QUALITY STANDARDS FOR THE CARE OF OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS

The silver book

Executive summary

Despite the majority of urgent care being delivered in the primary care setting, an increasing number of older people are attending emergency departments and accessing urgent care services. This is partly related to the demographic shift that has resulted in a rapid increase in the number of older people, but may also be due to lower thresholds for accessing urgent care. Over the next 20 years, the number of people aged 85 and over is set to increase by two-thirds, compared with a 10 per cent growth in the overall population. The recent NCEPOD report on the peri-operative care of older people showed inadequate care for older people undergoing surgery, and the Health Service Ombudsman's report highlighted major deficiencies in the care of older people in acute hospitals. Older people are admitted to hospital more frequently, have longer length of stay and occupy more bed days in acute hospitals compared to other patient groups. There is a pressing need to change how we care for older people with urgent care needs, to improve quality, outcomes and efficiency.

Important factors in primary care that impact on the use of urgent care services include a timely primary care response and ready access to general practitioners. More community based services with a rapid response time may reduce the need to access secondary care. There needs to be better communication between 'in-hours' and out of hours services. The ambulance service has a key role to play and can be an important contributor in doing things differently – for example, referring patients with falls not conveyed to hospital, to falls services.

Attendance at the Emergency Department is associated with a high risk of admission for older people, so the nature of the service and the environment in which is it provided in the emergency department needs to change to reflect the changing nature of health care in the 21st century, the bulk of which relates to older people, and increasingly frail older people. Staff need to develop their knowledge and skills and adapt their behaviour to be better placed to assess and manage frail older people. Dedicated teams delivering comprehensive geriatric assessment can support this, but in themselves are not sufficient to realise whole system change. Service In all settings including health and social care need to improve their communication and handover, and greater use of the voluntary sector is to be encouraged. In acute medical units, greater use of geriatric liaison services should increase the proportion of older people able to be managed in the community setting.

In all settings, staff need to develop their understanding and confidence in managing common frailty syndromes, such as confusion, falls and polypharmacy as well as issues such as safeguarding in older people. These syndromes are commonly overlooked, but attention to these has the potential to greatly improve patient outcomes. There needs to be greater working across disciplines, both between profession (e.g. physiotherapy and occupational therapy) and within professions (e.g. geriatricians working closely with emergency physicians).

Finally, commissioning evidence based integrated health and social care systems that address care across the continuum will help deliver safe, efficient, effective and a high quality care for frail older people in the years to come.

Contents

Preamble 5
Aims of the guide 5
Methodology 5
Purpose and scope of this document 6
Standards and recommendations 7
Underpinning principles 7
Standards 7
Generic recommendations that apply to all settings in the first 24 hours: 8
Discharge planning 8
Recommendations for Primary Care 8
Recommendations for Community hospitals 8
Recommendations for emergency departments, urgent care units (minor injury units, walk-in-centres etc) and acute medical units 9
Mental Health 9
Recommendations on safeguarding 9
Recommendations for Major Incident Planning 9
Recommendations for Commissioners 10
Chapter 1 The older person – challenges in urgent and emergency care 11
Chapter 2 Service design 12
Chapter 3 Older people in different clinical settings 15
Out of hours primary care 16
Pre-hospital – ambulance service 17
Emergency Department 19
Acute assessment units 20
Community hospitals 21
Chapter 4 Assessment and management within the first 24 hours 22
Dementia and delirium 22
Falls 25
Fractures and osteoporosis 27
Medication 27
Pre-operative care of older people: 28
Pain 28
Urinary tract infections 29
Nutrition 30
Skin care 30
Injuries 31
End of life care 31
Ethical issues 32
Discharge planning and community support 32

Chapter 5 Safeguarding Older People 34
Chapter 6 Training and development of staff 35
Medical staff 36
Nursing 37
Physiotherapy 38
Useful references 38
Occupational therapy 38
Chapter 7 Major incidents involving older people 40
Chapter 8 Information sharing 41
Chapter 9 Clinical Governance and Research 43
Clinical governance 43
Audit standards 43
Whole system metrics 47
Research in geriatric emergency care 47
Chapter 10 Commissioning urgent and emergency care for older people 48
Appendices 49
Appendix 1 Sample business case for an emergency frailty unit – Leicester Leicestershire & Rutland 49
Appendix 2 Whole system approach to managing frail older people 53
Appendix 3 Identification of Seniors At Risk tool 54
Appendix 4 AMT-4 short cognitive assessment tool 54
Appendix 5 Essence of Care benchmarks 55
Appendix 6 Guidelines on emergency control of the acutely disturbed adult patient 60
Appendix 7 Detecting elder abuse 63
Appendix 8 Mental Capacity Legislation Contact Points 66
Appendix 9 Examples of innovative urgent care for older people 68
Appendix 10 Complete list of audit standards 72
Appendix 11 Provenance 76
Appendix 12 Authors and acknowledgments 78
Appendix 13 Glossary 80
References 83

QUALITY STANDARDS FOR THE CARE OF OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS: THE "SILVER BOOK"

Preamble

Despite the majority of urgent care being delivered in the primary care setting, an increasing number of older people are attending emergency departments and accessing urgent care services. This is partly related to the demographic shift that has resulted in a rapid increase in the number of older people, but may also be due to lower thresholds for accessing urgent care[1]. Over the next 20 years, the number of people aged 85 and over is set to increase by two-thirds, compared with a 10 per cent growth in the overall population. Hospital Episode Statistics indicate that patients over 70 years of age account for more than 2 million attendances per annum (15% of attendances). There are growing concerns for the safety of older people who are admitted to acute hospitals. The recent NCEPOD report on the peri-operative care of older people showed inadequate care for older people undergoing surgery, and the Health Service Ombudsman's report highlighted major deficiencies in the care of older people in acute hospitals[2]. Older people are admitted to hospital more frequently, have longer length of stay and occupy more bed days in acute hospitals compared to other patient groups.

Aims of the guide

The focus of this guide is on care standards for older people over the first 24 hours of an urgent care episode, with the specific remit to:

- help decrease variations in practice
- influence the development of appropriate services across the urgent care system
- identify and disseminate best practice
- influence policy development

Methodology

- The Silver Book is an intercollegiate document, prepared by the contributors listed in Appendix 12. It is not owned by any one individual organisation.
- The initial scope of the document was agreed with the National Clinical Directors for Urgent Care, Older People and Dementia.
- The content and literature underpinning each chapter were authored by the intercollegiate group, with the author for each chapter reflecting the most relevant lead body.
- The standards and recommendations were drafted and then voted upon using a modified nominal group technique.
- The authors have not referred to the hierarchies of evidence with regards to the different recommendations to avoid differential implementation, as the final standards and recommendation are considered to be of equal importance.

Purpose and scope of this document

The scope of this document is to address the standards of care for older people, specifically frail older people, during the first 24 hours of an urgent care episode. The document describes the urgent care needs of older people and the competencies required to meet these needs. It does not describe how these competencies should be commissioned and delivered as this will vary according to local needs, resources and policies.

The older person's care needs might be delivered in the emergency department, the acute medical unit or a community setting depending on local service configuration but they need to be delivered within the first 24 hours and as part of a whole systems strategy.

This document is not a NICE guideline; it represents clinical guidance and suggested standards, written by clinicians for clinicians. This is the complete version of the Silver Book is to be considered in conjunction with the executive summary and the short version (http://www2.le.ac.uk/departments/cardiovascular-sciences/people/conroy/silver-book).

The purpose of this document is to:

- Help understand the issues relating to older people accessing urgent care in the first 24 hours irrespective of geographical setting and provider group
- Contextualise the care for older people at the interface between primary and secondary care and pre-hospital and hospital care
- Recommend urgent care standards for older people
- Improve satisfaction and outcomes for older people in urgent care
- Improve satisfaction and delivery of care by staff

This report seeks to inform the following:

- Policymakers:
    - Department of Health
- Commissioners:
    - GP consortia
    - Health and Wellbeing Boards
    - NHS commissioning boards
    - Primary care trusts (PCTs)
    - Adults social care
- Post-graduate deaneries
- Providers of services, managers and clinicians in:
    - General practitioners
    - Ambulance trusts
    - Community based services
    - Acute trusts
    - Mental health trusts
    - Voluntary sector
- Regulators of services:
    - Care Quality Commission
    - The National Audit Office
    - Monitor

The silver book

Standards and recommendations

Underpinning principles

1. Respect for the autonomy and dignity of the older person must underpin our approach and practice at all times. 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

2. 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

Standards

3. All older people accessing urgent care should be routinely assessed for:

○ 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

4. There must be an initial primary care response to an urgent request for help from an older person within 30 minutes

5. The presence of one or more frailty syndrome should trigger a more detailed comprehensive geriatric assessment, to start within 2 hours (14 hours overnight) either in the community, patient's own home or as an in-patient, according to the patient's needs

6. Ambulatory emergency pathways with access to multidisciplinary teams should be available with a response time of less than four hours for older people who do not require admission but need on-going treatment (e.g. in a Clinical Decisions Unit)[3-6]

7. Health and social services should be commissioned such that they can contribute to early assessment of older people, including mental health assessments. Mental health services should be commissioned such that they can contribute to specialist mental health assessments in older people within 30 minutes if appropriate[7]

8. A 24/7 single point of access (SPA) including a multidisciplinary response within 2 hours (14 hours overnight) should be commissioned. This should be coupled to a live directory of services underpinned by consistent clinical content (NHS pathways). Discharge to an older person's normal residence should be possible within 24 hours, seven days a week – unless continued hospital treatment is necessary

9. Older people coming into contact with any healthcare provider or services following a fall with or without a fragility fracture should be assessed for immediately reversible causes and subsequently referred for a falls and bone health assessment using locally agreed pathways

10. Older people who present with intentional self-harm should be considered as for failed suicide; along with older people with unintentional self-harm they should be assessed for on-going risk of further self-harm in any setting, including during transportation

The silver book

Generic recommendations that apply to all settings in the first 24 hours:

1. An acute crisis in a frail older person should prompt a structured medication review

2. When suspecting lower urinary tract infections in people unable to express themselves, urine dipstick testing should only be considered in patients with unexplained systemic sepsis (which may manifest as delirium) as it adds little to managing patients with lower urinary tract symptoms, and can be misleading in other patient groups

3. Older people should not be routinely catheterised unless there is evidence of urinary retention

4. End of life care at home should be encouraged and facilitated when appropriate and in keeping with the older person's preferences

Discharge planning

5. Older people should only be discharged from hospital with adequate support and with respect for their preferences

6. Adequate and timely information must be shared between services whenever there is a transfer of care between individuals or services

7. Older people being admitted following an urgent care episode (to any to a bed based facility) should have an expected discharge date set within 2 hours (14 hours overnight)

8. Older people, and where appropriate their carers and families, should be involved in the decision making process around assessment and management of on-going and future care, and self-care

9. Care home providers should be treated as equal partners in the planning and commissioning of care both for individuals and for ensuring the correct processes and procedures are in place in care homes to support best practice

10. When preparing for discharge, older people and carers should be offered details of local voluntary sector organisations, other sources of information, practical and emotional support including information on accessing financial support and reablement services

Recommendations for Primary Care

11. There should be primary care–led management of long term conditions which may reduce the number of unscheduled care episodes

12. General practices should monitor hospitalisation and avoidable ED attendances[8]

13. Clinicians referring to urgent care should have access to a simple referral system with an agreed policy provided by local geriatric, emergency medicine, acute medicine and social services

Recommendations for Community hospitals

14. Older people being admitted to community hospitals, whether for 'step-up' or 'step-down' care, should be assessed and managed in the same way as patients accessing urgent care in any other part of the health system

Recommendations for emergency departments, urgent care units (minor injury units, walk-in-centres etc) and acute medical units

15. There should be a distinct area in Emergency Departments which is visually and audibly distinct that can facilitate multidisciplinary assessments

16. All units should have ready access to time critical medication used commonly by older people, such as Levo-Dopa

17. If a procedure is required for a patient who is confused, two health care professionals should perform the procedure, one to monitor, comfort and distract, and the other to undertake the procedure; carers and/or family members should be involved if possible; cutaneous anaesthetic gel should be considered prior to cannulation, particularly if the person is confused.

18. All urgent and emergency care units should have accessible sources of patient information about local social services, falls services, healthy eating, staying warm, benefits and for carers of frail older people

Mental Health

19. All older people who self-harm should be offered a psychosocial assessment to determine on-going risk of self-harm and to detect and initiate management for any mental health problem that may be present.

20. There should be easier and greater access to mental health care summary records

21. Intra and inter-hospital transfers of older people at night, should be minimised as it increases the risk of delirium

Recommendations on safeguarding

22. Local 'No secrets' multiagency policies and procedures for adult safeguarding should be easily accessible to assist teams to identify and respond to concerns

23. All services should nominate a lead responsible for safeguarding older people within the service whilst accepting that it is everyone's responsibility

24. All health and social care facilities must have service specific guidelines for safeguarding older people, in addition to the multi-agency policies and procedures

Recommendations for Major Incident Planning

25. Major Incident Plans and Disaster Preparedness Plans need to include explicit contingencies for the management of multiple casualties of frail older people

26. Public health agencies, emergency responders, services for older people and Non-Governmental Organisations (e.g. charities) need to be aware of the local demographics and communicate each other's provision and capability so that coordination and response are effective in the event of an incident

27. Each area/region needs to have up to date lists of named key clinicians and social care personnel with contact numbers, who have specific responsibilities for older people in the event of a major incident

28. Local Major Incident Plans need to be updated to include a specific plan for older people that identifies alternative appropriate local accommodation should they be unable to return immediately to their own home, residential or nursing home

29. Appropriate public information on emergency preparedness in appropriate formats for older adults and their carers and details of local voluntary sector organisations that can offer information and practical support should/must be provided

30. Access to a telecare system in rural and remote areas that will permit professional health and social care workers to reach housebound older people in the event of a major incident should be provided

Recommendations for Commissioners

31. Health and social care commissioners and those responsible for commissioning support arrangements must always reflect a joint approach across all disciplines which takes account of the multi-disciplinary nature of care for and working with older people.

32. Commissioners should ensure that all providers of acute or emergency care for older people conduct audit against the standards set out in the Silver Book as well as participating fully in all relevant national audits (e.g. stroke, hip fracture, dementia, fall and bone health, continence)

See: http://www.rcgp.org.uk/pdf/Urgent_emergency_care_whole_system_approach.pdf

Chapter 1 The older person – challenges in urgent and emergency care

Context

Approximately 95% of urgent care is delivered in primary care. According to estimates, approximately 300 million urgent care consultations are annually provided in primary care[9] as opposed to 20 million encounters in emergency departments[10]. A timely primary care response can avert the need for a hospital attendance; for example, a 1% decrease in the primary care response to a crisis can lead to a 20% increase in demand in secondary care. This is a consequence of the gearing effect of the different urgent care delivery between primary and secondary care. Patient characteristics including increasing deprivation and age over 65 years are important predictors of hospital admission rates[11]. Larger practices and increasing distance from a hospital are associated with lower admission rates[11]. Being able to consult a particular GP, an aspect of continuity, is associated with lower emergency admission rates[12]. General practitioners and community teams are crucial to the success of any efforts to improve the quality of urgent care. Urgent care must meet the same standards wherever delivered – primary care, secondary care or intermediate care.

The primary care role notwithstanding, a substantial proportion of hospital care concerns older people. The oldest old (aged 85+) accounted for 585,057 of the 12.2 million (4.8%) first attendances to English Emergency Departments (EDs) in 2008/9, and 62% were admitted to hospital. People aged 85+are nearly 10 times more likely to have an emergency admission than those aged 20-40[1]. The oldest old are often physically, cognitively or socially frail (i.e. need help with basic activities of daily living or have a diagnosis of dementia, delirium or both or have poor social support networks). If admitted for inpatient hospital care, the oldest old have the highest readmission rates and highest rate of long term care use after discharge[13 14]. Managing demand with community based preventive interventions and providing urgent care in community settings[15] provides some scope for reducing acute hospital admissions, but despite the increasing availability of such care models, they have had only modest impact[16-20], and cost effectiveness has not yet been widely and robustly demonstrated.

Most older people who are admitted to hospital come via the Emergency Department which is a key interface in the health and social care system where older people with crises can be assessed. It is important that Emergency Departments are appropriately supported in the management of older people.

The clinical assessment 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. History taking may be challenging because of sensory impairment, dementia or delirium. Often additional information and collateral history is needed which may not be readily accessible in the emergency setting; time pressures may prevent staff from focussing on anything other than immediate problem.

A positive attitude to managing frail older people is essentials; health care professionals' attitudes towards frail older people could be better and ageism remains a problem in the health system[21-23].

Key points

- Frail older people must be able to access the same standard of urgent care irrespective of where that is delivered
- Privacy and dignity must be respected in all urgent care settings

Chapter 2 Service design

Context

General practitioners can provide early and appropriate response to urgent care needs in primary care as well as targeted early intervention for people with long term conditions and care home residents. Integrated working within secondary care involving emergency physicians, geriatricians, acute physicians, nurses and therapists working closely with community mental and physical health and social care teams may provide the best model for decreasing admission, readmission, and minimising length of stay, morbidity and mortality. There must be an emphasis on evidence-based early decision making and holistic management. For selected people other disciplines will need to be involved early (e.g. surgeons and anaesthetists). Ambulance services and their response to emergency calls need to be part of the community services' response to optimise the balance between keeping people at home with early targeted community management when appropriate.

Facts

There are several key themes that emerge from the literature which describe the pre-requisites for successful care of frail older people[24]. These include:

- Integrated care schemes including case management, geriatric assessment, multidisciplinary working, a single entry point and financial levers[25]
- Continuity of care[26 27], which can be informational, managerial or relational. This is characterised by the extent to which discrete healthcare events are experienced as 'coherent, connected and consistent'.
- A positive attitude towards older people is associated with better quality care[28]
- Person centred nursing care[29], encapsulated by four concepts:
    - 'being in relation' (knowing the individual)
    - 'being in a social world' (the centrality of individuals' values)
    - 'being in a place' (knowing individuals' biography and relationships) and
    - 'being with self' (seeing beyond the immediate needs)

If the supporting environment described above can be implemented, then specific models of care may be effective in ensuring that frail older people receive the right care by the right team and at the right time.

Multidisciplinary care & Comprehensive Geriatric Assessment

There is robust evidence to support multidimensional assessment and multiagency management of older people leading to better outcomes, including reduced readmissions, reduced long term care, greater satisfaction and lower costs[30-40]. An evidence based form of multidisciplinary care is Comprehensive Geriatric Assessment (CGA), which is defined as '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'[41]. While integrating standard medical diagnostic evaluation, CGA emphasises quality of life and functional status, prognosis, and outcome that entails a workup of more depth and breadth. The hallmarks of CGA are the employment of interdisciplinary teams and the use of standardised instruments to evaluate function, impairment, and social support.

Discharge planning

Although there is some uncertainty surrounding the evidence base for discharge planning[42], it is logical that discharge should occur as soon as the patient's problems have been addressed so they can return safely to their own home. Frail old people may require complex support

networks, both formal and informal, to support them in their own homes. Early attention to comprehensive discharge planning is likely to be beneficial in improving patient care, reducing length of stay and reducing readmissions. Discharge planning should commence as early as possible once the decision to admit an older person to hospital has been taken[42 43], but must not compromise adequate assessment.

Case study 1 An example of joint discharge planning and outreach support

Occupational Therapy and Physiotherapy received a referral for a 92 year old lady, who had come to A&E following a fall. She had been seen in the majors area where bony injuries had been ruled out, and transferred to the Emergency Frailty Unit for Comprehensive Geriatric Assessment.

The lady normally lived alone in a bungalow, receiving carers twice a day for personal care. She had good informal support from friends and family. She was adamant she wanted to go home and declined going for a period of rehabilitation before returning home. She was assessed by physiotherapy as independent mobilising with her mobilator around the ward, despite having limitations on her functional range of movement and strength due to arthritis. The occupational therapist (OT) found her to be independent on and off the bed, chair and toilet with her existing equipment and declined any extra help with meal preparation and domestic activities. The therapists referred her for an outreach visit.

The patient returned home that night and the OT visited the patient the following morning to conduct an outreach follow-up. On arrival at her house the OT found an ambulance crew in attendance as the lady had fallen overnight. The ambulance crew carried out the relevant medical tests and the OT helped them mobilise her to the bathroom so she could be cleaned up. She was found to be independently mobile around her bungalow, and able to manage on and off all of her furniture with the existing equipment. The lady refused to go to hospital, and refused an intermediate care bed, but was persuaded to receive carers at mealtimes, which was arranged during the visit. A referral to intermediate care was also arranged to practice meal tasks as the patient wanted to remain independent with these in the long-term.

'This outreach visit was a great opportunity to work alongside our community colleagues to really make a difference for this patient. She got to return home but with increased services that she had initially thought she didn't need. Our goal was to reduce the risk of her falling and of needing to come to hospital again. We arranged extra support to help get her back on her feet and return to her previous baseline, or better'. (Senior OT)

Promoting wellbeing

Alongside the medical reasons that bring older people in contact with urgent and emergency care services, problems affecting their general wellbeing may have been building up over time. These are often social problems, such as living alone or having heavy caring responsibilities, financial worries, difficulties maintaining and managing their home, loneliness and isolation. As well as addressing medical and social care needs it is important to aim to put older people back in a position to cope and help them live as fulfilling lives as possible.

As well as statutory services, voluntary sector organisations can help older people who live alone or with a partner to maintain as much control as possible over their own lives, to resume or engage in social activities that are important to them and reduce isolation. Such support can improve general wellbeing and help reduce the likelihood of needing to call upon urgent or emergency services in the future.

Support from voluntary sector organisations might include providing independent advice and information about entitlement to benefits, home improvements or equipment - along with help to complete application or claim forms. This helps maximise income, make homes more comfortable and reduce stress levels. Advocacy services can help people understand their options and make more informed choices. Help with small jobs around the home and garden maintenance can mean improved home safety and security and continued independence. Home visiting and befriending services bring regular social contact and a chance to laugh and

share experiences to people who, for whatever reason, rarely meet and enjoy the company of others. Such services can, in some cases, help build confidence so that people feel able to engage in social activities away from their home. Other services provide an opportunity to meet people for a hot meal and participate in activities such as chair based or other exercise classes.

