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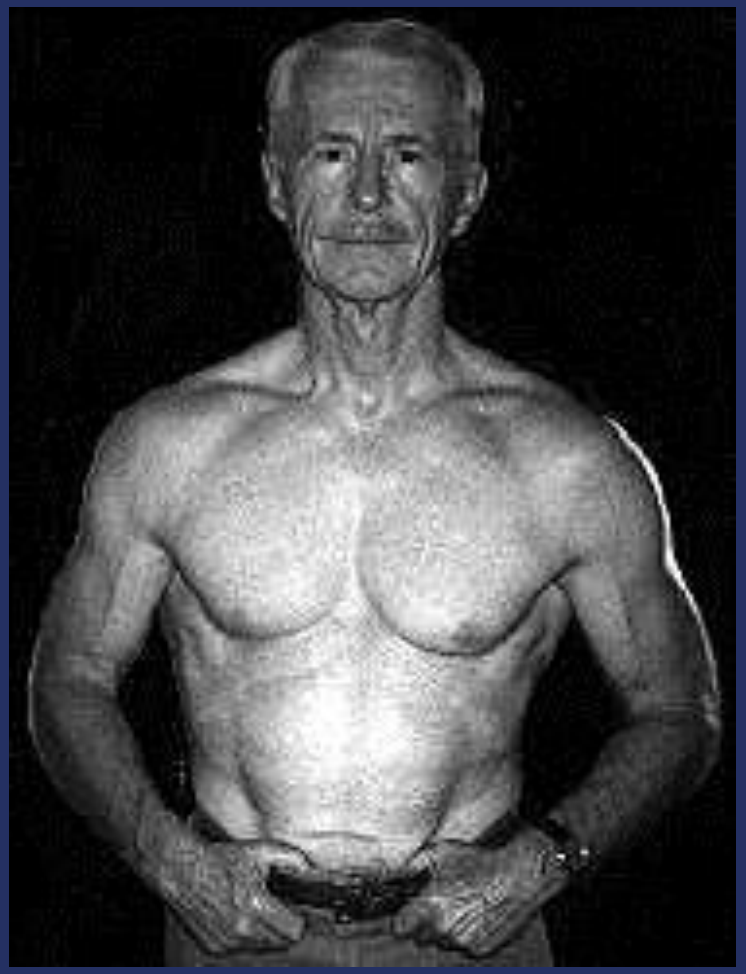
Geriatric medicine in the acute care setting

