

**QUALITY STANDARDS FOR CARE OF OLDER
PEOPLE WITH URGENT AND EMERGENCY
CARE NEEDS**

Preamble

Approximately 95% of urgent care is delivered in primary care. According to estimates, 300 million urgent care consultations are annually provided in primary care¹ as opposed to 20 million encounters in emergency departments². Despite the majority of urgent care delivered in the primary care setting, an increasing number of older people are accessing emergency departments. This is related to the increasing number of older people, but may also be due to lower thresholds for accessing urgent care³.

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^{4 5}. 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 and will put an increasing strain on an urgent care system not resourced to deal with this.

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

Membership

Age UK, Ambulance Service 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 Royal College of Psychiatrists and the Community Hospitals Association

Special advisors

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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 the commissioning and mode of delivery of the competencies, as these will vary according to local needs, resources and policies. The older person's care needs may be delivered in the emergency room, the acute medical unit or a community setting depending on local service configuration.
- This document is a best practice guideline, comprising recommendations based on a review of the literature and refers to evidence where available. The authors have not referred to the hierarchies of evidence to avoid piecemeal implementation.
- This is the short version of the Silver Book and is to be considered in conjunction with the executive summary and the complete on-line version (www.)

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 document seeks to inform clinicians, educators, commissioners, policy makers and regulators.

Standards and recommendations

Underpinning principles

- 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
- 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

1. All older people accessing urgent care should be routinely assessed for pain, vital signs, delirium and dementia, depression, skin integrity, nutrition and hydration, sensory loss, falls and mobility, continence, activities of daily living, safeguarding issues and end of life issues.
2. There must be an initial primary care response to an urgent request for help from an older person within 30 minutes
3. 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
4. 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)⁶⁻⁹
5. 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 appropriate¹⁰
6. 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
7. 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
8. 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

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, consider urine dipstick testing 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. Do not routinely catheterise older people 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. Discharge older people from hospital with adequate support and with respect for their preferences.
6. Services should share adequate and timely information whenever there is a transfer of care between individuals or services.
7. Older people admitted following an urgent care episode (to any bed based facility) should have an expected discharge date set within 2 hours (14 hours overnight).
8. Involve older people, and where appropriate their carers and families, 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 proce-

dures 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 specific settings**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.
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, primary care 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 Levodopa.

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.
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 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 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)

- '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)

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. 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

Successful care of frail older people includes the following strategies:

- Integrated care schemes including case management, geriatric assessment, multidisciplinary working, a single entry point and financial levers¹¹
- Care^{12 13} needs to be coherent, connected and consistent across place and person.
- A positive attitude towards older people is associated with better quality care¹⁴
- Person centred nursing care¹⁵, encapsulated by four concepts:
 - 'being in relation' (knowing the individual)

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 costs¹⁶⁻²⁶. 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.'²⁷ 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 planning²⁸, 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^{28 29}, but must not compromise adequate assessment.

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, and difficulties maintaining and managing their home, loneliness and isolation. 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 addressing medical and social care needs.

Alongside 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.

Many voluntary services also offer help to carers in their caring role.

Whole systems approach

Multidimensional assessment and multiagency management of older people leads to better outcomes³⁰. 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.

Error! Reference source not found. 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.

Older people in different clinical settings

Urgent care at home

Context and facts

The underlying factors giving rise to urgent and emergency care needs of frail older people include physical illnesses, mental health problems, and the end of life. This group of people may also be carers themselves to similarly predisposed relatives, which means that the 24/7 urgent care response has to consider the needs of dependants as well if the carer becomes seriously unwell.

Despite some variation within defined parameters, response times for an urgent health need are measured in minutes for the ambulance ser-

vice, but in hours for other health services, including GP services. 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.

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 essentials, yet overall contact hours of home care provided appears to have declined.

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.
- 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

Caring for older people out of hours presents its own set of challenges. The clinician may not be familiar with the patient's history, understand all the local services available or 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 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.

Key points

- 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

Emergency Department

Context and facts

The delivery of such complex interventions, such as 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 discharge³¹⁻³⁵ and a meta-analysis of these studies provide some evidence of improved outcomes³⁶. Hospital at home schemes that include multidisciplinary care and medical input can be effective^{18 19 28 37} 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 and over stimulation 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
- The Emergency Department should be 'frailty-friendly', with signs in large font as added visual aid accompanied by pictures. Signs to toilets should be bold, visible and multicue. All signage should be 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 discomfort³⁸.
- 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
- 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 has 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 confusion³⁹.

Interventions

- Certain conditions common in older people require rapid access to relevant medication, such as such as Levodopa 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 2 hours (14 hours overnight) 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'⁴⁰.

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 received⁴⁰.

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 people⁴¹, 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 policies⁴² 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 appropri-

ate interventions. Internationally, Acute Geriatric Units have been shown to reduce the risk of functional decline and increase the probability of returning home¹⁷, such units have not been compared directly to an AMU in the UK.

The local population, services, and resources available within, and outside the hospital will dictate exact models of care.