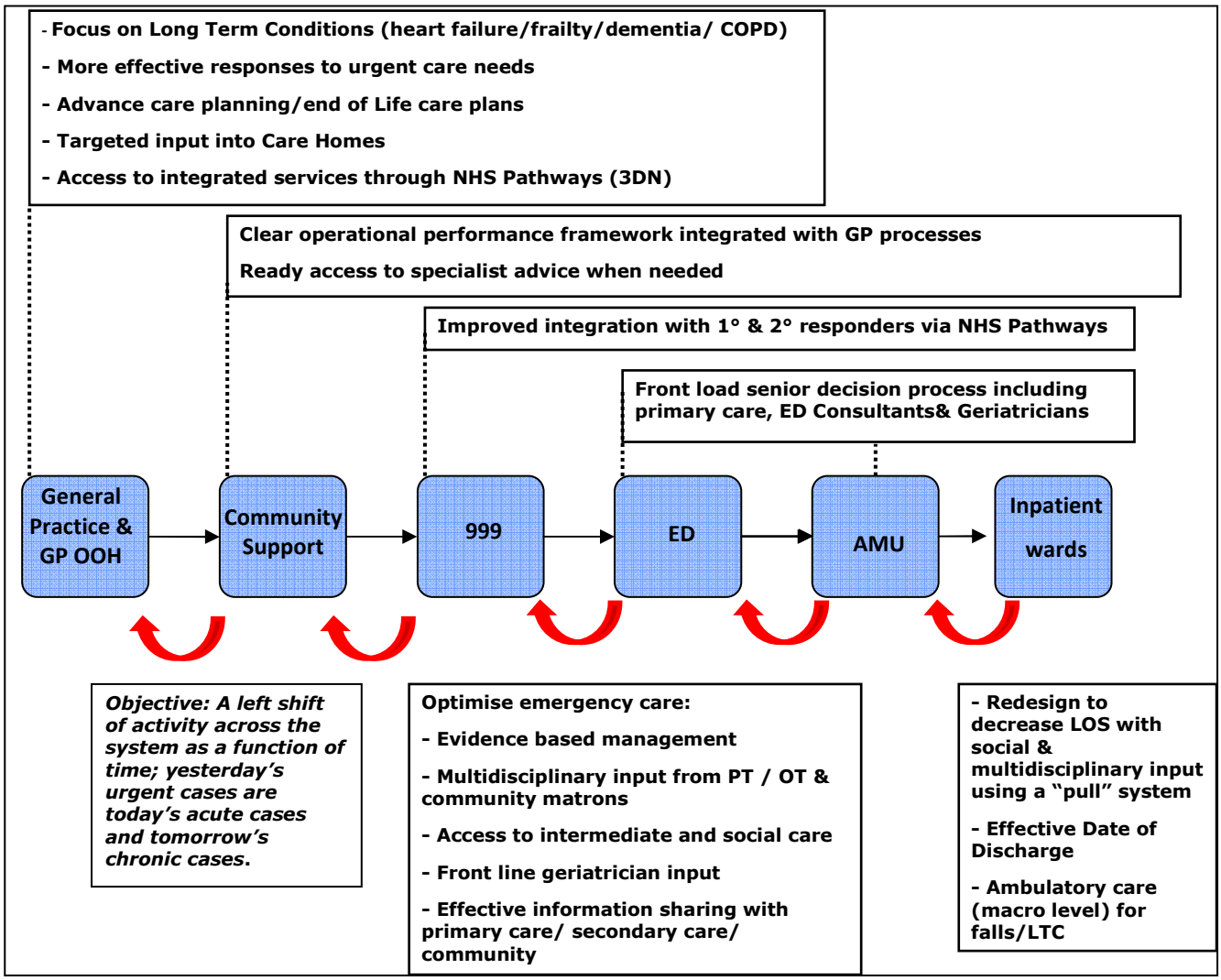
Many voluntary services offer help to carers in their caring role. This may be through sitting or other respite services, or providing opportunities for carers and those they care for to meet in a café style environment and perhaps enjoy a massage, reflexology or other complementary therapies.

Whole systems approach

Multidimensional assessment and multiagency management of older people leads to better outcomes[44]. For such services to be effective, they must be delivered in an integrated manner across the primary and secondary care, and health and social care interface.

Figure 1 is a representation of the urgent care axis and the possible interventions that might help with transformational change to increase appropriate response to urgent and emergency care needs.

Figure 1 Urgent care axis – points for intervention



Urgent care at home

Context and facts

The current system of health and social care is not joined up and struggles to meet the urgent care needs of older people. All too often the default position is for frail older people is to be taken to the Emergency Department (ED), with a high probability of being admitted to hospital. Very rarely is the urgent care need in the first 24 hours entirely dependent on a response by health services in this group of people. There are often inadequate or poorly coordinated services to care for older people safely in the community if this is clinically appropriate; support for carers is also variable. A consistent 24/7 urgent care response is important.

Despite some variation within defined parameters, response times for an urgent health need are measured in minutes for the ambulance service, but in hours for other health services, including GP services with often greater variability in the urgent care response by GP practices during office hours compared to out of hours.

There is also a mismatch and variability with the extent, speed and integration of response of health and social care which is essential for caring for older people in the community with urgent healthcare needs. The number of service users 65 years and over receiving community based services provided by local authorities has reduced (Figure 2) and the speed of the social care response through assessment (Figure 3) has hardly changed in recent years. These minimum time frames for a social care response with an assessment are not always conducive to an urgent care response that will support older people being looked after in the community in their own homes with immediate care needs. All too often older people are referred to ED or admitted to hospital because of a lack of timely social care rather than there being a clinical indication for this level of care.

Figure 2 Number of service users receiving community based services, 2004-05 to 2009-10, England[45]

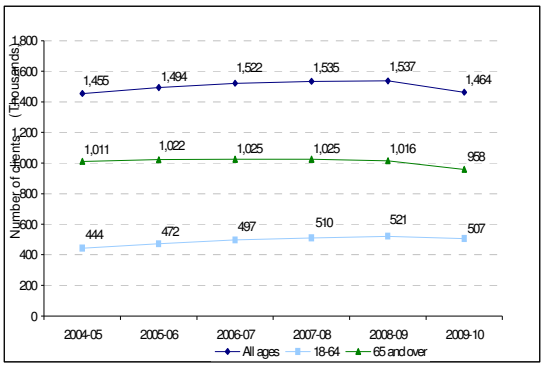
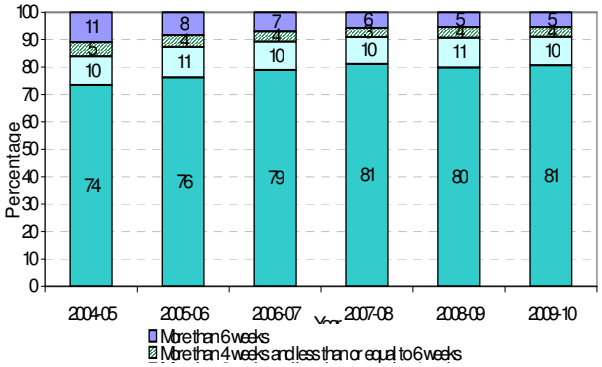


Figure 3 Length of time from completed assessment to receipt of all services for new service users aged 65 and over, 2004-05 to 2009-10



In managing older people with urgent care needs in the community, the first 24 hours of timely, effective health and social care support is crucial. Home care and provision of equipment e.g. commodes are often the bare essentials, yet overall contact hours of home care provided appears to have declined.

Despite the growing population of people aged 65+, especially those over 85 years, the number of residents supported in residential or nursing homes has been in decline. This means

that even before the current austerity measures of reduced funding to local authorities, most vulnerable older people will be living independently. To effectively address the needs of older people, there must be innovative strategies to provide a timely health and social care response.

Key points

- Any urgent care service response to older people must be patient focused and driven by patient needs.
- Patients must be treated as individuals with dignity and respect; their wishes and those of their carers must be acknowledged, with shared decision making based on clinical considerations.
- Disease prevalence alone cannot explain the rise in self-referrals and attendances[1] at ED, with those aged 65+ more likely to be admitted. More consistent and timely urgent same day access to GPs during working hours is required.
- When there is an urgent or emergency care need frail older people, their carers or professionals involved in their care should only need to make one phone call to a central telephone number to mobilise a '24/7 integrated health and social care response' to address their needs, be they physical, psychological, social or to support carers
- A 24/7 integrated health and social care response should include an initial contact by the integrated rapid response team on the telephone within 30 minutes and an appropriate rapid assessment within 2 hours (14 hours overnight) with the necessary arrangements instituted to address the older person's acute health and social care needs and the support needs of their dependants or carers over the following 24 hours[9]. This should also act as a trigger for more detailed assessments e.g. falls and other care packages thereafter
- There should be a '24/7 Integrated Rapid Response Team' staffed by health and social care professionals. Key roles include prescribing, nursing, occupational therapy, physiotherapy and social care. An integrated rapid response team coordinating care in the first 24 hours could then put into motion other measures and assessments to support recovery and independence.
- For more complex urgent health care needs the older person's GP or out of hours service can be contacted to review as part of the integrated urgent care response. When specialist medical advice is required community geriatricians should be available to give advice on issues of medical management.
- Reablement services are not only relevant after discharge from hospital but also as part of the integrated health and social care response in managing older people with acute medical needs in the community when clinically acceptable to do so.
- The use of telehealth may help support older people in their own homes, especially to anticipate problems and to support treatment and monitoring.

Out of hours primary care

Context and facts

GP out of hours services are charged with delivering general medical services in the out of hours period (18.30-08.00) every day. There is a legal requirement on commissioners of GP services to deliver this service to the population. While services can use any skill mix they deem appropriate, there is a requirement to deliver access to a GP if required.

Caring for older people out of hours presents its own set of challenges. The clinician will not be familiar with the patient's history or understand all the local services available. Clinicians who only work occasional sessions face particular challenges in updating themselves on best practice and, in some cases, may feel under pressure to complete too many episodes per hour and potentially rush decision making. Special notes or care plans summarising care agreed

with the doctor or nurse responsible for their care during the day have great potential for improving continuity of care.

The main challenge for services is that acutely ill older people are very sensitive to delays in care. The longer they wait for a definitive consultation, opinion, investigation and treatment, the more likely they are to end up attending the hospital. Services do have national standards to adhere to, mainly in terms of response times. These are, however, dependent on a solid and high quality clinical prioritisation system which ensures that those at risk of admission do not wait hours before being seen.

Out of hours services are particularly important for people nearing the end of their lives. In too many places older people are admitted only to die shortly after in hospital despite good care plans being in place. The plans fail either as a result of poor communication with the out of hours provider or poor use of the information by the out of hours provider or lack of other support services.

Services everywhere are under significant pressure to avoid admissions and reduce costs. There tends to be an implicit assumption that this should be delivered alongside the highest possible quality of care. When admission avoidance is seen as the top priority, it may result in poorer quality care for some older people inappropriately denied hospital care.

Aside from the role of assessing older people in the community, out of hours services can also help with expedited discharge from the acute setting.

Case study 2 Out of hours services and urgent care

'If we all did the basics right, things would go a lot more smoothly. A recent typical incident concerned a 77 year man with sudden onset of leg oedema. He was seen at his home by his GP at 3.30pm on a Protected Learning afternoon. The GP phoned the Primary Care Assessment Unit (PCAU) to arrange an assessment. The GP booked a 1 hour ambulance and specifies PCAU and gets records faxed to PCAU (the GP did not go via the Single Point of Access (SPA), which would be normal process). The ambulance took 2.5 hours to arrive with no further communication, took the patient to local Acute Medical Unit, not PCAU. The AMU ad no record and patient got sent to the ED. At 8.30pm patient's wife phones to ask why he was in ED; however by then it was too late to access PCAU, where GP goes home at 10pm (bloods take two hours) so the patient was admitted unnecessarily.

Key points

- Commissioners should seek to ensure a consistent response around the clock
- There is a responsibility on the older person's host general practice to ensure the local out of hours service is aware of patients at risk, those with special needs and those with end of life care plans.
- Timely access to relevant information is necessary for good clinical decision making; ensuring that there is good communication with other local services is central to a well-functioning integrated urgent care response

Pre-hospital – ambulance service

Context and facts

Ambulance clinicians, predominantly paramedics, face a number of challenges when responding to older people, especially those who live alone or are cognitively impaired. This, compounded by polypharmacy, complex co-morbidities and a frequent lack of patient information, makes the assessment of urgent rather than emergency conditions more difficult and the decision to manage the patient safely at home more challenging. Lack of an integrated community-based approach in risk assessment and information sharing also adds to this risk.

Responding to urgent care needs; including call handling, signposting and face to face clinical management would be safer if it was part of a commissioned, integrated, systematic, health and social care response to urgent and emergency care needs in older people.

The new Ambulance Clinical Quality Indicators relate to all aspects of pre-hospital emergency and urgent care for older people, and influence outcomes (Table 1).

Table 1 New indicators for ambulance services

• Time to answer call (999)	• Time to treatment
• Service experience	• Calls closed with telephone advice or managed without transport to A&E
• Outcome from stroke	• Call abandonment rate

• Outcome from cardiac arrest
  ○ return of spontaneous circulation
  ○ discharge from hospital
	• Category A eight-minute response time to life-threatening calls
	• Category A 19-minute response time to serious but not life-threatening calls

• Outcome from ST elevated myocardial infarction	• Recontact rate following discharge of care

The aim of these new quality indicators is to start the process to improve care by facilitating an integrated patient pathway. Timeliness of care remains an important factor, and the focus will be on both emergency and urgent care.

The Quality Innovation Prevention and Productivity (QIPP) urgent care work stream involves:

- A Single Point of Access
- Local Directory of Services
- Commonality of offer
- GP dashboard

A 10 per cent reduction in the number of patients attending Emergency Departments (EDs) will need to be achieved as part of the QIPP agenda for urgent care. This has implications for regional NHS Ambulance Trusts. It presents challenges when managing appropriate patients safely, without immediate conveyance to Emergency Departments. This should either be through conveyance to suitable alternative systems or preferably through management at home using alternative care pathways. In the absence of an integrated response available 24/7, these outcomes will not be achievable. There are good examples of alternative pathways for older people with falls leading to improved outcomes e.g. through referral to community falls services[46] and the management of urgent care undertaken by advanced paramedics who have completed a specific education programme[47].

For further information on how ambulance services across the country are affecting urgent and emergency care, refer to 'Taking Healthcare to the Patients':

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4114270.pdf

http://aace.org.uk/ambulance-leadership-forum/

Emergency Department

Context and facts

The delivery of such complex interventions, such as Comprehensive Geriatric Assessment (CGA) is challenging within a busy, time-constrained ED. Several studies have examined the role of a team identifying older people in the ED and delivering coordinated care in the community setting upon discharge[48-52] and a meta-analysis of these studies provide some evidence of improved outcomes[53]. Hospital at home schemes that include multidisciplinary care and medical input can be effective[15 32 33 42] and could support ED based teams such as those described above.

Key points

Environment

- The assessment area for older people should be located in a quieter, preferably separate, area of the department where observation is possible but noise, interruptions, over stimulation and so on is minimised. However it should not be close to an exit.
- Food and drink should be readily available; helping with nutrition should be provided when necessary (Case study 3)

Case study 3

An 82 year old lady with cognitive impairment is found by her carer lying on the floor at 9am. She had fallen the previous evening sometime around 8pm and lain overnight. She is confused and sleepy. The GP is called who attends at 10 am. He calls an ambulance which arrives around 11am. The patient is first seen in the department around 12noon (it has been a busy day) and is eventually transferred to the receiving ward at about 3pm. She is written up for IV fluids which because of her advanced age the doctor has prescribed cautiously and are started around 3:30pm. Her hypoactive delirium has become more marked and so she is barely able to manage meals and cannot reach the oral fluids on her bedside table and is too sleepy to express thirst. Up to 21 hours could have passed since she last had a reasonable meal or drink and her delirium will have been exacerbated by inadequately managed dehydration.

- The Emergency Department should be 'age-friendly', with signs in large font as added visual aid accompanied by pictures. Signs to toilets should be bold, visible and multicue i.e. a picture of a toilet beside a toilet sign. All signage should at eye level so the older patient does not have to crane their neck to read it as this can cause them to lose their balance. Pictures in the cubicles should also be hung at eye level so the patient can gaze at them without discomfort[54].
- Bins should all have silent lids, those that snap down and make a loud bang cause unnecessary distress to those who are confused and visually impaired (Case study 4).

Case study 4

An older Iranian lady was brought to the ED by her daughter, who was her main carer.The lady was blind and had advanced dementia. She was quiet and lying on the trolley waiting to be assessed by the doctor. Suddenly she became very distressed, crying and trying desperately to climb off the trolley.Her daughter was exasperated and upset because what had disturbed her mother was the sudden banging noise of bin lids snapping shut, and the thoughtlessness of staff who did not anticipate that such sudden noises may cause undue distress to a blind patient who also had dementia. This lady had lived through the Iran /Iraq war and any sudden loud noises were a source of terror and anxiety to her.It took a long time to calm and settle the patient.

- Clinical equipment should be kept to an absolute minimum and where possible create an ambience consistent with the age of the patient (examples that are proven to work are

pastel shades, flowery curtains, old fashioned pictures, a clock with large numbers, comfortable armchair).

- If the department also had a clinical decisions unit (CDU) or short stay unit (SSU) it is helpful to replicate exactly the décor from the ED to one of the cubicles in CDU so transfer does not add to confusion[55].

Interventions

- Certain conditions common in older people require rapid access to relevant medication, such as such as Leva-Dopa for Parkinson's disease.
- Older people with cognitive impairment or sensory deprivation may become distressed by interventions such as cannulation or urinary catheterisation
- For selected older people, comprehensive geriatric assessment should commence within four hours (maximum 2 hours (14 hours overnight)) of point of access to a hospital

Information

- Older people attending the emergency department do so because of a crisis. This may be medical, psychological, social or and other form of crisis. This presents an ideal opportunity to offer information to older people at a time when it is most relevant to their needs. Information sharing, verbal or written should be tailored and presented in a format which is easy to understand.

Acute assessment units

Context and facts

In 2007 the Royal College of Physicians (RCP) urged Acute Medical Units (AMUs) to 'tailor their operations to meet the needs and expectations of an ageing population with more complex illness'[56].

Key points

There should be no discrimination on the basis of patient age when decisions are made about access to acute medical services, and about the quality of service subsequently provided and received[56].

Models of care

The RCP considered a variety of models of care for admitting older people to an AMU, but in order to limit discrimination, models based on age were rejected. However, they recognised that older people with complex needs would benefit from prompt review by specialist geriatric teams comprising geriatricians and a multidisciplinary team. The British Geriatrics Society recommends that there is a role for a dedicated geriatrician embedded within the AMU focussing on frail older people[57], similarly physiotherapists and occupational therapists should be employed in Assessment units. The presence of a frailty syndrome, evidence based risk stratification tools, or locally acceptable policies[58] may be used by to identify older people with complex needs.

Comprehensive Geriatric Assessment (CGA) can lead to improved function and quality of life, and reduce hospital stay, re-admission rates and institutionalisation. An AMU is a suitable environment to complete CGA and initiate appropriate interventions. Internationally, Acute Geriatric Units have been shown to reduce the risk of functional decline and increase the probability of returning home[31], such units have not been compared directly to an AMU in the UK.

A good example of a specialist team which has improved outcomes in this setting is the Older Persons' Assessment and Liaison team (OPAL)[59].

Exact models of care will be dictated by the local population and services and resources available within, and outside the hospital.

Community hospitals

Context and facts

Within the United Kingdom there are over 400 Community Hospitals. In the past such hospitals were reserved for rehabilitation of largely well people who had spent their acute illness phase in acute hospitals. This has altered significantly and in the past few years patients being admitted to community hospitals admitted are typically frail older people, and increasingly are admitted directly from their homes, and may be more acutely unwell than in the past. This presents a challenge for staff to assure the environment, whilst maintaining a caring homely atmosphere can meet the needs of such older people.

Medical models of care differ from hospital to hospital with some having local GP's input each day, with out of hours cover in the evenings and weekends. Others have a named doctor responsible for the provision of care with a consultant providing a weekly input. In some areas nurse practitioners are increasingly becoming part of the provision of care in community hospital wards.

Also community hospitals vary 'greatly in their role and function with a very broad range of different services provided'[60]. In addition the clear policy direction of providing care in the community closer to home[61] has been a key driver in care provision in community hospital settings. This has led to a need for staff skills and competency to encompass the care of older people, specifically in appreciating the complexity of care, when older patients have multiple long term conditions and are increasingly frail.

Community hospitals are part of the community and should have excellent links with community teams enabling communication to be swift and personal which should lead to a greater integration between hospital and home care.

Key points

- Older patient's assessments need to be comprehensive and provided by skilled medical and nursing clinicians in a timely manner, within 2 hours (14 hours overnight) of admission
- Signs of deterioration maybe subtle in the older patient and as the community hospital may not have the full resources available to them it is essential that staff are vigilant in recognising and responding effectively, in order to prevent an emergency situation
- Medicine reconciliation in community hospital settings should be as stringent as in acute care to assure older people are not exposed to unnecessary polypharmacy or missed medications
- Investigations need to be conducted in a timely manner and not viewed as if the patient was in their own home
- All staff involved in assessment and examination must have competence in older peoples care needs and have an in depth understanding of the long term condition management

Chapter 4 Assessment and management within the first 24 hours

Context and facts

Older people will benefit from the same level of assessment as people of any age, for example, early warning scores predict mortality in older people[62-68]. However, some frail older people may need additional assessments which are not currently mandatory. The delivery of a holistic assessment is challenging within urgent care, and careful thought needs to be given as to the best place where such assessment can be continued – this could be as an in-patient, or in the community setting. Some of the important assessments to be considered in the urgent care context are detailed below:

Generic national guidance on urgent care can be found at:

http://www.nice.org.uk/CG50

http://www.bgs.org.uk/index.php?option=com_content&view=article&id=44:gpgacutecare&catid=12:goodpractice&Itemid=106

http://www.bgs.org.uk/index.php?option=com_content&view=article&id=35:gpgstandardsofcare&catid=12:goodpractice&Itemid=106

http://www.bgs.org.uk/index.php?option=com_content&view=article&id=45:gpgaae&catid=12:goodpractice&Itemid=106

Guidance on issues relating to the primary-secondary-social care interfaces can be found at:

http://www.bgs.org.uk/index.php?option=com_content&view=article&id=46:gpgdischarge&catid=12:goodpractice&Itemid=106

http://www.bgs.org.uk/index.php?option=com_content&view=article&id=363:intermediatecare&catid=12:goodpractice&Itemid=106

http://www.bgs.org.uk/index.php?option=com_content&view=article&id=360%3Aprimarysecondarycareinterface&catid=12%3Agoodpractice&Itemid=106

Dementia and delirium

There are two common organic brain syndromes, dementia and delirium. 40% of people over age 70 admitted to medical wards have dementia, 20% of these from care homes, yet 40% have Ambulatory Care Sensitive Conditions that might be amenable to treatment without recourse to hospital admission[69].

Dementia and delirium are syndromes and not pathologies and so the diagnosis is entirely dependent on the skill of health professionals. Some features are common to both:

- both age related (increasing with age, particularly after age 65)
- both under/misdiagnosed (50% of dementia in the community and general hospital is undiagnosed, 50% of delirium in hospital is undiagnosed and they are often mistaken for each other or for other mental disorders)
- both are common presentations in the emergency sector
- both predict a poor outcome with increased mortality, length of hospital say and admission to institutional care[69-72]

Routine assessment of cognition will identify moderate to severe cognitive impairment. The 4-point Abbreviated Mental Test score (AMT-4)is quick to complete, and has good correlation with the 10 point scale but is easier to apply requiring only place, age, date of birth and year[73]. However the detection of cognitive impairment in the ED context should always be accompanied by an assessment for delirium (see below).

Dementia

Dementia is a chronic disorder, the course is slowly progressive, typically with a history of several months and more and usually caused by irreversible degenerative brain disease. People with dementia will come to the attention of emergency services for a number of reasons:

- new medical problems that may be accompanied by delirium (most commonly, falls, infections, fractures, loss of consciousness)
- decompensated long term conditions due to compliance problems
- neglect
- abuse
- behavioural symptoms (if new these may represent delirium)
- social breakdown

For most people with dementia admitted to hospital there will be a primary medical diagnosis (or more often diagnoses) and the importance of dementia is overlooked.

Episodes of disturbed behaviour, referred to as the Behavioural & Psychological Symptoms of Dementia (BPSD), will occur in over 90% of people with dementia at some point. Typically, these present in the moderate and severe stages of dementia. Managing BPSD can be difficult and requires a careful analysis of contributing factors that will include physical (e.g. pain), psychological (e.g. depression, hallucinations) and environmental (e.g. change). People with dementia are notoriously susceptible to change of environment or routine that can precipitate BPSD, for example, admission to hospital. New onset BPSD should prompt a suspicion of superimposed delirium, which can be precipitated with relatively minor physical illness in people with dementia. Concern over inappropriate prescribing of antipsychotic drugs for people with dementia has led to a new national agenda to reduce the use of these drugs and indications for appropriate prescribing are clear for people with dementia and delirium and management includes non-pharmacological as well as pharmacological interventions[72 74].

