What's so *Comprehensive* about Comprehensive Geriatric Assessment?

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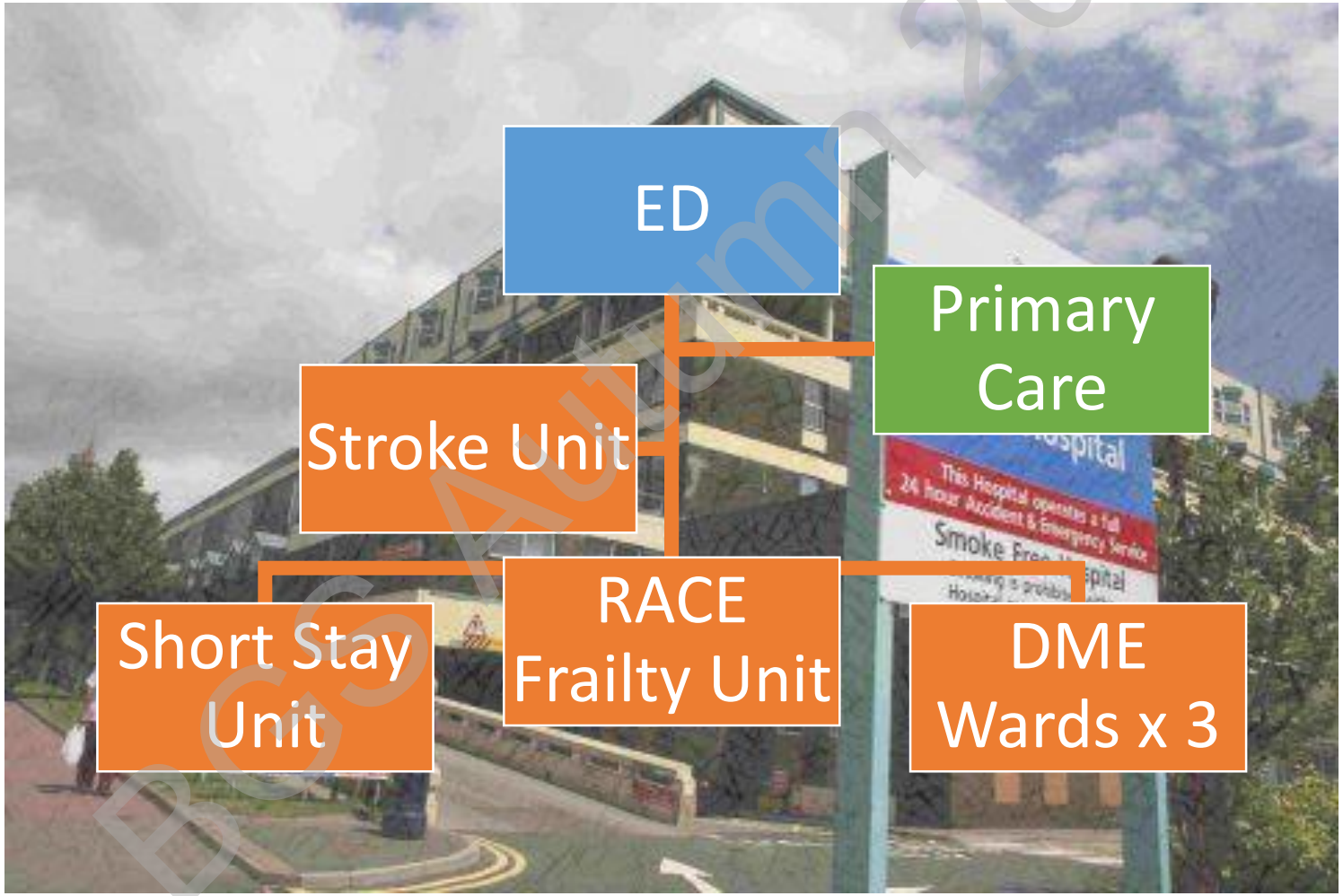
Comprehensive Geriatric Assessment

"Older patients are more likely to be alive and in their own homes at 1 year follow-up if they received CGA on admission to hospital"

"NNT to prevent one unnecessary death or admission to residential care 33"