- normalising Comprehensive Geriatric Assessment

Simon Conroy
Geriatrician & Honorary Senior Lecturer

It’s not just ageing…

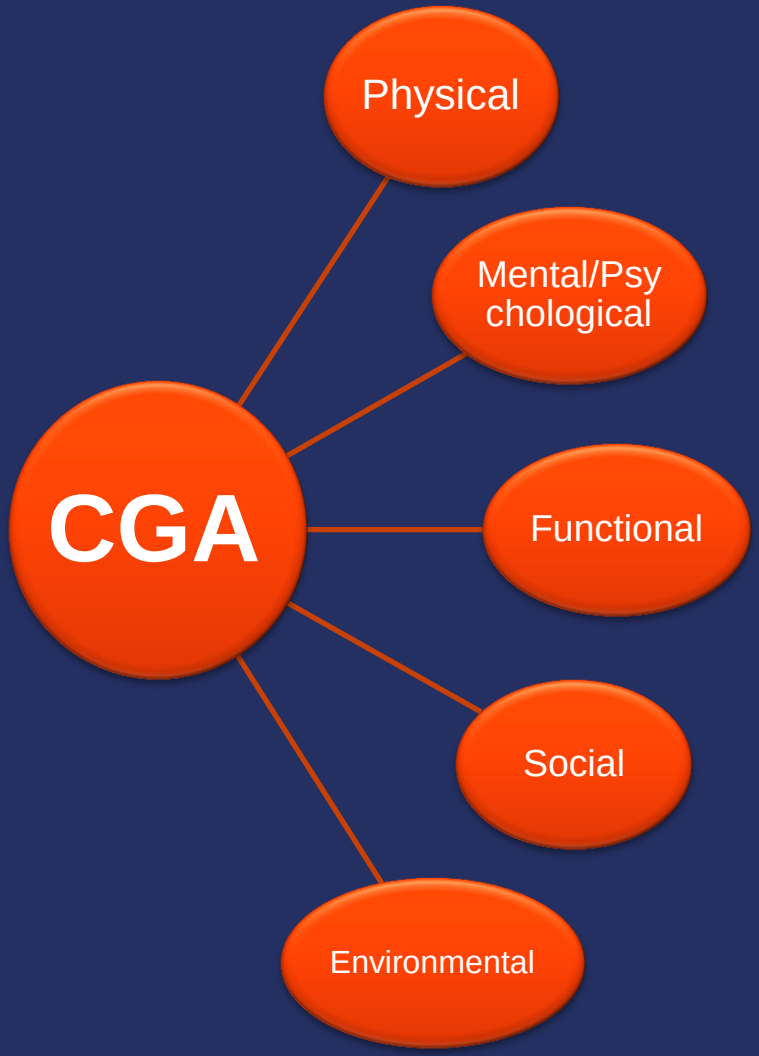


Frailty…

- 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

Comprehensive Geriatric Assessment

‘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

Courtesy of Adam Gordon, University of Nottingham

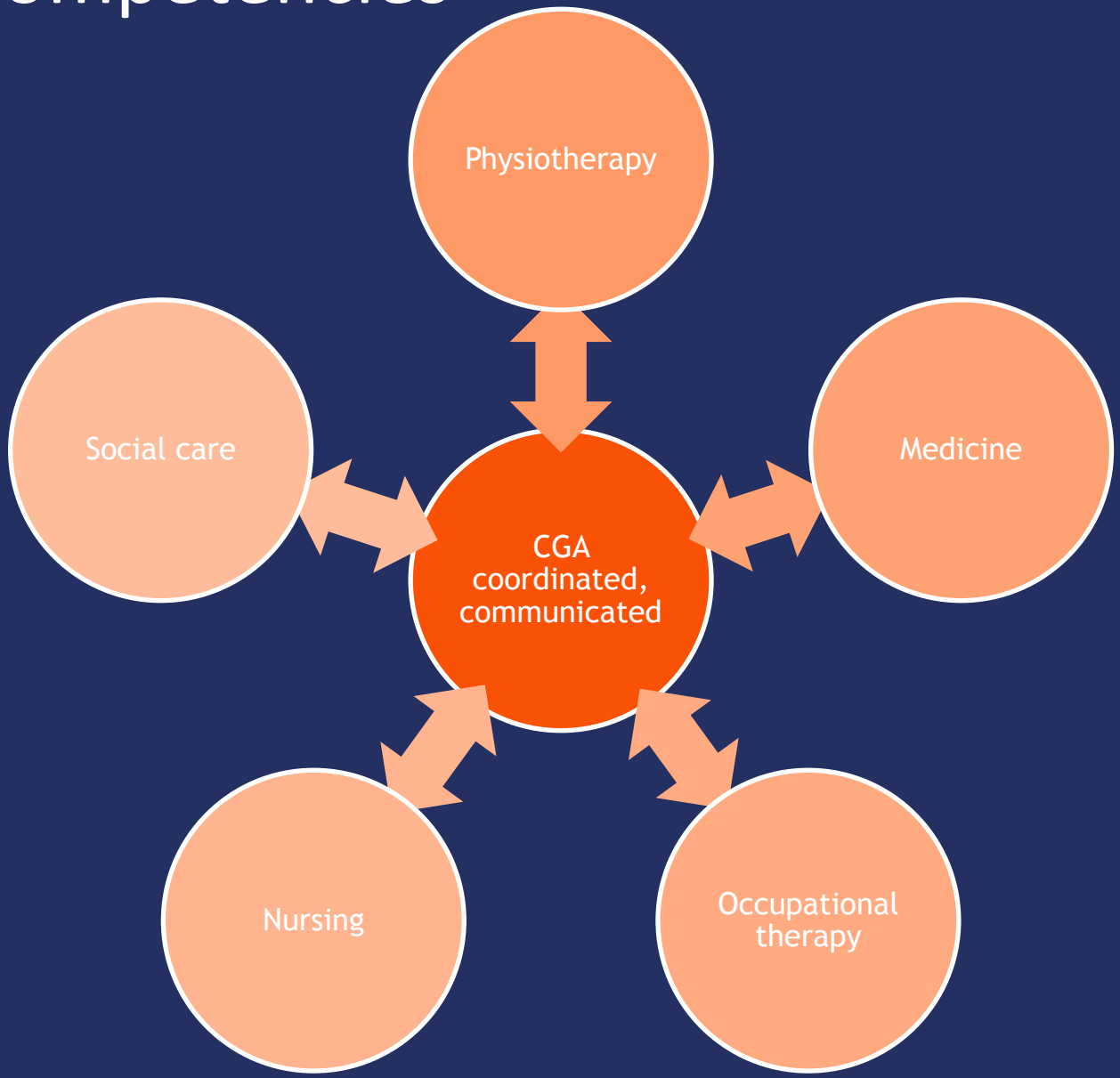
Evidence for CGA

- 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



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

Pain	Delirium and dementia
Depression	Nutrition and hydration
Skin integrity	Sensory loss