National standards and guidelines on the assessment and management of dementia can be found at:

http://www.nice.org.uk/CG42

http://www.bgs.org.uk/Publications/Publication%20Downloads/Delirious-about-dementia.pdf

Delirium

Delirium has acute onset, the course typically over days and weeks. The major risk factors for delirium are increasing age (three times more common over age 65) and dementia/cognitive impairment (6-11 times more common), severity of illness and hip fracture[72]. It is a common non-specific presentation of physical illness in older people and the most common complication of a hospital admission[75]. Despite this, it is poorly detected and recorded with 33-66% of cases undiagnosed or misdiagnosed[75-77]. Failed detection in emergency departments is associated with a seven-fold hazard for increased mortality[75 78], and delirium in the ED is an independent predictor of hospital length of stay[79]. Symptoms may not only be cognitive. They may be behavioural, psychotic (hallucinations, delusions) or mood symptoms with little or absent signs of disorientation or cognitive impairment. For example, symptoms of depression in a delirious patient may be indistinguishable from people suffering from depressive disorder. The key is to suspect delirium with any sudden change of mental state or behaviour in older people. Characteristic signs of delirium, which also help distinguish this from dementia, are:

- clouded consciousness
- poor attention and concentration
- a fluctuating pattern of symptoms

Detection of changes in mental state may be hampered by a limited availability of information on previous mental health assessments in the ED as a result of information governance and data protection issues. It may not be possible for an ED clinician to be able to tell whether the cognitive impairment they have detected is different from the usual state.

The importance of distinguishing delirium from dementia is critical but not always straightforward. People with dementia are 6-11 times more likely to develop delirium, this co-morbidity can be difficult to recognise. Recognition is essential as delirium is a common presentation of acute physical illness (with no localising signs) in people with dementia. The key is the history of acute onset and short duration of new symptoms. Information from carers or third parties is essential and will often hold the key.

Both conditions will often pose questions about a person's capacity to make health and welfare decisions; all emergency sector professionals need to have a good knowledge of capacity and mental health legislation to deal appropriately with the person who is incapable of consenting to treatment.

National standards and guidelines on the assessment and management of delirium can be found at:

http://guidance.nice.org.uk/CG103

http://www.bgs.org.uk/Publications/Clinical%20Guidelines/clinical_1-2_delirium.htm

Managing challenging behaviour

There are few statistics on the frequency with which older people display aggression and overt violence in emergency care settings. The Healthcare Commission's National Audit of Violence 2006-07, (RCPsych 2007) looking at violent incidents on acute psychiatric in-patient units found the highest levels of physical assaults on staff by patients occurred on wards for older people with organic impairments. The frailty of the patients did not prevent serious injuries being inflicted. These incidents occurred despite the staff involved being skilled at using person-centred approaches to maximise patient dignity and good compliance with standards for privacy and choice. It is likely that issues will sometimes arise in emergency care settings where action will be needed to protect staff and other patients from acts of aggression and where tranquillisation will be needed to allow adequate assessments of patient's physical health.

Guidance on the short-term management of disturbed / violent by psychiatric patients in emergency departments has been issued by NICE (2005). This derives chiefly from recommendations on the management of physically fit patients with functional illness in in-patient psychiatric settings.

Ill older people will not always be able to articulate the reasons for their distress and it is always important to establish whether pain, constipation, urinary retention or psychosis lie behind disturbed behaviour. The NICE guideline gives helpful advice on recognising situations which may progress to violence and how to avert this (de-escalation). Medication should only be used where it is the safest and least restrictive way of managing behaviour, which is a serious risk to other patients, the staff or other people in the emergency setting, or to patients themselves. (See appendix for an example of a policy.)

National guidance on rapid sedation can be found at:

http://www.nice.org.uk/nicemedia/live/10964/29715/29715.pdf

Depression and self-harm

Depression is the commonest mental health problem in old age, and aetiological factors such as social isolation and chronic physical illness mean that an ageing population will be a more depressed one too. The Geriatric Depression Score-5[80] is a quick useful tool to screen for depression.

Self-harm in older people is much less common than at a younger age; of 5038 consecutive self-harm attendances in one Emergency Department, 110 (2.2%) were of people aged 65 years or over [81]. However older people who self-harm have high levels of suicidal intent[82 83] and often have on-going suicidal ideation after presentation. Older people comprise about 25% of all UK suicides, and there is a much stronger association between self-harm or completed suicide and mental health problems in old age than in adults of working age. About 15% of older people with a first episode of self-harm go on to repeat the act, and there is a 49-fold increase in risk of suicide[83]. The adverse effects on cognitive function of common drugs used in self-harm, such as tricyclic antidepressants, may make detection of the act more difficult. Additionally, older people with delirium or dementia may present with unintentional self-harm which, if undetected, could have adverse consequences.

Older people who present with self-harm are more likely to receive a psychosocial assessment and be admitted to the general hospital than adults of working age[84]. This may be because they are perceived as high risk, or because they more commonly use methods requiring physical treatment as an in-patient. Mental health services for older people are often configured differently to those for adults of working age, with less provision of specialist liaison input into general hospital settings including emergency departments[85]. NICE states that mental health professionals must be experienced in assessing older adults who have self-harmed to undertake assessment of this age group[86]. This means that a rapid response for psychosocial assessment after self-harm may not be available from an adequately skilled clinician. Many parts of the UK lack the equivalent of crisis teams for older people, meaning that alternatives to mental health admission are not available for some older people, who may then spend more time in the emergency department and in general hospital wards.

Alcohol and substance abuse

Alcohol and substance is a problem in older people although less common than in younger age groups, in part related to survivor bias. Older people are more vulnerable to the adverse effects of alcohol and substance abuse, because of changes in physiology and drug handling, comorbidities and polypharmacy. Safe drinking levels are the same for older people as for younger people (14 units of alcohol a week for women, 21 units for men) although in practice safe drinking levels are probably less than this.

National guidance can be found at:

http://old.rcplondon.ac.uk/professional-Issues/Public-Health/Pages/Alcohol.aspx

http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/alcoholanddrugs/alcoholandolderpeople.aspx

Falls

Falls are also the commonest single reason for older people to present to urgent care. Falls are not an inevitable part of ageing but are often due to underlying disease or impairment that may be amendable to treatment or modification.

Screening for falls risk

Even if not presenting with a fall, all older people presenting to urgent care should be asked whether they have fallen in the past year. If a person reports a fall, a more detailed history of the frequency and circumstance(s) of falls should be taken. Further assessment depends on the level of future falls risk for that individual. The American Geriatrics Society/British

Geriatrics Society (AGS/BGS) Guideline[87] recommends three questions should be asked of all older people (aged 65 and over) who report any falls in the last 12 months:

- Have you had two or more falls in the last 12 months?
- Have you presented acutely with a fall?
- Do you have problems with walking or balance (not necessarily restricting activity)?

If a person gives a positive answer to any of these questions, they should be considered at high-risk of further falls and assessed as such. Those who have had a single, non-injurious fall are categorised as low-risk. Due to high numbers, it may not be possible for all high-risk fallers to be seen in a falls service, in which case the second criteria should be modified to include only those presenting with an injury as the result of a fall. People with non-hip fractures are half as likely as hip fracture patients to be referred to falls service, despite being at high risk of future fracture and falls.

Assessment of high-risk fallers

Most older people with falls have more than one risk factor for falling. Consequently, high-risk fallers should receive a multi-factorial assessment for falls risk factors, with intervention tailored to modify the identified risks. In most cases, this will be performed in a falls clinic, or community-based falls service. Most fallers will not require admission, so urgent care services must have robust pathways for identification and referral of fallers. The further assessment and management of falls risk factors should be based on NICE Clinical Guideline 21[88] or the AGS/BGS Guideline[87]. Falls are particularly common in people with dementia, so a collateral or witness history should be obtained wherever possible. Up to 20% of falls are thought to be due to transient loss of consciousness. This should be specifically considered and further management should follow NICE Clinical Guideline 109 (Transient loss of consciousness in adults and young people)[89]. There may be amnesia for syncope, so this should be suspected whenever a person cannot clearly recall the impact on the ground or floor. An ECG should be recorded and analysed on any faller where loss of consciousness cannot be excluded. In addition, a cardiac examination should specifically look for murmurs and there should be a record of the patient's lying and standing blood pressure. These examinations can be performed by any appropriately-trained member of the multi-professional team. All high-risk fallers should receive a review of medication, with particular regard for sedative, psychotropic, hypotensive or anti-cholinergic medication. Withdrawal of psychotropic medication, in particular, can reduce falls risk[90]. All high-risk fallers should have an assessment of mobility, gait, balance and function, including activities of daily living, as well as any perceived impairment in relation to falls or the fear of falling. An assessment of the home environment will often be appropriate[91].

Assessment of low-risk fallers

A single fall could be the first sign of difficulties with walking and/or balance and provides an opportunity for early intervention. Most older people who fall have an underlying musculoskeletal reason for falling. Therefore, all older people reporting a single fall should undergo a simple assessment of gait and balance in the acute setting. There are many tools for assessing gait and balance, none of which are sufficiently sensitive or specific to allow recommendation as the 'best' test for predicting falls risk. Simple tools include the Timed Up and Go Test[92]. An older person who has had a single non-injurious fall and who has normal gait and balance (normal Up and Go Test) does not require further assessment or intervention. Fallers with abnormal gait and balance should be treated as high-risk.

National standards and guidelines on falls assessment and management can be found at:

http://www.nice.org.uk/CG021

http://www.bgs.org.uk/Publications/Compendium/compend_4-5.htm

http://www.rcplondon.ac.uk/resources/national-audit-falls-and-bone-health-older-people

Fractures and osteoporosis

Fragility fractures are a common emergency presentation, the most devastating of which is hip fracture. Hip fracture usually requires an admission to hospital for on-going management, but other fractures present an opportunity to identify and manage osteoporosis at an early stage though the establishment of fracture liaison services. People presenting with a fragility fracture should be referred to local falls prevention services.

National standards and guidelines on bone health assessment and management can be found at:

http://www.nhfd.co.uk/003/hipfractureR.nsf/vwContent/BlueBook?Opendocument

http://www.nice.org.uk/TA161

http://guidance.nice.org.uk/CG124

Medication

Polypharmacy is often one of the main causes of emergency admissions. Adverse Drug Events account for approximately 6.5% of all hospital admissions[93], but more in older people, leading to increased hospital stay and significant morbidity and mortality[94 95].

Inappropriate prescribing is a common and serious problem in older people. Inappropriate prescribing includes prescribing drugs that are contra-indicated, over-prescribing a drug (inappropriate dose or duration), prescribing a drug which is likely to decrease patient prognosis, or failure to use a drug that may improve patient outcomes[96].

Inappropriate prescribing is more common in older, as compared to younger, older people[97-100]. Potential reasons for inappropriate prescribing in older people are related to the higher prevalence of chronic diseases and polypharmacy, which render prescribing more complex[101 102]. Older people are more susceptible to Adverse Drug Events (ADEs), due to age-related physiological changes, such as reduced hepatic and renal function and lower Body Mass Index (BMI), which result in altered pharmacokinetics and pharmacodynamics[103]. In addition, the relative under-representation of older people in drug trials means that many potential ADEs are only detected during post-marketing surveillance of a drug[104], and recognition of ADEs in older people is complicated by non-specific clinical presentations[105].

Various guidelines have been developed to help reduce potentially inappropriate prescriptions amongst older people[101 106], although there is no internationally agreed standard[107]. The STOPP/START criteria (Screening Tool of Older Persons potentially inappropriate Prescriptions/Screening Tool to Alert doctors to the Right Treatment) have been developed and validated[107 108], and early results from a small RCT suggest these criteria may be beneficial[109].

Key points

- Community pharmacists should be empowered to deliver more comprehensive Medicines Use Reviews/ Clinical Medication Reviews that are considered and actioned by GPs and other prescribers. To encourage the development of more pharmacists as independent prescribers would help with this goal
- Secondary and primary care organisations should offer a structured compliance assessment and medicines support service to those older people that have been identified as needing increased support with their medication (e.g. compliance devices, follow-up medication reviews in community)

Pre-operative care of older people:

The NCEPOD report into the care of older people undergoing surgery[110] found that:

- 38% received good care
- 44% had room for improvement in either clinical or organisational care; 13% in both
- 6% received care that was less than satisfactory

The National Falls & Bone Health Audit (2010) revealed that:

- Only 30% of hip fracture patients received good basic urgent care (adequate pain relief in the first hour, pressure area care in the first four hours, and intravenous fluids in the first twelve hours)
- Only 22% met the core best practice tariff (BPT) standards (surgery within 36 hours, specialist geriatric assessment within 72 hours, and use of an agreed care pathway)
- 26% received all components of a basic pre-operative medical assessment.

The report from the NCEPOD includes the following recommendations:

- Routine input from geriatricians should be available to older patients undergoing surgery
- Delays in surgery for older people are associated with poor outcome
- Pain is the 5th vital sign, and requires the same status as heart rate and blood pressure in the assessment and management of all patients

Given the frequent presence of complex co-morbidities in these patients and their degree of need, early assessment and resuscitation should commence and continue in the ambulance and emergency departments. Rapid access to geriatricians, anaesthetists, intensivists and surgeons is essential to develop early plan of intervention and provide targeted management of existing co-morbidities to decrease intra-operative and post-operative complications. Early senior decision making is also essential to provide the appropriate palliative care for moribund patients who would not benefit from invasive management. The Royal College of Anaesthetists has set up a multi-disciplinary Short-Life Working Party to draft a response to the NCEPOD Report which will be available in early summer of 2012.

Pain

The use of traditional pain scales can be difficult because of communication barriers, such as cognitive impairment, alternative assessment process that rely on non-verbal cues may be more useful in some older people. Pain management in patients with dementia may be challenging because of comorbidities but also because of polypharmacy. One of the main reasons for such poor levels of analgesia is lack of recognition particularly in the non-verbal patient. To address this, consideration should be given to the use of alternative Pain Assessment tools such as the Abbey Pain Tool which is particularly suitable for use in the urgent care setting. The importance of assessing changes in the patient's normal behaviour patterns as an indicator of increasing stress levels or potential pain cannot be underestimated. This can be difficult to do in emergency settings as nurses are often unfamiliar with the patient and their normal behaviour. The modified Abbey pain scale has a strong emphasis on involving the patients carers/family and includes a section on their perception of pain in their loved one as well as highlighting 'triggers' to aid staff recognition.

National standards and guidelines on pain assessment and management can be found at:

http://www.britishpainsociety.org_pain_scales.htm

http://www.bgs.org.uk/Publications/Clinical%20Guidelines/pain%20concise%20guidelines%20WEB.pdf[111]

Urinary tract infections

Possible urinary tract infection (UTI) is a common presenting problems or initial diagnosis in the ED, however, the diagnosis of UTI is frequently overestimated, especially in care home residents[112], and frail older people more generally.

Asymptomatic bacteriuria should not be treated and symptomatic enquiry should therefore guide diagnosis. In patients with Lower urinary Tract Symptoms (LUTS), a the absence of leucocytes and nitrites on the urine dip has the highest negative likelihood ratio to rule out UTI.

Bedside tests are useful only as an adjunct to clinical diagnosis. Visual inspection of urine has a 90.4% sensitivity but only a 66.4% specificity for bacteriuria, is dependent upon the experience of the observer and is not, therefore, a useful test[113]. Dipstick tests, meanwhile, are frequently positive for leucocytes due to the high prevalence of asymptomatic bacteriuria in frail older people. A dipstick positive for leucocytes and nitrites has a disappointingly low positive predictive value of 44%[114], and should only be considered in patient with unexplained systemic sepsis[115]. Dipstick tests can also miss UTI as a consequence of the fact that some organisms, including *Streptococcus pneumoniae, Enterococcus* or *Pseudomonas aeruginosa,* do not express bacterial nitrate reductase[116] and are therefore of limited value. Men have a high incidence of UTI secondary to organisms which may not form nitrites and should have urine sent for culture if they have symptoms of UTI, regardless of dipstick result[113]. Dipstick tests should not be performed in older people with long-term catheters as constant bacteriuria and pyuria means that the test is not useful.A suggested approach to the diagnosis of UTI in older people is shown in Table.

Table 2 Suggested approach to the investigation of possible Urinary Tract Infection in older people

Patient history	Symptoms	Signs	Urine dip
Clear and unambiguous	New onset of frequency, dysuria;	Abdominal pain Haematuria Offensive smelling urine Fever	Negative – seek other cause. Do not send MSU
			Positive for leucocytes and nitrites – likely UTI, send MSU and treat
	No urinary symptoms		Do not dip urine, do not send MSU
Lacking because of communication barriers	Increased confusion, apathy, irritability (delirium), reduced mobility, off food	Abdominal pain Haematuria Offensive smelling urine Fever	Negative – seek other cause. Do not send MSU
			Positive for leucocytes and nitrites – likely UTI, send MSU and treat
			Leucocyte positive only – seek alternative diagnosis Nitrite positive only – send MSU and start treatment

National standards and guidelines on the assessment and management of UTI and continence can be found at:

http://www.nice.org.uk/guidance/CG40

http://www.bgs.org.uk/index.php?option=com_content&view=article&id=377:continence&catid=12:goodpractice&Itemid=106

Nutrition

The incidence of under nutrition among patients admitted to hospitals in UK is 23% on those aged less than 65 years but 32% for those aged 65+[117]. Under nutrition is poorly detected by nursing and medical staff. The Malnutrition Universal Screening Tool (MUST) developed by the Malnutrition Advisory Group of BAPEN is commonly used in UK although locally devised tools are in use in many hospitals.

The importance of creating the right environment to support eating and drinking has been highlighted through key policy initiatives. The Essence of Care Benchmark on nutrition is a patient-focused approach and can provide organisations with an auditable standard upon which to base practice. Every hospital should implement the seven steps to end malnutrition in hospital as recommended by the Age Concern Hungry to be Heard report:

- Hospital staff must listen to older people, their relatives and carers and act on what they say
- Staff must become 'food aware'
- Hospital staff must follow their own professional codes and guidance from other bodies
- Older people must be assessed for signs or danger of malnutrition on admission and at regular intervals during their stay
- Hospital should introduce a 'red tray' system to help those who need assistance in feeding and ensure it works in practice

Recommended further reading:

Nutrition support in adults Oral nutrition support, enteral tube feeding and parenteral nutrition, National Collaborating Centre for Urgent care, London:

http://www.nice.org.uk/nicemedia/pdf/cg032fullguideline.pdf

BGS Nutritional Advice in Common Clinical Situations:

http://www.bgs.org.uk/index.php?option=com_content&view=article&id=41:gpgnutrition&catid=12:goodpractice&Itemid=106

BAPEN MUST Tool:

http://www.bapen.org.uk/pdfs/must/must_full.pdf

Skin care

It is estimated that just under half a million people in the UK will develop at least one pressure ulcer in any given year. This is usually people with an underlying health condition. For example, around 1 in 20 people who are admitted to hospital with an acute illness will develop a pressure ulcer.

People over 70 years old are particularly vulnerable to pressure ulcers due to a combination of factors, such as:

- reduced blood supply
- ageing of the skin
- older people having a higher rate of mobility problems

(taken from http://www.nhs.uk/conditions/pressure-ulcers/Pages/Introduction.aspx)

Prevention is key and older people accessing urgent care should be routinely screened for their risk of developing pressure sores, for example using the Waterlow score. Important measures that can prevent the development of pressure sores include:

- Mobilisation
- Good nutrition
- Appropriate mattresses and cushions
- Appropriate skin care

For further information see:

RCN Pressure Ulcer Risk Assessment and Prevention. Royal College of Nursing:

http://www.rcn.org.uk/__data/assets/pdf_file/0003/109839/002166.pdf

Injuries

A patient safety focused approach is an essential underlying principle for the safe assessment of any person accessing urgent care; part of this approach is to identify any injuries that need attention.

Older people presenting with poly-trauma need to be managed according to Advanced Trauma and Life Support (ATLS) principles with special consideration of the fact they do not respond well to prolonged immobilisation and balanced resuscitation. Advanced imaging including early CT scanning is important for quicker and definitive diagnosis, and as an adjunct to clinical assessment in prompt decision making, adequate management and efficient disposal. However use of contrast enhanced scans requires careful deliberation to strike the right balance of risk between identifying life threatening injuries and precipitating renal failure.

There is an association between increasing age and poor outcome following trauma, although any individual factor or combinations fail to predict an unacceptable outcome. Hence it is always advisable to embark on aggressive therapy irrespective of age or injury, except in the initially moribund patient. Older people who do not respond to this initial resuscitation have adverse outcomes. The responders have a good prognosis including a complete return to their pre-morbid state[118].

End of life care

In the United Kingdom, there has been a concerted policy drive to try and reduce deaths in hospital, underpinned by the belief that many deaths can be anticipated, and that dignity and quality of life is best served by a death at home – a concept supported by the public[119 120]. But in frail older people, especially those with dementia, end of life care needs remain somewhat neglected, and over-investigation and inappropriate interventions remain a costly exercise for both patients and the health and social care economy[121]. Advance Care Planning (ACP) is one proposed mechanism by which individuals' wishes and preferences may be better respected, especially in end of life care where the loss of decision making ability is common. Policy and guidelines promote the use of ACP with varying levels of caution[122 123].

National standards and guidelines on end of life care can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277

and commissioning guidance from the National Council of Palliative Care can be found at: www.ncpc.org.uk/news/61)

Information on the Liverpool care pathway can be found at: http://www.liv.ac.uk/mcpcil/liverpool-care-pathway/

Ethical issues

Early in the context of a crisis, a senior clinician should be in a position to have a discussion with the patient, and any other concerned parties such as next of kin or carers, about resuscitation – if appropriate to do so. This may avoid inappropriate escalation of care for some older people. It may also prompt the involvement of palliative care in certain situations. Such a discussion may need to take place much earlier within the resuscitation setting of an emergency department to avoid unnecessary life-prolonging interventions where the outcome may not useful or desirable. It is good practice to enquire about advance care plans, or more informal expressions of preferences early on in the patient's stay[124].

National standards and guidelines on the assessment of mental capacity can be found at:

http://www.publicguardian.gov.uk/docs/code-of-practice-041007.pdf

National guidelines on advance care planning can be found at:

http://bookshop.rcplondon.ac.uk/details.aspx?e=267

Discharge planning and community support

Frail older people may be especially vulnerable and will often require a holistic assessment of their home circumstances before discharge. Taking a broad perspective on the safety of a discharge home, or to any other stetting will enhance patient satisfaction and reduce the risk of readmissions, and ultimately the need for long term care. To facilitate more detailed assessment in selected older people, the emergency department will need to have timely access to therapy staff and social services support. Many older people will have on-going health issues that need to be addressed, although not necessarily requiring a hospital admission. For such people, timely access to ambulatory care services, such as a rapid access falls clinic, can facilitate early discharge from the ED. The patient's GP will be key to support in the community, so accurate communication to the GP is important. As the emergency department is part of a wider community serving older people, it will need to know about relevant services, and will need to be able to contact them in a timely manner to coordinate discharge planning.

The use of validated ED assessment tools such as Identification of Seniors At Risk (ISAR) tool should be considered to identify older persons at risk for mortality, functional decline, readmission and institutionalisation on discharge (Appendix 3).