Cochrane Review, 2017

Our pathway for older patients



NHS Dorset Clinical Commissioning Group

NHS South Western Ambulance Service NHS Foundation Trust

Dorset HealthCare NHS University NHS Foundation Trust

Borough of Poole

Dorset County Council

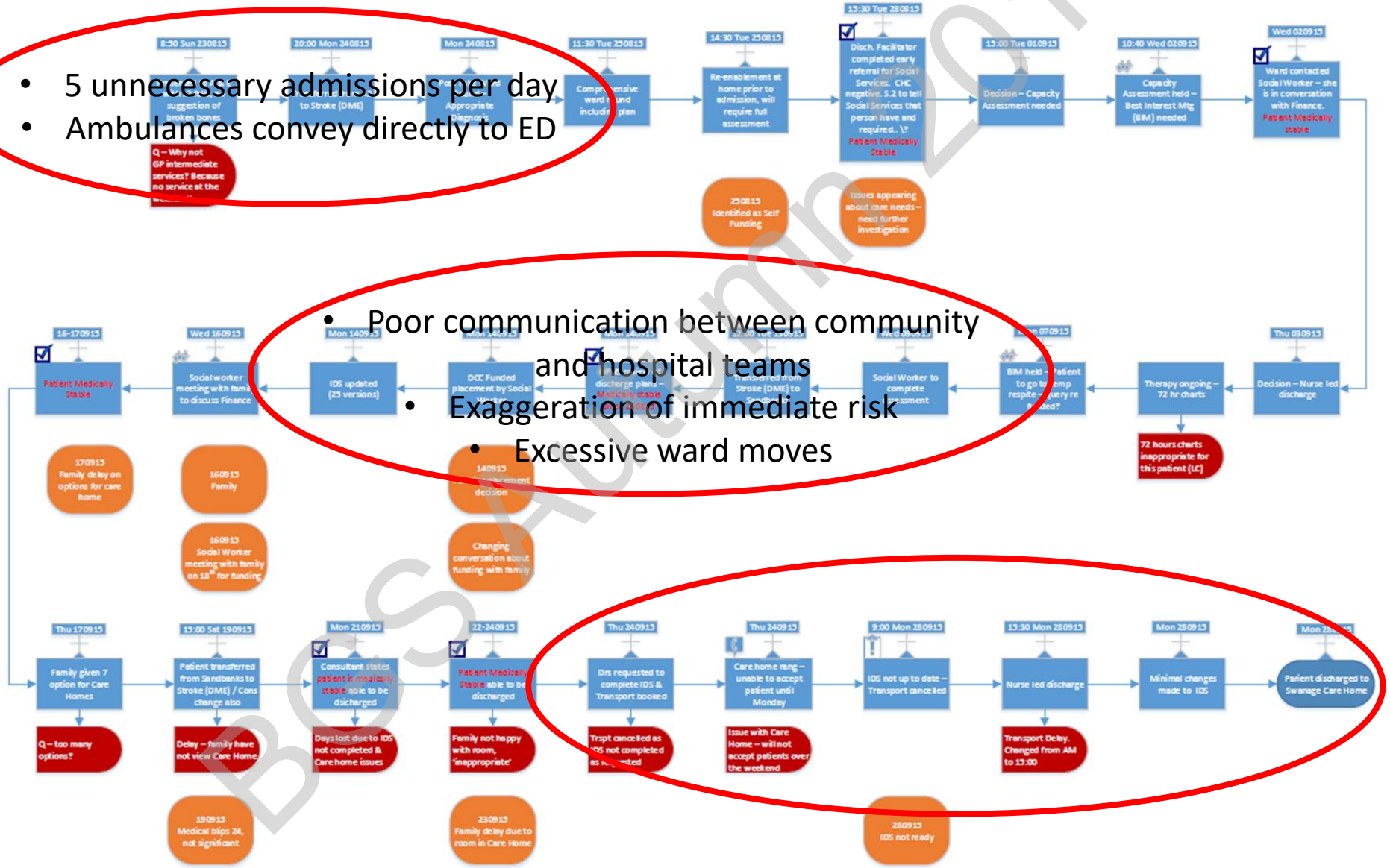
Bournemouth Borough Council

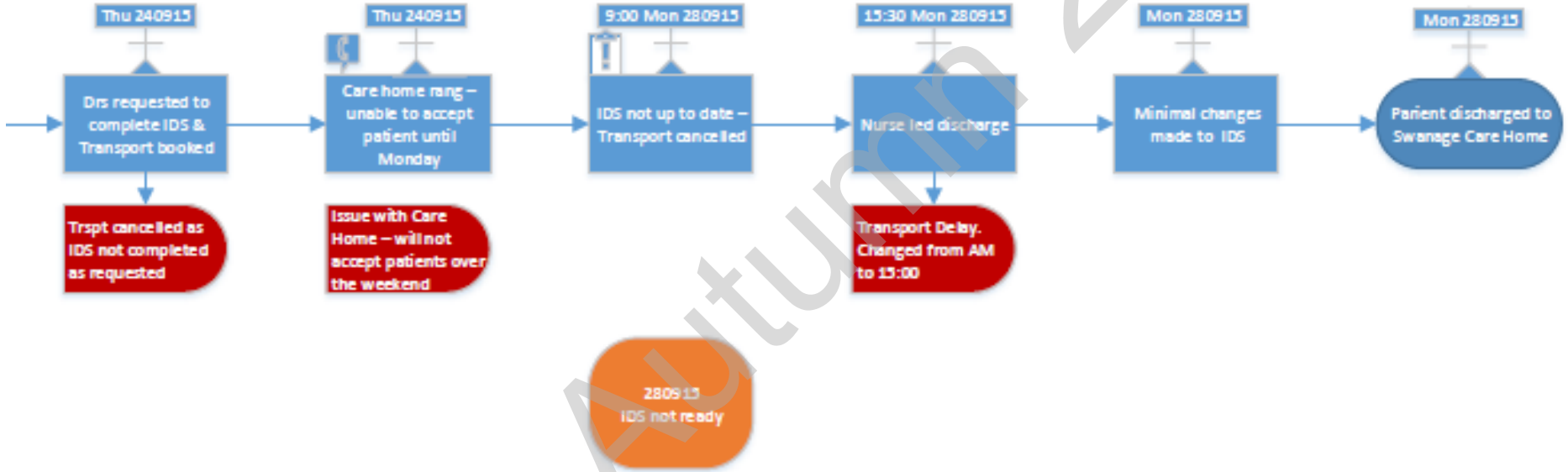
British Red Cross