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 people⁴³⁻⁴⁹. 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:

<p>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:gpacutecare&catid=12:goodpractice&Itemid=106 http://www.bgs.org.uk/index.php?option=com_content&view=article&id=35:gpstandardsofcare&catid=12:goodpractice&Itemid=106 http://www.bgs.org.uk/index.php?option=com_content&view=article&id=45:gpqaae&catid=12:goodpractice&Itemid=106</p>
<p>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:gpdischarge&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</p>

Mental health

Dementia and delirium

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 year⁵⁰. However, the detection of cognitive impairment in the ED context should be accompanied by an assessment for delirium. For most people with dementia admitted to hospital there will be a primary medical diagnosis (or more often diagnoses) and the importance of dementia overlooked. Alcohol and substance abuse can be a cause of presentation of older people to the ED.

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 should be suspected 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

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

Guidance on the short-term management of disturbed and violent 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.

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-5⁵¹ is a quick useful tool to screen for depression.

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 departments⁵². This means that a rapid response for psychosocial assessment after self-harm may not be available from an adequately skilled clinician.

Falls

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

Screening for falls risk

The American Geriatrics Society/British Geriatrics Society (AGS/BGS) Guideline⁵³ 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)?

A positive answer to any of these questions indicates high-risk of further falls and merits further assessments.

High-risk fallers should receive a multi-factorial assessment, with intervention tailored to modify the identified risks. In most cases, this is 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 21⁵⁴ or the AGS/BGS Guideline⁵³.

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/compendium4-5.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, may require an admission to hospital for on-going management, and present an opportunity to identify and manage osteoporosis at an early stage through the establishment of fracture liaison services. People presenting with a fragility fracture need referral 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 and Adverse Drug Events account for approximately 6.5% of all

hospital admissions⁵⁵. This is more in older people and leads to increased hospital stay and significant morbidity and mortality^{56,57}.

Various guidelines have been developed to help reduce potentially inappropriate prescriptions amongst older people^{58,59}, although there is no internationally agreed standard⁶⁰. 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^{60,61}, and early results from a small RCT suggest these criteria may be beneficial⁶².

Key points

- Community pharmacists should be empowered to deliver more comprehensive Medicines Use Reviews/ Clinical Medication Reviews that are considered and acted on by prescribers
- Secondary and primary care organisations should offer a structured compliance assessment and medicines support service to older people 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 surgery⁶³ as well as the National Falls & Bone Health Audit (2010) demonstrated that significant improvement were required in the peri-operative management of older people.

Key points

- Routine daily 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

- Early senior decision-making is essential to provide the appropriate palliative care for moribund patients who would not benefit from invasive management.

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 people⁶⁴.

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.britishtainsociety.org_pain_scales.htm
<http://www.bgs.org.uk/Publications/Clinical%20Guidelines/pain%20concise%20guidelines%20WEB.pdf>⁶⁵

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 residents⁶⁶, and frail older people more generally.

Asymptomatic bacteriuria should not be treated and symptomatic enquiry should therefore guide diagnosis (Table 1 Suggested approach to the investigation of possible Urinary Tract Infection in older people).

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
<http://www.sign.ac.uk/guidelines/fulltext/88/index.html>

Nutrition

Under nutrition is poorly detected by nursing and medical staff. The Malnutrition Universal Screening Tool (MUST) developed by the Malnutrition Advisory Group of the British Association for Parenteral and Enteral Nutrition (BAPEN) is commonly used in UK although locally devised tools are in use in many hospitals.

Key points

- Hospital staff must listen to older people, their relatives and carers and act on what they say regarding nutritional needs
- Staff must become 'food aware'

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 fewer than 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 crucial 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/development/practice/clinicalguidelines/pressure-ulcers>

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. It is always advisable to embark on aggressive initial therapy irrespective of age or injury, although early consideration should be given to ethical issues and justification of such action. 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 state⁶⁷.

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^{68 69}. 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 economy⁷⁰.

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^{71 72}.

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 be 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 stay⁷³.

National standards and guidelines on the assessment of mental capacity can be found at:
<http://www.justice.gov.uk/guidance/protecting-the-vulnerable/mental-capacity-act/index.htm>
 National guidelines on advance care planning can be found at: <http://bookshop.rcplondon.ac.uk/details.aspx?e=267>

Safeguarding Older People

Context

Abuse of older people is common^{74 75}. 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^{76 77} introduced a new criminal offence of or wilfully neglecting a person without capacity.

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 year⁷⁵. 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

Training and development of staff

Context

Training of both 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 ageing⁷⁸. 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.

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.

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

Specific competencies and suggested training programmes for individual disciplines are described in the full version of the "Silver Book".

Information sharing

Context

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 and 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.

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.

Clinical Governance and Research

Clinical governance

The following national audits are 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)
- Stroke Improvement National Audit Programme (SINAP)

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 in the full version of the "Silver Book".

Whole system metrics

Health care systems may wish to analyse the following metrics, which should describe the system's performance about older peoples' care.

- 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 carer satisfaction survey
- Staff satisfaction survey

Research in geriatric emergency care

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.

Commissioning urgent and emergency care for older people

Service planning and delivery needs to align Acute and Emergency physicians, Geriatricians, General Practitioners and social care with multi-disciplinary 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. This will lead to reduced admission rates, reduced readmission rates and ultimately reduced need for long-term care. See: http://www.rcgp.org.uk/pdf/Urgent_emergency_care_whole_system_approach.pdf

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