



## **BGS Best Practice Guide Acute Medical Care of Older People** (Revised August 2004)

### **Introduction**

Acute medicine has been defined as that part of General (Internal) Medicine concerned with the immediate and early specialist management of adult patients, with a wide range of medical conditions, who present in hospital as emergencies. The demand for acute medical admission has risen relentlessly over recent decades and older people constitute the fastest growing section of the admitted population. This rise exceeds demographic change and may reflect an increase in multiple admissions of individual patients. The rise in demand for acute admissions has been accompanied by a decline in the number of acute hospital beds and this has driven the development of early supported discharge and admission avoidance schemes. The clinical problems and needs of older patients are often substantially different from those of younger patients. Many older patients are admitted with acute or sub-acute medical illness, which often presents in an atypical or non-specific manner, and may be accompanied by cognitive or functional deterioration. Furthermore, many older patients have multiple co-morbidities, poly-pharmacy and complex social care needs. Comprehensive Geriatric assessment provides an evidence-based model for the provision of the co-ordinated multi-disciplinary care that these patients need. Geriatricians' involvement in acute medical care has substantially increased in recent years. It is not yet clear what impact the development of the specialty of Acute Medicine will have on this workload for Geriatricians.

### **Models of Service Provision**

The evolution of acute medical services for older people has resulted in various models of service provision: the needs – related (traditional), age-defined and integrated models (*see Appendix 1*). All these models share the same strategic aim which is to ensure that older people have access to the specialist skills and experience of a Geriatrician and a multi-disciplinary team. The central tenet must be that an acutely ill older patient has immediate access to investigations and treatment by appropriately trained medical, nursing and allied health professionals. All models are age-related, in that virtually all patients in the specialty department are aged over 65. A combination of models, or variations, may be appropriate in some areas, but the type of service provided should be the one which meets the local needs of the older population.

### **Principles of Service Provision**

The General Practitioner (GP) has a long - term knowledge of the patient and is best placed to decide whether referral should be for acute care or less acute assessment and rehabilitation, which may be on another site. GPs should be guaranteed a simple referral system with an agreed policy provided by the Geriatric, Accident and Emergency and General Medical services. It is essential that there is no duplication of services within the same area.

Older people with single pathology, whether under the care of Geriatricians or General Physicians, should have adequate and equal access to sub-specialty Physicians. Those with non-specific symptoms of acute illness manifest as failed function (confusion, falls or immobility), and the very elderly, are more appropriately cared for by Geriatricians and a multi-disciplinary team. All older patients should have access to investigations and treatments based on need, without age-defined restriction to resources. By confirming the acute provision to those older people who benefit from the multi-disciplinary team, the Geriatrician is able to provide the spectrum of services which have long been established as an integral part of Geriatric Medicine e.g. assessment, rehabilitation, day hospital, continuing and respite care, outpatient and community liaison work.

By working alongside the General Physician in the acute hospital, using whichever model is appropriate locally, close liaison between specialists, sharing of junior staff and their appreciation of the value of the Geriatric multi-disciplinary team is encouraged. Junior medical staff in all specialities should be made aware of the local policies regarding care of the older patient as part of their induction programme. Nursing staff also gain from seeing the Geriatric multi-disciplinary team at work. Most General Physicians with a sub-specialty interest will be dealing with older people and it is beneficial to have had some experience in a specialist Geriatric setting. Discharge planning will improve in units where General Physicians are working alongside Geriatricians.

It has been proposed that the following are requirements for a system of care of older people with acute illness or sudden functional decline :

1. Provision of rapid , accurate investigation , diagnosis and treatment of medical problems.
2. Provision of rapid , accurate assessment and support of functional needs.
3. Provision of a period of co-ordinated rehabilitation.
4. Equity of access to specialist investigation and treatment.
5. Respect for individual patients` and / or carers` preferences regarding style and location of care.
6. Efficient and effective use of resources.

## **RECOMMENDATIONS**

### **Acute Services**

1. Admission for acutely-ill medical patients should be offered, without delay, regardless of age.
2. The acute medical assessment unit should have a clearly defined and written operational policy and a strategy for the delivery of acute medical care to older people, whether on the traditional, age-defined or integrated model.
3. A single referral point for GPs, to ensure the rapid admission of an acutely-ill person and, thereby, rapid referral to the most appropriate service soon after admission, should be provided. This can be facilitated by the use of common admission wards, to which patients of all ages are admitted, with daily involvement in post-take ward rounds by Geriatricians.
4. Closer liaison between Geriatricians and the Accident and Emergency department will benefit patients and improve junior medical staff training.
5. Medical and nursing staff of receiving units must be trained appropriately in the assessment and care of older people, wards must be properly equipped and patients must have ready access to relevant investigations and specialist advice. This means that all acute medical patients, regardless of age, should be admitted to the Acute (District General or Teaching) Hospital.
6. Management protocols for individual conditions, e.g. myocardial infarction and gastrointestinal haemorrhage, that have been agreed between specialists and Geriatricians, will help to ensure proper management of such acute illness in older people. These should be audited.
7. Transfer of patient care between colleagues in Geriatric and General Medicine (and other specialties ) should occur at a senior level.
8. Consultants in all specialties who treat older in-patients should always be aware of the need to plan their discharge from the day of admission.