Edith's story

- 5 unnecessary admissions per day
- Ambulances convey directly to ED

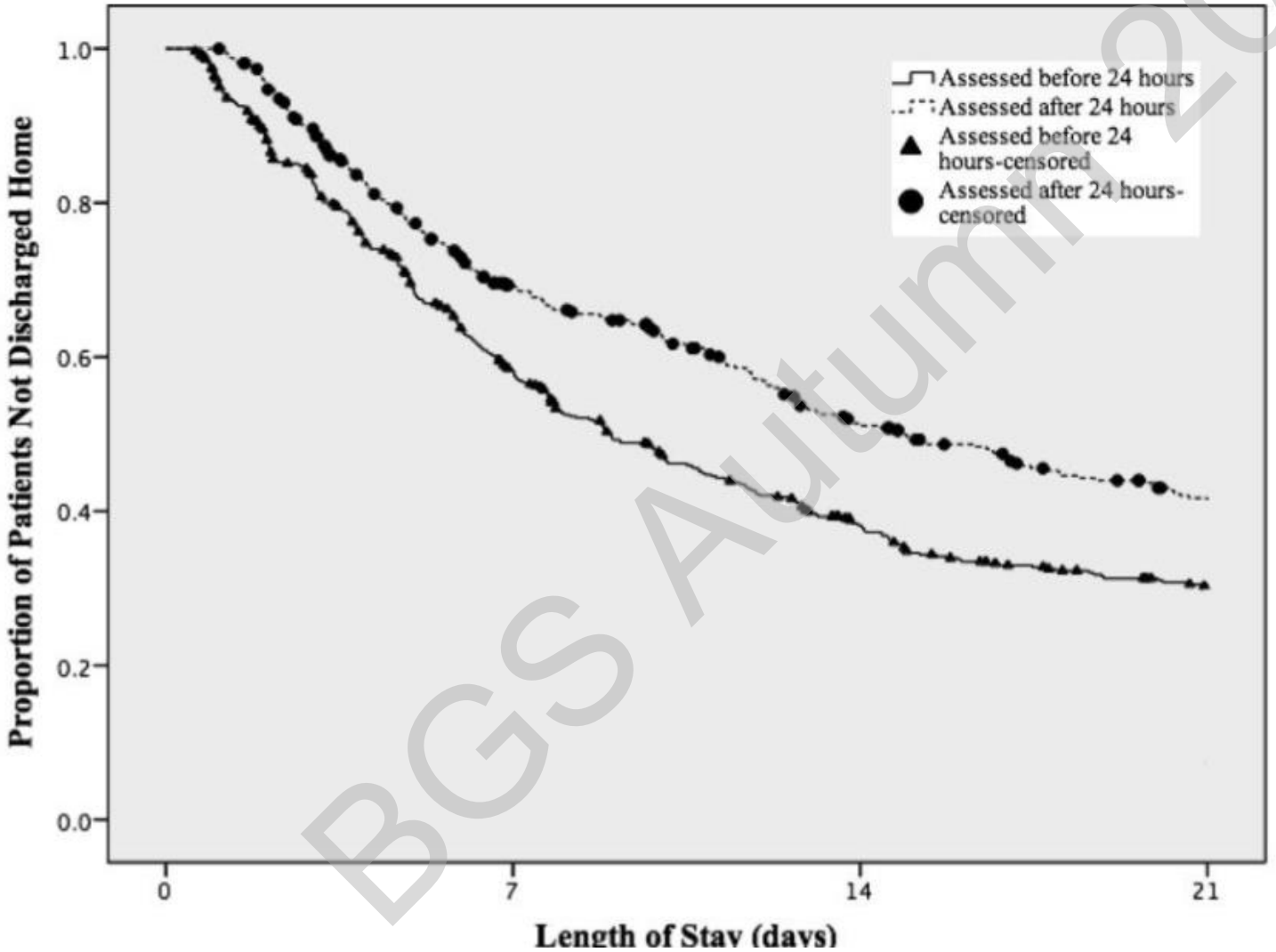
- Poor communication between community and hospital teams
- Exaggeration of immediate risk
  - Excessive ward moves





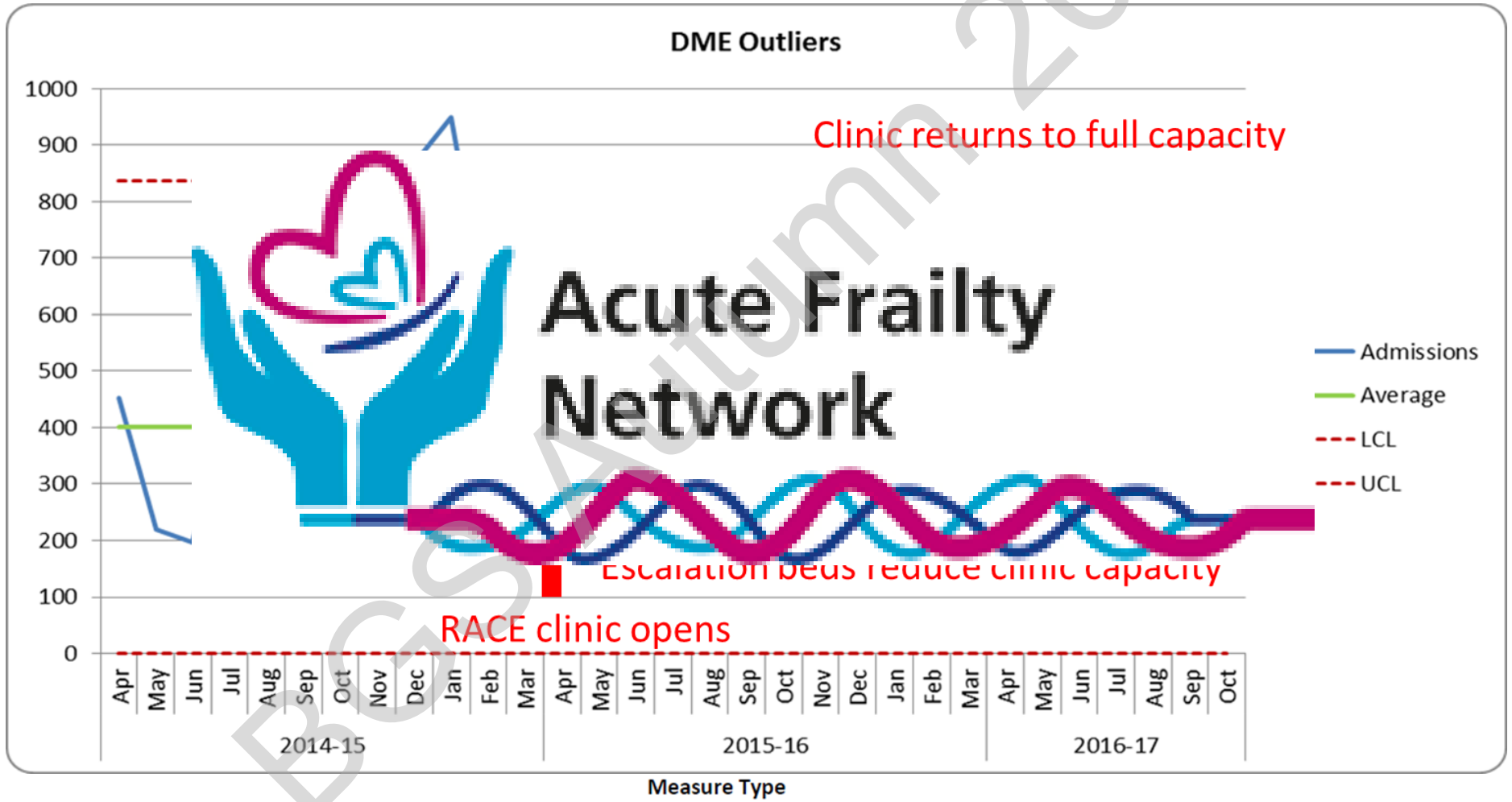
2 hour delay in completing discharge summary led to 4 extra days in hospital