Falls and mobility	Activities of daily living
Continence	Vital signs
Safeguarding issues	End of life care issues

1. Identify frailty
2. Broaden the assessment:
   a. Wide angle lens for non-specific presentations
   b. Check the brain – AMT-4,

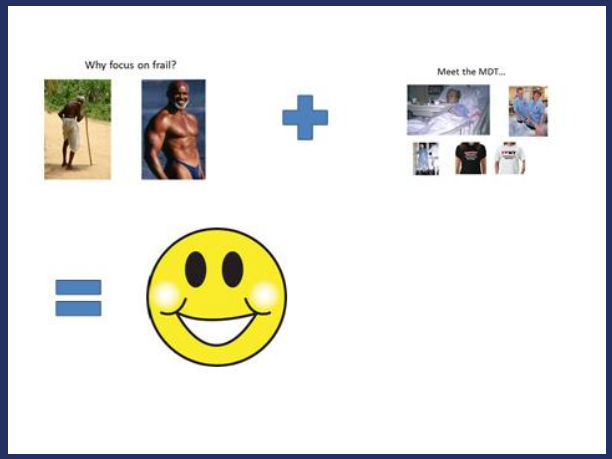
   c. Mood – how are you feeling?
   d. Ask about falls and mobility – can they walk?
   e. Bowels/bladder OK?
      - Don’t dip the urine unless LUTS or delirium

Practical CGA in the ED

Pain	Delirium and dementia
Depression	Nutrition and hydration
Skin integrity	Sensory loss
Falls and mobility	Activities of daily living
Continence	Vital signs
Safeguarding issues	End of life care issues

