



Acute care toolkit 3

Acute care for older people living with frailty December 2020

Who should read this toolkit?

This toolkit is intended to be used by acute physicians, geriatricians, emergency physicians, therapists, nurses and other clinical staff caring for older people in acute hospitals.

All staff working in acute medical units (AMUs) will be familiar with the increasing number of older people living with frailty who require access to acute care. The AMU provides a key role in identifying frailty, along with urgent and important issues that need addressing. When these are assessed accurately and holistically, patient outcomes will improve. Accordingly, acute medical teams need to possess the knowledge and skills, and demonstrate the appropriate behaviours, for managing older people living with frailty.

Delivering a holistic assessment in the AMU is difficult for acute teams with large numbers of patients to see quickly; geriatric liaison teams or frailty units with staff who have the skills and time to focus on older people with frailty can be helpful. Better integration between primary care, emergency departments (EDs), AMUs and geriatric services, all working towards achieving high standards of urgent care,¹ should reduce duplication and improve outcomes.

Background

Older people (aged 75+) with severe frailty comprise a relatively small proportion of all patients attending the ED, but form a much higher proportion of patients in the AMU and a substantial proportion (60–70%) of hospital inpatients.^{2,3} Most patients will be admitted through the AMU, making it an ideal area in which care for older people can be influenced.

Older people with frailty who attend hospitals are prone to decompensation in the face of apparently minor stressors.⁴

Older people with frailty have the longest lengths of stay, highest readmission rates and highest rates of use of long-term care after discharge.^{3,5} Admission to hospital also adds the specific hazard of iatrogenic harms, comprising deconditioning, falls, delirium and nosocomial infection.

Getting the assessment and management of older people right in the AMU has the potential to improve outcomes, reduce inappropriate hospitalisation and reduce the need for long-term care.⁶

Identification

Hospitals should identify patients with frailty within 30 minutes of their arrival in order to prompt the clinician to consider holistic assessment (comprehensive geriatric assessment; CGA), which takes into account not only the presenting problems but also the broader factors at play, including prognosis.⁷

Recommendation

- > Ensure that a system is in place to identify older people with frailty as they attend hospital, eg the Clinical Frailty Scale (CFS)⁷ can be used at ED triage.

Assessment

Done well, the clinical assessment of older people with frailty can be fascinating and hugely rewarding – like unravelling a detective story. History taking might involve speaking to key informants as well as the individual themselves, as sensory and/or cognitive impairment may confound the initial assessment.

Recommendations

- > Do not delay, defer or delegate the collateral history – a 5-minute conversation with a carer can rapidly reveal the diagnosis and direct ongoing management.
- > Ensure that aids to communication are readily available (eg hearing aid batteries, visual aids).
- > Pain can be difficult to assess in older people who have communication barriers – consider using a structured pain scale.⁸

Frailty syndromes

Frailty syndromes (eg falls, immobility or delirium) can make the immediate diagnosis obscure and mask serious underlying pathology. Importantly, these frailty syndromes are usually multifactorial. Do not content yourself with identifying just one cause, but challenge yourself to try and identify at least five. For example, delirium due to cellulitis, anticholinergic burden, small vessel disease, pain and constipation. By identifying all the causes the management plan will be more effective, thus reducing length of stay – this is good for the patient, the carer and the system.

Do not content yourself with identifying just one cause, but challenge yourself to try and identify at least five.

Falls

Distinguish between falls that are syncopal (eg cardiac, polypharmacy) and non-syncopal (strength, balance, vision, proprioception, vestibular and environmental hazards all to be assessed).^{9,10} However, note that there is often significant overlap; be highly suspicious of cerebral hypoperfusion as a contributing factor to falls where systolic blood pressure in an older person is below 120 mmHg, especially if they are taking vasodilators or anti-hypertensives. These medications are often historical prescribing remnants and can usually be deprescribed safely.

Recommendation

- > Older people accessing any healthcare provider or services following a fall, with or without a fragility fracture, should be assessed for reversible causes (at least five) and subsequently referred for a falls and bone health assessment using locally agreed pathways.

Dementia, delirium and depression

Dementia and delirium are closely interrelated, but each requires clinically distinct management. A collateral history is key to detect a recent change in cognition suggestive of delirium; it is common for delirium to be superimposed on pre-existing dementia. Delirium can be hyperactive, hypoactive or mixed.

Delirium in the AMU is usually caused by metabolic disturbance, infection, pain, constipation, urinary retention or polypharmacy (check anticholinergic burden¹¹). Bedside tests such as 'months of the year backwards' can help to identify inattention, a key component of delirium diagnosis.^{12,13} The 4AT is quick and user-friendly.¹² In contrast, dementia is a long-term condition.^{14,15}

It is important to recognise that depression is common in older people living with frailty and should be considered in your assessment. It is an important differential diagnosis for dementia and hypoactive delirium, and the history (often a collateral) is key.