Early physical therapy in hospital



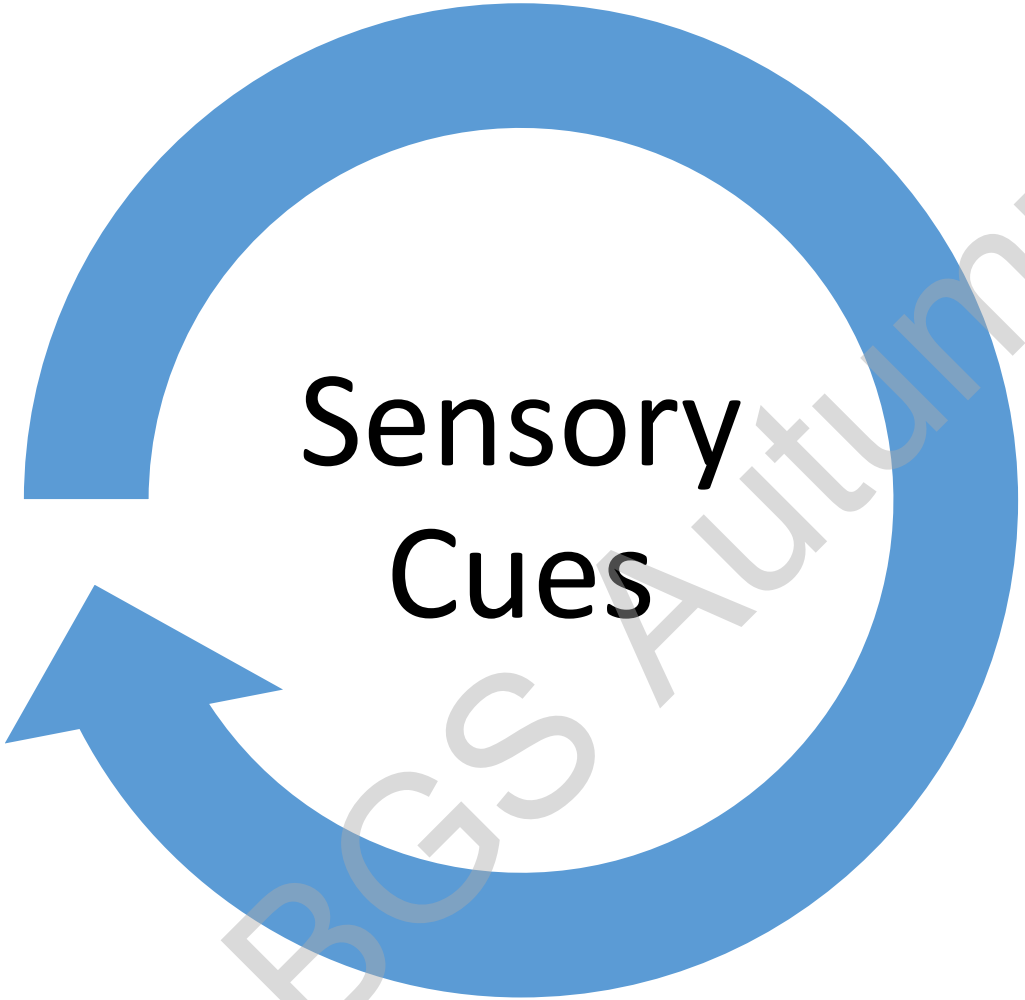
Hartley et al, 2017

ANP-led Ambulatory Clinic



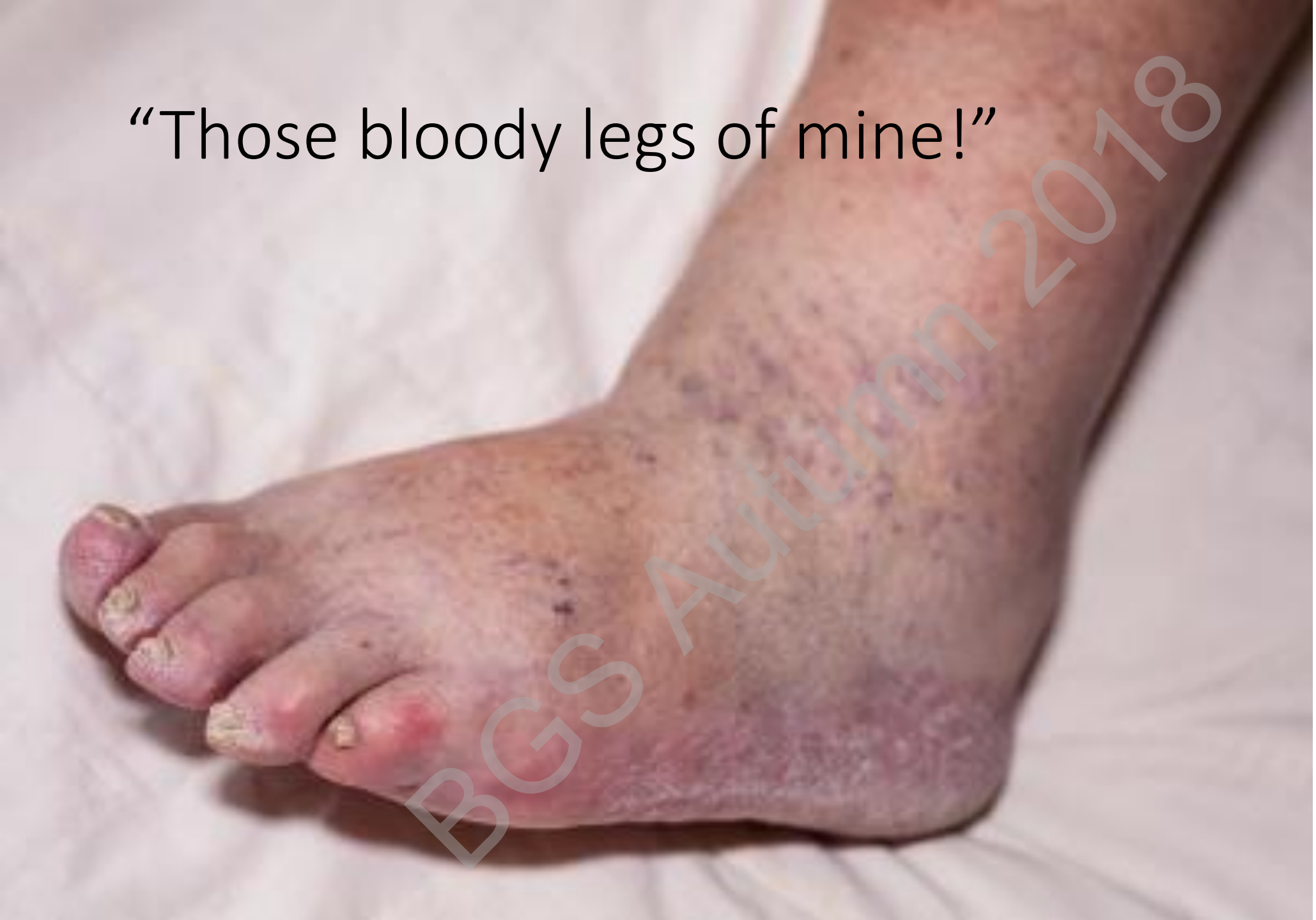
Meet Gordon

Opportunistic assessment



- Mood
- Social interaction
- Eye contact
- Appearance
- Movement/ Gait
- Speech
- Odours
- Cognition

“Those bloody legs of mine!”