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

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

Leicester EFU

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

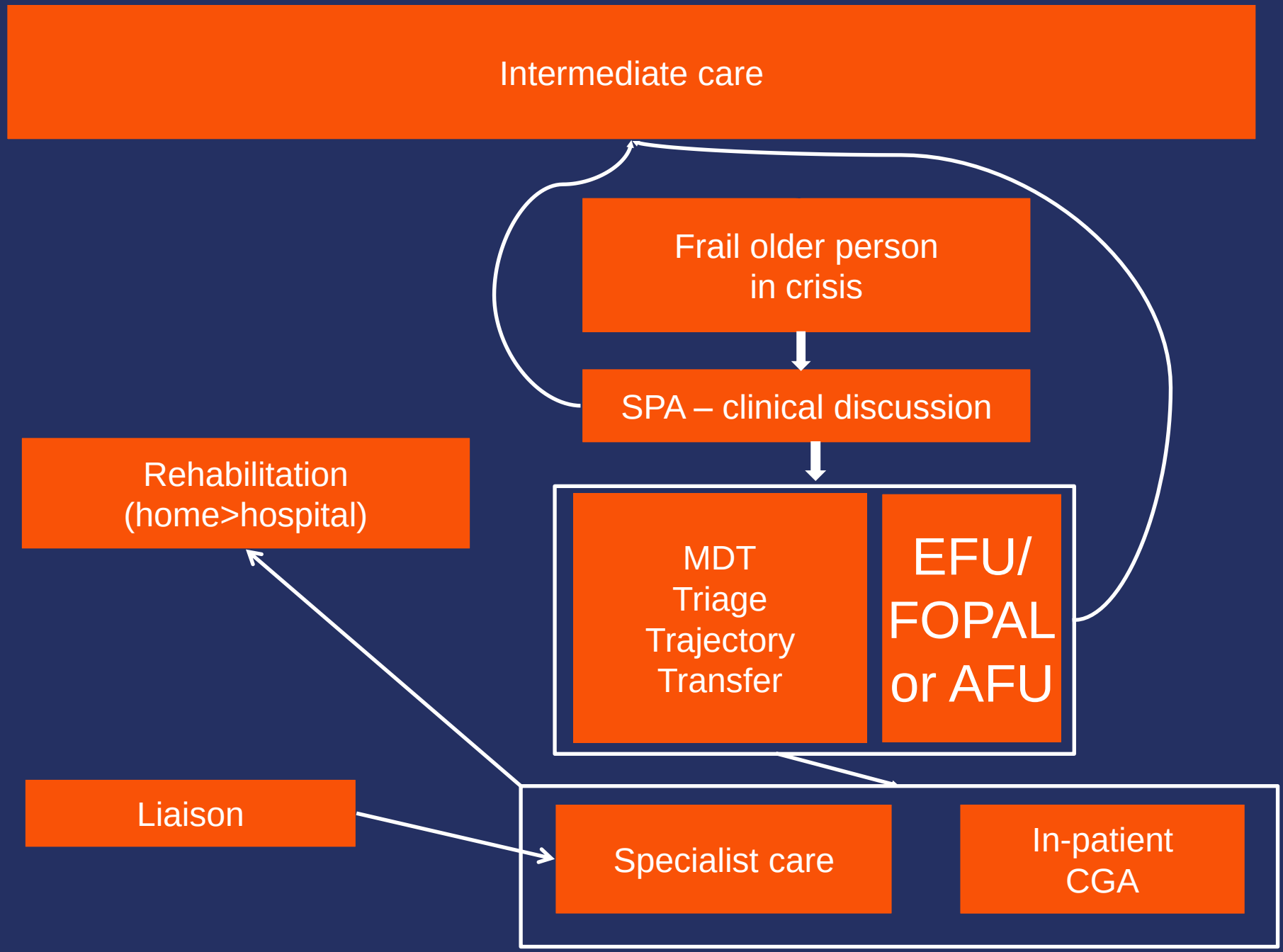
Simon Paul Conroy[1], Kharwar Ansari[2], Mark Williams[2], Emily Laithwaite[3], Ben Teasdale[2], Jeremy Dawson[4], Suzanne Mason[4], Jay Banerjee[2]

[1]University of Leicester School of Medicine, Room 540, Clinical Sciences Building Leicester Royal Infirmary, Leicester LE2 7LX, UK
[2]Emergency Medicine, University Hospitals of Leicester, Leicester, Leicestershire, UK
[3]Geriatric Medicine, University Hospitals of Leicester, Leicester, Leicestershire, UK
[4]ScHARR, University of Sheffield, Sheffield, UK

Address correspondence to: S. P. Conroy. Tel: +44 (0)116 258 7635; Fax: +44 (0)116 258 6737. Email: spc3@le.ac.uk

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


Intermediate care
Frail older person in crisis
SPA – clinical discussion
Rehabilitation (home>hospital)
MDT
Triage
Trajectory
Transfer
EFU/ FOPAL or AFU
Liaison
Specialist care
In-patient CGA

University of

ED STAT / nurse assessment

Date | Time | STAT doctor | Nurse – name and ID

Patient details

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Full name

DoB

Unit number

(use sticker if available)

APT : Over 65

Pain score

0 1 2 3 4 5 6 7 8 9 10

Time analgesia was offered — Time HH:MM (use 24h clock)

☐ Analgesia declined in spite of reassurance and careful explanation of the effects

0 1 2 3 4 5 6 7 8 9 10

Time pain score was repeated — Time HH:MM

☐ Analgesia again declined

Triaged to ☐ ER ☐ Maj ☐ Min ☐ To be seen by _____ ☐ UCC ☐ Own GP ☐ Self-care

Bloods and IV access

Done by

- IV access: ☐ required
- Near-pt bloods: ☐ FBC (NB: send to lab after near-patient test) ☐ Venous blood gas
- Lab bloods: ☐ U&E ☐ cTnI ☐ Amylase ☐ LFT ☐ CK ☐ TFT ☐ Paracetamol ☐ Salicylate ☐ Other _____ ☐ BNP ☐ D-Dimer ☐ G&S ☐ X-match ☐ 2 ☐ 4 ☐ 6 ☐ 10 units ☐ Malaria screen ☐ Hepatitis serology ☐ HIV test
- Red top
- Orange top
- Brown top
- Green top
- Large red top
- White top
- Blood culture ☐ — Culture bottles
- Arterial gas ☐ — ABG syringe
- Delayed bloods ☐ Paracetamol required at Time HH:MM — Brown top

