Dr Matt Thomas, Poole Hospital NHS FT

Same day care for frail older people

Same day care for frail older people

isn't it just too risky?

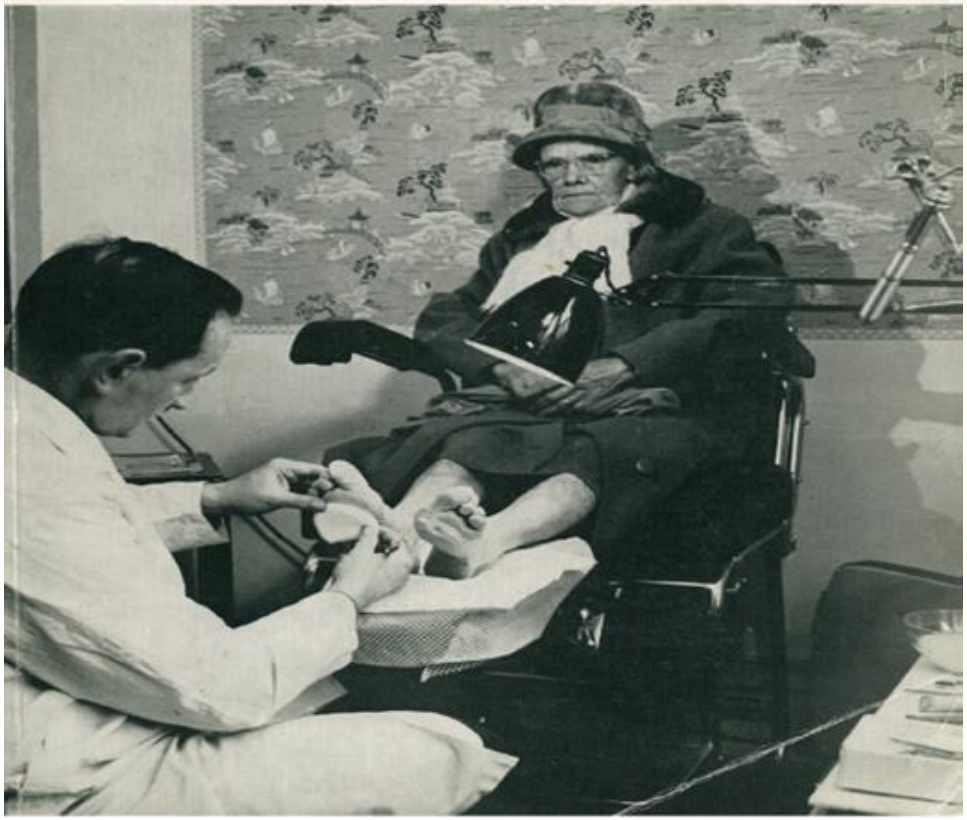
Dr Matt Thomas

Consultant Physician

Department of Medicine for the Elderly

Poole

MODERN BRITISH GERIATRIC CARE



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- Isn’t it risky seeing frail older patients in clinic?

- Did I just take a risk in starting the talk like that?
- Did I just manage the risk?

- Am I going to pose questions - yes
- Am I going to give the answers – no
- Will you leave feeling you need to find them –I hope so

