Geriatric medicine in the acute care setting
- normalising Comprehensive Geriatric Assessment

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It’s not just ageing...
Frailty...

- Distinctive late-life health state in which apparently minor stressor events are associated with adverse health outcomes

- Independent predictor:
  - Falls
  - Delirium
  - Disability
  - Hospitalisation
  - Care home admission
‘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
Evidence for CGA

- Acute care
  - 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’s the problem?

- Not enough CGA & too much specialism
  - Protocols vs patient centred care
- Everybody’s business can become nobody’s business
- CGA ≠ geriatricians (although they are good at it 😊)
CGA competencies

- Physiotherapy
- Medicine
- Social care
- Nursing
- Occupational therapy

CGA coordinated, communicated

Courtesy of Adam Gordon, University of Nottingham
Practical CGA in the ED

1. Identify frailty
   a. Easy & simple
   b. Syndromes
   c. Age
   d. Frailty scores??
Practical CGA in the ED

1. Identify frailty

2. Broaden the assessment:
   a. Wide angle lens for non-specific presentations
   b. Check the brain – AMT-4,
   c. Mood – how are you feeling?
   d. Ask about falls and mobility – can they walk?
   e. Bowels/bladder OK?
      • Don’t dip the urine unless LUTS or delirium

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<tr>
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<td>Activities of daily living</td>
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<td>Safeguarding issues</td>
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Practical CGA in the ED

1. Identify frailty

2. Broaden the assessment:
   f. BADLs – eat, drink, wash, dress, toilet etc
   g. EADLs – social, outdoor mobility, interactions etc
   h. Nutrition
   i. Skin
   j. Safeguarding & support

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Practical CGA in the ED

1. Identify frailty

2. Broaden the assessment

3. Do something different:
   a. All patients – communicate & coordinate a stratified problem list, follow-up & case manage
   b. Admitted patients – frailty unit/service
   c. Ambulatory patients – Emergency Frailty Unit (<24 hours), or home with community support/falls service/intermediate care etc
A controlled evaluation of comprehensive geriatric assessment in the emergency department: the ‘Emergency Frailty Unit’

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What we did...

- Integrated take ➔ dedicated geriatric take
- Vertically integrated services for frail older people
- Focussed comprehensive geriatric assessment, including social care
  - At and across the interfaces;
  - Coordinated and communicated
- Horizontal integration (ED and GER)
- Whole system, collaborative leadership
Frail older person in crisis

SPA – clinical discussion

Rehabilitation (home>hospital)

MDT Triage Trajectory Transfer

EFU/ FOPAL or AFU

Specialist care

In-patient CGA

Intermediate care

Liaison
This pathway is to be used to highlight patients who might benefit from Comprehensive Geriatric Assessment (CGA).

**Step 1**
**Inclusion criteria**
- Aged 85+
- OR aged 70+ AND 1 or more of the following
- Patients from residential or nursing homes
- Patients with delirium or dementia (check AMT-4)
- Patients with fragility fracture not requiring surgery

**Step 2**
**Streaming**
- If you think that your patient has a good chance of going home in the next 24 hours, please refer to the Emergency Frailty Unit (EFU)
- If not, or no EFU beds available, please refer to Acute Frailty Unit (AFU) on level 5
- If very sick consider Acute Care Bay (ACB) – contact the medical registrar on call

**Special notes**
- Patients with fractures need to have fracture clinic referral completed in ED and initial fracture management in place prior to transfer to AMU/AFU
Leicester EFU
CGA in the Acute Medical (Frailty) Unit

1. Identify frailty
2. Broaden the assessment
3. Do something different
   a. Frailty service – has to be more than liaison...
   b. Frailty unit – needs to be inclusive
Outcomes: 85+ discharged from AFU
Timely care for frail older people referred to hospital improves efficiency and reduces mortality without the need for extra resources

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Sheffield AFU
Practical examples of MDT working
Comprehensive Geriatric Assessment - common pitfalls

- CGA ≠ geriatricians (but they are good at it…)
- The not quite doing it trap
  - Does it have five domains?
  - Is it multidisciplinary?
  - Is it case managed?
  - Does it establish measurable treatment goals?
  - Is it iterative?

Courtesy of Adam Gordon, University of Nottingham
CGA – the future

- Embedded, evidenced and educated
  - Embed excellent services that focus on the care of frail older people
  - Evidence that CGA is being delivered and monitor the outcomes
  - Educate all staff how to play their role

- ‘Know what to do, know that you are doing it, know that it is working’
Take home messages

• Care for frail older people is core business
• Early CGA effective and efficient
  – The earlier the better
  – ‘Separate, not separatist’
• Needs strong interface with community services
• Clinical pathway needs to drive integration not vice versa
Acute Frailty Network

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