QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS

Clinical

[Logos of various organizations]
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 as opposed to 20 million encounters in emergency departments. 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. Larger practices and increasing distance from a hospital are associated with lower admission rates. Being able to consult a particular GP, an aspect of continuity, is associated with lower emergency admission rates. 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. 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. Managing demand with community based preventive interventions and providing urgent care in community settings provides some scope for reducing acute hospital admissions, but despite the increasing availability of such care models, they have had only modest impact, 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.

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
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. In many instances, careful and early consideration of the actual and potential role being played by social care in preventing admission and/or facilitating early discharge will pay dividends – both in terms of benefit to the older person and in terms of smoother and quicker pathways and patient journey. 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 caring for 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\(^\text{17}\). These include:

- Integrated care schemes including case management, geriatric assessment, multidisciplinary working, a single entry point and financial levers\(^\text{18}\)
- Continuity of care\(^\text{19, 20}\), 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\(^\text{21}\)
- Person centred nursing care\(^\text{22}\), encapsulated by:
  - ‘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)
- Personalisation is the way of delivering person centred social care which also can include people managing their own care and increasingly their own personal budget

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\(^\text{23-33}\). 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’\(^\text{34}\). 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\(^{35}\), it is logical that discharge should occur as soon as the individual’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\(^{35}\)\(^{36}\), 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 therapies.

**Whole systems approach**

Multidimensional assessment and multiagency management of older people leads to better outcomes\(37\). 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. is a representation of the urgent care axis and the possible interventions that might help with transformational change to increase appropriate response to urgent care needs.

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**Figure 1 Urgent care axis – points for intervention**
Chapter 3 Older people in different clinical settings

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

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. Domiciliary care and provision of equipment e.g. commodes are often the bare essentials, yet overall contact hours of domiciliary 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 person focused and driven by individual needs.

• People 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.

• Advance care planning and patient held records can support appropriate decision making in the contact of long term conditions management and end of life care.

• Disease prevalence alone cannot explain the rise in self-referrals and attendances 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.

• GPs working jointly with pharmacists undertaking medicine reviews can lead to better outcomes including reduced falls and hospital admissions.

• 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. 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 and telecare may help support older people in their own homes, especially to anticipate problems and to support treatment and monitoring.
Out of hours 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 individual’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 services cost around £1.9Bn or 2% of NHS spend each year but have an impact on over £20Bn or 20% of NHS spend (National Audit Office, 2011). The regional NHS ambulance services receive and respond to approximately 7.5 million emergency calls each year; in addition to providing a high quality emergency clinical response to patients they also have an essential role in the care of patients with urgent care needs to dial 999.

Increasingly, ambulance services are being recognised as having a wider role, as being pivotal to the performance of the entire urgent and emergency care system. They have developed considerably from the days when their only response was to transport patients to hospitals. Ambulance services now manage between 30% and 50% of all 999 calls without taking a person to a hospital, by providing advice (hear & treat), referring to an appropriate alternative service (see & refer), or by treating the person on scene (see & treat). As a result of the implementation of these local services, the role of NHS ambulance services, and the skills and competencies of their clinicians, has changed significantly. Responsive ambulance services that can initiate an effective emergency response, but that are well integrated with unscheduled but non-emergency care can therefore be critical to effective demand management, and the efficiency of wider local health systems. There is good evidence to support the role of the ambulance services in both providing high quality clinical care and signposting patients to the right care, either through telephone or face to face clinical assessment. This is supported by the development of intelligent telephone triage systems (such as NHS Pathways) that are linked via a capacity management system (CMS) to local directories of health and social care services (DoS) which Ambulance Trusts are implementing to support system planning and management. Ambulance services will continue to have an increasing role in the centre of urgent and emergency care systems providing emergency care for those who need it and to utilise alternative care pathways.