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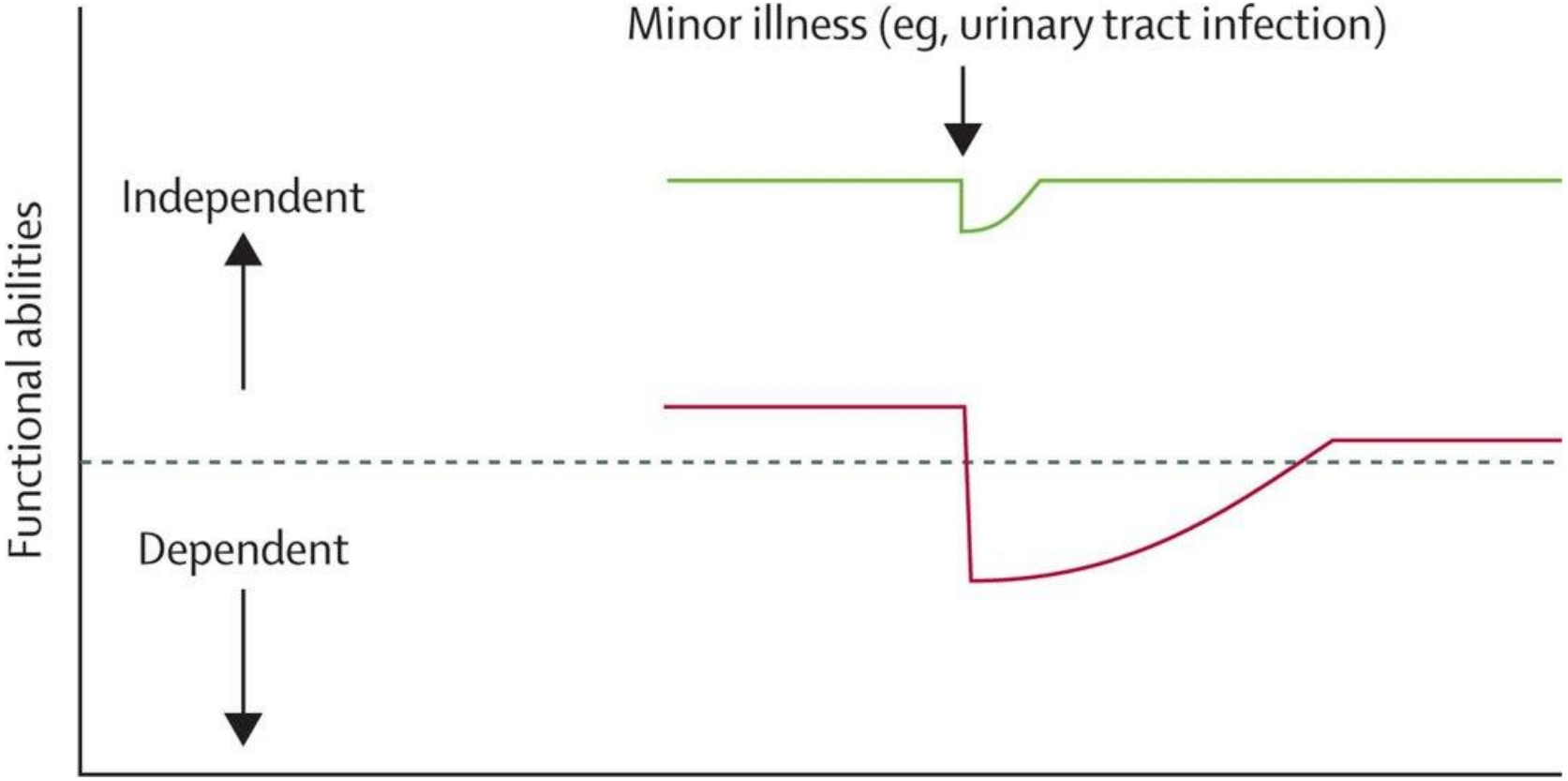
Taking a risk or managing a risk

- Manage it Together
  - GP
  - Int care
  - S Services
  - Vol sector eg Red Cross
  - Dealing with expectations
  - Patient and carers

They are just too frail – we need to admit


Minor illness (eg, urinary tract infection)
Independent
Functional abilities
Dependent

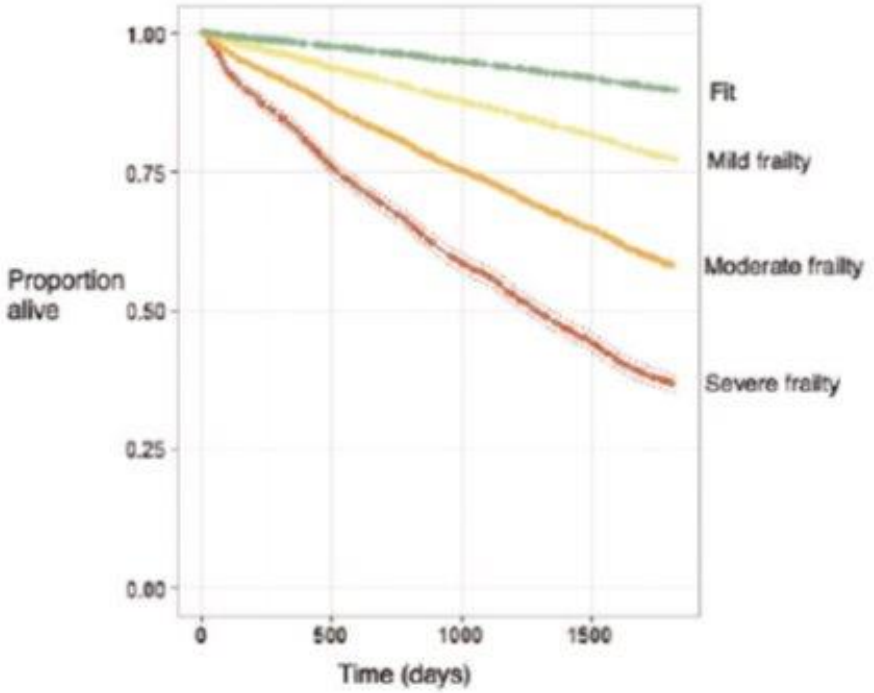


Figure 1. Five-year Kaplan–Meier survival curve for the outcome of mortality for categories of fit, mild frailty, moderate frailty and severe frailty (internal validation cohort).