Further tests

Done by

- ECG
- Urine tests: ☐ Dipstick urinalysis ☐ Beta HCG ☐ Culture and sensitivity
- Imaging
- BP lying/standing
- Cardiac tool
- Visual acuity

Interventions

Done by

- ☐ O2 - target SpO2 _____
- ☐ Analgesia
- ☐ Other medicines
- ☐ IV fluids
- ☐ PO fluid bolus
- ☐ Arm sling
- ☐ Leg splint
- ☐ Wound dressing
- ☐ Eye irrigation
- ☐ Amatop
- ☐ Undressing / gown
- ☐ Personal hygiene
- ☐ Toileting

Initial Obs

- Weight (kg)
- PEF (L/min)
- SpO_2 (%)
- ☐ on air ☐ on O_2 (%):
- Resp rate (/min)
- Pulse rate (/min)
- BP (mm Hg) — Initial | lying/standing
- Temp (°C)
- GCS E V M Total
- Pupils: Size (mm) | Reaction — L R
- BM (mmol/L)
- EWS

Property

- ☐ Patient able to take responsibility (NB: ensure policy has been explained)
- ☐ Valuables sent to 'Patient Affairs'
- ☐ Clothes cut, checked and EITHER
  - ☐ Given to relative OR
  - ☐ Disposed of

Allergies

Name band on patient (tick when done) ☐

Good communication

Does someone know patient is in ED?	☐ Y	☐ N
Dependants needing care?	☐ N	☐ Y
'A' form needed? (if YES: ensure this is done)	☐ N	☐ Y
Does the patient have a social worker?	☐ N	☐ Y
NBM or other diet restrictions?	☐ N	☐ Y
Is this a vulnerable adult?	☐ N	☐ Y
Are pts ADL restricted? (if YES: give buzzer)	☐ N	☐ Y
Does patient need further explanation as to what is happening with them?	☐ N	☐ Y
Falls risk?	☐ N	☐ Y
Risk of wandering? (if YES: give description)	☐ N	☐ Y

Mat Wensley (Marie Wass , Mar 11 , Version 12

Complete for all patients

AMT4 (4-item Abbreviated Mental Test) [1]

Write down patient's answer below

What was your date of birth?	☐ Wrong	☐ Correct
What is the name of this place?	☐ Wrong	☐ Correct
How old are you?	☐ Wrong	☐ Correct
What year is it?	☐ Wrong	☐ Correct

A score of less than 4 suggests cognitive impairment; look for evidence of dementia, delirium, or both

Number of questions answered correctly

EFU (Emergency Frailty Unit) physician review

Consider if any of the below

- ☐ Fragility fracture
- ☐ Care home resident (nursing or residential)
- ☐ AMT4 less than 4
- ☐ On emergency frailty pathway

Complete for patients being discharged from ED

ISAR screening tool (Identification of Seniors At Risk) [2] *Ask carer if patient unable to answer*

Before the illness or injury that brought you to the Emergency Department, did you need someone to help you on a regular basis?	☐ No	☐ Yes
Since the illness or injury that brought you to the Emergency Department, have you needed more help than usual to take care of yourself?	☐ No	☐ Yes
Have you been hospitalised for one or more nights during the past 6 months (excluding a stay in the Emergency Department)?	☐ No	☐ Yes
In general, do you have serious problems with your vision, that can't be corrected by glasses?	☐ No	☐ Yes
In general, do you have serious problems with your memory?	☐ No	☐ Yes
Do you take more than three different medications every day?	☐ No	☐ Yes

If scoring more than 1

- *Ask Primary Care Coordinator to review (if one is around)*
- *Inform GP that patient is '**Senior At Risk**' over the next 6 months of the adverse health outcomes listed below:*

Number of questions answered with a YES

Frequent hospitalisation (10%) Severe functional impairment (8%)

Falls Care and Bone Health

☐ Patient presented with a fall – ensure the following actions ☐ Pt did not present with a fall

- Refer to falls clinic (referral form / sticker to front of ED record)
- Suggest long-term Calcium & Vitamin D treatment to GP (if not already)

References

1. Schofield I et al. Screening for cognitive impairment in older people attending accident and emergency using the 4-item Abbreviated Mental Test. Eur J Emerg Med 2010;17:340-2.
2. Dendukuri N et al. The identification of seniors at risk screening tool: further evidence of concurrent and predictive validity. Journal of the American Geriatrics Society 2004;52:290-6.