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 individual 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

<table>
<thead>
<tr>
<th>Outcome from stroke</th>
<th>Outcome from cardiac arrest</th>
<th>Outcome from ST elevated myocardial infarction</th>
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<tr>
<td>o return of spontaneous circulation</td>
<td>o discharge from hospital</td>
<td>Time to answer call (999)</td>
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<tr>
<td>Outcome from stroke</td>
<td>Outcome from cardiac arrest</td>
<td>Time to treatment</td>
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<tr>
<td>Call abandonment rate</td>
<td>Category A eight-minute response time to life-threatening calls</td>
<td>Calls closed with telephone advice or managed without transport to A&amp;E</td>
</tr>
<tr>
<td>Category A 19-minute response time to serious but not life-threatening calls</td>
<td>Recontact rate following discharge of care</td>
<td>Service experience</td>
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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 people 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 which can reduce falls-related hospital attendances/advanced paramedics who have completed a specific education programme can provide the initial management and stabilisation of a variety of conditions including hypoglycaemia, COPD, heart failure and other frequent fallers.

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

- [http://aace.org.uk/ambulance-leadership-forum/](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, and a meta-analysis of these studies provide some evidence of improved outcomes. Hospital at home schemes that include multidisciplinary care and medical input can be effective and could support ED based teams such as those described above, as well as reducing the need to access EDs.

**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, overstimulation and so on is minimised. However it should not be close to an exit.
- EDs should be configured in such a way that they can screen for common frailty syndromes in all older people, and then initiate (but not necessarily deliver entirely) more detailed assessments in selected individuals. This will need to be commissioned and provided on a local basis according to locally agree pathways and service models.

**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 is 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 person 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 individual can gaze at them without discomfort.

- 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 individual (examples that are proven to work are pastel shades, flowery curtains, 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.

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"50.

Key points
There should be no discrimination on the basis of individuals’ age when decisions are made about access to acute medical services, and about the quality of service subsequently provided and received50.

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 people51, 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 policies52 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 home24, 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)53.

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 people 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’54. In addition the clear policy direction of providing care in the community closer to home55 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 people 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 people’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 older people 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 individual 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\textsuperscript{56–62}. 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

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


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\textsuperscript{63}.

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 stay and admission to institutional care\textsuperscript{63–66}

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\textsuperscript{67}. 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.66-68

National standards and guidelines on the assessment and management of dementia can be found at:
http://www.nice.org.uk/CG42

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.66 It is a common non-specific presentation of physical illness in older people and the most common complication of a hospital admission.69 Despite this, it is poorly detected and recorded with 33-66% of cases undiagnosed or misdiagnosed.69-71 Failed detection in emergency departments is associated with a seven-fold hazard for increased mortality.69 72 Delirium in the ED is an independent predictor of hospital length of stay.73 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 individual 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 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 individual’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 people 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:

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 is a quick useful tool to screen for depression, shorter versions are available that might be suitable for brief screening in the ED (e.g. GDS-1).

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. However older people who self-harm have high levels of suicidal intent 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. 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. 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. NICE states that mental health professionals must be experienced in assessing older adults who have self-harmed to undertake assessment of this age group. 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\(^{81}\) 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 people with hip fracture 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\(^{82}\) or the AGS/BGS Guideline\(^{81}\). 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)\(^{83}\). 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 individual’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 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\(^{85}\).

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\(^{86}\). 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.nice.org.uk/CG021)
- [http://www.bgs.org.uk/Publications/Compendium/compend_4-5.htm](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](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 through 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, but more in older people, leading to increased hospital stay and significant morbidity and mortality.

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 the individual’s prognosis, or failure to use a drug that may improve outcomes.

Inappropriate prescribing is more common in older, as compared to younger, older people. Potential reasons for inappropriate prescribing in older people are related to the higher prevalence of chronic diseases and polypharmacy, which render prescribing more complex. 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.

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, and recognition of ADEs in older people is complicated by non-specific clinical presentations.

Various guidelines have been developed to help reduce potentially inappropriate prescriptions amongst older people, although there is no internationally agreed standard. 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, and early results from a small RCT suggest these criteria may be beneficial.

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\textsuperscript{104} 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 people with hip fracture 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 people 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 assessment and management

Given the frequent presence of complex co-morbidities in these individuals 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 people who are dying 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 2012.