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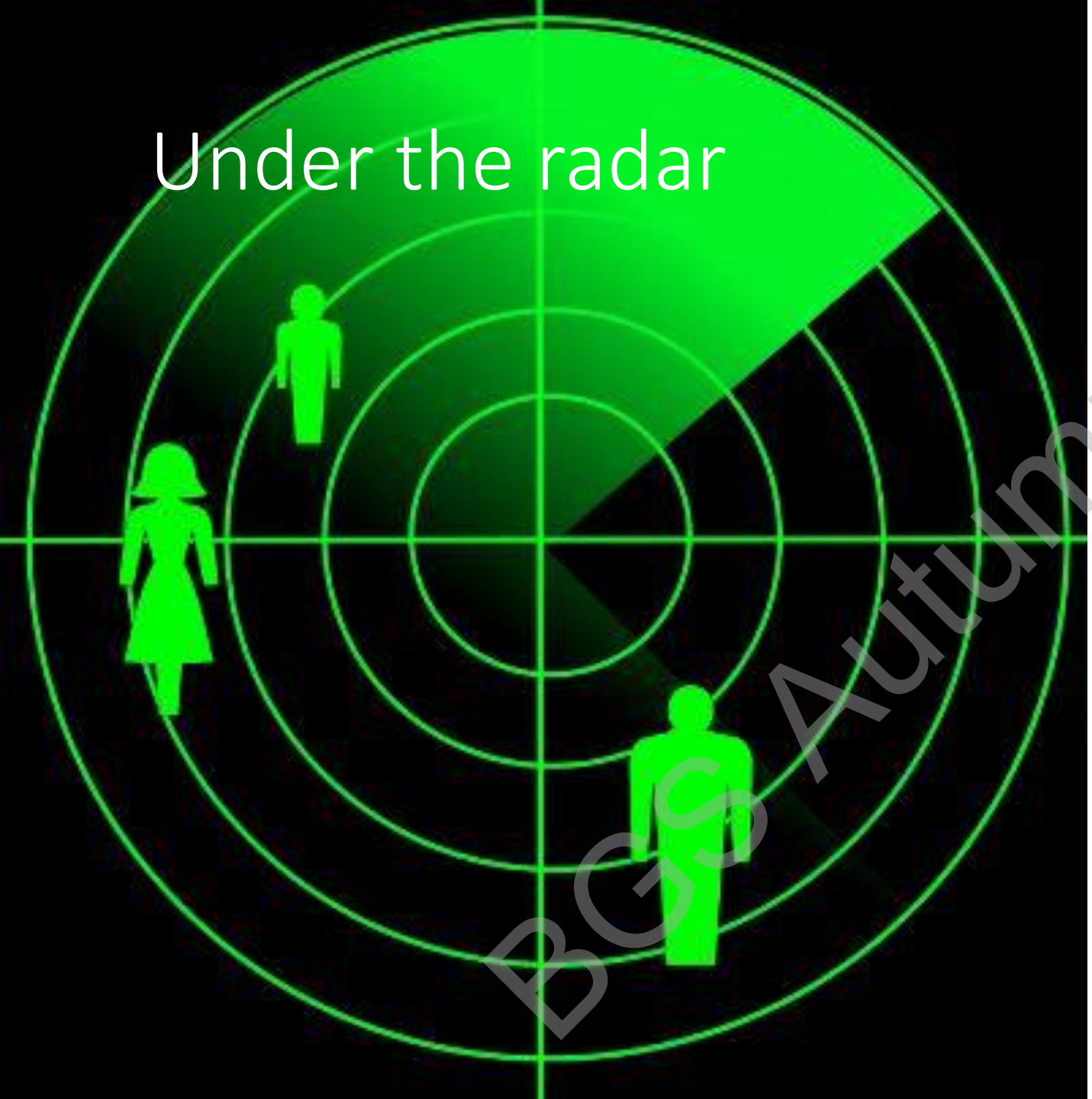
Clinical Examination

Under the radar



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Following full therapy initial assessment (psychosocial & physical)
Gordon was keen to be discharged home & agreed to support & review at home.