Recommendations

- > Ensure that staff working in the AMU can readily distinguish delirium from dementia, for example through using the delirium toolkit¹⁵ or RCP guidelines.¹⁶
- > Use the 4AT screening tool to screen for delirium.¹²
- > Minimise intra- and inter-hospital transfers of older people at night, which can increase the risk of delirium.
- > All older people who self-harm should be offered a psychosocial assessment to determine ongoing risk of self-harm, and to detect and initiate management for any mental health problems.

Polypharmacy

Adverse drug events lead to increased hospital stay, morbidity and mortality.¹⁷ Consider a medication review focusing on identifying inappropriate prescribing and anticholinergic burden, as well as drug omissions (eg STOPP/START¹⁸). Consider also medicines reconciliation.¹⁹

Recommendations

- > An acute crisis in an older person with frailty should prompt a structured medication review.
- > AMUs should have ready access to time-critical medication commonly used by older people, such as L-Dopa.
- > Use a tool such as ACB Calculator to assess for anticholinergic burden.¹¹

Incontinence

Incontinence is an unusual acute presentation, but a marker of frailty and a risk factor for adverse outcomes. More common is abuse of urine dipstick testing leading to erroneous diagnosis of infection, inappropriate antibiotics and increased risk of complications such as clostridial diarrhoea. Dipstick tests are frequently positive for leucocytes due to the high prevalence of asymptomatic bacteriuria in older adults. A dipstick positive for leucocytes and nitrites has a disappointingly low positive predictive value for infection of 44% and should not be used at all.²⁰

Recommendations

- > When suspecting urinary tract infection in patients with communication barriers, seek out objective clinical evidence and don't rely on urine dipstick tests.²¹
- > Older people should not be routinely catheterised unless there is clear, objective evidence of urinary retention (eg post-void residual volume >500 mL).
- > Routinely assess patients on the AMU for constipation.

Immobility

'Off legs' is a frailty syndrome that can hide many diagnoses, ranging from cord compression to end-stage dementia. As with all the frailty syndromes, there will usually be multiple causes; don't underestimate the importance of osteoarthritis, which may create weakness and proprioceptive failure.

Recommendation

- > When a patient presents 'off legs', a holistic assessment is needed to identify urgent and important issues – consider it as a red-flag diagnosis until further evaluated.

End-of-life care

In-hospital mortality is high, increasing from 3% in CFS 1 to 31% in CFS 9 cohorts. Attendance at the AMU is therefore an ideal opportunity to consider advance care planning.²²

Recommendation

- > Crises beget crises – consider whether advance care planning might be appropriate to prevent future unhelpful and non-patient-centred admissions.

Comprehensive geriatric assessment (CGA)

The presence of one or more frailty syndromes should prompt the need for holistic assessment. In addition to medical assessment, many older people will require support from other disciplines (eg physiotherapy, occupational therapy, nursing, social care) in order to deliver a holistic overview and arrange ongoing treatment, whether in hospital or in the community. Delivering such a holistic assessment in a pressured acute environment requires staff, time, coordination and high-quality communication.

30 seconds on CGA

Definition: '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'.²³



What is different about it? While integrating standard medical diagnostic evaluation, CGA emphasises patient-focused care, quality of life, functional status, prognosis and outcome; standardised assessment tools are commonly used.

Typical team: geriatrician, nurse specialist, occupational therapist, physiotherapist, pharmacist, others as needed (speech and language therapy, dietetics).

Evidence: CGA leads to better outcomes, including fewer deaths and reduced long-term care.²⁴

It is important to recognise that depression is common in older people living with frailty and should be considered in your assessment.

Domains of CGA

Areas of assessment required for CGA are detailed in broad terms in Table 1; the precise nature of the assessment will vary between individuals.

Table 1. Main domains of CGA

Domain	Items to be assessed
Medical	Comorbid conditions and disease severity
	Medication review
	Nutritional status
	Problem list
Mental health	Cognition
	Mood and anxiety
	Fears
Functional capacity	Loneliness
	Basic activities of daily living
	Gait and balance
	Activity/exercise status
Social circumstances	Instrumental activities of daily living
	Informal support available from family or friends
	Social network such as visitors or daytime activities
	Eligibility for being offered care resources
Environment	Home comfort, facilities and safety
	Use or potential use of telehealth technology etc
	Transport facilities
	Accessibility to local resources

All members of the acute care team will contribute to CGA – for example, the acute physician will address the range of relevant, active medical problems, physiotherapists will assess strength, balance and falls risk, and occupational therapists will assess home circumstances. Other team members may include (among others) nurses, pharmacists and social workers. However, it is the coordination and communication of the team – typically achieved through focused board rounds – where the true benefits of the multidisciplinary team (MDT) lie.