Living with one of more long term conditions can be stressful for older people and their informal carers, who may also have multiple health conditions and require support in their caring role. Carers should be informed of their entitlement to a carers assessment to identify how they may be supported in their caring role. Condition-specific national support organisations can provide information and advice for people living with a particular condition and the chance to share problems and ideas in a web-based discussion forum. Many also have local groups that offer the chance for individuals and their carers to meet, share experiences and support each other in a relaxed and social environment

Key points

- Older people presenting to emergency services should be assessed and managed promptly with special consideration of their physical, emotional and cognitive states and with reference to privacy, dignity, socio-cultural and religious issues.
- The extent of this holistic assessment within a bio-psychosocial model will depend on the acuity of the presentation and some of it may not be possible based on timely individual needs
- The ED and AMU are well placed for opportunistic case finding as by virtue of their interface position; many people with falls[48 125] and cognitive impairment may present for the first time to the ED/AMU
- It may be difficult to deliver comprehensive geriatric assessment outside inpatient wards or outpatients, but the process could be contributed to, and indeed, triggered from an urgent care episode attendance
- Frail older people often present with complex medical problems and early engagement and 'in-reach' from geriatric and psychogeriatric teams is essential
- Effective teams often work in an interdisciplinary way improving communication and relationship
- If a patient requires an acute admission to hospital, planning for discharge or transfer of care should begin as soon as possible[56], operationalised as the setting of an Estimated Date of Discharge (EDD)[43 126].

Chapter 5 Safeguarding Older People

Context

Abuse of older people is common[127 128]. It may occur in many settings: private homes, care homes and hospitals (including Emergency Departments). Safeguarding is a range of activity aimed at upholding an adult's fundamental right to be safe. It is of particular importance for people who, because of their situation or circumstances, are unable to keep themselves safe. The Mental Capacity Act [129 130]introduced a new criminal offence of or wilfully neglecting a person without capacity. The nature of abuse and the fact that it is commonplace makes it critical that it is clearly understood that recognising and tackling abuse is everyone's responsibility. Studies from around the world suggest that one in four vulnerable older people are at risk of abuse, however only a small proportion of this is currently detected. In the UK of a sample of people aged 66 or over living in private households between 2.6% and 4% of respondents reported that they had experienced "mistreatment" by a family member, close friend or care worker during the previous year[128]. This equates to a figure of between 227,000 and 342,000 people aged 66 or across the UK.

Nature of abuse

Five types of abuse are recognised:

1. Physical abuse, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions

2. Psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks

3. Financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits

4. Sexual abuse, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting

5. Neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

Assessment and assessment tools

Action on Elder Abuse have produced the guidance on recognising abuse:

http://www.elderabuse.org.uk/About%20Abuse/What_is_abuse%20define.htm

Department of Health guidance on Safeguarding of Adults Boards
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126748

See Appendix 7 for more information.

Key points

- Action on victims of abuse attending ED
- All EDs have arrangements with local social services, police and other agencies about how to notify concerns about the abuse of vulnerable people.
- All EDs understand the role of Safeguarding of Adults Boards and have training to ensure all clinicians and others working with older people, not only know what safeguarding is and what abuse looks like, but are clear what to do about it and who is responsible for what

Chapter 6 Training and development of staff

Context

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.

Training of both Emergency Department doctors and nurses has not traditionally focused on the needs of older people, thus there is a lack of confidence and expertise in managing older people and conditions associated with ageing. Junior doctors are usually the 'first receivers' at the front door (emergency department or acute medical unit), and few will have any substantial training in geriatric medicine and the formulation of the non-specific presentation. This may be in part due to the possible decline in the teaching of geriatric medicine in UK medical schools[20 131].

Aside from the knowledge of frailty 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 not be readily accessible in the emergency setting and time pressures, not least the four hour emergency care target, may place pressure on staff not to focus on anything other than immediate triage.

A positive attitude to managing frail older people is a pre-requisite for implementing the appropriate knowledge and skills; health care professionals' attitudes towards frail older people could be better, and ageism remains a problem in the health system[21-23].

It follows that because the nature of the assessment and care for older people is multi-disciplinary, the principles of joint training for all professionals should be considered where appropriate.

Skills and competencies

Generic

- Communication skills, often under challenging conditions e.g. to take a detailed history from the patient, ability to explain things in more than one way, give encouragement
- Listening skills
- Compassion, empathy and respect
- Clinical reasoning and assessment skills
- Time/patience and the ability to build a rapport/relationship quickly
- Awareness of community services
- Risk assessment/management skills surrounding discharge planning
- Multidisciplinary team working skills
- Personal care training skills
- Moving and handling skills
- Basic life support skills
- Ability to balance contrasting needs of a complex patient

Additional training and development of staff in managing frail older people

Comprehensive training of staff managing care of older people in the emergency settings is paramount to safe and effective delivery of care. This should not be restricted to medical staff, but all health care agencies, social services and community teams involved in older peoples' care. Where ever possible and appropriate, this training should be undertaken jointly.

The silver book

British Geriatrics society best practice guide 2008[132] elaborates on the care of the older person in the ED. It focuses on patient-centered care and equity of access to full range of investigations and treatment. Particular emphasis is placed on information giving to older people and carers, effective management plans, consideration of advance care planning, dignity, end of life care, cognitive assessments and palliative care. Where older people need to be admitted, local providers should ensure prompt assessment, management plan and fast tracking of older people with fracture neck of femur, stroke and multidisciplinary assessment and care planning including discharge planning and intermediate care facilities. Specialist areas will also include assessment for falls, rapid assessment geriatric clinic, day hospital, and TIA (transient ischaemic attack) clinics as part of comprehensive geriatric assessment and may include a combination of medical, nursing, physiotherapists, occupational therapists, social worker, specialist nursing and therapy staff. The multidisciplinary team should also be aware of Department of Health guidance on care pathways for older people with complex health needs[133].

Medical staff

Doctors in training follow a defined curriculum dependent on their grade and specialism, with defined learning objectives as outlined in their learning portfolio, knowledge skills and work based assessments through a competency based curriculum approved by the General Medical Council and the guidance provided in the Gold Guide. Senior staff should regularly update their skills in aspects of care of older people[132]. Training of nurses, doctors and allied health professionalsshould include skills, knowledge and attitudes in relation to:

- Assessments, particularly mental state, cognitive assessments and functional ability
- Updated clinical practice guidelines
- Local operational policies on assessment and management of the older person

Background in Emergency Medicine

- Post-registration modules for emergency care doctors, nurses and allied health professionals should include sessions on the needs of the older person accessing emergency care which includes the aging process, dementia, delirium, falls and frailty
- Emergency Nurse Practitioner/Advanced Nurse Practitioner/Advanced Clinical Practitioner/Physician Assistant/Consultant Allied Health Professional awards should also include the content outlined above; this is especially important as they may be the only clinician to assess, plan and implement care for the older patient
- Clinical advocates for the older patient in emergency care should provide clinical updates to ED staff as and when necessary, e.g. following the publication of relevant guidelines.
- There should be an emergency care network of such clinical advocates in order to share information and develop new initiatives
- Universities and Emergency Departments should consider asking older service users to provide input to any education and training provided

Background in geriatric medicine

Geriatricians should be well trained in the clinical assessment and management of frail older people, but may be unfamiliar with the specific challenges of working within an emergency department.

Areas that may need additional training include:

- System based risk assessment
- Handover and communication in a full-shift system
- Structured assessment of older people with trauma including hip fractures, head injury and poly trauma

Background in Acute Medicine

For trainees in Acute Medicine the curriculum recommends that in the ST4 or ST5 year there should be at least four months experience of acute geriatric care. Within the specialist skill section of the acute internal medicine curriculum is the opportunity for acute medicine trainees to gain extra competencies in more specialised areas. Trainees have to achieve competences that are prescribed by the relevant supervising authorities and among these specialties, and directly relevant to care of frail older people, are stroke medicine and palliative care.

Useful references

Curriculum for Urgent care Common Stem trainees http://www.accsuk.org.uk/curriculumfolder/curriculum.html Curriculum for Core Medical Training http://www.gmc-uk.org/GIM_level_1___May_07.pdf_30346050.pdf Acute medical task force report http://bookshop.rcplondon.ac.uk/contents/pub235-b42eb97d-209b-4ecd-9127-ef95cc21c819.pdf

Nursing

The recent Health Service Ombudsman's[2] report tells the stories of ten people over the age of 65, from all walks of life and from across England. Friends and families described them variously as loving partners, parents and grandparents. Many of them were people with energy and vitality, active in their retirement and well known and liked within their communities. They had in common experiences of suffering unnecessary pain, indignity and distress while in the care of the NHS. Poor care or badly managed medication contributed to their deteriorating health, as they were transformed from alert and able individuals to people who were dehydrated, malnourished or unable to communicate. As one relative reported: 'Our dad was not treated as a capable man in ill-health, but as someone whom staff could not have cared less whether he lived or died'.

Patients attending the emergency department come with a multitude of nursing care needs ranging from minor injuries and illness through to life threatening conditions. In addition to physical needs, the patient has psychological, social and emotional needs that can often require highly skilled nursing interventions. Often, relatives and friends of older people may also have needs whilst attending Urgent Care Services. Nurses provide continuity to all aspects of care; it is essential that the quality of nursing care should be of the highest standards.

The Essence of Care[134] benchmarks launched by the Department of Health in 2010 include bladder, bowel & continence care, nutrition, prevention and management of pain, personal hygiene, pressure ulcer prevention and care, respect and dignity, safety and communication. The Royal College of Nursing recently launched the Principles of Nursing Practice (2010). Developed in partnership with patient and user organisations; the Department of Health (DH) and The Nursing and Midwifery Council (NMC), they describe what patients and service users can expect from nursing services (in any setting) and from those providing their nursing care - be it from a Registrant, Health Care Assistant, or a Nursing Student.

The Principles underpin practice with patients' expectations and rights to be autonomous, treated equally and fairly and treated with dignity and respect. To put it simply, the Principles of Nursing Practice describe what everyone can expect from nursing.

Appendix 5 provides a summary of the Essence of Care benchmarks which should be used in conjunction with the Principles of Nursing Practice when planning and implementing nursing care for Older Persons in Acute Hospital settings.

Useful references

http://www.rcn.org.uk/development/practice/principles/the_principles

Physiotherapy

Within the acute geriatric setting, physiotherapists should have all the general skills expected in terms of communication and clinical reasoning together with an understanding of the hospital organisation and community services available. Therapists would be expected to have advanced skills in risk assessment and assessment of mental capacity and common presentations in older people such as falls, delirium, dementia, malnutrition, fragility fractures etc. Due to the nature of the acute assessment, including home visits, physiotherapists will often be working alone and as such they will need to be competent and confident in making safe and effective decisions with the patient. Knowledge of the complexity of health and social needs and an ability to constructively liaise with other professions and agencies to meet the needs of the patient is essential. Physiotherapists often work alongside occupational therapists, and other health care professionals, triaging older people in an urgent care situation or at the emergency department.

Therapists need to demonstrate their own professional development and may be asked to present this to the Health Professions Council if requested. Advanced courses are available to physiotherapists choosing to specialise in geriatrics and acute healthcare.

Useful references

CSP (2010) Developing a CSP vision for the future of Physiotherapy: draft materials. Available at:

http://www.csp.org.uk/uploads/documents/csp_vision_-2010.pdf

Scottish qualifications website with specific information on falls and fractures not specifically therapy related

http://www.sqa.org.uk/sqa/46010.html

PGCert in falls and osteoporosis management

http://www.derby.ac.uk/osteoporosis-and-falls-management-pg-cert

Masters in Gerontology

http://www.educaedu.co.uk/msc-gerontological-practice-masters-19433.html

Occupational therapy

Undergraduate occupational therapy training gives a sound basis for working with frail older people. Many older people attend emergency departments with medical problems which affect their ability to carry out their usual activities of daily living, such as using the toilet or getting in and out of bed[135-137]. In some cases this results in older people staying in hospital for longer than their medical condition alone would require. This can be detrimental to older peoples' recovery by increasing their dependence and delaying their transfer back to the community but also results in additional health care costs whilst they receive rehabilitation or arrangements for support at home.

Recognising the complex needs of older adults attending ED many hospitals now employ occupational therapists to work in the ED. Occupational therapists are able to provide assessment for functional and social needs and provide the equipment and support

required, thus preventing unnecessary admissions for older people.

The added expertise and involvement of occupational therapists in reablement teams contribute to successful reablement services as they have extensive knowledge and understanding of the equipment and adaptations that are a major part of reablement services[138]). Occupational therapists are well placed to provide enhanced training to home care staff to deliver efficient and effective reablement services[139].

Useful references

College of Occupational Therapists http://www.cot.co.uk/.

College of Occupational Therapists Specialist Section - Older People http://www.cot.co.uk/cotss-older-people/cot-ss-older-people

Masters in gerontology http://www.educaedu.co.uk/masters/gerontology

Reablement evidence: http://www.scie.org.uk/publications/ataglance/ataglance46.asp

Chapter 7 Major incidents involving older people

Numerous factors need to be considered when planning major incident and disaster preparedness. Frail older people, those with serious physical, cognitive, economic, and psycho-social problems, are at especially high risk[140].

The vulnerability of older people to disasters and in any major incident situation in whatever setting is related to their impaired physical mobility, diminished sensory awareness, chronic health conditions, and social and economic limitations that hinder their alacrity and adaptability in a major incident or emergency situation. In the UK whilst the number of older people who have been immediate casualties in a major incident is low there is a significant challenge in evacuating emergency departments in order to receive new casualties, particularly when the older people to be evacuated have impaired cognitive function and mobility problems. In recent years extremes of weather have caused a number of natural disasters such as flooding and heat waves which have resulted in significant rises in ED attendances and in many cases deaths[141 142]. Natural disasters may be relatively rare but the impact can be devastating and far reaching. It is notable that of the 1,330 people known to have perished in Hurricane Katrina in America in 2005, 71% were over the age of 60 and 47% were older than 75 years and at least 68 people died in nursing homes. Whilst such extreme natural disasters are unlikely in the UK, a fire in a residential home would pose significant challenges for the emergency services in the community as well as in the hospital setting. Making specific provision for the vulnerable in Major Incident plans is not only prudent but essential to preserve life.

Chapter 8 Information sharing

The importance of data in the care of older people

The emergency care workload has increased over the years and the percentage of older people presenting has increased, but this increase in complexity has been poorly documented in the UK. Unfortunately, without data to demonstrate good quality and/or gaps in service provision, it is impossible to plan or run medical services effectively: UK Emergency Care has been highly deficient in this regard. Good quality diagnostic data about older people presentation, diagnosis and treatment is vital to inform service provision, audit and research.

Diagnostic data should be collected in a standardised format e.g. the CEM Unified Diagnostic DAtaset (UDDA) (http://secure.collemergencymed.ac.uk/Shop-Floor/Informatics/CEM%20Unified%20Diagnostic%20Dataset%20(UDDA)/).

Older people attending for urgent care may not be able to communicate details about their health, social care and wishes for treatment which may be recorded in mental health trust and social services records.

Emergency Department Information Systems should have the ability to exchange data about older people with other systems, especially primary care as this reduces the risk of prescribing errors.

It is essential to share adequate and appropriate information between services to facilitate health and social care management and address safeguarding issues.

A minimum dataset, such as a Summary Care Record, will facilitate such information gathering and sharing.

This needs to include certain essentials:

- Demographic details including next of kin
- Special needs requirements – medical and social
- Communication of medical and social situation including treatment history and results of recent salient investigations
- Results of recent diagnostic tests including copies of ECGs
- Advance decisions to refuse treatment
- Proxy decision makers – attorneys, deputies, guardians etc. This information can be obtained from the Offices of the Public Guardians

Such information may be made available as 'Patient held record' as in hand-held files in care home residents that include copies of MARR sheets and are updated after important interventions.

Developments such as datasets may help define activity and casemix more specifically although the critical challenge of coding frailty remains to be solved.

Possible data fields to agree sharing a across organisations

Who?

- Primary Care
- Secondary Care, including Mental Health
- Local Authorities

Sharing What?

- Demographic details
- Next of Kin
- Allergies

- Child protection/Vulnerable adult alerts
- Care provision

With limited access rights to selected appropriate users only:

- Diagnoses
- Most recent care plan
- Care co-ordinator
- Child protection/vulnerable adult information
- Medications

How?

- Agreed information sharing policies and protocols
- Agreed information sharing datasets and information architecture (e.g. read only access, shared IT platform, database access etc.)

Chapter 9 Clinical Governance and Research

Clinical governance

Guidelines are important for quality improvement, but will be ineffective unless supported by change management techniques and clinical champions.

Clinical audit is another key component of quality improvement. It provides a review of existing practice or performance against standards, ideally from evidence-based or expert-derived guidelines. Areas for improvement are then identified before changes are recommended and, hopefully, implemented. Further audit cycles can demonstrate both where improvements have been made and where work is still needed. There is good evidence that repeated audit, local or national, can lead to progressive and sustained improvements in clinical care and older people outcome.

Audit may be periodic or continuous, depending on the nature of the condition or process being measured, and the level of detail required. Periodic audit, i.e. audits where each cycle is separated in time from the next, are the most common type. For example, the National Sentinel Stroke Audit has competed 7 detailed cycles of audit over more than a decade and has seen the universal introduction of stroke units, amongst many improvements. Continuous audits, such as the National Hip Fracture Database, collect relatively small amounts of information on all older people, providing near-real time data, benchmarked against other hospitals. This has proved a powerful lever for change for better hip fracture services in many hospitals. Locally, a continuous audit could collect daily data on time to first analgesia, reported back to the clinical team on a weekly basis. This would rapidly lead to reductions in delays in older people receiving pain relief.

The National Clinical Audit and Patient Outcomes Programme is funded centrally by the Department of Health and administered by the Healthcare Quality Improvement Partnership (HQIP). It currently includes the following national audits relevant to the urgent care of older people:

- National Sentinel Stroke Audit
- National Audit of Falls and Bone Health in Older People (NAFBH)
- National Hip Fracture Database (NHFD)
- National Audit of Continence Care
- Myocardial Ischaemia National Audit Project (MINAP)

In addition, there is the Stroke Improvement National Audit Programme (SINAP), which is a continuous audit of acute stroke treatment, including thrombolysis, and outcome. From 2012, the NHFD and NAFBH will be combined in a new falls and fragility fracture audit programme. It is hoped that one or more new national audits, relevant to other aspects of emergency care of older people, will be commissioned following the publication of this report.

It is recommended that providers of urgent care introduce regular local audit of the emergency care and outcomes of older people. The key audit standards, as recommended in this report, are detailed below.

Audit standards

The key audit standards mapping to each of the main recommendations are proposed here. Some of these audit standards could be managed systematically; others will need to be assessed using spot audits.

Organisational audit standard (2.1) – There is a local policy or procedure that specifies a primary care response to an urgent request from an older person within 30 minutes.

Organisational audit standard (2.2) – There is local audit of primary care response time at least annually.

Clinical audit standard (2c.1) – Percentage of older people receiving a primary care response within 30 minutes of urgent request

Organisational audit standard (3.1) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for pain using a standardised pain score.

Clinical audit standard (3c.1.1) – Percentage of older people accessing urgent care with evidence of assessment for pain using a standardised pain score within 15 minutes of first contact.

Clinical audit standard (3c.1.2) – Percentage of older people accessing urgent care with evidence of assessment for pain using a standardised pain score within 15 minutes of first contact.

Clinical audit standard (3c.1.3) – Percentage of older people unable to express pain who have pain assessed using a standardised tool.

Organisational audit standard (3.2.1) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for cognitive impairment using a validated tool (AMT4, AMT10, MMSE).

Organisational audit standard (3.2.2) – There is a local policy or procedure that requires all older people with cognitive impairment to be assessed for delirium using a standardised tool (CAM, 4AT (http://www.the4at.com/)).

Clinical audit standard (3c.2.1) – Percentage of older people accessing urgent care with evidence of assessment for cognitive impairment using a validated tool within 4 hours of first contact.

Clinical audit standard (3c.2.2) – Percentage of older people accessing urgent care with evidence of assessment for delirium using a standardised tool within 4 hours of first contact.

Organisational audit standard (3.3) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for depression using a validated tool (e.g. GDS).

Clinical audit standard (3c.3) – Percentage of older people accessing urgent care with evidence of assessment for depression using a validated tool (e.g. GDS) within 24 hours of first contact.

Organisational audit standard (3.4) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed of nutrition using a standardised tool (e.g. MUST).

Clinical audit standard (3c.4) – Percentage of older people accessing urgent care with evidence of assessment of nutrition using a standardised tool (e.g. MUST) within 4 hours of first contact.

Organisational audit standard (3.5) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for skin integrity and risk of pressure sores using a standardised tool (e.g. Waterlow).

Clinical audit standard (3c.5) – Percentage of older people accessing urgent care with evidence of assessment for skin integrity and risk of pressure sores using a standardised tool (e.g. Waterlow) within 4 hours of first contact.

Organisational audit standard (3.6.1) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for hearing impairment.

Organisational audit standard (3.6.2) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for vision impairment.

Clinical audit standard (3c.6.1) – Percentage of older people accessing urgent care with evidence of assessment for hearing impairment within 4 hours of first contact.

Clinical audit standard (3c.6.2) – Percentage of older people accessing urgent care with evidence of assessment for vision impairment within 4 hours of first contact.

Organisational audit standard (3.7) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for falls risk, including a minimum of asking about

a history of falls in the previous 12 months and basic assessment of gait and balance (e.g. Timed Up and Go test).

Clinical audit standard (3c.7.1) – Percentage of older people accessing urgent care with evidence of assessment for a history of falls within 4 hours of first contact.

Clinical audit standard (3c.7.2) – Percentage of older people accessing urgent care with evidence of assessment of mobility (either by a standardised tool such as Timed Up and Go test, or documented observation of patient walking) within 4 hours of first contact.

Organisational audit standard (3.8) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for problems with activities of daily living.

Clinical audit standard (3c.8) - Percentage of older people accessing urgent care with evidence of assessment of activities of daily living using a standardised tool (e.g. Barthel) within 4 hours of first contact.

Organisational audit standard (3.9.1) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for urinary problems.

Organisational audit standard (3.9.2) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for bowel problems.

Clinical audit standard (3c.9.1) – Percentage of older people accessing urgent care with evidence of assessment for urinary problems within 4 hours of first contact.

Clinical audit standard (3c.9.2) – Percentage of older people accessing urgent care with evidence of assessment for bowel problems within 4 hours of first contact.

Organisational audit standard (3.10) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for vital signs (level of consciousness, temperature, pulse, blood pressure, respiratory rate).

Clinical audit standard (3c.10) – Percentage of older people accessing urgent care with evidence of assessment of vital signs (level of consciousness, temperature, pulse, blood pressure and respiratory rate within 15 minutes of first contact.

Clinical audit standard (3c.11) Percentage of older people, identified as requiring end of life care, with a documented preferred place of care.

Clinical audit standard (3c.12) Percentage of older people, identified as requiring end of life care, that die in their preferred place of care, or at home if no place of care identified.

Organisational audit standard (4.1) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for the presence of frailty syndromes (falls, immobility, incontinence, confusion).

Organisational audit standard (4.2) - There is a local policy or procedure that requires comprehensive geriatric assessment of all older people accessing urgent care that have been identified as presenting with one or more frailty syndromes (falls, immobility, incontinence, confusion).

Organisational audit standard (4.3) – there is evidence of local commissioning of multidisciplinary geriatric services that can contribute towards early CGA across primary and secondary care.

Clinical audit standard (4c.1) – Percentage of older people accessing urgent care with evidence of assessment for the presence of frailty syndromes within 4 hours of first contact.

