setting. Placements included community hospital ward rounds, intermediate care and rehabilitation services. Accompanying consultants on domiciliary visits and nursing home visits provided an opportunity to find out what was involved in advance care planning.[8] Detailed discussions were observed taking place between frail older people, their families and a community geriatrician. Advance care planning provides an opportunity for people to make a statement about their preferences and wishes which would then be available to GPs, paramedics and hospital teams so that should they lose capacity on becoming unwell, their opinions would be known and can be respected.

Locally, falls account for around 5% of attendances to the emergency department. Falls clinics provided excellent training on

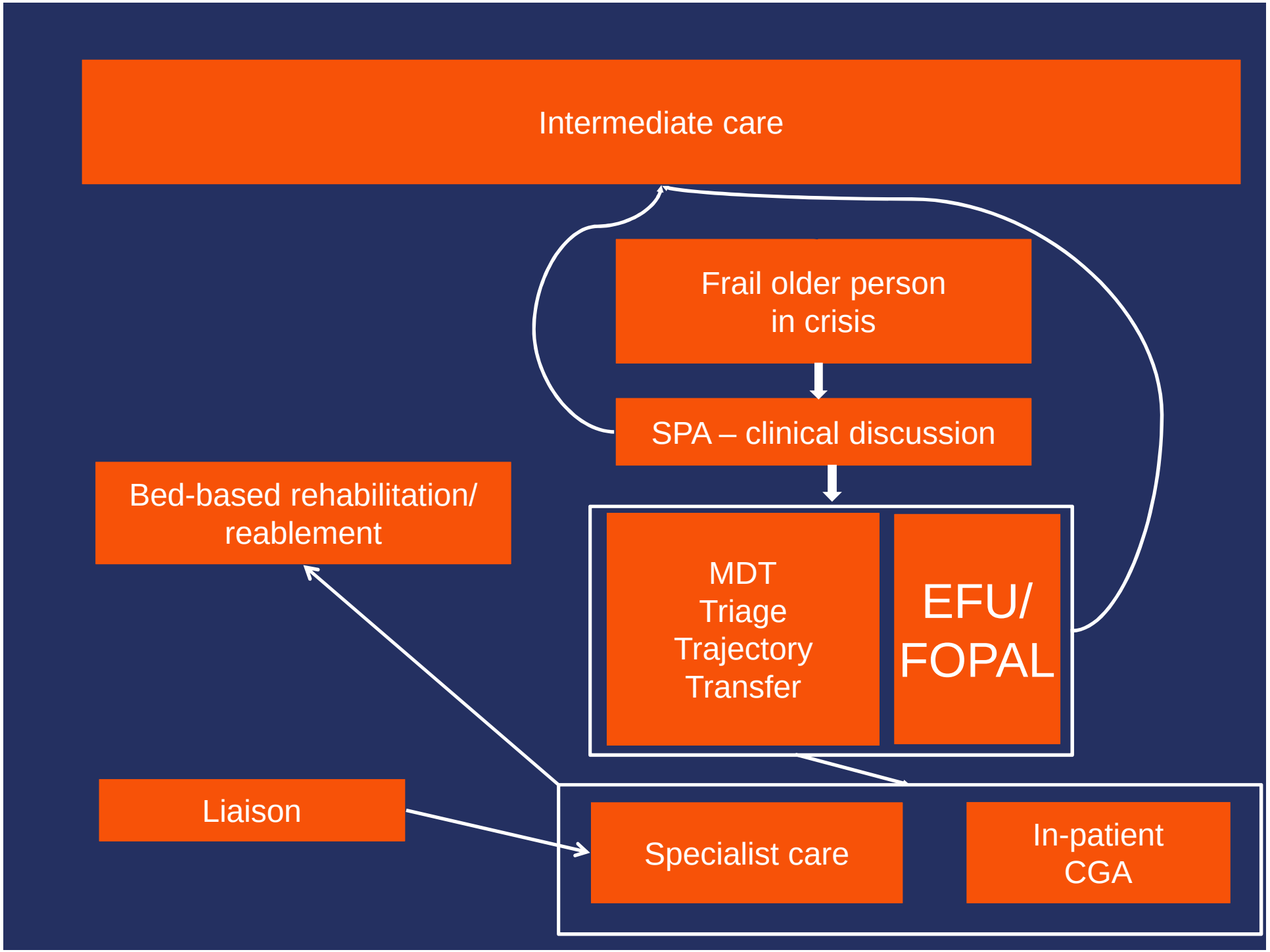


Geriatric Emergency Medicine: another night in resus.....