Recommendations

- > Make provision for multidisciplinary assessments in the AMU so that they are expected, planned and orderly.
- > Ensure that the patient is at the centre of any management plan and use the ‘What matters to me’ approach.
- > Configure services so that they can deliver early CGA for older people with frailty.⁶

CGA in acute and community settings

While the assessment and initial management may be initiated in the acute setting, it does not follow that all ongoing management needs to be in hospital. The national drive for same-day emergency care may ensure that patients are managed in an outpatient setting, avoiding the need for hospital admission. There is also a growing array of community services that can provide ongoing care; however, navigating these services can be difficult, especially for staff who are rotating through the AMU. Dedicated liaison services or lead nurses for discharge in the AMU can be effective.

Recommendation

- > Consider rotating staff through community services or having ‘staff swaps’ to promote a better understanding of the role of each sector and its pressures.

The decision to discharge (or indeed admit) is always a balance of risks. Risk assessment is especially complicated in older people, as there are usually multiple competing priorities. Treatment goals may be different – for some patients, a more palliative rather than curative approach may be required. The CFS gives some insight as to prognosis, but must always be accompanied by a broader, more holistic assessment before such critical decisions are undertaken.

No risk stratification tool has enough precision to be able to direct individual patient care. For example, patients at high risk of falls are sometimes admitted to hospital as a ‘place of safety’, although being in hospital may increase the risk of falling (unfamiliar environment, increased risk of delirium, cannulas and catheters that get in the way, high beds etc). Care at home may well be a safer alternative.

Communication between professionals, and with patients and their carers (formal or informal) when planning for transfer or discharge, is important – try to identify *what* matters most to the patient, or *who* matters most to them – rather than focusing exclusively on what is the matter with them.

Recommendations

- > Do not assume that hospitals are safe places for older people.
- > Consider carefully what needs to be done in hospital and what might better be achieved in the community setting.

Try to identify *what* matters most to the patient, or *who* matters most to them.

Delivering frailty-attuned care in the AMU

It is important that a model of supportive care for older people with frailty, to provide early CGA, is established within the acute setting (be that the ED or AMU). Increasingly there is a move towards the development of acute frailty or acute geriatric units, involving geriatricians in the first 72 hours. While this is not yet mandated by NICE,²⁵ over half of acute hospitals in England have adopted the philosophy of the Acute Frailty Network, which promotes early CGA for older people with frailty.²⁶ In practice, what model, who, where and when will depend on local resources and culture.

Recommendation

Agree local criteria for which patients might best benefit from early CGA – examples include:

- > patients with moderate or severe frailty (CFS ≥ 6)
- > patients with dementia and/or delirium (screen for delirium using the 4AT)¹²
- > patients with falls and/or immobility
- > patients from care homes or people with fragility fractures
- > patients with pressure sores
- > patients approaching the end of life.

The presence of one or more frailty syndromes should trigger CGA. The British Geriatrics Society and National Institute for Health Research have produced a service self-assessment toolkit that can help you to identify gaps in your service, and thoughts on how these might be addressed.²⁷