This assessment was carried out by

Print name | Signature | Position | Date | Time completed

Mat Wensley (Marie Wass, Jay Banerjee, Simon Carley , Mar 11 , Version 12

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Acute Medical Unit

Acute Frailty Pathway

Date DD/MM/YY

Time

Patient details

Full name

DoB

Unit number

(use sticker if available)

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

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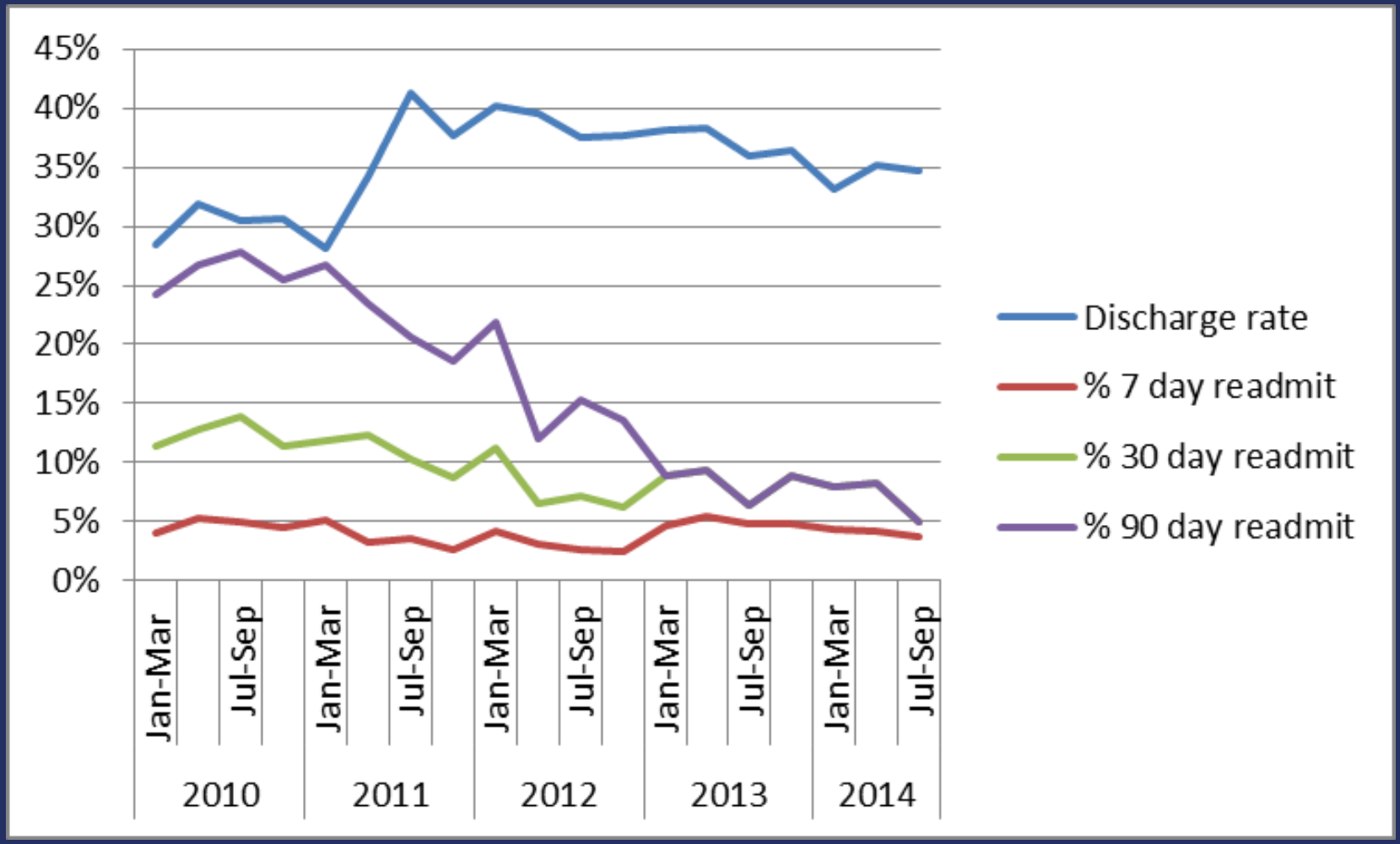

