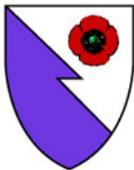


QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS

Executive Summary



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 health and social 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. Recent national reports including from Patient UK, Care Quality Commission, NCEPOD and the Health Service Ombudsman highlighted major deficiencies in the care of older people in acute hospitals ranging from issues around privacy and dignity to peri-operative care. Older people are admitted to hospital more frequently, have longer length of stay and occupy more bed days in acute hospitals compared to other individual groups. There is a pressing need to change how we care for older people with urgent care needs, to improve quality, outcomes and efficiency. Emergency departments need to be supported to deliver the right care for these people, as no one component of the health and social care systems can manage this challenge in isolation; implementation of improved care for older people requires a whole system approach.

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 non-conveyed individuals directly to urgent care, community and primary care services, including falls services.

Attendance at the Emergency Department is associated with a high risk of admission for older people, and the nature of the service and the environment in which it is provided 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. Dedicated teams delivering comprehensive geriatric assessment can support this, but in themselves are not sufficient to realise whole system change. Services 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 outcomes. There needs to be greater working across disciplines, both between professions (e.g. social care, 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 holistic care for frail older people in the years to come.

Silver Book Membership

Age UK, National Ambulance Service Medical Directors, Association of Directors of Adult Social Services, British Geriatrics Society, Chartered Society of Physiotherapy, 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, Emergency Nurse Consultants Association and the 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

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 the 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 person centred approach provides the only means to achieve the best outcomes for frail older people with health and social crises

Standards

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

These assessments will need to be undertaken by various teams and should be prioritised according to the needs of the individual

The presence of one or more frailty syndrome (see box 1) should trigger a more detailed comprehensive geriatric assessment, to start within 2 hours (14 hours overnight) either in the community, person's own home or as an in-patient, according to the person's needs

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

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)⁵⁻⁸

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 appropriate⁹

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

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

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

Box 1 Frailty syndromes – a 30 second guide

Older people tend to present to clinicians with non-specific presentations or frailty syndromes, in contrast to the classical presentation seen in younger people. The reasons behind the non-specific presentations include the presence of multiple comorbidities, disability and communication barriers. The ability to recognise and interpret non-specific syndromes is key, as they are markers of poor outcomes.

Falls

Distinguish between syncopal (e.g. cardiac, polypharmacy), or non-syncopal (strength, balance, vision, proprioception, vestibular and environmental hazards all to be assessed).

Immobility

'Off legs' can hide many diagnoses ranging from cord compression to end-stage dementia. A comprehensive assessment is needed to focus on the urgent and important issues to be addressed.

Delirium and dementia

These are closely interrelated but each requires clinically distinct management – collateral history is key to detect a recent change in cognition; it is common for delirium to be super-imposed on pre-existing dementia. Delirium can be hyperactive, hypoactive or mixed.

Polypharmacy

Adverse drug events lead to increased hospital stay, morbidity and mortality⁹. Consider a medication review focussing on identifying inappropriate prescribing, as well as drug omissions (e.g. STOPP/START¹⁰). Consider also medicines reconciliation

Incontinence

An unusual acute presentation, but a marker of frailty and a risk factor for adverse outcomes. More common is abuse of urine dipstick testing leading to erroneous diagnosis of infection, inappropriate antibiotics and increased risk of complications such as clostridial diarrhoea.

End of life care

Mortality rates for frail older people in the year following discharge from hospital, which presents an ideal opportunity to consider advance care planning¹³.

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

An acute crisis in a frail older person should prompt a structured medication review; this may require the support of pharmacists in some settings.

When suspecting lower urinary tract infections in people unable to express themselves, urine dipstick testing should only be considered in individuals with unexplained systemic sepsis (which may manifest as delirium). A urine dip should not be used to diagnose a urinary tract infection in coherent individuals without lower urinary tract symptoms, it can be misleading.

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

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

Discharge planning

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

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

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

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

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

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

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

General practices should monitor hospitalisation and avoidable ED attendances and determine whether alternative care pathways might have been more appropriate

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

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 people 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

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

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

If a procedure is required for a person 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.

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

Mental Health

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.

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

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

Recommendations on safeguarding

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

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

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

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

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

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

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

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

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

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.

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, falls and bone health, continence). See:

http://www.rcgp.org.uk/pdf/Urgent_emergency_care_who_le_system_approach.pdf