Clinical audit standard (4c.2) – Percentage of older people accessing urgent care and presenting with evidence of any frailty syndromes (from standard 4c.1) that receive comprehensive geriatric assessment commencing within 4 hours of first contact.

Clinical audit standard (5c.1) – Percentage of older people accessing urgent care and presenting with evidence of any frailty syndromes (from standard 4c.1) that receive comprehensive geriatric assessment commencing within 4 hours if admitted to hospital.

Organisational audit standard (8.1) – There is a local policy or procedure that recommends assessment for falls risk factors of all older people presenting to healthcare services following a fall.

Organisational audit standard (8.2) – There is a local falls service that includes multifactorial falls risk factor assessment and management, including medication review, and access to therapeutic falls prevention exercise (Otago and/or FaME programmes).

Organisational audit standard (8.3) – There is a pathway for older people presenting to urgent care following a fall to be referred to the local falls service.

Clinical audit standard (8c.1) – Percentage of older people presenting to urgent care following a fall that have a record of further assessment of reversible causes for falls including, as a minimum, assessment of gait and balance, lying and standing blood pressure, medication review – within 4 hours of presentation.

Clinical audit standard (8c.2) – Percentage of older people presenting to urgent care with a history of 2 or more falls in the last 12 months, or a single injurious fall, that are referred to a local fall service.

Organisational audit standard (9.1) – There is a local fracture liaison service.

Clinical audit standard (9c.1) – Percentage of older people presenting to urgent care with a fragility fracture who are referred to a fracture liaison service.

Organisational audit standard (10.1) – There is a local policy that older people are discharged to their normal residence within 24 hours unless continuing hospital treatment in necessary.

Organisational audit standard (10.2) – There is a local service specification that enables older people to be discharged to their normal residence within 24 hours, 7 days a week, with increased care or support at home if required.

Clinical audit standard (10c.1) – Percentage of older people discharged to their normal residence within 24 hours of acute presentation to hospital. (Note – the target for this cannot be 100%, but will allow benchmarking within sites over time, or between comparable sites)

Local services are also encouraged to audit periodically a random sample of case notes of older patients who were admitted or readmitted for between 24 hours and 7 days to identify where improvements in rapid safe discharge can be made.

Organisational audit standard (11.1) – There is a locally commissioned single point of access (SPA) and directory of services (DOS) linked to consistent clinical content (e.g. NHS Pathways, Map of Medicine).

Organisational audit standard (11.2) – There is a quarterly audit of SPA response times and referral accuracy.

Organisational audit standard (12.1) – There is a locally commissioned rapid response team, or equivalent, that includes nursing, occupational therapy, physiotherapy, mental health and social services. The team should provide 24 hour access 7 days/week and respond within 12 hours of referral via SPA.

Organisational audit standard (12.2) – There is a quarterly audit of the team's response times.

Clinical audit standard (12c.1) – Percentage of SPA referrals that are triaged to a rapid response team, or equivalent, and assessment by a team member commences within 2 hours (14 hours overnight) of contact with SPA.

Organisational audit standard (13.1) – There is a local policy or procedure whereby all older people who present with self-harm are assessed for on-going risk of further self-harm during transportation, whilst in ED and whilst in hospital. (Note - Not all settings will apply to all

services, and older adults should be considered to have suicidal intent until assessed and proved otherwise)

Clinical audit standard (13c.1) – Percentage of older adults presenting acutely with self-harm that are assessed by senior decision maker of the mental health team.

Organisational audit standard (13.1) – There is a local policy or procedure whereby all older people who present with unintentional self-harm are assessed for on-going risk of further self-harm prior to discharge.

Whole system metrics

- Proportion of urgent care encounters in primary care leading to a hospital attendance and separately hospital admission in people aged 65+/75+/85+
- ED attendance and re-attendance rate per 1000 population of 65+/75+/85+
- Emergency department conversion rate for people aged 65+/75+/85+ per 1000 population
- Hospital readmission rates for people aged 65+/75+/85+ and ED re-attendance rate for same group
- Rates of long term care use at 90 days post-discharge following ED attendance and discharge from hospital for people aged 65+/75+/85+
- Mortality rate per 1000 in the 65+/75+ and 85+
- Patient and/or carer satisfaction survey

Research in geriatric emergency care

There is an embarrassing paucity of research into the needs of frail older people in general, and hardly any directly relevant research addressing urgent care. The reasons for this mismatch in research versus population needs are partly historical, but also related to some of the difficulties in recruiting frail older people into research studies. Possible barriers include patient reluctance, and fears of being a 'guinea pig', difficulties recruiting people without capacity and the challenges of loss to follow up in a population with inherently high rates of mortality. There is the additional complexity and challenge of conducting service related research (e.g. testing a new unit or multidisciplinary team) in contrast to condition specific research (e.g. aspirin in stroke) where human factors may be multiple and funding bodies are generally more cautious.

None of these barriers are insurmountable – for example, greater public awareness about research can change perceptions, recent developments in ethical regulations and the Mental Capacity Act have clarified the procedures to recruit people without capacity[129], and newer outcome measures are being developed that address the issues of loss to follow up[143].

Changes in national research funding mechanism, specifically the introduction of research funding streams such as the National Institute of Health Research (NIHR) 'Research for Patient Benefit' and 'Programme Grants for Applied Research' have increased the amount of funding available to deliver high quality research that has direct relevance to the needs of the NHS. Notably, recent NIHR calls have focussed on dementia, a hitherto much neglected are of research.

The challenge for the research community interested in frail older people is to develop sufficient expertise, quality and critical mass to take advantage of the research infrastructure now in place. Given the dearth of research on the urgent care needs of frail older people, there is considerable scope to develop a substantial body of work addressing this issue. This is likely to need to start with developing an in-depth understanding of the issues, from the patient, carer, professional and system perspective. Once this is achieved, then there is a need for high quality randomised studies that test different models and systems of care, which must also include measures of cost-effectiveness.

The silver book

Chapter 10 Commissioning urgent and emergency care for older people

Commissioning urgent and emergency care services for older people merits a strategic approach which is:

- needs led based on local prevalence of health and social care related issues
- patient and public centred
- commissioner led
- developed in conjunction with providers based on locally available resources
- supporting innovation while delivering evidence based intervention
- focus on improving clinical outcomes through "service integration" between primary and secondary care and health and social care

Service planning and delivery needs to strategically align Emergency Physicians, Geriatricians, General Practitioners and social care with multidisciplinary teams in hospital and in the community together with timely information to deliver these outcomes from the moment that an older person presents to the Emergency Department. The combination not only provides the optimal blend of expertise to provide the right clinical risk assessment and management for the older person who attends the Emergency Department but also to develop systems to reduce the need for these and other older people attending in the future.

Commissioning evidence based integrated health and social care systems that address care across the continuum will help deliver safe, efficient, effective and a high quality care for frail older people in the years to come.

See: http://www.rcgp.org.uk/pdf/Urgent_emergency_care_whole_system_approach.pdf

Appendices

Appendix 1 Sample business case for an emergency frailty unit – Leicester Leicestershire & Rutland

Aims and Objectives

The aim of this project is to improve care for frail older people throughout Leicester, Leicestershire and Rutland (LLR), by delivering Comprehensive Geriatric Assessment for frail older people at the time of a medical crisis. The objectives are:

- To establish a team of 'interface geriatricians' who will actively manage frail older people at the 'front door' and in the community around the time of a medical crisis
- Improved seamless, efficient, and effective care for frail older people, measured by death rates, hospital admission and re-admissions rates, and patient satisfaction

Proposal – the intervention

To establish a team of interface geriatricians, whose role will be to assess and manage frail older people attending the Emergency department (ED) or the Acute Medical Unit (AMU) at the Leicester Royal Infirmary. The role of the interface geriatricians will to deliver specialist geriatric assessment at the key interfaces between acute and community care, namely the emergency department (including the emergency decisions unit), and the acute medical unit. The posts could be extended to cover community hospitals and intermediate care services, with the initial contact in the urgent care setting being followed up if necessary in the community setting, either by means of a clinic appointment of home visit. The geriatric assessment will be in addition to current services, which include a multidisciplinary assessment and access to community matrons.

Ultimately the new 'interface geriatrician' will have acute and community responsibilities and will be locality based, ensuring that they get to know and be known by already established teams. There will be a greater reliance on personal communication between practitioners rather than policies and protocols. The vision is that it will be easy and natural for a primary care professional to pick up the phone and discuss a patient rather than arrange an emergency admission. Urgent referrals can be seen on the same day in the emergency frailty unit, but those that are more stable can be seen on the next day in the community sessions.

The impact of the interface geriatrician will be on both UHL and PCTs – by reducing inappropriate admissions to hospital through front door assessments and community assessments (cost saving for PCT) and also by providing efficiency savings within UHL (earlier, rapid coordinated discharges from acute settings). Pilot data suggest that up to 25% of frail older people could be safely and appropriately turned around within the Emergency Department or the acute medical unit – so avoiding hospital admissions for some and reducing the length of stay for others. The impact of specialist geriatric care on the AMU has been a doubling of discharge rates without any increase in 30 or 90 day readmission rates for complex older patients.

To achieve this we will need to ensure the existing geriatric team can support the service initially in ED whilst reviewing other medical appointments in order to prioritise the use of existing funding. The longer term plan to ensure roll out into the community would be to work to provide a team of:

- 4 WTE consultant geriatricians dedicated to support the AFU and ED, with a reciprocal role in one community based locality.
- 1 WTE secretary to act as a central point of contact and provide administrative support

In the first instance we are seeking to provide one interface geriatrician to pilot the scheme. This is in the context of a pilot utilising existing resource and budgets whilst acknowledging the current financial climate.

Health issues or issues for patients

There is robust evidence supporting Comprehensive Geriatric Assessment (CGA) as an effective intervention to improve the quality of care for frail older people settings. Benefits have been shown in both hospital and community settings, including care homes, in a variety of countries. CGA involves a multidisciplinary team, including a specialist geriatric medical component, assessing and arranging interventions for patients. When applied successfully, this can improve survival and functional ability, and reduce institutionalisation - and we thereby infer, improve quality of life.

CGA reduces hospital admissions and readmissions when applied effectively; local data has shown a doubling of appropriate discharges from the AMU. The consequences of unnecessary (and often unwanted) hospital admissions for frail older people are significant, and include functional decline, increased risk of falls, delirium and other iatrogenic complications, as well as an increased risk of institutionalisation. Often, community services (community hospitals or intermediate care schemes) providing an appropriate service focusing on rehabilitation have better outcomes, increasing the proportion of people retaining their independence, without any adverse impact upon satisfaction or carer burden.

Strategic relevance

The care of frail older people has changed dramatically over the last 10-15 years. Previously, much acute care and the ongoing rehabilitation of older people was delivered in acute hospital settings. Now, acute hospital care is over very short time periods, with on-going care and rehabilitation being provided in a variety of community settings. These settings include intermediate care schemes (home based or residential) and community hospitals.

Some older patients with complex needs who would previously been managed in hospitals by geriatricians, may not receive a specialist geriatric assessment even though they may still access other aspects of comprehensive geriatric care (physiotherapy, occupational therapy etc).

The optimal model of care which brings together acute and community geriatric care is not well established, but better liaison between acute and community services is one key aspect which we are seeking to address in this project.

The importance of getting care for frail older people right cannot be underestimated; they are major users of hospital services and the most rapidly growing proportion of society. Excellence in the care of older people is not an option – it is the core business of the NHS.

Funding

These estimates are based on UHL data for patients aged 70+ with an HRG code including 99 – complex. The estimates are conservative, not least because the service as described would not be 24/7, but in mitigation, it is likely that the interface geriatricians would have an impact on a wider range of patients than just those coded as HRG 99. For example, 17% of the 150,000 (25,500) ED attendees each year are aged 65+, and there are 6000 fallers who attend each year, many of whom might benefit from geriatric input.

Supporting evidence for this intervention comes from pilot work already undertaken in the Acute Frailty Unit at the LRI. Approximately 1800 frail older people are admitted to the AMU at the LRI annually. We anticipate preventing about half of the 20% of unnecessary AMU admissions within the emergency department (20% of all complex older patients are discharged within 24 hours).

Only 8% of frail older people were discharged direct from AMU in 2009. 30 day readmission rates were 24%, and 90 day readmission rates were 35%. Pilot work on the acute frailty unit with limited geriatric input has shown a reduction in 30 day readmission rates from 24% to 18% (25% relative risk reduction). Additional savings can be anticipated by increasing the discharge rate from AMU; this is currently 8%, having increased in 2009 from a historical 5%

baseline for all complex older patients in AMU. For patients in the AFU, with geriatric input 3 mornings per week, the discharge rate is 9%; with a more robust team in place, we estimate an increase in the discharge rate from all complex older patients across the AMU from 8% to at least 10%. By combining the acute work with a short term geriatric outreach element, we can also anticipate reducing 90 day readmissions (over and above 30 day readmissions).

The actual projected savings from this project are based on proposed activity. A geriatrician working in the ED should be able to see at least eight frail older patients in a four hour shift - two geriatricians would see sixteen over eight hours. Based on the pilot data outlined above, approximately 25% should be discharged home who would otherwise have been admitted.

Table 3 Projected admissions avoidance

Benefit from interface geriatrician presence in ED		
Geriatrician activity		
Geriatrician shift in ED	8	Hours
Patients seen in shift who have been referred to AMU	16	
Shifts per week	5	
Shift per annum	260	
Patients seen in ED per annum	4160	
Proportion of patients seen not admitted	25%	
Admissions avoided	1040	
Benefit from interface geriatrician in AMU		
Complex elderly admitted to AMU	1600	
Die in AMU	8%	
Currently discharged from AMU	8%	
Complex elderly admitted to base ward	84%	
Discharge rate with geriatrician presence on AMU	10%	
Complex elderly admitted to base ward	82%	
Avoided admissions to base ward	32	
LOS for complex older people		
Average LOS days	11	
Occupancy	90%	

NB. The above acknowledges that as the EFU starts to reduce the number of complex older people attending the AMU, the opportunity to discharge appropriately from the AMU will diminish.

Table 4 Projected cost savings

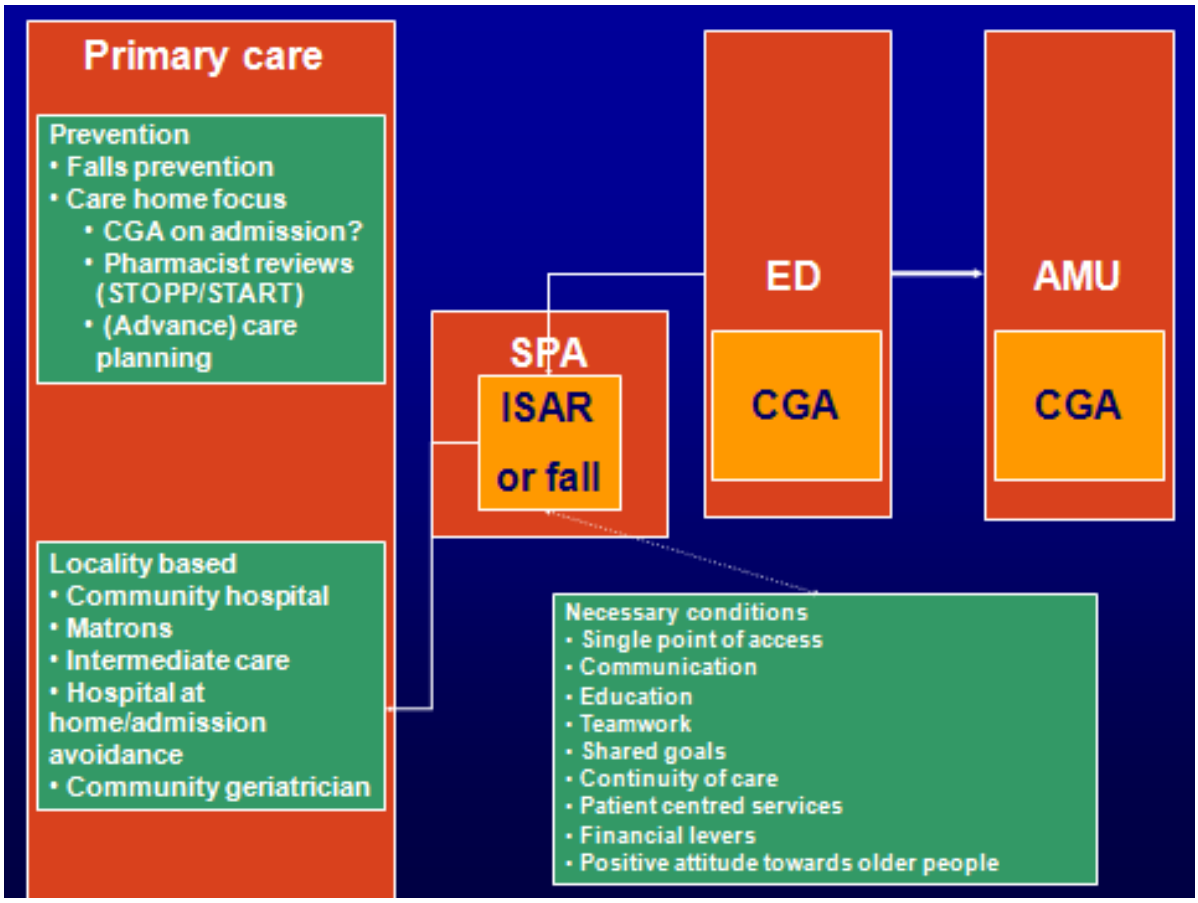
Admissions avoided							
Admissions to AMU avoided		1,040					
Admissions from AMU to base ward avoided		32					
Bed day benefits							
		Admissions	Avg LoS	Bed days	Beds	Cost / bed day, £	Saving £'000
Admissions to AMU avoided		1,040	2	2,080	6		346
	Stay in AMU		*1*	*1,040*	*3*	*227*	*236*
	Stay on base ward		*1*	*1,040*	*3*	*106*	*110*
Admissions from AMU to base ward avoided		32	11	352	1	106	37
Totals		**1,072**		**4,512**	**7**		**383**

Post		**2010 £000s**	**2011 £000s**
Consultant (existing)	1.0	125	125
TOTAL		125	125
Funding (see tables 1&2)		383	383
Surplus		258	258

Appendix 2 Whole system approach to managing frail older people

Figure 4 highlights some of the activities in primary care that can promote health and potentially reduce crises. This may include for example, Advance Care Planning[144] and appropriate prescribing (for example using the STOPP/START tool[96 107 108 145 146]), amongst other interventions. However, it acknowledges that crises will occur and that frail older people will still need to access urgent care. The ISAR tool[147] can be used to identify people at risk of adverse outcome being sent home from the Emergency Department, so that they can access long term conditions services, such as case managers[147-150].

Figure 4 Whole system approach to managing frail older people



STOPP/START - Screening Tool of Older Persons potentially inappropriate Prescriptions/Screening Tool to Alert doctors to the Right Treatment

SPA – Single Point of Access

ISAR – Identification of Seniors At Risk tool

CGA – Comprehensive Geriatric Assessment

A key component of the model is the presence of geriatricians and MDT in the Emergency Department. Whilst a full assessment may not be possible, early appropriate decision making may identify more older people who could be managed in the community setting. In order for discharge from ED to be safe, there needs to be provision in the community for on-going management – hence the locality teams.

One of the challenges is delivering CGA in acute medical units, with rapid turnover of older people and staff. Whilst the evidence base does not generally support liaison services[40 151], it maybe that in the AMU, such a service is necessary[59].

Appendix 3 Identification of Seniors At Risk tool

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

A score greater than 1 suggests increased risk of severe functional impairment, frequent hospitalisation and depression over the following six months; in this case please

- *Ask a Primary Care Coordinator to review (if one is available)*
- *Inform GP*

Number of questions answered with YES ☐

Appendix 4 AMT-4 short cognitive assessment tool

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 ☐

Appendix 5 Essence of Care benchmarks

Number	Standard	Key Outcome	Domain	Description	Relevant Tools
1	**Bladder, Bowel & Continence Care**	People's bladder and bowel care needs are met.	**Screening and assessment** **Planning, implementation, evaluation and revision of care** **Environment**	Older people receive bladder and bowel continence screening and assessment on initial contact Care is planned, implemented, continuously evaluated and revised to meet individual bladder and bowel care and preferences. All bladder and bowel care is given in an environment appropriate to *patient's* needs and preferences	
2	**Food and Drink**	People are enabled to consume food and drink (orally) which meets their needs and preferences.	**Screening and assessment** **Planning, implementation, evaluation and revision of care** **Availability** **Presentation** **Assistance**	*Older people* are screened on initial contact and those identified at risk receive a full nutritional assessment Care is planned, implemented, continuously evaluated and revised to meet individual needs and preferences for food and drink. *Older people* can access food and drink at a time according to their needs and preferences *F*ood and drink is presented in a way that is appealing to them *Older people* receive the care and assistance they require with eating and drinking *F*ood and drink intake is monitored and recorded	British Association for Parenteral and Enteral Nutrition "MUST" Screening Tool. http://www.bapen.org.uk/pdfs/must/must_full.pdf

			Monitoring		
3	**Prevention and Management of Pain**	People experience individualised, timely and supportive care that anticipates, recognises and manages pain and optimises function and quality of life.	**Assessment** **Care planning, intervention, evaluation, review and prevention**	Older people have an initial assessment within 15 minutes of arrival and ongoing, comprehensive assessment of their pain. *Older people* individualised care concerning pain that is planned, implemented, continuously evaluated and revised in partnership with *people*, staff and carers	Royal College of Physicians, British Geriatrics Society and British Pain Society. *The assessment of pain in older people: national guidelines*. Concise guidance to good practice series, No 8. London: RCP, 2007 Appendices 2/3/4
4	**Personal Hygiene**	People's personal hygiene needs and preferences are met according to their individual and clinical needs.	**Assessment** **Assistance**	Older people are assessed to identify the advice and/or care required to maintain and promote their personal hygiene. Older people receive the care and assistance they require to meet personal hygiene needs and preferences.	
5	**Prevention and Management of Pressure**	People experience care that maintains or improves the	**Screening and assessment**	Older people are screened on initial contact and those identified at risk of developing pressure ulcers receive a full assessment of their risk.	RCN Pressure Ulcer Risk Assessment and

	Ulcers	condition of their skin and underlying tissues.	**Planning, implementation, evaluation and revision of care** **Prevention – repositioning** **Prevention – pressure redistribution**	Care is planned, implemented, continuously evaluated and revised to meet their individual needs and preferences concerning pressure ulcer prevention and management *Older people* are repositioned to reduce the risk, and manage the care, of pressure ulcers *Older people* are cared for on pressure redistributing support surfaces to reduce the risk, and manage the care, of pressure ulcers	Prevention. Royal College of Nursing 2003. National Institute for Health and Clinical Excellence. Quick reference guide Sept 2005
6	**Respect and Dignity**	People experience care that is focused upon respect and dignity.	**Attitudes and behaviours** **Personal boundaries and space** **Communication** **Privacy – confidentiality**	*Older people* and carers feel that they matter all of the time *Older people* personal space is protected by staff *Older people* and carers experience effective communication with staff, which respects their individuality *Older people* experience care that maintains their confidentiality *Older people* care ensures their privacy and dignity,	

			Privacy - dignity and modesty	and protects their modesty	
7	**Safety**	People, their carer, visitors and staff feel safe, secure and supported.	**Observation and Privacy** **Planning, implementation, evaluation and revision of care**	*Older people* experience care in an environment that allows safe observation and privacy *Older people* care is planned, implemented, continuously evaluated and revised to meet their safety needs and preferences	
8	**Communication**	People and their carers experience effective communication.	**Interpersonal skills** **Assessment of communication needs** **Information sharing** **Identification**	All staff demonstrate effective interpersonal skills All communication needs are assessed on initial contact and are regularly reassessed. Additional communication support is negotiated and provided when a need is identified or requested Information that is accessible, acceptable, accurate and meets needs is shared actively and consistently with all *people* and carers and widely promoted across all communities When appropriate, the principal carer is identified and an assessment is made with them of their needs, involvement, willingness and ability to collaborate with staff in order to provide care All staff communicates fully and effectively with each	

			and assessment of principal carer **Co-ordination of care** **Empowerment to communicate needs**	other to ensure that older people and carers benefit from a comprehensive and agreed plan of care which is regularly updated and evaluated. *Older people* and carers are enabled to communicate their individual needs and preferences at all times	

Appendix 6 Guidelines on emergency control of the acutely disturbed adult patient

These guidelines are for use when a patient is acutely, and severely, 'disturbed', that is, physically aggressive, or threatening to become so, a danger to him or herself, staff, visitors or other patients, or exhibiting behaviour disruptive to the functioning of the ward, and with a presumed medical or psychiatric cause. Consent is generally required for treatment. If the patient is not competent to give or refuse consent (see notes 1 and 2), act on your judgement of what is in the patient's best interest.