4 items issued to take home from AEC

1. Wheeled frame with Buckingham Caddy attached.

2. Scandia toilet frame

3. Blue leg lifter &
4. Urinary bottle + lid

Kitchen Trolley NOT issued,
as too unsteady.

Problem	Action
Pain Management	Analgesia, **IRCT** nurses to follow up and review
Medicine Management	**IRCT** review medicine and provide advise regarding MCA
High Risk of **Falls**	Refer to IRCT for further risk assessment and installation of Lifeline and keysafe
Reduced **mobility** (balance and transfers)	Issued with **equipment** for safe discharge. No **D2A** capacity. **IRCT** to review at home – especially to sleep in bed not recliner chair
pADL's / **dADL**'s	**IRCT** to assess further in home environment to identify further equipment/rehab needed-refer to social services
Weight Loss/Unbalanced **diet**	**Weighed**. **Red Cross** initial support (72 hours) –shopping, meal provision-explore meal delivery options. *Once home find belt for trousers & better shoes/slippers!*
Deteriorating **Vision**	**Red Cross** to arrange to take to usual opticians
Low mood/ **lifestyle change/ bereavement**	IRCT to support and review at home- refer to Silverline, Befriending service, bereavement support
Outpatient appointments	**Red Cross** to convey for outpatient echo
Continence & leg dressing	**SPOA** for **District nurse** to review continence and moisture lesion

OUTCOME

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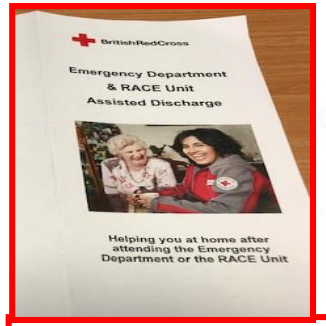
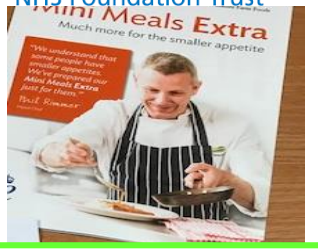


Red Cross support 72 hours & then
Support at home service
once a week for 4 / 52.

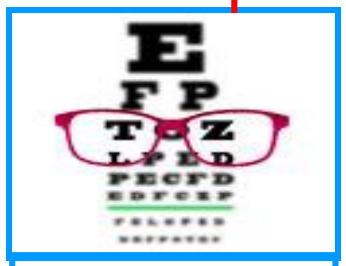
Sleeping in bed & leg oedema reduced

Skin heeled & weight gain & more stamina.
Regular nail cutting.



4/7 hot meal delivery

Happy at home,
Outpatient ECHO – (Red Cross)



New prescription glasses

District Nurses assessed continence. He chose to use small male Tena pads for reassurance - self purchased.

Lifeline & Key safe installed

Community walker using stick to local shops/ café/ library/ bank

IRCT ended. Kept toilet frame & new issue of kitchen trolley.
Motivated to exercise & awaiting next balance/falls group class in community.

MCA now delivered, compliant & much less pain in legs

The pre-hospital pathway

British Geriatrics Society
Improving healthcare for older people

Effective healthcare for older people

Position statement on primary care for older people

This paper sets out our views on how primary care can deliver better health outcomes for older people. We call for the changes required to achieve this to be built into the Government's long term plans for the NHS.

Introduction

The British Geriatrics Society (BGS) is the professional body of specialists in the healthcare of older people in the United Kingdom. Our vision is of a society where all older people receive high quality, patient-centred care when and where they need it. We have a strong interest in the effectiveness of primary care and the successful delivery of the NHS Five Year Forward View. We welcomed the increased investment included in the GP Forward View published in 2016 and the commitment to new models of care. We ask that this be built on now through the development and delivery of the NHS Long Term Plan due to be published this Autumn.

The identification and treatment of the effects of frailty in older people is now a core part of primary care. Our view is that there are some significant changes that would help to support and strengthen the delivery of primary care for older people living with frailty, whether mild, moderate or severe, and as people approach the end of life. They would help to ensure that older people are able to access the right care at the right time, would focus on prevention of deterioration and optimisation of independence, and help to better realise the benefits of financial investment.

We continue to call for increased financial investment in health and social care at a level that is sufficient to deliver high quality, patient-centred care, and for system wide reform in the longer term.

Identification and stratification

Frailty is a long-term condition affecting older people in which loss of homeostatic reserves means that minor changes in health lead to increased risk of serious adverse outcomes[1]. There is good evidence to show that early intervention can prevent some aspects of deterioration and enable people to live independently for longer.

The introduction in 2017 of the requirement for GPs to practice routine frailty identification for patients who are 65 and over, and those most at risk of adverse events (including hospitalisation, nursing home admission and death), is a development which we warmly welcomed. By using frailty identification tools such as the electronic frailty index (e-FI)[2] (backed up by clinical correlation) in primary care settings there is an increasingly strong evidence base to inform service design and planning, and to adapt interventions to better meet individual need.

Embedding planning, support and services in the community

As part of BGS's work we aim to raise awareness among healthcare professionals of the role of 'living well' in preventing disease. While keeping fit and maintaining a healthy lifestyle helps to prevent frailty[3] we cannot prevent the ageing process. Our view is that a significant shift is needed to deliver more care and treatment in the community, and that this shift requires a more proactive, planned and evidence-based approach. We are optimistic because much of the evidence and some of the tools required to deliver it already exist. Our vision is about ensuring that there is a clear strategic focus on prevention, optimising independence, and better health outcomes for older people, using multidisciplinary teams embedded in primary care services as a vehicle for improvement. Aligned financial incentives, clear leadership, a collaborative culture, and IT which supports integrated care are key to success of this approach. Clear evidence exists for this model of care.[4,5,6,7]