Pain

The use of traditional pain scales can be difficult because of communication barriers, such as cognitive impairment, alternative assessment processes that rely on non-verbal cues may be more useful in some older people. Pain management in people 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 individual. 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 individual’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 person and their normal behaviour. The modified Abbey pain scale has a strong emphasis on involving the person’s 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\textsuperscript{105}
**Urinary tract infections**

Possible urinary tract infection (UTI) is a common presenting problem or initial diagnosis in the ED, however, the diagnosis of UTI is frequently overestimated, especially in care home residents\(^\text{106}\), and frail older people more generally.

Asymptomatic bacteriuria should not be treated and symptomatic enquiry should therefore guide diagnosis. In people with Lower Urinary Tract Symptoms (LUTS), the absence of leucocytes and nitrates 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\(^\text{107}\). 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 nitrates has a disappointingly low positive predictive value of 44%\(^\text{108}\), and should only be considered in individuals with unexplained systemic sepsis\(^\text{109}\). 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\(^\text{110}\) and are therefore of limited value. Men have a high incidence of UTI secondary to organisms which may not form nitrates and should have urine sent for culture if they have symptoms of UTI, regardless of dipstick result\(^\text{107}\). 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**

<table>
<thead>
<tr>
<th>Patient history</th>
<th>Symptoms</th>
<th>Signs</th>
<th>Urine dip</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clear and unambiguous</strong></td>
<td>New onset of frequency, dysuria; Abdominal pain; Haematuria; Offensive smelling urine; Fever</td>
<td></td>
<td>Negative – seek other cause. Do not send MSU</td>
</tr>
<tr>
<td></td>
<td>No urinary symptoms</td>
<td></td>
<td>Do not dip urine, do not send MSU</td>
</tr>
<tr>
<td><strong>Lacking because of communication barriers</strong></td>
<td>Increased confusion, apathy, irritability (delirium), reduced mobility, off food Abdominal pain; Haematuria; Offensive smelling urine; Fever</td>
<td></td>
<td>Negative – seek other cause. Do not send MSU</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Positive for leucocytes and nitrates – likely UTI, send MSU and treat</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Leucocyte positive only – seek alternative diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nitrite positive only – send MSU and start treatment</td>
</tr>
</tbody>
</table>
National standards and guidelines on the assessment and management of UTI and continence can be found at:
http://www.nice.org.uk/guidance/CG40

**Nutrition**

The incidence of under nutrition amongst people admitted to hospitals in UK is 23% on those aged less than 65 years but 32% for those aged 65+[^111]. 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:

BGS Nutritional Advice in Common Clinical Situations:

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:
Quality Care for Older People with Urgent & Emergency Care Needs
“SILVER BOOK”

• 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:

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 usually advisable to embark on aggressive therapy irrespective of age or injury, except in the initially moribund individual. 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\textsuperscript{112}.

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\textsuperscript{113,114}. 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\textsuperscript{115}. 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\textsuperscript{116,117}. 

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National standards and guidelines on end of life care can be found at:
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 individual, 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 individual’s stay.

National standards and guidelines on the assessment of mental capacity can be found at:
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 setting will enhance person 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 person’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 (Error! Reference source not found.).

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 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 person requires an acute admission to hospital, planning for discharge or transfer of care should begin as soon as possible, operationalised as the setting of an Estimated Date of Discharge (EDD).

The Environment

Older people need to be cared for in environments that have a positive impact on physical and mental well-being including being nursed for in single-sex accommodation with adequate natural lighting and respect for privacy and dignity.

For further guidance please refer to:

http://www.bma.org.uk/health_promotion_ethics/psychologicalandsocialneedsofpatients.jsp?page=8
http://www.kingsfund.org.uk/publications/enhancing_the.html

The impact of global climate change with more resultant storms, floods and heatwaves in England in future, could have serious effects on the services, buildings, and communication routes that support the delivery of health and social care for older people. This is the subject of a current research project:

http://www.dur.ac.uk/geography/research/researchprojects/biopiccc/background/
Chapter 5 Safeguarding Older People

Context
Abuse of older people is common\textsuperscript{121 122}. 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 \textsuperscript{123 124} 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\textsuperscript{122}. 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 has 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

Key points
- 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