CGA in the Acute Medical (Frailty) Unit

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

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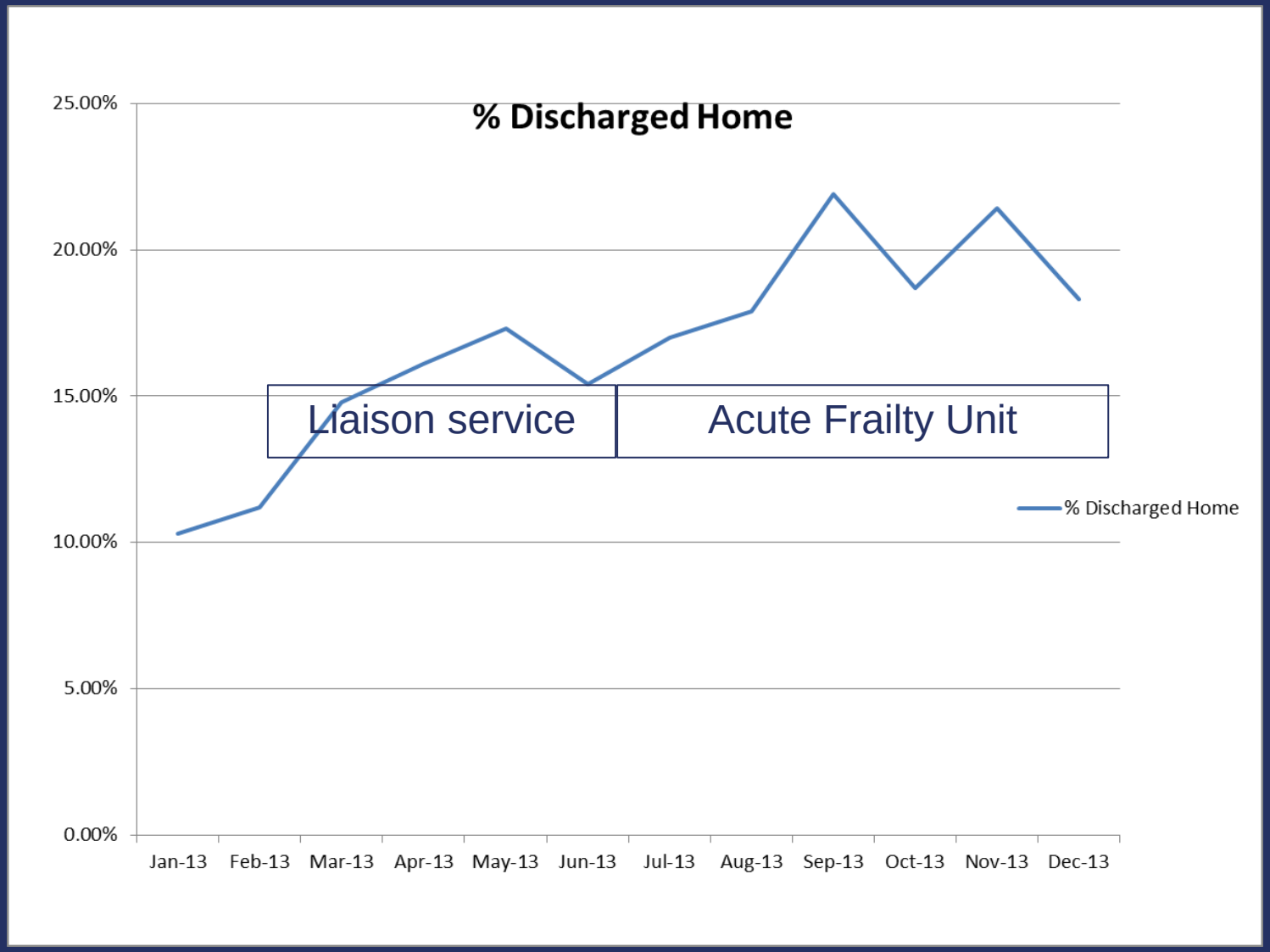
Outcomes: 85+ discharged from AFU