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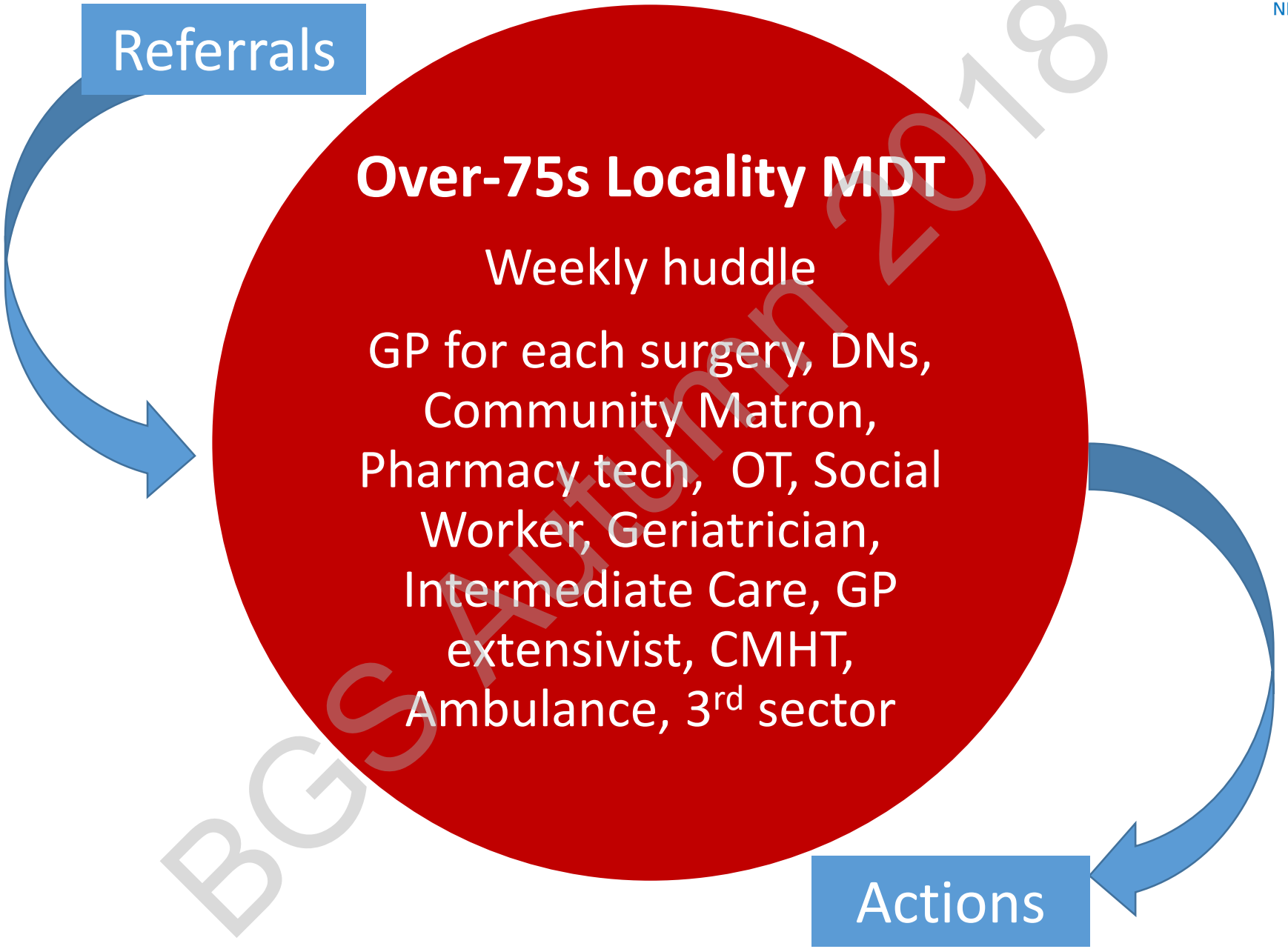
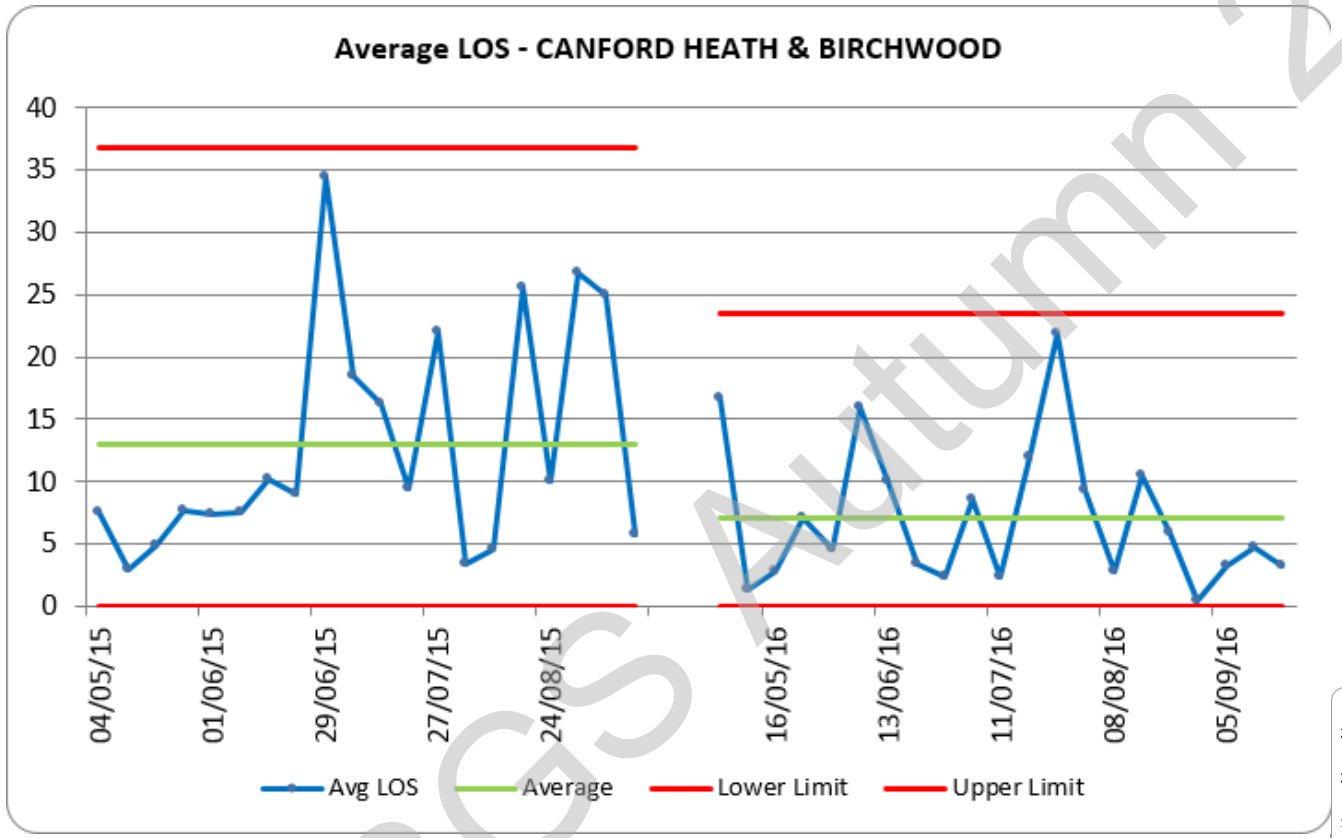
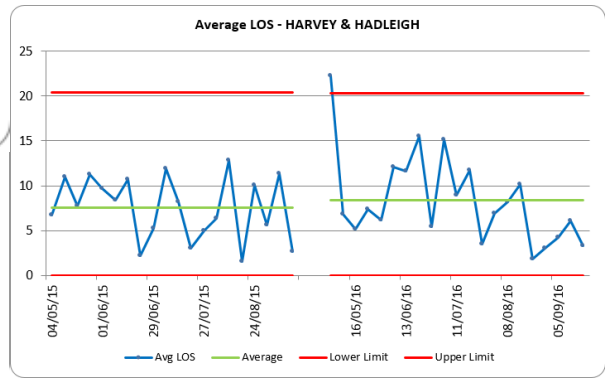