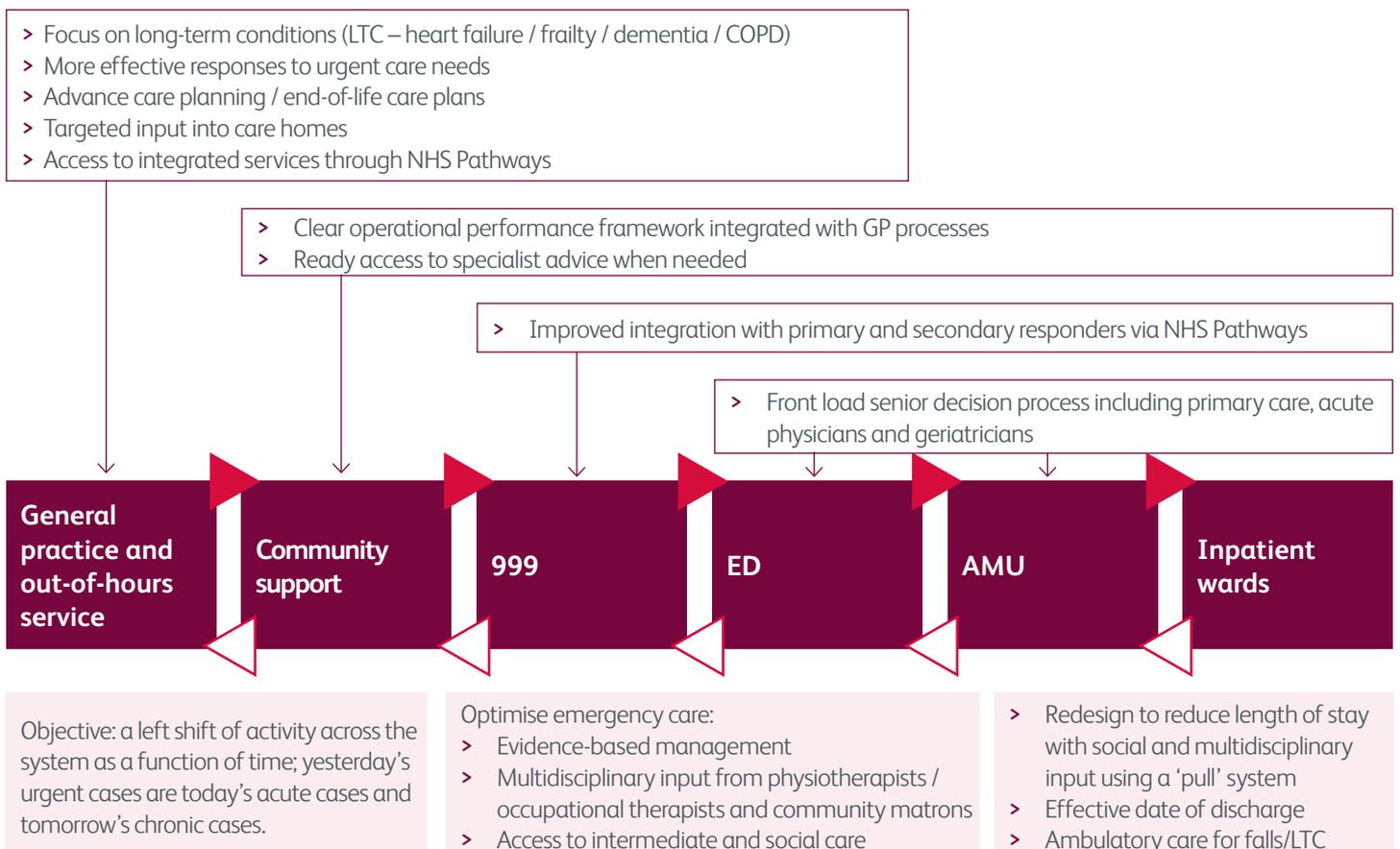
Whole-systems approach

Multidimensional assessment and multi-agency management of older people lead to better outcomes.²⁸ For such services to be effective, they must be delivered in an integrated manner across the interfaces between primary and secondary care, and between health and social care. Joined-up working between the ED, AMU and geriatric services can help facilitate better, less duplicative and more coordinated care for older people in the acute setting (Fig 1).

Recommendations

- > An MDT capable of assessing and managing geriatric syndromes should be available 10 hours a day, 7 days a week.⁷
- > Engage with health and care commissioners about whole-system initiatives to tackle urgent care; for older people with frailty, social care and community services will be key partners. The NHS RightCare guidance can be helpful in these discussions.³⁰

Fig 1 Urgent care axis – points for intervention (adapted from the Silver Book²⁹)



Education and training

Much of the training in the AMU is directed towards issues such as patient safety, team working, handover and managing acute medical conditions. These are all important, but the AMU provides an ideal opportunity to augment training and education in geriatric medicine, ensuring that all teams (not just geriatricians) possess the skills required to care for older patients with frailty.

The training programme for acute internal medicine now requires a minimum of 4 months of training in geriatric medicine. The 2019 internal medicine stage 1 curriculum mandates training in geriatric medicine.

Perhaps most importantly, clinicians in the AMU can model the behaviours necessary to implement geriatric expertise. Clinical examples include not attributing immobility to age or frailty alone, ensuring a comprehensive review of a confused patient and not relying on a positive urine dipstick to diagnose urinary tract infection. Clinicians must also demonstrate patience and consideration when assessing older people with communication barriers (cognitive or sensory impairment, dysphasia etc) and involve carers to understand how recently any changes have occurred and whether they are attributable to a specific incident, rather than 'typical' behaviour.

Recommendation

- Given the prevalence of frailty issues in the AMU, there is justification for a lead clinician based in the AMU to focus on frailty issues, including education.

Summary

Older people are major users of acute care; the AMU is a key area for initial decision making, and for education and training relevant to older people.

Different models will be suited to different hospitals, but all need to be able to initiate CGA within the AMU and to have strong links with community health and social services.

Geriatricians supporting the AMU will be able to help to identify older people who may be safely managed in the community, improving patient outcomes and reducing hospital bed-days.

Delivering a holistic assessment in the AMU is difficult for acute teams with large numbers of patients to see quickly; geriatric liaison teams or frailty units with staff who have the skills and time to focus on older people with frailty can be helpful.

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Acknowledgement

Thanks to Professor Simon Conroy and Dr Deborah Bertfield for their significant contributions to writing this toolkit.

The acute care toolkit series can be accessed online at www.rcplondon.ac.uk/act

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