Sheffield AFU

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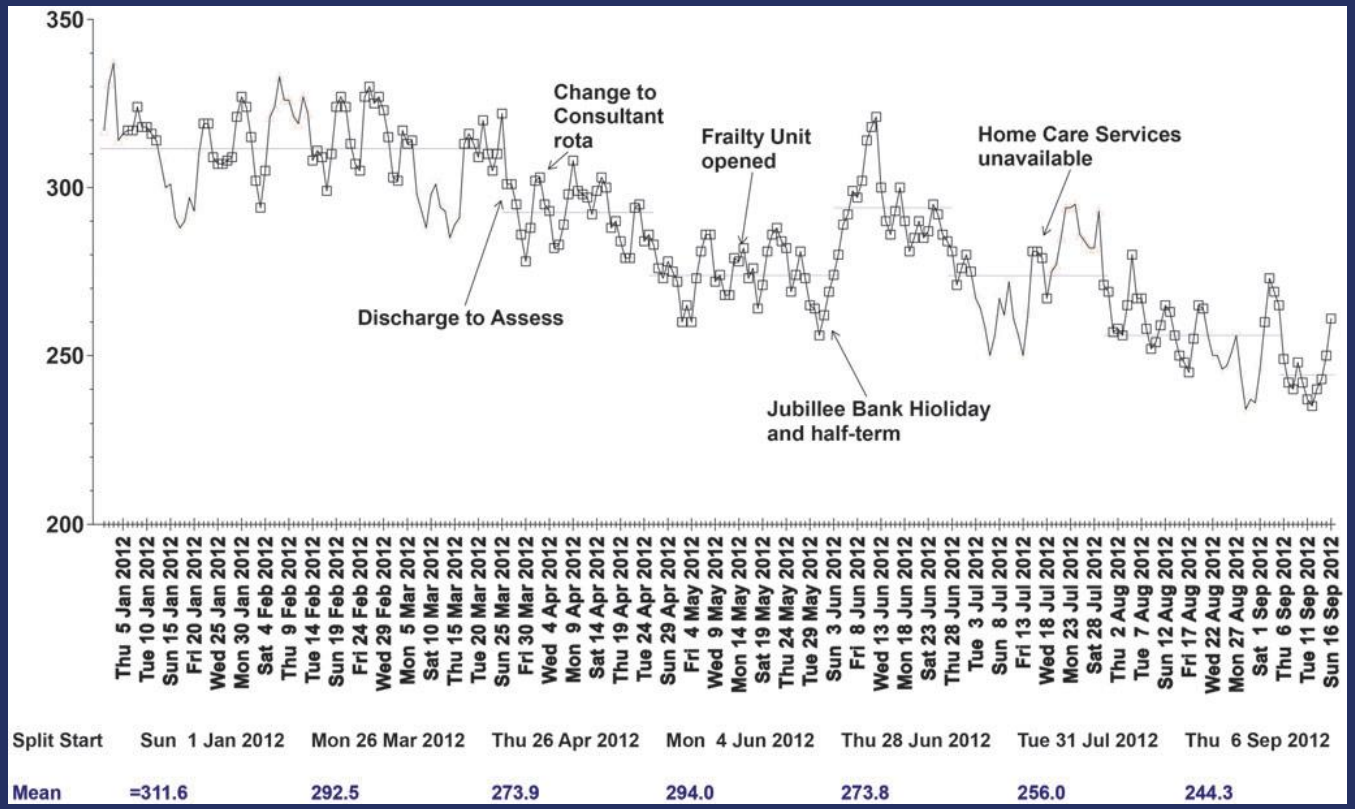
Timely care for frail older people referred to hospital improves efficiency and reduces mortality without the need for extra resources

Kate M. Silvester[1,2], Mohammed A. Mohammed[3], Paul Harriman[4], Anna Girolami[4], Tom W. Downes[5]

[1]Health Sciences Research Institute, Warwick Medical School, Warwick, Warwickshire, UK
[2]University of Warwick, Warwick, Warwickshire, UK
[3]School of Health Studies, University of Bradford, Bradford, UK
[4]Service Improvement, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK
[5]Geriatric Medicine Department, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK

Address correspondence to: Tom Downes. Tel: +44 114 2711591; Fax: +44 114 2261177. Email: tom.downes@sth.nhs.uk



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

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’

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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

Acute Frailty Network

frailty@nhselect.org.uk
@acutefrailty
www.acutefrailtynetwork.org.uk

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