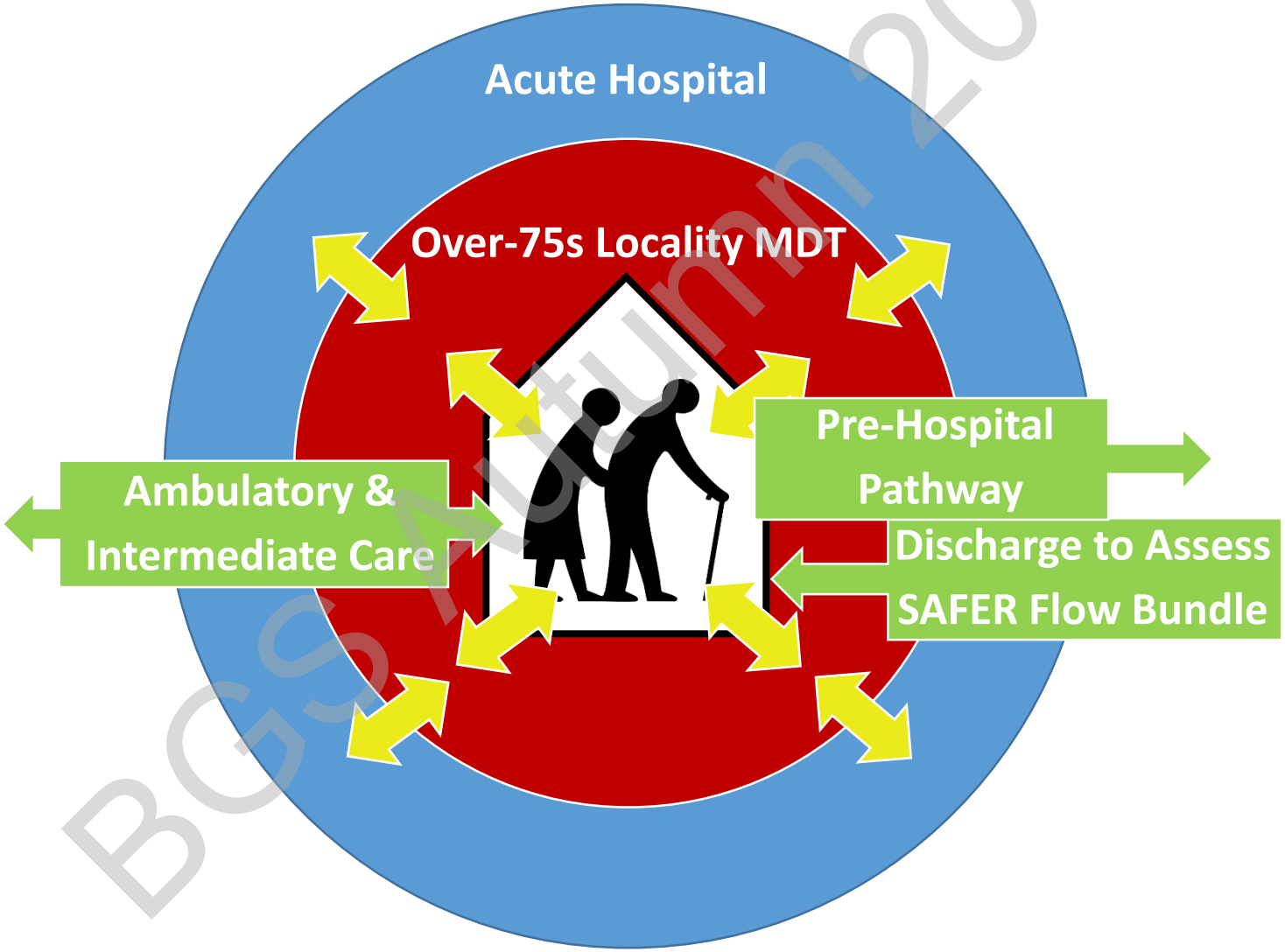


Is it effective?





How does it all fit together?



Thank you

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