Think of the possibility of a treatable medical cause for the disturbance (e.g. hypoglycaemia, pain, hypoxia, urinary retention).

For guidance only – rigid adherence may not be appropriate. Seek more senior advice, at any stage, if in doubt.

ACTION

1. Use non-drug measures first. Remain calm and do not get angry (it never helps). Avoid direct confrontation and provocation. Find out what is worrying the patient and what they want done about it. Offer to help. Reassure patient that he or she is not going to be harmed. Negotiate a return to room/chair/bed or try distraction (watch TV, have a drink). If necessary, use physical restraint - the minimum practicable for the minimum length of time. Call Security to assist with restraint if required.

2. Offer oral medication, preferably in liquid form, HALOPERIDOL 5 mg, or LORAZEPAM 2 mg (crush tablets and dissolve in a small volume of water). Halve doses if elderly and frail.

3. If rapid, parenteral, sedation with drugs is required look at the table. Use your clinical judgement to decide what category of patient you are dealing with.

Get the patient safely restrained. Give first suggested drug intramuscularly. Wait 20-30 minutes. If no, or inadequate, response give second suggested drug. Repeat these at intervals of 20-30 minutes until control is achieved or maximum dose is reached.

Patient group	**Try first**	**Try second**	**Maximum dose in first 6h**	**NOTES**
Already on depot/regular high dose antipsychotics	Lorazepam 2mg IM	Repeat lorazepam, then try haloperidol 5mg IM	Lorazepam 4mg + Haloperidol 18mg	3-7
Acute alcohol withdrawal	Lorazepam 2mg IM	Repeat	Lorazepam 8mg	3,4,5,8
Frail elderly OR Severe respiratory disease	Haloperidol 2.5mg IM	Lorazepam 1mg IM	Lorazepam 4mg + Haloperidol 10mg	3-7, 9-10
Highly aroused, physically robust, adult	Lorazepam 2mg IM + Haloperidol 5mg IM	Repeat	Lorazepam 4mg + Haloperidol 18mg	3-7,9,10

If control has not been achieved 30 minutes after reaching maximum doses, inform a consultant. Transfer to High Dependency Unit (or resuscitation room if in A&E). Ensure patient is safely restrained, secure IV access and give MIDAZOLAM as intravenous boluses of 1-2mg, at 2 minute intervals, maximum 20mg (see note 11). Monitor respiratory rate, oxygen

saturation and blood pressure. If respiration cannot be maintained at the level of sedation required, call an anaesthetist.

AFTERCARE

Nurse in a light, quiet room. Separate from other patients. Nursing observation should be appropriate to the level of sedation. Nurse in the recovery position, and continue to observe respiratory rate and oxygen saturation. Once awake, offer glasses and hearing aid, if worn.

A diagnosis for the behavioural disturbance must be made, and the underlying cause treated. Consider drugs (including illicit), alcohol, hypoglycaemia, infection, metabolic disturbance, acute neurological disease (including trauma, infections, vascular and space-occupying lesions), pain, urinary retention, constipation. Urgently get a third party history of previous psychiatric problems and previous cognitive function (use the phone; relatives, GP).

Record the treatment given, and the basis of the decisions taken, in the medical notes. Consider the need for starting or increasing regular oral medication before emergency sedation wears off. Be wary, however, of regular sedation without a good explanation of what is going on medically. Review all sedative drugs daily.

BE CAREFUL. READ THE NOTES OVER THE PAGE. YOU MAY BE UNFAMILIAR WITH THE DRUGS USED.

NOTES

1. Capacity for consent requires that an adult (18 years of age or over) can understand the purpose, nature and effects of the proposed treatment, including adverse effects and the consequences of refusal; retain the information; weigh up and make a judgement about it; and communicate a decision. Capacity can be lost temporarily for psychological reasons, including severe anxiety. An adult who does not have capacity to consent can be given medical treatment in an emergency, in their best interests. A parent may consent for a young person under 18. If unavailable, in an emergency proceed in the patient's best interest as for an adult.

2. Sedation must have therapeutic intent, e.g. to prevent harm to the patient, other patients, staff or visitors; to permit the administration of other definitive treatment in the patient's best interest; or to relieve distressing symptoms like psychosis, fear or severe anxiety. If there is doubt, consult a senior colleague or a psychiatrist. A section of the Mental Health Act (1983) may need to be applied, but do not allow this to delay treatment which is immediately necessary. Some conflict situations may be managed best by acceding to the patients demands (e.g. to be allowed to leave hospital).

3. Benzodiazepines depress respiration. FLUMAZENIL should be available. Give if respiratory rate is < 10 breaths/minute (200micrograms IV, then 100microg at 60 second intervals, if required, maximum dose 1mg). It is short-acting and may need repeating or infusing (100-400microg/hour).

4. For IM use, LORAZEPAM should be diluted with an equal volume of water for injection or 0.9% NaCl, immediately before injection.

5. Combinations of benzodiazepines and antipsychotics have an additive effect allowing smaller doses of each to be used.

6. Never mix LORAZEPAM (or DIAZEPAM) with any other drugs in the same syringe. Give separate injections.

7. PROCYCLIDINE (5mg IM) injection must be available for acute dystonias. Repeat, if necessary, after 20 minutes. Maximum dose 20mg in 24 hours.

8. Avoid phenothiazines or other antipsychotics in acute alcohol withdrawal. There are separate guidelines for non-emergency alcohol withdrawal and detoxification. Oral CHLORDIAZEPOXIDE is the drug of first choice.

9. Use small doses for small people. Required dose of neuroleptic depends on age, body build, physical frailty, co-morbid diagnoses, severity of management problem, previous exposure/response to neuroleptics, skill of nurses.

10. Patients with dementia, especially Lewy body dementia, are particularly prone to side-effects. If antipsychotics are given at all, very low doses should be used.

11. MIDAZOLAM comes as 10mg in a 5ml ampoule. Dilute with an equal volume of 0.9% NaCl for IV use to make a solution of 1mg/ml. (It also comes as 10mg in 2ml; make sure you have the right one). Normal dose is up to 7.5mg, but in exceptional circumstances more may be used.

Appendix 7 Detecting elder abuse

Physical abuse

The signs of physical abuse are often evident but can also be hidden by the abuser or the victim. Any unexplained injuries should always be fully investigated. Evidence to look out for includes:

- Cuts, lacerations, puncture wounds, open wounds, bruises, welts, discoloration, black eyes, burns, bone fractures, broken bones, and skull fractures
- Untreated injuries in various stages of healing or not properly treated
- Poor skin condition or poor skin hygiene
- Dehydration and/or malnourished without illness-related cause
- Loss of weight
- Soiled clothing or bed
- Broken eyeglasses/frames, physical signs of being subjected to punishment, or signs of being restrained
- Inappropriate use of medication, overdosing or under-dosing
- An older person telling you they have been hit, slapped, kicked, or mistreated

Psychological abuse

Psychological abuse is the most common type of abuse. It invariably involves identifying something - a person or an object - that matters to an older person and then threatening to endanger it unless the older person complies with demands. The most common examples are threatening access to grandchildren (if someone lives at home) or denying access to family visits (if someone lives in a residential home).

It is rare for psychological abuse to happen in isolation and often it is linked to financial abuse. Other terms for psychological abuse would be coercion or intimidation, and these are usually crimes.

Psychological abuse can have a profound impact on someone's mental health; they can feel trapped, threatened, humiliated, used or a combination of all these. Most signs therefore relate to someone's mental state, and changes in behaviour.

- Helplessness
- Hesitation to talk openly
- Implausible stories
- Confusion or disorientation
- Anger without apparent cause
- Sudden change in behaviour
- Emotionally upset or agitated
- Unusual behaviour (sucking, biting, or rocking)
- Unexplained fear
- Denial of a situation
- Extremely withdrawn and non-communicative or non-responsive
- An older person telling you they are being verbally or emotionally abused

Financial abuse

- Signatures on cheques etc., that do not resemble the older person's signature, or signed when the older person cannot write;
- Sudden changes in bank accounts, including unexplained withdrawals of large sums of money by a person accompanying the older person
- The inclusion of additional names on an older person's bank account
- Abrupt changes to, or the sudden establishment of, wills
- The sudden appearance of previously uninvolved relatives claiming their rights to an older person's affairs or possessions
- The unexplained sudden transfer of assets to a family member or someone outside the family
- Numerous unpaid bills, or overdue rent, when someone else is supposed to be paying the bills
- Unusual concern by someone that an excessive amount of money is being expended on the care of the older person
- Lack of amenities, such as TV, personal grooming items, appropriate clothing, that the older person should be able to afford
- The unexplained disappearance of funds or valuable possessions such as art, silverware, or jewellery
- Deliberate isolation of an older person from friends and family, resulting in the caregiver alone having total control

On occasions banks and solicitors are found to have assisted in the misuse of Enduring Powers of Attorney. Only the new Lasting Power of Attorney needs to be registered with the Court of Protection before it is used and even then there is little to prevent a determined attorney from financially abusing an incapacitated donor. A useful first step if abuse is suspected is to contact by letter the bank of the donor and any estate agent involved – they will be able to let the solicitor know that someone is keeping a watching brief.

Sexual abuse

Very often the behaviour of an older person, even if they have confusion, will tell you that something is wrong. Even with dementia people can often make their feelings known to you if you take the time to listen, observe and take notice. It is the capacity to believe that elder sexual abuse is possible, without seeing it everywhere, that will increase the potential to detect and respond to it when it happens.

Just 2% of calls to the AEA helpline relate to sexual abuse. This is certainly an under-representation, taking all that we know about elder abuse in general and about sexual abuse in its widest sense.

- Some of the physical signs to watch for are:
- Bruises around the breasts or genital area;
- Unexplained venereal disease or genital infections;
- Unexplained vaginal or anal bleeding;
- Difficulty in walking or standing;
- Marked changes in behaviour
- Torn, stained, or bloody underclothing;
- An older person telling you they have been sexually assaulted or raped.

If you suspect sexual abuse do NOT wash the older person or their clothing. Do NOT let time drift by while you think about your course of action. Call the police immediately as they are the experts and will have the skills, expertise and equipment to appropriately and sensitively respond.

Neglect

Neglect will often manifest in the physical, social or health circumstances of the older person.

- Dirt, faecal or urine smell, or other health and safety hazards in older person's living environment
- Rashes, sores, or lice on him/her
- The older person is inadequately clothed
- The older person is malnourished or dehydrated
- The older person has an untreated medical condition
- The older person has poor personal hygiene
- There is evidence of the withholding of medication or over-medication of the older person;
- There is evidence of a lack of assistance with eating and drinking
- There are unsanitary and unclean conditions

In considering neglect it is also important to recognise that there are occasions when someone will choose a particular lifestyle that is considered by others to be poor. There is a difference between a chosen pattern of behaviour and neglect by others that causes a deterioration in an older person's circumstances and condition. If there is doubt the tests from the Mental Capacity Act 2005 can be applied, particularly as it recognises the right if all of us to at times make unwise decisions.

In addition, it is important in taking responsibility for tackling potentially abusive situations that everyone accepts their own responsibility and understands the role of the Safe Guarding Board. This section outlines the primary responsibility of those working in ED and the hospital setting but also needs to recognise and deal with attendance or admissions where there is suspected abuse or safe discharge practice where abuse is a risk when the person returns home.

Appendix 8 Mental Capacity Legislation Contact Points

England and Wales	
Office of the Public Guardian	PO Box 15118 Birmingham B16 6GX Phone number: 0300 456 0300 - Phone lines are open Monday - Friday 9am - 5pm (Except Wednesday 10am - 5pm) Fax number: 0870 739 5780 Email: customerservices@publicguardian.gsi.gov.uk Website http://www.publicguardian.gov.uk
Care Quality Commission	The Belgrave Centre Stanley Place Talbot Street Nottingham, NG1 5GG Tel: 0115 8736250 Fax (for making SOAD referrals) 0115 873 6251 Website: http://www.cqc.org.uk
Scotland	
Mental Welfare Commission for Scotland	MWCS Thistle House 91 Haymarket Terrace Edinburgh EH12 5HE Tel; 0131 313 8777 Service user and carer freephone; 0800 389 6809 Monday - Thursday 9am to 5pm; Friday 9am to 4.30pm Fax 0131 313 8778 Website: http://www.mwcscot.org.uk Email enquiries@mwcscot.org.uk
Public Guardian	The Office of the Public Guardian Hadrian House Callendar Business Park Callendar Road Falkirk

	FK1 1XR Tel: 01324 678300 Fax: 01324 678301 DX 550360 FALKIRK 3 LP-17 FALKIRK Email: opg@scotcourts.gov.uk Website http://www.publicguardian-scotland.gov.uk
Northern Ireland	
The Regulation and Quality Improvement Authority	9th floor Riverside Tower, 5 Lanyon Place Belfast BT1 3BT County Antrim Telephone: 028 9051 7500 Fax: 028 9051 7501 Website: Http://www.rqia.org.uk
	Omagh office The Regulation and Quality Improvement Authority Hilltop Tyrone and Fermanagh Hospital Omagh Co Tyrone BT79 0NS Telephone: 028 8224 5828 Fax: 028 8225 2544
Republic of Ireland	
Mental Health Commission (Ireland)	St Martin's House Waterloo Road Dublin 4 Telephone +353 (1) 636 2400 Fax: +353 (1) 636 2440 Website: http://www.mhcirl.ie Email: info@mhcirl.org

Appendix 9 Examples of innovative urgent care for older people

The development of acute geriatrics in St George's

Background

St Georges Healthcare covers a population of approximately 300,000 people. All acute medical admissions are dealt with by the on call team based in the Acute Medical Unit (AMU). This has 72 beds with an average length of stay of 0.9 days and readmission rate of 7% (March 2011).

Challenges

- There was no geriatric input in the emergency department which meant that older people did not receive a comprehensive geriatric assessment which meant critical decisions on safe admissions avoidance, early discharge and follow up with other services such as the day hospital could not be made.
- Combined with this there were insufficient therapists with expertise in older people's complex conditions to allow safe and early mobilisation and multi-disciplinary care assessments to allow discharge to rehabilitation services in the community.
- Services at St Georges were also not adjusted to the change in local demographics which has seen the increase proportion of older people.

This all led to inappropriate admissions, especially for some care home residents at the end of their life. An audit done in A&E found that the majority of older patients were over 86 years old and 60% did not need an acute medical admission and could be managed as outpatients or in other ways.

Developing a new model

- Appointment of an acute geriatrician and physician based in AMU. This raised the number of geriatricians to two but turned out to be a partial solution as demand increased. A third senior acute geriatrician was appointed based at the front door to allow flexibility and capacity to develop an outreach role into the community.
- Development of the first Rapid Access Clinic for Elderly and Acute Medicine. This service had the use of a virtual clinic to facilitate follow up without the need for unnecessary outpatient appointments.
- Review of local social services and integration of community services with the trust.
- Increase the number and hours covered by the Social and Therapists Assessment and Rehabilitation team (STAR) to enable better discharge to intermediate care facilities.

Initial results

Since the placing a geriatrician in AMU and the increased resources of the STAR team the number of patients discharged and not admitted to hospital has increased from a mean of 47 per month (July to September 2010) to 117 per month (October 2010 to February 2011).

Next steps – completing the model

- Clinical governance structure: audit cycles with implementation of results.
- Education and training: be part of the geriatric medicine teaching programme.
- Champions for range of areas including dementia and falls and bone heath.
- Establish links with specialties for in-reach including cardiology and palliative care.
- Provide geriatric expertise to develop pathways to medicine and surgery.
- Establish an acute geriatrics unit (AGU). This will be crated after the model is developed. Patients admitted to the AGU would be expected to have a maximum length of stay of 5 days. Patients suitable for this service would have one or more of the following two or

more co-morbidities, history of falls, social issues, recurrent attendances/admission to hospital and cognitive problems.

- Establish the Consultant in Elderly Medicine Assessment Tool (CEMAT). This is based on the comprehensive geriatric assessment tool for use on frail older people in emergency care settings.
- Improve links with community services, local care homes and GPs.
- Outreach Geriatric service. The model would seek to develop a proactive service to GPs to help manage patients with complex conditions in their own homes or care homes.

Contact: Dr Carmen Martin-Marero, Consultant Acute Physician and Geriatrician, Carmen.Martin-Marero@stgeorges.nhs.uk

The development of acute geriatric in Lanarkshire

NHS Lanarkshire has been developing a more proactive role in the front door of their acute hospitals. Geriatricians take part in parallel receiving in the Medical Admissions Units alongside General physicians. Case finding is achieved by advanced nurse practitioners (Urgent care for the Elderly or ACE Nurses) who are responsible for identifying patients who would benefit from CGA review according to need. They are involved in multidimensional assessment ensuring their cognition, mobility, falls risks, nutrition and social and family circumstances are correctly identified in time for discussion at a multidisciplinary ward round. They are also involved in onward referrals and feedback to families and carers. Access to CGA beds for appropriate patients is seen as a local standard and prospectively audited.

Access to a specialty bed for all frail older patients was an agreed aim of the specialty and the goal of achieving 'the right patient to the right place *right away'* was felt to add quality, efficiency and capacity management potential. In one hospital, resourced with Consultant sessions and an additional ACE Nurse, a quiet, well lit four bedded acute assessment room (ACE Unit) was opened next to A&E and the admissions ward. Patients were identified as appropriate for specialty as early after arrival in A&E as possible, discussed with relevant clinicians and 'pulled through' to the assessment area. Patients were restricted as little as possible, medications were rationalised, cannulae and catheters were avoided where possible and immediate or early mobilisation was the routine. Families were involved early in the patients care and proactive, multidimensional assessment, rapid diagnostics and senior review were standard. Patients who could safely be managed at home were actively discharged and other patients appropriate for specialty were transferred where possible direct to acute geriatric beds on the day of admission. Where appropriate, discussions with patients and families might include anticipatory care plans, discussions of CPR and occasionally the Liverpool Care Pathway. All discharges were communicated in writing to the GP within 48 hours. Onward referrals to Social services, Early Supported Discharge schemes and district nurses were coordinated from the unit.

The unit resulted in 25% same day discharges, a reduced overall mean and median length of stay for admissions by one day, improved patient and carer satisfaction and reduced complaints. Staff satisfaction in A&E was high. The unit was able to reduce demand on downstream CGA beds as well as manage the demand on senior clinicians' workloads. In part as a consequence of reduced downstream bed requirements a ward of 20 beds was closed. The ACE Nurses have also been in receipt of a Scottish Health Care Award. The challenge in maintaining the units effectiveness are bed capacity downstream leading to reduced discharge or direct specialty admission capacity.

The silver book

The development of interface geriatrics in Leicester

The development of the Emergency Frailty Unit and the Frail Older Peoples' Advice and Liaison Service at Leicester Royal Infirmary make up the strategy at University Hospitals of Leicester (UHL) for creating a 'frail friendly front door'. The aim of these services is to try to improve the care received by frail older people in hospital and reduce unnecessary hospital admissions, lengths of stay and readmissions. Each of the services works to deliver comprehensive geriatric assessment for each identified frail older person, joining together doctors, nurses, physiotherapists, occupational therapists, primary care co-ordinators, physician assistants and discharge specialists to provide an integrated response.

Emergency Frailty Unit (EFU)

The EFU is a central area within the Emergency Decisions Unit designed to improve the quality of care and decision making for frail older people in the Emergency department. It delivers multidisciplinary assessment from nurses, primary care coordinators, therapists and geriatricians at the front door enabling patients to have comprehensive geriatric assessment at presentation to facilitate an appropriate patient pathway. Appropriate patients are identified by the ED staff, assisted by using the Identification of seniors at risk tool which is a 6 item questionnaire used to identify older people at risk of functional decline, institutionalisation and death following discharge from ED. These patients are transferred to EFU rather than admitted to AMU for assessment.

There is a multidisciplinary ward round of these patients every morning focussed on determining a frail older person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and follow-up. The length of stay for patients 85+ on EFU is 0.4 days, and the overall discharge rate for 85+ has increased by 20% compared to last year. The Geriatricians work closely with ED and provide in reach into ED throughout the day – supporting the ED staff with the assessment of older people.

We are currently developing an EFU outreach service. This would see a primary care coordinator from the EFU work in a joint fashion with community teams to case manage selected high risk frail older people who have recently been discharged from EFU to ensure they receive the right care, at the right time, in the right place.

Frail Older Persons' Advice and Liaison (FOPAL)

Frail older patients are identified daily on AMU by the Urgent care Admissions Specialist Nurses for FOPAL intervention. The nurses are employed by the Trust to help facilitate timely discharge for patients with complex medical and social needs. The majority of their work is with frail older adults and their carers and relatives, as well as social services, nursing and residential home staff. Once a patient has been identified and they have been seen by the Acute Medical team, a comprehensive assessment by the FOPAL team begins. At present the FOPAL team is made up of a Consultant Geriatrician, physician assistant, physiotherapy and occupational therapy colleagues. In the future it is hoped to expand the team to include mental health colleagues specialising in older adults. A FOPAL review is not intended to repeat the work done in the Emergency Department or by the AMU team but provides a comprehensive geriatric assessment for the patient. We have the time to look through past admissions, look for themes, talk to patients, their relatives and carers, General Practitioners, social workers and do the investigative work that is so often missed, not always due to lack of wanting but often lack of time. Once a FOPAL plan has been agreed for the patient a discussion with AMU team leads to an agreed final management plan which can be implemented. This could be for the patient to be discharged home, with or without community interventions, or to go to a community hospital or a ward. Patients can be referred as necessary to falls prevention programmes, geriatrician clinic follow ups, district nurses, Intermediate Care teams and the myriad of community services available. Also issues such as advanced care planning can be instigated with patients, families and GPs to give patients a better quality of life out of hospital.

The FOPAL service discharges six times as many frail older people as the AMU, with low readmission rates and to date no inappropriate deaths following discharge.

The combined impact of these services is a reduction in acute medical admissions in people aged 85+ of 14%.

An example of joint working in Essex

As reported recently in the Guardian, 6.12.11, South-east Essex, comprising Southend, Castle Point and Rochford, used to have a high rate of hospital admissions. In 2008-09, there were 9,624 admissions into acute care of people aged 65 or over at a cost of £22.8m. Forecast spending for this year is £21.5m and admissions are 20% down on 2010.

Emergency care practitioners (ECP) are first on the scene and are able to make initial diagnoses, call upon therapy and recovery teams which together can formulate an action plan.