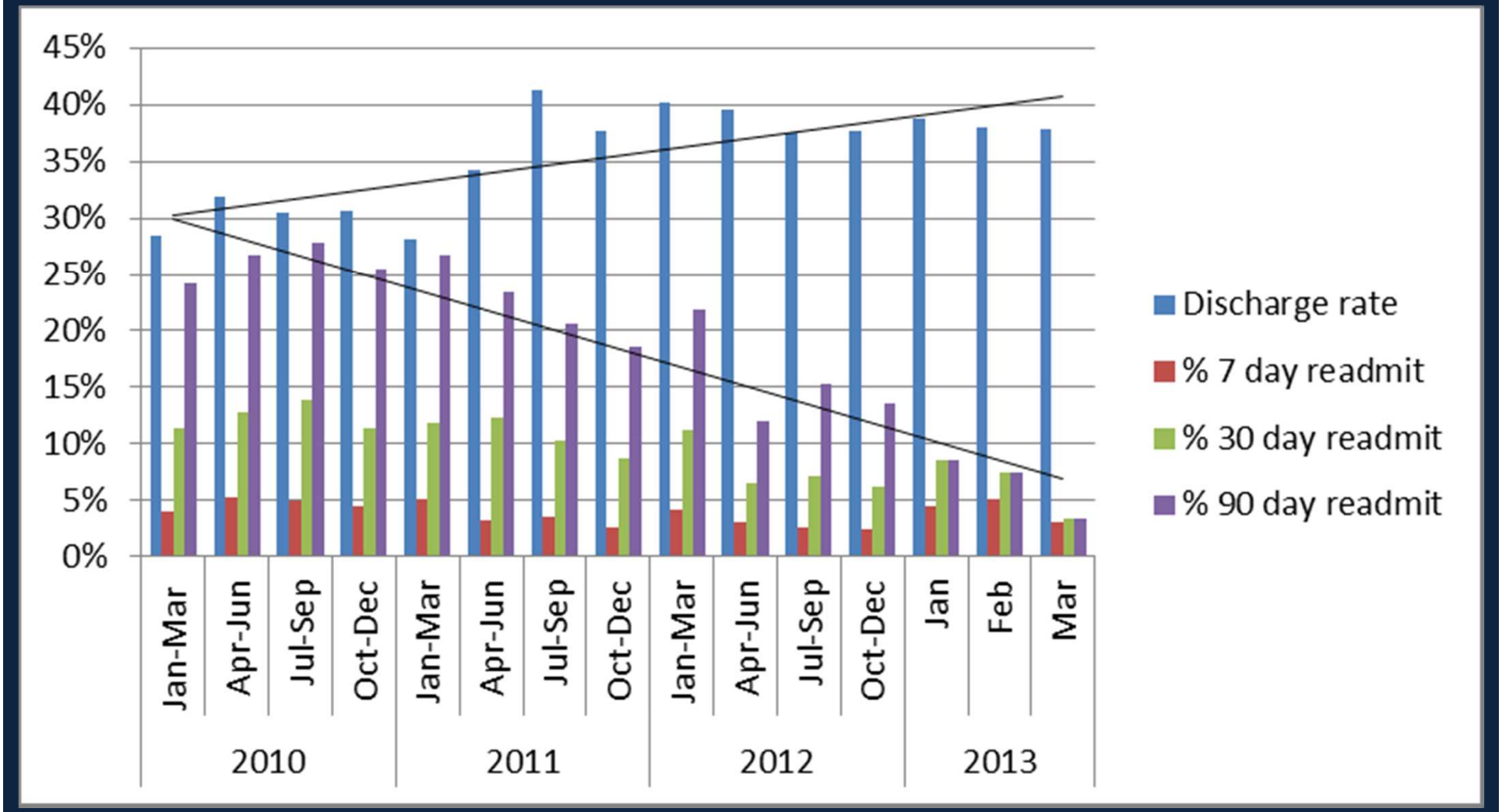
Thursday evening, 9 o'clock, I stand waiting. We have received a pre-alert call from the ambulance service; a 2-week-old baby is expected and they are pale, floppy and tachycardic. I know that this could be a life threatening presentation of anything from sepsis to heart failure to metabolic disturbance, and breathe a sigh of relief when I see the paediatric emergency medicine consultant walk through the doors, knowing that I will be fully supported to navigate the physiological differences and non-specific presentations that are seen at this extreme of age.

In the next cubical is May, a 93-year-old woman from a residential home. She is also pale, tachycardic and drowsy. The only history available is from the ambulance service patient report form telling us she is 'off legs' and today has not been eating. The presentation is equally vague, the differential diagnosis is just as wide and the patient just as vulnerable. Patients like May are a far more common sight in our resuscitation room than shocked neonates, yet our expertise and training in this group's specific care needs is somewhat more variable and less formalised to effectively manage this extreme of age.

A practical example


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

ED performance 2010-13: people 85+



Summary

- Urgent care = older people
  - Needs to be vertically integrated
  - Holistic & interdisciplinary
  - Underpinned by robust communication and cooperation
  - Informed by the Silver Book

Cure better than prevention?

	Admit	Non-admit			
Screen+	27000	13000	40000		
Screen-	3000	117000	120000		
	30000	130000	160000		
Sn	0.9				
Sp	0.9			40,000 treated at £250	= £10,000,000
PPV	0.675				
NPV	0.975			10% reduction in admissions @ £2000	=27000*.10= 2700*2000= £5,400,000

Such precise tools do not exist!