### **Training**

1. The Royal Colleges of Physicians have recognised the desirability of experience in Geriatric Medicine at the level of General Professional Training. Further efforts must be made to facilitate such experience in the training of future Consultant Physicians in all specialties by encouraging the inclusion of such posts in rotational training programmes and improving the educational value of SHO posts in Geriatric Medicine.
2. All those who may be involved in the medical management of acutely - ill older people should have post-graduate training in Geriatric Medicine.
3. The Royal College of Physicians of London has recently stated that Geriatric Medicine is a crucial specialty in terms of its contribution both to service delivery of Acute Medicine and to the training of the next generation of Acute Physicians.

### **References**

1. Stuck A.E. et al. " Comprehensive geriatric assessment : a meta-analysis of controlled trials " Lancet 1993 ; 342 : 1032 – 6.
2. Royal College of Physicians of London Report May 1994: "Ensuring Equity and Quality of Care for Elderly People".
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4. Royal College of Physicians of Edinburgh. Scottish Intercollegiate Working Party Report April 1998 : " Acute Medical Admissions and the Future of General Medicine " .

5. Royal College of Physicians of London Working Party Report June 2000 : “ Management of the Older Medical Patient: Teamwork in the Journey of Care– the Interface between General ( Internal ) Medicine and Geriatric Medicine”.
6. Elder A.“ Can we manage more acutely ill elderly patients in the community ?”. Age & Aging 2001 ; 30 : 441-443.
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8. Royal College of Physicians of London, College Commentary September / October 2003 : “Emergency Medical Admissions : New Recommendations ”.
9. Royal College of Physicians of London Report April 2004: “ Acute Medicine: making it work for patients ”.
10. BGS England Council. May 2004 : “The Challenge of Consultant Geriatric Medicine in England ”.

## ***APPENDIX 1***

### **a) THE NEEDS - RELATED (TRADITIONAL) MODEL**

Patients are selected by non-Geriatricians, usually by GPs or, after preliminary assessment, by medical staff in the Accident and Emergency Department, for referral either to Geriatric or General Medical services. This model is based on the premise that Geriatric Medicine is the specialty which best deals with older people who present in a certain way i.e. non-specific symptoms combined with cognitive or functional decline, on a background of multiple pathology and complex social care needs. Particular problems (e.g. confusional states or recurrent falls) may be identified as automatically appropriate for Geriatric care in some centres.

### **b) THE AGE - DEFINED MODEL**

All medical patients above a certain age, referred to hospital, are admitted to the Geriatric service .The commonest defining age is 75 years (but this varies from 65 to 85 years). This model has been justified on biological, screening and pragmatic grounds. However, biological distinction between younger and older adults is difficult to substantiate on medical grounds and age has not yet been shown to be a valid screening variable for identifying those patients who would do better under Geriatric than General Medical care. Surveys of age-defined services in the UK reveal that the defining age is often determined, on pragmatic grounds, by the number of patients who a Geriatric service can accommodate within its current allocation of acute care beds.

### **c) THE INTEGRATED MODEL**

Geriatricians serve as members of multi-Consultant Medical teams, take equal part in acute General Medical work and are also responsible for providing specialist Geriatric services including rehabilitation, day hospital, outpatient, continuing care, and community liaison work. A Consultant Geriatrician shares a team of junior doctors with other General Medical colleagues: this is recommended by some as a rational response to the biological nature of ageing and the pattern of health and social needs of an ageing population.

A combination of the three models is possible, and may be appropriate.

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patients. Many older patients are admitted with acute or sub-acute medical illness, which often presents in an atypical or non-specific manner, and may be accompanied by cognitive or functional deterioration. Furthermore, many older patients have multiple co-morbidities, poly-pharmacy and complex social care needs. Comprehensive Geriatric assessment provides an evidence-based model for the provision of the co-ordinated multi-disciplinary care that these patients need. Geriatricians' involvement in acute medical care has substantially increased in recent years. It is not yet clear what impact the development of the specialty of Acute Medicine will have on this workload for Geriatricians.

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