Falls are the chief reason for hospital admission of older people. Since last September, a "community falls car" driven by an ECP has been responding to selected emergency calls on behalf of older people across south-east Essex. By the end of March this year, it had attended 966 calls, of which 756 resulted in treatment on the spot and only 210 led to a hospital admission.

Other innovations include: a community geriatrician scheme, offering the kind of multi-disciplinary care and support of people in their own homes that they would get in hospital; a "filter" team, including GPs, nurses and social workers, at Southend hospital's A&E department, to help prevent unnecessary admissions; and a day assessment unit at the hospital, a specialist falls team and a 25-bed intermediate care ward to help people prepare to return home after an admission and to help prevent their readmission.

The major innovation is the SPOR – a single point of referral, operating 24/7, by which GPs and others can engage the focus of all health and social care agencies on the needs of an individual older person who can be assured of action within two hours in urgent cases.

Taking account of all strands of the programme, including fewer admissions to residential care, a total saving of £7.3m was initially forecast for 2011-12 across south-east Essex. That has been revised down to £3.8m, partly because the hospital admissions that have been avoided so far have typically been relatively low-cost. Fewer admissions of more complex cases, such as stroke, have been avoided than had been anticipated. Understanding the Risk Stratification helped with this as did a positive history of joint working across health and social care. Essex. Another factor is relatively sophisticated information technology: the Care Trak system enables identification of the precise costs of one individual's care package, and care history, relative to others.

This will really make a big difference," says Dr Sarah Zaidi, a GP leading one of the local clinical commissioning groups being set up under the government's NHS reforms. "Before, there were 20 different numbers and 20 different forms to fill.

Appendix 10 Complete list of audit standards

Organisational audit standard (1.1) – There is a local mechanism whereby local commissioners carry out analysis of GP performance in QOF at least annually.

Organisational audit standard (1.2) – There is a local system of case management for long term conditions which is not solely disease-specific (i.e. not just a heart failure service).

Organisational audit standard (2.1) – There is a local policy or procedure that specifies a primary care response to an urgent request from an older person within 30 minutes.

Organisational audit standard (2.2) – There is local audit of primary care response time at least annually.

Clinical audit standard (2c.1) – Percentage of older people receiving a primary care response within 30 minutes of urgent request

Organisational audit standard (3.1) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for pain using a standardised pain score.

Clinical audit standard (3c.1.1) – Percentage of older people accessing urgent care with evidence of assessment for pain using a standardised pain score within 15 minutes of first contact.

Clinical audit standard (3c.1.2) – Percentage of older people accessing urgent care with evidence of assessment for pain using a standardised pain score within 15 minutes of first contact.

Clinical audit standard (3c.1.3) – Percentage of older people unable to express pain who have pain assessed using a standardised tool.

Organisational audit standard (3.2.1) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for cognitive impairment using a validated tool (AMT4, AMT10, MMSE).

Organisational audit standard (3.2.2) – There is a local policy or procedure that requires all older people with cognitive impairment to be assessed for delirium using a standardised tool (CAM, 4AT (http://www.the4at.com/)).

Clinical audit standard (3c.2.1) – Percentage of older people accessing urgent care with evidence of assessment for cognitive impairment using a validated tool within 4 hours of first contact.

Clinical audit standard (3c.2.2) – Percentage of older people accessing urgent care with evidence of assessment for delirium using a standardised tool within 4 hours of first contact.

Organisational audit standard (3.3) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for depression using a validated tool (e.g. GDS).

Clinical audit standard (3c.3) – Percentage of older people accessing urgent care with evidence of assessment for depression using a validated tool (e.g. GDS) within 24 hours of first contact.

Organisational audit standard (3.4) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed of nutrition using a standardised tool (e.g. MUST).

Clinical audit standard (3c.4) – Percentage of older people accessing urgent care with evidence of assessment of nutrition using a standardised tool (e.g. MUST) within 4 hours of first contact.

Organisational audit standard (3.5) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for skin integrity and risk of pressure sores using a standardised tool (e.g. Waterlow).

Clinical audit standard (3c.5) – Percentage of older people accessing urgent care with evidence of assessment for skin integrity and risk of pressure sores using a standardised tool (e.g. Waterlow) within 4 hours of first contact.

Organisational audit standard (3.6.1) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for hearing impairment.Does Jay think this and the next one is feasible for all 65+

Organisational audit standard (3.6.2) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for vision impairment.

Clinical audit standard (3c.6.1) – Percentage of older people accessing urgent care with evidence of assessment for hearing impairment within 4 hours of first contact.

Clinical audit standard (3c.6.2) – Percentage of older people accessing urgent care with evidence of assessment for vision impairment within 4 hours of first contact.

Organisational audit standard (3.7) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for falls risk, including a minimum of asking about a history of falls in the previous 12 months and basic assessment of gait and balance (e.g. Timed Up and Go test).

Clinical audit standard (3c.7.1) – Percentage of older people accessing urgent care with evidence of assessment for a history of falls within 4 hours of first contact.

Clinical audit standard (3c.7.2) – Percentage of older people accessing urgent care with evidence of assessment of mobility (either by a standardised tool such as Timed Up and Go test, or documented observation of patient walking) within 4 hours of first contact.

Organisational audit standard (3.8) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for problems with activities of daily living.

Clinical audit standard (3c.8) - Percentage of older people accessing urgent care with evidence of assessment of activities of daily living using a standardised tool (e.g. Barthel) within 4 hours of first contact.

Organisational audit standard (3.9.1) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for urinary problems.

Organisational audit standard (3.9.2) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for bowel problems.

Clinical audit standard (3c.9.1) – Percentage of older people accessing urgent care with evidence of assessment for urinary problems within 4 hours of first contact.

Clinical audit standard (3c.9.2) – Percentage of older people accessing urgent care with evidence of assessment for bowel problems within 4 hours of first contact.

Organisational audit standard (3.10) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for vital signs (level of consciousness, temperature, pulse, blood pressure, respiratory rate).

Clinical audit standard (3c.10) – Percentage of older people accessing urgent care with evidence of assessment of vital signs (level of consciousness, temperature, pulse, blood pressure and respiratory rate within 15 minutes of first contact.

Clinical audit standard (3c.11) Percentage of older people, identified as requiring end of life care, with a documented preferred place of care.

Clinical audit standard (3c.12) Percentage of older people, identified as requiring end of life care, that die in their preferred place of care, or at home if no place of care identified.

Organisational audit standard (4.1) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for the presence of frailty syndromes (falls, immobility, incontinence, confusion).

Organisational audit standard (4.2) - There is a local policy or procedure that requires comprehensive geriatric assessment of all older people accessing urgent care that have been

identified as presenting with one or more frailty syndromes (falls, immobility, incontinence, confusion).

Organisational audit standard (4.3) – there is evidence of local commissioning of multidisciplinary geriatric services that can contribute towards early CGA across primary and secondary care.

Clinical audit standard (4c.1) – Percentage of older people accessing urgent care with evidence of assessment for the presence of frailty syndromes within 4 hours of first contact.

Clinical audit standard (4c.2) – Percentage of older people accessing urgent care and presenting with evidence of any frailty syndromes (from standard 4c.1) that receive comprehensive geriatric assessment commencing within 4 hours of first contact.

Clinical audit standard (5c.1) – Percentage of older people accessing urgent care and presenting with evidence of any frailty syndromes (from standard 4c.1) that receive comprehensive geriatric assessment commencing within 4 hours if admitted to hospital.

Organisational audit standard (6.1) - There is an environmental audit, carried out as part of the annual Patient Environment Action Teams (PEAT) review

Organisational audit standard (7.1) - There is a local policy or procedure that mandates training of all staff involved in urgent care of older people to receive training in assessment and management of dementia and delirium.

Organisational audit standard (7.2) – There is local provision of regular training in assessment and management of dementia and delirium for all appropriate (define) staffing groups.

Organisational audit standard (7.3) – Percentage of staff working in urgent care settings that have received any training in dementia and delirium in the previous 12 months.

Organisational audit standard (8.1) – There is a local policy or procedure that recommends assessment for falls risk factors of all older people presenting to healthcare services following a fall.

Organisational audit standard (8.2) – There is a local falls service that includes multifactorial falls risk factor assessment and management, including medication review, and access to therapeutic falls prevention exercise (Otago and/or FaME programmes).This is wide of the scope of acute care standards

Organisational audit standard (8.3) – There is a pathway for older people presenting to urgent care following a fall to be referred to the local falls service.

Clinical audit standard (8c.1) – Percentage of older people presenting to urgent care following a fall that have a record of further assessment of reversible causes for falls including, as a minimum, assessment of gait and balance, lying and standing blood pressure, medication review – within 4 hours of presentation.

Clinical audit standard (8c.2) – Percentage of older people presenting to urgent care with a history of 2 or more falls in the last 12 months, or a single injurious fall, that are referred to a local fall service.

Organisational audit standard (9.1) – There is a local fracture liaison service.

Clinical audit standard (9c.1) – Percentage of older people presenting to urgent care with a fragility fracture who are referred to a fracture liaison service.

Organisational audit standard (10.1) – There is a local policy whose policy acute trust social; services etc that older people are discharged to their normal residence within 24 hours unless continuing hospital treatment in necessary.

Organisational audit standard (10.2) – There is a local service specification for social care?? that enables older people to be discharged to their normal residence within 24 hours, 7 days a week, with increased care or support at home if required.

Clinical audit standard (10c.1) – Percentage of older people discharged to their normal residence within 24 hours of acute presentation to hospital. (Note – the target for this cannot be 100%, but will allow benchmarking within sites over time, or between comparable sites)

Local services are also encouraged to audit periodically a random sample of case notes of older patients who were admitted or readmitted for between 24 hours and 7 days to identify where improvements in rapid safe discharge can be made.

Organisational audit standard (11.1) – There is a locally commissioned single point of access (SPA) and directory of services (DOS) linked to consistent clinical content (e.g. NHS Pathways, Map of Medicine).

Organisational audit standard (11.2) – There is a quarterly audit of SPA response times and referral accuracy.

Organisational audit standard (12.1) – There is a locally commissioned rapid response team, or equivalent, that includes nursing, occupational therapy, physiotherapy, mental health and social services. The team should provide 24 hour access 7 days/week and respond within 12 hours of referral via SPA.

Organisational audit standard (12.2) – There is a quarterly audit of the team's response times.

Clinical audit standard (12c.1) – Percentage of SPA referrals that are triaged to a rapid response team, or equivalent, and assessment by a team member commences within 12 hours of contact with SPA.

Organisational audit standard (13.1) – There is a local policy or procedure whereby all older people who present with self-harm are assessed for on-going risk of further self-harm during transportation, whilst in ED and whilst in hospital. (Note - Not all settings will apply to all services, and older adults should be considered to have suicidal intent until assessed and proved otherwise)

Clinical audit standard (13c.1) – Percentage of older adults presenting acutely with self-harm that are assessed by senior decision maker of the mental health team.

Organisational audit standard (13.1) – There is a local policy or procedure whereby all older people who present with unintentional self-harm are assessed for on-going risk of further self-harm prior to discharge.

Organisational audit standard (15.1) – There is a local policy whereby education and training in safeguarding older people is mandatory for all clinical staff dealing with older people.

Organisational audit standard (15.2) – There is a local formal programme of education and training in safeguarding older people for all clinical staff dealing with older people.

Organisational audit standard (15.3) – Percentage of staff in acute settings who have received training in safeguarding older adults in the previous 12 months.

Organisational audit standard (16.1) – The local Major Incident Plan(s) includes explicit contingencies for the management of multiple casualties of frail older people

Organisational audit standard (16.2) – Local Major Incident training includes explicit contingencies for the management of multiple casualties of frail older people

Appendix 11 Provenance

Date	**Comments from**
8th August	Created from version 4.1
8th August	Faculty of Old Age Psychiatry, Dave Anderson
26th August	Age UK
26th August	SCIE (Pamela Holmes, Carolyn Denne)
26th August	Mark Ainsworth-Smith, Consultant ECP, South Central Ambulance Service
26th August	UK Clinical Pharmacy Association Care of the Elderly Group
26th August	Royal Pharmaceutical Society, Ruth Wakeman
29th August	College of Occupational Therapists, College of Occupational Therapists Specialist Section Older People
29th August	The Royal College of Anaesthetists – Patient Liaison Group
29th August	Imran Rafi
29th August	CSP comments incorporated by RK
31st August	Silver book steering committee
22nd September	Simon Williams Director of Community and Housing London Borough of Merton and ADASS lead for Emergency Care for Older people Julia Ross Associate Member of ADASS
22nd September	Phil Dyer, Nicki Trepte, David Ward; Society of Acute Medicine
6th November	All comments and edits from consultation
14th November	Dr David Ward, SAM
26thNovemeber	Jonathan Benger, CEM
6th December	Julia Roberts, College of Occupational Therapists
14th December	Comments and edits from stakeholder groups
21st December 2011	Rachel King on behalf of the Chartered Society of Physiotherapists and AGILE
23rd December 2011	Mandy Rumley-Buss on behalf of the Community Hospital Association
22nd December 2011	Julia Roberts, Genevieve Smyth, Judi Edmans

The silver book

Date	By	Sign off from
21st September 2011	Clive Constable, Director of Professional Affairs, Royal College of Physicians	Royal College of Physicians of London Rescinded November 2011
1st September 2011	Julia Roberts, Quality Programme Manager	College of Occupational Therapists
11th August 2011	Kitti Kottasz, Committee Manager	Royal College of Psychiatrists
Awaited	Finbarr Martin, President	British Geriatrics Society
19th September 2011	James Wenman - Clinical Development Manager	South Western Ambulance Service NHS Foundation Trust
22nd September	Tim Morse, Corporate Publications and Production Officer	The Chartered Society of Physiotherapy
	Dr Bee Wee, President, Association for Palliative Medicine of Great Britain and Ireland	The Association for Palliative Medicine of Great Britain and Ireland
31st August 2011	Miss Jane Griggs, Professional Standards Directorate, Royal College of Anaesthetists	Royal College of Anaesthetists
10th January 2012	Mary Dawood	Emergency Care Nursing Association
Support from		
22nd September 2011	Agnelo Fernandez, RCGP Urgent & Emergency Care Lead & national commissioning champion	Royal College of General Practitioners

Appendix 12 Authors and acknowledgments

Membership

Age UK, Ambulance Directors of Clinical Care, 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 and the Royal College of Psychiatrists, Community Hospitals Association

Special advisors

- Prof Matthew Cooke, National Clinical Director for Urgent & Emergency Care
- Prof Alistair Burns, National Clinical Director for Dementia
- Prof David Oliver, National Clinical Director for Older People

Authors

Jay Banerjee (Lead), CEM, University Hospitals of Leicester NHS Trust

Simon Conroy (co-lead), BGS, University of Leicester

Vicky O'Leary, Great Western Ambulance Service

Stephen Rawstorne, Great Western Ambulance Service, Clinical Director of Care

Sheelagh Donovan (Age UK)

Dr Subir Mukherjee, (BGS)East Kent NHS Trust

Ian Sturgess, (BGS) East Kent NHS Trust

Carmen Martin-Marero, (SAM, BGS) St Georges Healthcare NHS Trust

Fiona Beech, (CEM) Royal United Hospital Bath

Magdy Sakr, (CEM) University Hospitals Coventry NHS Trust

Rebecca Strachan, (CEM) Lay representat

Mary Dawood, (Emergency Nursing Faculty) St Marys Hospital NHS Trust

Judi Edmans, (COT) University of Nottingham Medical School

Rachel King, (CSP, Agile) NHS East London and the City

Agnelo Fernandes, (RCGP),

Alan Dobson, (RCN)

Jim Bethel, (RCN)

Jonathan Treml, (RCP), University Hospitals of Birmingham NHS Trust

David Ward, (SAM),

Nicola Trepte, (SAM) Ipswich Hospitals NHS Trust

Jonathan Waite, (RCPsych)

Dave Anderson, (RCPsych) Merseycare NHS Trust

John Holmes, (RCPsych) University of Leeds

Acknowledgements

The authors would like to thank all their colleagues for their support and especially to:

- Prof Matthew Cooke for springing the idea of the 'Silver Book'
- Prof Alistair Burns and Prof David Oliver for their advice
- Mr Tom Thorpe & Mr Mark Stewart (BGS) & Mrs Gerardine Beckett (CEM) for all their support
- Mr Martin Williams and Prof Richard Baker, NIHR CLAHRC LNR for their help with the website
- Mr John Heyworth, Past President of the College of Emergency Medicine & Dr Finbarr Martin, President of the British Geriatrics Society for their tremendous support for the project
- Dr Clare Gerada, Chair of Council, Royal College of General Practitioners for her input into the manuscript
- Dr Mike Jones, Acute Physician, Royal Infirmary of Edinburgh, SAC Chair Acute Internal Medicine, Vice President, Royal College of Physicians of Edinburgh
- Mr Rick Stern & Dr David Carson (Primary Care Foundation) Ray Montague (Medical Director of Brisdoc and member of the NHS Alliance Urgent Primary Care Leadership Group)&Kathy Ryan (Medical Director Unplanned Care, Wirral Community Foundation Trust and member of the NHS Alliance Urgent Primary Care Leadership Group) for the section on Out of Hours Services
- Dr Adam Gordon for contributing to section on urinary tract infections
- Dr Neil Lillywhite for assistance with editing
- Dr Ruth Brown, Prof Jonathan Benger, Dr James Frances for peer reviewing
- Dr Imran Rafi, for peer reviewing

Appendix 13 Glossary

Activities of daily living	• Basic activities of daily living include:
	  ○ Washing and dressing
	  ○ Eating and drinking
	  ○ Using the toilet (bowels and bladder)
	  ○ Transfers (e.g. on and off a chair, bed or toilet)

	• Extended activities of daily living include:
	  ○ Preparing meals and shopping
	  ○ Housework and laundry
	  ○ Outdoor mobility, including using public transport

Assessment vs. screening	• Assessment tools are used to assess individuals presenting with a specific problem (e.g. falls) and determine which factors are present which can be managed in order to improve outcomes (e.g. visual assessment leading to referral for cataract surgery). • Screening is a public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by, a disease or its complications, are asked a question or offered a test to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of disease or its complications[152].

Comprehensive Geriatric Assessment	Comprehensive Geriatric Assessment (CGA), is defined as '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.'
Frail older people	Older people are defined as those aged 65 years or more, and frail older people are defined as older people with complex needs, typically with multiple co-morbidities, and often a combination of physical disability and cognitive impairment. A widely used definition of frailty includes those people who are 'dependent on others for the activities of daily living, or terminally ill or help is needed with both instrumental and non-instrumental activities of daily living'[153].
Geriatric giants, also referred to as frailty syndromes	These syndromes are common presentations of acute illness in older people, and include: • Falls, collapse and syncope • Sudden onset of reduced mobility • Confusion • Polypharmacy (>3 prescribed drugs) • Continence issues (bladder or bowels) • Social issues, including isolation • Suspected older abuse
Interdisciplinary vs. multidisciplinary	Practitioners from different disciplines working collaboratively with shared responsibility towards a common patient goal. Interdisciplinary teams have greater interdependencies with some shared interdependent roles vs. multi-disciplinary teams of practitioners working in parallel to address various patient care needs.
Self-efficacy	People's belief in their capabilities to achieve a goal or outcome, as such, self-efficacy plays a key role in motivation and how people engage e.g. with health care professionals
Senior decision maker	A senior decision maker is a consultant (doctor, nurse or therapist), ST4+ trainee or equivalent non-training grade doctor, or a specialist nurse or therapist.

Urgent care	According to the Department of Health[154] 'urgent and emergency care is the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly. People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need.'
Clinician	Throughout this document we have used the term clinician to imply a health professional from any background, which will vary according the context. Where appropriate, specific disciplines are highlighted individually.

References

1. Blunt I, Bardsley M, Dixon J. Trends in emergency admissions in England 2004 - 2009: is greater efficiency breeding inefficiency? London: Nuffield Trust, 2010.

2. Ombudsman HS. Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people. In: Department of Health, editor. London, 2011.

3. Society RUotRCoPatBG. Geriatric day hospitals: their role and guidelines for good practice. London: Royal College of Physicians, 1994.

4. Royal College of Physicians. Acute care toolkit 2. High-quality acute care. London: Royal College of Physicians, 2011.

5. Royal College of Physicians. Care of medical patients out of hours - RCP position statement. London: Royal College of Physicians, 2010.

6. National Institute for Health and Clinical Excellence. Recognition of and response to acute illness in adults in hospital. Concise Guidance 50. London, 2007.

7. Anon. Managing Urgent Mental Health Needs in the Acute Trust: A guide by practitioners, for managers and commissioners in England and Wales: Academy of Medical Royal Colleges, 2008.

8. British Medical Association. QOF Quality and Productivity (QP) Accident and Emergency Indicators. In: Association BM, editor. London, 2011.

9. Primary Care Foundation. Urgent Care in Primary Care, 2009.

10. HESonline. Hospital Episode Statistics. Headline Figures, 2007-08. London: The Information Centre for Health and Social Care, 2009.

11. Bankart MJ, Baker R, Rashid A, Habiba M, Banerjee J, Hsu R, et al. Characteristics of general practices associated with emergency admission rates to hospital: a cross-sectional study. *Emerg Med J* 2011.

12. Baker R, Bankart MJ, Rashid A, Banerjee J, Conroy S, Habiba M, et al. Characteristics of general practices associated with emergency-department attendance rates: a cross-sectional study. *BMJ Quality & Safety* 2011.

13. Sager MA, Franke T, Inouye SK, Landefeld CS, Morgan TM, Rudberg MA, et al. Functional Outcomes of Acute Medical Illness and Hospitalization in Older Persons. *Arch Intern Med* 1996;156(6):645-52.

14. Woodard J, Gladman J, Conroy S. Frail older people at the interface. *Age Ageing* 2010;39(S1):i36.

15. Caplan G. Meta-analysis of hospital in the home (HITH): the effect of substituting care at home for care in hospital. *The Journal of Nutrition, Health & Aging* 2009;13(1):SD7 145-2.

16. Gravelle H, Dusheiko M, Sheaff R, Sargent P, Boaden R, Pickard S, et al. Impact of case management (Evercare) on frail elderly patients: controlled before and after analysis of quantitative outcome data.[see comment]. *BMJ* 2007;334(7583):31.

17. Phelan EA, Balderson B, Levine M, Erro JH, Jordan L, Grothaus L, et al. Delivering effective primary care to older adults: a randomized, controlled trial of the senior resource team at group health cooperative. *Journal of the American Geriatrics Society* 2007;55(11):1748-56.

18. Rubenstein LZ, Alessi CA, Josephson KR, Trinidad Hoyl M, Harker JO, Pietruszka FM. A randomized trial of a screening, case finding, and referral system for older veterans in primary care. *Journal of the American Geriatrics Society* 2007;55(2):166-74.

19. Steven RC, Christopher MC, Wanzhu T, Timothy ES, Gregory WA. Cost Analysis of the Geriatric Resources for Assessment and Care of Elders Care Management Intervention. *Journal of the American Geriatrics Society* 2009;57(8):1420-26.

20. Fletcher P. Will undergraduate geriatric medicine survive? *Age & Ageing* 2007(36):358-60.

21. Morris J, Beaumont D, Oliver D. Decent health care for older people. *BMJ* 2006;332(7551):1166-68.

22. Oliver D. Age based discrimination in health and social care services. *BMJ* 2009;339(aug25_1):b3400-.

23. Oliver D. Geriatric syndromes continue to be poorly managed and recognised. *BMJ* 2008;337(jul22_1):a892-.

24. Conroy S, Stephens T, Gladman J. The acute community - hospital interface: a mapping review. 2010(6).

25. Johri M, Beland F, Bergman H. International experiments in integrated care for the elderly: A synthesis of the evidence. *International Journal of Geriatric Psychiatry* 2003(18):222-35.

26. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. *BMJ* 2003;327(7425):1219-21.

27. Crilly J, Chaboyer W. Continuity of care for acutely unwell older adults from nursing homes. *Scandinavian Journal of Caring Sciences* 2006(20):122-34.

28. Courtney M, Tong S, Walsh A. Acute-care nurses' attitudes towards older patients: A literature review. . *International Journal of Nursing Practice* 2000(6):62-69.

29. McCormack B. Person-centredness in gerontological nursing: an overview of the literature. *Journal of Clinical Nursing* 2004(13):31-38.

30. Beswick AD, Rees K, Dieppe P, Ayis S, Gooberman-Hill R, Horwood J, et al. Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis.[see comment]. *Lancet* 2008;371(9614):725-35.

31. Baztan JJ, Suarez-Garcia FM, Lopez-Arrieta J, Rodriguez-Manas L, Rodriguez-Artalejo F. Effectiveness of acute geriatric units on functional decline, living at home, and case fatality among older patients admitted to hospital for acute medical disorders: meta-analysis. *BMJ* 2009;338(jan22_2):b50-.

32. Shepperd S, Doll H, Broad J, Gladman J, Iliffe S, Langhorne P, et al. Early discharge hospital at home. *Cochrane Database of Systematic Reviews Issue 1*, 2009.

33. Shepperd S, Doll H, Angus R, Clarke M, Iliffe S, Kalra L, et al. Admission avoidance hospital at home. *Cochrane Database of Systematic Reviews Issue 4*, 2008.

34. Ward D, Drahota A, Gal D, Severs M, Dean T. Care home versus hospital and own home environments for rehabilitation of older people. *Cochrane Database of Systematic Reviews Issue 4*, 2008.

35. Smith S, Allwright S, O'Dowd T. Effectiveness of shared care across the interface between primary and specialty care in chronic disease management. *Cochrane Database of Systematic Reviews Issue 3*, 2007.

36. Chang JT, Morton SC, Rubenstein LZ, Mojica WA, Maglione M, Suttorp MJ, et al. Interventions for the prevention of falls in older adults: systematic review and meta-analysis of randomised clinical trials. *BMJ* 2004;328(7441):680-.

37. Stuck AE, Siu AL, Wieland GD, Rubenstein LZ, Adams J. Comprehensive geriatric assessment: a meta-analysis of controlled trials. *The Lancet* 1993;342(8878):1032-36.

38. Ellis G, Langhorne P. Comprehensive geriatric assessment for older hospital patients. *Br Med Bull* 2005;71(1):45-59.

39. Ali W, Rasmussen P. What is the evidence for the effectiveness of managing the hospital / community interface for older people? *New Zealand Health Technology Assessment report* 2004;7(1).

40. Ellis G, Whitehead M, O'Neill D, Robinson D, Langhorne P. Comprehensive geriatric assessment for older adults admitted to hospital. . *Cochrane Library*: Cochrane collaboration, 2011.

41. Campbell A, Robertson M. Randomised controlled trial of a general practice program of home based exercise to prevent falls in elderly women. *British Medical Journal* 1997(315):1065-9.

42. Shepperd S, Parkes J, McClaran J, Phillips C. Discharge planning from hospital to home. The Cochrane Database of Systematic Reviews. *Cochrane Database of Systematic Reviews* 2004;1(CD000313.pub2).

43. Heath H, Sturdy D, Cheesly A. Discharge planning: A summary of the Department of Health's guidance Ready to go? *Planning the discharge and the transfer of patients from hospital and intermediate care*. Harrow: RCN Publishing Company Ltd, 2010.

44. Beswick AD, Rees K, Dieppe P, Ayis S, Gooberman-Hill R, Horwood J, et al. Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *The Lancet* 2008;371(9614):725-35.

45. Department of Social Services. Community Care Statistics: Social Services Activity, England 2009-10, 2011.

46. Logan PA, Coupland CAC, Gladman JRF, Sahota O, Stoner-Hobbs V, Robertson K, et al. Community falls prevention for people who call an emergency ambulance after a fall: randomised controlled trial. *BMJ* 2010;340.

47. Mason S, Knowles E, Colwell B, Dixon S, Wardrope J, Gorringe R, et al. Effectiveness of paramedic practitioners in attending 999 calls from elderly people in the community: cluster randomised controlled trial. *BMJ* 2007.

48. Davison J, Bond J, Dawson P, Steen IN, Kenny RA. Patients with recurrent falls attending Accident & Emergency benefit from multifactorial intervention--a randomised controlled trial.[see comment]. *Age & Ageing* 2005;34(2):162-8.

49. Close J, Ellis M, Hooper R, Glucksman E, Jackson S, Swift C. Prevention of falls in the elderly trial (PROFET): a randomised controlled trial. *Lancet* 1999(353):93-7.

50. McCusker J, Dendukuri N, Tousignant P, Verdon J, Poulin de Courval L, Belzile E. Rapid two-stage emergency department intervention for seniors: impact on continuity of care.[see comment]. *Academic Emergency Medicine* 2003;10(3):233-43.

51. Mion LC, Palmer RM, Meldon SW, Bass DM, Singer ME, Payne SMC, et al. Case finding and referral model for emergency department elders: a randomized clinical trial.[see comment]. *Annals of Emergency Medicine* 2003;41(1):57-68.

52. Caplan GA, Williams AJ, Daly B, Abraham K. A randomized, controlled trial of comprehensive geriatric assessment and multidisciplinary intervention after discharge of elderly from the emergency department--the DEED II study. *Journal of the American Geriatrics Society* 2004;52(9):1417-23.

53. Conroy SP, Stevens T, Parker SG, Gladman JRF. A systematic review of comprehensive geriatric assessment to improve outcomes for frail older people being rapidly discharged from acute hospital: 'interface geriatrics'. *Age and Ageing* 2011;40(4):436-43.

54. Silverstein N, Maslow K. *Improving Hospital Care For patients with Dementia.* New York: Springer Publishing Company, 2006.

55. Benson S. The Use of Colour in Dementia Specific Design. *Journal of Dementia Care* 2002.

56. Acute Medicine Task Force. Acute medical care: The right person, in the right setting – first time. London: Royal College of Physicians, 2007.

57. Conroy S, Cooper N. Acute medical care of elderly people. London: British Geriatrics Society, 2010.

58. British Geriatrics Society. Acute Medical Care of Elderly People. In: Society BG, editor. London, 2010.

59. Harari D, Martin FC, Buttery A, O'Neill S, Hopper A. The older persons' assessment and liaison team 'OPAL': evaluation of comprehensive geriatric assessment in acute medical inpatients. *Age Ageing* 2007(6):670-75.

60. Partnership CsI. Reviews of Community hospital/Intermediate care provision: Good practice guide. In: Care DoHaS, editor. London, 2008.

61. Department of Health. Our health, our care, our say: a new direction for community services, 2006.

62. Groarke JD, Gallagher J, Stack J, Aftab A, Dwyer C, McGovern R, et al. Use of an admission early warning score to predict patient morbidity and mortality and treatment success. *Emergency Medicine Journal* 2008;25(12):803-6.

63. Burch VC, Tarr G, Morroni C. Modified early warning score predicts the need for hospital admission and inhospital mortality. *Emergency Medicine Journal* 2008;25(10):674-8.

64. Gardner-Thorpe J, Love N, Wrightson J, Walsh S, Keeling N. The value of Modified Early Warning Score (MEWS) in surgical in-patients: a prospective observational study. *Annals of the Royal College of Surgeons of England* 2006;88(6):571-5.

65. Paterson R, MacLeod DC, Thetford D, Beattie A, Graham C, Lam S, et al. Prediction of in-hospital mortality and length of stay using an early warning scoring system: clinical audit.[see comment]. *Clinical Medicine* 2006;6(3):281-4.

66. Frost P. In response to 'Effect of introducing the Modified Early Warning score on clinical outcomes, cardio-pulmonary arrests and intensive care utilisation in acute medical admissions', Subbe CP et al., Anaesthesia 2003; 58: 797-802.[comment]. *Anaesthesia* 2003;58(11):1154.

67. Subbe CP, Kruger M, Rutherford P, Gemmel L. Validation of a modified Early Warning Score in medical admissions.[see comment]. *Qjm* 2001;94(10):521-6.

68. Cei M, Bartolomei C, Mumoli N. In-hospital mortality and morbidity of elderly medical patients can be predicted at admission by the Modified Early Warning Score: a prospective study. *International Journal of Clinical Practice* 2009;63(4):591-5.

69. Sampson E, Blanchard M, Jones L, Tookman A, King M. Dementia in the acute hospital: a prospective cohort study of prevalence & mortality. *British Journal of Psychiatry* 2009(195):61-6.

70. Lang et al. Early Markers of Prolonged Hospital stays in demented inpatients: A Multicentre and Prospective study. *Journal Of American Geriatrics Society* 2006:141-47.

71. Psychiatrists RCo. Who Cares Wins: Improving the outcome for older people admitted to the general hospital. 2005.

72. National Institute for Health & Clinical Excellence. Delirium: diagnosis, prevention & management.: NICE Clinical Guideline Centre, 2010.

73. Swain et al. Cognitive assessment in elderly patients admitted to hospital. Relationship between shortened version of AMT and the AMT and MMSE. *Clinical Rehabilitation* 2000:608-10.

74. National Institute for Health & Clinical Excellence & Social Care Institute for Excellence. Dementia: supporting people with dementia & their carers in health & social care: National Collaborating Centre for Mental Health, 2006.

75. Young J, Inouye S. Delirium in older people. *BMJ* 2007(334):842-6.

76. Elie M, Rousseau F, Cole M, Primeau F, McCusker J, Bellavance F. Prevalence & detection of delirium in elderly emergency department patients. *Canadian Medical Association Journal* 2000(163):977-81.

77. Cole M, You Y, McCusker J, Ciampi A, Belzile E. The 6 & 12 months outcome of older medical inpatients who recover from delirium. *International Journal of Geriatric Psychiatry* 2008(23):301-7.

78. Han J, Wilson A, Wesley E. Delirium in the Older Emergency Department Patient: A Quiet Epidemic. . *Emerg Med Clin N Am* 2010(28):611-31.

79. Han et al. Delirium in Older Emergency Department Patients: Recognition, Risk Factors, and Psychomotor Subtypes. *Academic Emergency Medicine* 2011(18):451-57.

80. Rinaldi P, Mecocci P, Benedetti C, Ercolani S, Bregnocchi M, Menculini G, et al. Validation of the Five-Item Geriatric Depression Scale in Elderly Subjects in Three Different Settings. *Journal of the American Geriatrics Society* 2003;51(5):694-98.

81. Horrocks J, Price S, House A, Owens D. Self-injury attendances in the accident and emergency department: Clinical database study. *British Journal of Psychiatry* 2003;183(1):34-39.

82. Dennis MS, Wakefield P, Molloy C, Andrews H, Friedman T, Dennis MS, et al. A study of self-harm in older people: mental disorder, social factors and motives. *Aging & Mental Health* 2007;11(5):520-5.

83. Hawton K, Harriss L, Hawton K, Harriss L. Deliberate self-harm in people aged 60 years and over: characteristics and outcome of a 20-year cohort. *International Journal of Geriatric Psychiatry* 2006;21(6):572-81.

84. Marriott R, Horrocks J, House A, Owens D, Marriott R, Horrocks J, et al. Assessment and management of self-harm in older adults attending accident and emergency: a comparative cross-sectional study. *International Journal of Geriatric Psychiatry* 2003;18(7):645-52.

85. Psychiatrists RCo. Who Cares Wins: Improving the outcome for older people admitted to the general hospital. Leeds Royal College of Psychiatrists, 2005.

86. NICE. Clinical Guideline 16: Self-harm: the short-term physical and psychological management and secondary prevention of

self-harm in primary and secondary care, 2004.

87. American Geriatrics Society, British Geriatrics Society. AGS/BGS Clinical Practice Guideline: Prevention of Falls in Older Persons, 2010.

88. National Institute of Clinical Excellence. Falls: the assessment and prevention of falls in older people: NICE, 2004.

89. National Institute of Clinical Excellence. Clinical Guideline 109: transient loss of consciousness in adults and young people. London, 2010.

90. Campbell A, Robertson M, Gardner M. Psychotropic medication withdrawal and a home-based exercise program to prevent falls: A randomized controlled trial. *J Am Geriatr Soc* 1999(39):142-48.

91. Close J, Ellis M, Hooper R, Glucksman E, Jackson S, Swift C. Prevention of falls in the elderly trial (PROFET): a randomised controlled trial. *Lancet 1999 Jan 9; 353(9147): 93-7 (33 ref)*.

92. Podsiadlo DA RS. The timed up and go: a test of basic functional mobility for frail elder persons. *Journal of the American Geriatrics Society* 1991(39):142-48.

93. Pirmohamed M, James S, Meakin S, Green C, Scott AK, Walley TJ, et al. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. *BMJ* 2004;329(7456):15-19.

94. Beijer H, de Blaey C. Hospitalisations caused by adverse drug reactions (ADR): a meta-analysis of observational studies. *Pharm World Sci* 2002(24):46-54.

95. Mannesse CK, Derkx FH, de Ridder MA, Man in 't Veld AJ, van der Cammen TJ. Contribution of adverse drug reactions to hospital admission of older patients. *Age and Ageing* 2000;29(1):35-39.

96. Barry PJ, Gallagher P, Ryan C, O'mahony D. START (screening tool to alert doctors to the right treatment)—an evidence-based screening tool to detect prescribing omissions in elderly patients. *Age and Ageing* 2007;36(6):632-38.

97. Spinewine A, Schmader KE, Barber N, Hughes C, Lapane KL, Swine C, et al. Appropriate prescribing in elderly people: how well can it be measured and optimised? *The Lancet*;370(9582):173-84.

98. Spinewine A, Swine C, Dhillon S. Effect of a collaborative approach on the quality of prescribing for geriatric in-patients: a randomised, controlled trial. *J Am Geriatr Soc* 2007(55):658-65.

99. Lindley C, Tully M, Paramsothy V. Inappropriate medication is a major cause of adverse drug reactions in elderly patients. *Age and Ageing* 1992;21 (4):294-30.

100. Gurwitz J, Field T, Avorn J, McCormick D, Jain S, Eckler M, et al. Incidence and preventability of adverse drug events in nursing homes. *Am J Med* 2000(209):87-94.

101. Laroche M, Charmes J, Merle L. Potentially inappropriate medications in the elderly: a French consensus panel list. *Eur J Clin Pharmacol* 2007(63):725-31.

102. Lazarou J, Pomeranz B, Corey P. Incidence of adverse drug reactions in hospitalised patients: a meta-analysis of prospective studies. *JAMA* 1998;279 (15):1200-5.

103. Mangoni A, Jackson S. Age-related changes in pharmacokinetics and pharmacodynamics: basic principles and practical applications. *Br J Clin Pharmacol* 2003(57):6-14.

104. Lee P, Alexander K, Hammill B, Pasquali S, Peterson E. Representation of Elderly Persons and Women in Published Randomized Trials of Acute Coronary Syndromes. *JAMA* 2001;286(6):708-13.

105. Tangiisuran B, Wright J. Adverse drug reactions in elderly: challenges in identification and improving preventative strategies. *Age and Ageing* 2009(38):358-59.

106. Beers MH. Explicit criteria for determining potentially inappropriate medication use by the elderly. An update. *Arch Intern Med* 1997(157):1531-36.

107. Gallagher P, Ryan C, Byrne S, Kennedy J, O'Mahony D. STOPP (Screening Tool of Older Person's Prescriptions) and START (Screening Tool to Alert doctors to Right Treatment). Consensus validation. *Int J Clin Pharmacol Ther* 2008 46(2):72-83.

108. Gallagher P, Baeyens J-P, Topinkova E, Madlova P, Cherubini A, Gasperini B, et al. Inter-rater reliability of STOPP (Screening Tool of Older Persons' Prescriptions) and START (Screening Tool to Alert doctors to Right Treatment) criteria amongst physicians in six European countries. *Age and Ageing* 2009;38(5):603-06.

109. http://clinicaltrials.gov/ct2/show/NCT00915824 & http://www.bgs.org.uk/powerpoint/aut10/Mahony_inappropriate_prescribing.pdf

110. National Confidential Enquiry into Patient Outcome and Death. An Age Old Problem: A review of the care received by elderly patients undergoing surgery. London, 2010.

111. Royal College of Physicians BGSaBPS. The assessment of pain in older people: national guidelines. *Concise guidance to good practice series* 2007(8).

112. Stevenson KB, Moore JW, Sleeper B. Validity of the Minimum Data Set in Identifying Urinary Tract Infections in Residents of Long-Term Care Facilities. *Journal of the American Geriatrics Society* 2004;52(5):707-11.

113. SIGN. Management of suspected bacterial urinary tract infection in adults. A national clinical guideline, 2006.

114. Juthani-Mehta M, Quagliarello V, Perrelli E, Towle V, Van Ness PH, Tinetti M, et al. Clinical features to identify urinary tract infection in nursing home residents: a cohort study. *Journal of the American Geriatrics Society* 2009;57(6):963-70.

115. Cormican M, Murphy A, Vellinga A. Interpreting asymptomatic bacteriuria. *British Medical Journal* 2011;343(d4780).

116. Beier MT. Management of Urinary tract infections in the nursing home elderly: a proposed algorithmic approach. *International Journal of Antimicrobial Agents* 1999;11(3-4):275-84.

117. Russell C, Elia M. Nutrition Screening Survey in the UK in 2008. *British Association for Parental and Enteral Nutrition* 2009.

118. The Eastern Association for the Surgery of Trauma. *The EAST practice management guidelines workshop: Practice management guidelines for geriatric trauma.*, 2001.

119. Department of Health. End of Life Care Strategy. Promoting high quality care for all adults at the end of life. London: Department of Health, 2008.

120. National End of Life Care Programme. Supporting people to live and die well. A framework for social care at the end of life. London: Department of health, 2010.

121. Brook RH, Kamberg CJ, Mayer-Oakes A, Beers MH, Raube K, Steiner A. Appropriateness of acute medical care for the elderly: an analysis of the literature. *Health Policy* 1990;14(3):225-42.

122. NHS End of Life Care Programme. Advance Care Planning: A Guide for Health and Social Care Staff. London, 2007.

123. Conroy S, Fade P, Fraser A, Schiff R. Advance care planning: concise evidence-based guidelines. In: Turner-Stokes L, editor. *Concise Guidance to Good Practice series*. London: RCP, 2009.

124. Conroy S. Advance Care Planning for older people. In: Lobo B, Thomas K, editors. *Advance Care Planning in End of Life Care*: Oxford University Press, 2010.

125. Close J, Ellis M, Hooper R, Glucksman E, Jackson S, Swift C. Prevention of falls in the elderly trial (PROFET): a randomised controlled trial.[see comment]. *Lancet* 1999;353(9147):93-7.

126. Heath H, Sturdy D, Cheesly A. *Discharge planning: A summary of the Department of Health's guidance Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care*. Harrow: RCN Publishing Company Ltd., 2010.

127. Cooper C, Selwood A, Livingston G. The prevalence of elder abuse and neglect: a systematic review. *Age Ageing* 2008(37):151-60.

128. O'Keefe M, Hills A, Doyle M et al. UK study of abuse and neglect of older people prevalence survey report.: Comic Relief & Dept of Health, 2007.

129. Department for Constitutional Affairs. Mental Capacity Act 2005 Code of Practice: The Stationery Office, 2007.

130. Department for Constitutional Affairs. Mental Capacity Act. London, 2005.

131. Lally F, Crome P. Undergraduate training in geriatric medicine: getting it right. *Age Ageing* 2007;36(4):366-8.

132. Anonymous. The Older Person in the Accident & Emergency Department London: British Geriatrics Society, 2008.

133. Department of Health. Urgent care pathways for older people with complex needs. London: Department of Health, 2007.

134. Department of Health. Essence of Care Benchmarks for Respect and Dignity, 2010

135. Runciman P, Currie C, Nicol M, Green L, McKay V. Discharge of elderly people from an accident and emergency department: evaluation of health visitor follow-up. *Journal of Advanced Nursing* 1996(24):711-18.

136. Castro J, Anderson M, Hanson K, Helms L. Home care referral after emergency department discharge. *Journal of Emergency Nursing* 1998(24):127-32.

137. Lee V, Wong T, Lau C. Home accidents in elderly patients presenting to an emergency department. *Accident and Emergency Nursing* 1999(7):96-102.

138. Rabiee P, Glendining C. The organisation and content of home care reablement services. York: University of York: Social Policy Research Unit., 2010.

139. Glendinning C, Newbronner E. The effectiveness of home care reablement; developing the evidence base. *Journal of Integrated Care* 2008;16(4):32-39.

140. Fernandez L, Byard D, Lin C, Benson S, Barbera J. Frail elderly as disaster victims: emergency management strategies. *Pre Hospital Disaster Medicine* 2002;17(2):67-74.

141. Vandentorren S, Bretin Z, Mandereau –Bruno L. August 2003 Heat Wave in France: Risk Factors for Death of Elderly People Living at Home. *European Journal of Public Health* 2006;16 (6):583-89.

142. Kovats R, Johnson H, Grifiths C. Mortality in southern England during the 2003 heat wave by place of death. 2006.

143. Gladman J, Harwood R, Conroy S, On behalf of the Medical Crises In Older People Study Group. Days at home: an outcome measure in studies of specialist services providing care for older people. *Medical Crises in Older People. Discussion paper series.* Nottingham: University of Nottingham, 2010.

144. Conroy S, P F, Fraser A, Schiff R. Advance care planning: concise evidence-based guidelines. In: Turner-Stokes L, editor. *Concise Guidance to Good Practice series*. London: Royal College of Physicians of London, 2009.

145. Gallagher P, O'Mahony D. STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions): application to acutely ill elderly patients and comparison with Beers' criteria. *Age Ageing* 2008;37(6):673-79.

146. McCusker J BF, Cardin S, Trepanier S, Verdon J, Ardman O,. Detection of older people at increased risk of adverse health outcomes after an emergency visit: the ISAR screening tool. *Journal of the American Geriatrics Society* 1999;47(10).

147. Dendukuri N, McCusker J, Belzile E. The identification of seniors at risk screening tool: further evidence of concurrent and predictive validity. *Journal of the American Geriatrics Society* 2004;52(2):290-6.

148. McCusker J, Verdon J, Tousignant P, de Courval LP, Dendukuri N, Belzile E. Rapid emergency department intervention for older people reduces risk of functional decline: results of a multicenter randomized trial.[see comment]. *Journal of the American Geriatrics Society* 2001;49(10):1272-81.

149. McCusker J, Bellavance F, Cardin S, Belzile E, Verdon J. Prediction of hospital utilization among elderly patients during the 6 months after an emergency department visit. *Annals of Emergency Medicine* 2000;36(5):438-45.

150. McCusker J, Cardin S, Bellavance F, Belzile E. Return to the Emergency Department among Elders: Patterns And Predictors. *Acad Emerg Med* 2000;7(3):249-59.

151. Gray L. Geriatric consultation: is there a future? *Age Ageing* 2007;36(1):1-2.

152. UK National Screening Committee. Second report of the UK national screening committee, 2005.

153. Rockwood K, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, et al. A global clinical measure of fitness and frailty in elderly people. *Cmaj* 2005;173(5):489-95.

154. Department of Health. Urgent and emergency care definition London, 2011.