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

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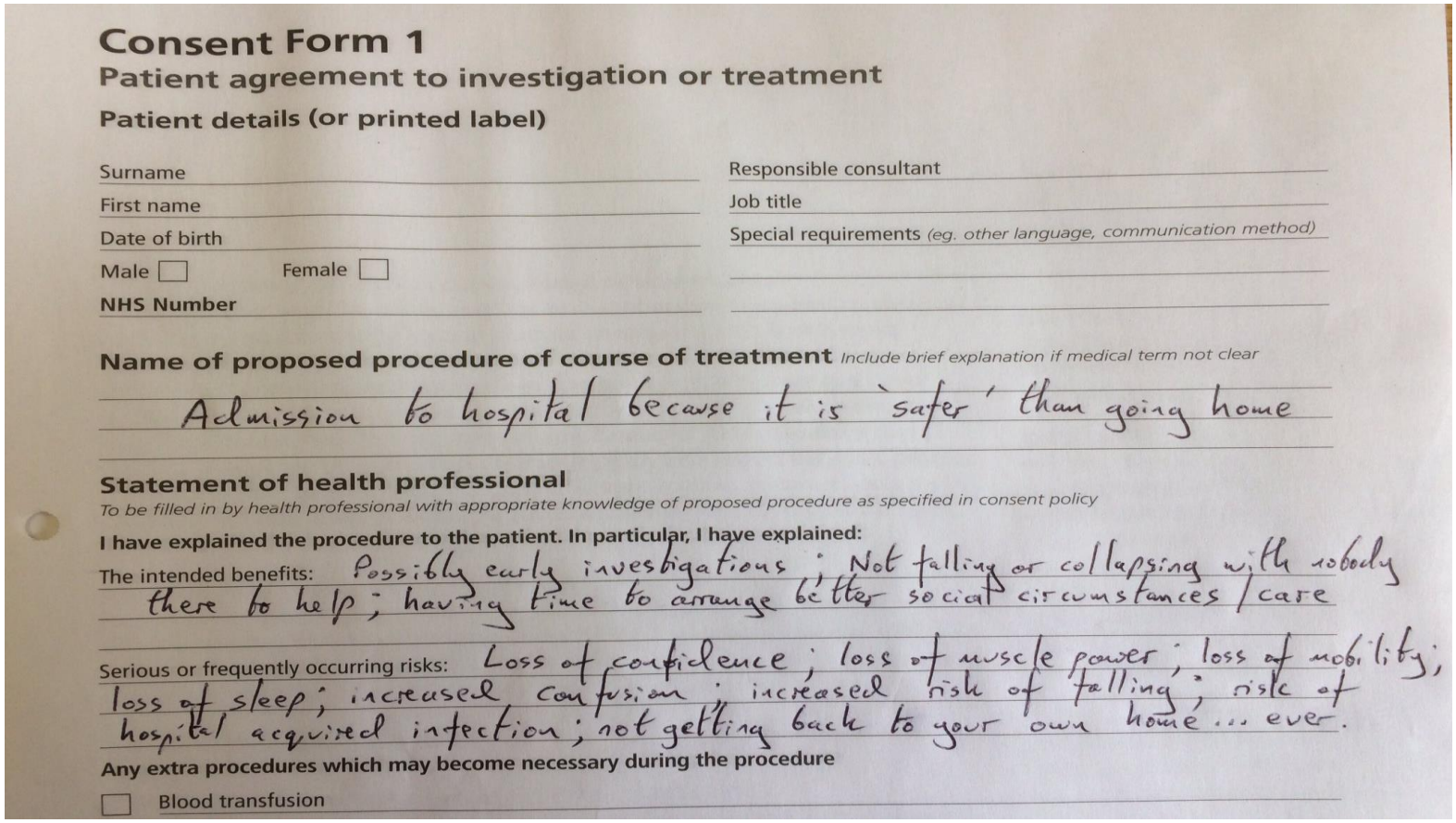

Consent Form 1

Patient agreement to investigation or treatment

Patient details (or printed label)

Surname

First name

Date of birth

Male ☐ Female ☐

NHS Number

Responsible consultant

Job title

Special requirements *(eg. other language, communication method)*

Name of proposed procedure of course of treatment *Include brief explanation if medical term not clear*

Admission to hospital because it is 'safer' than going home

Statement of health professional

To be filled in by health professional with appropriate knowledge of proposed procedure as specified in consent policy

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits: Possibly early investigations; Not falling or collapsing with nobody there to help; having time to arrange better social circumstances / care

Serious or frequently occurring risks: Loss of confidence; loss of muscle power; loss of mobility; loss of sleep; increased confusion; increased risk of falling; risk of hospital acquired infection; not getting back to your own home ... ever.

Any extra procedures which may become necessary during the procedure

☐ Blood transfusion

@DrSimonMc

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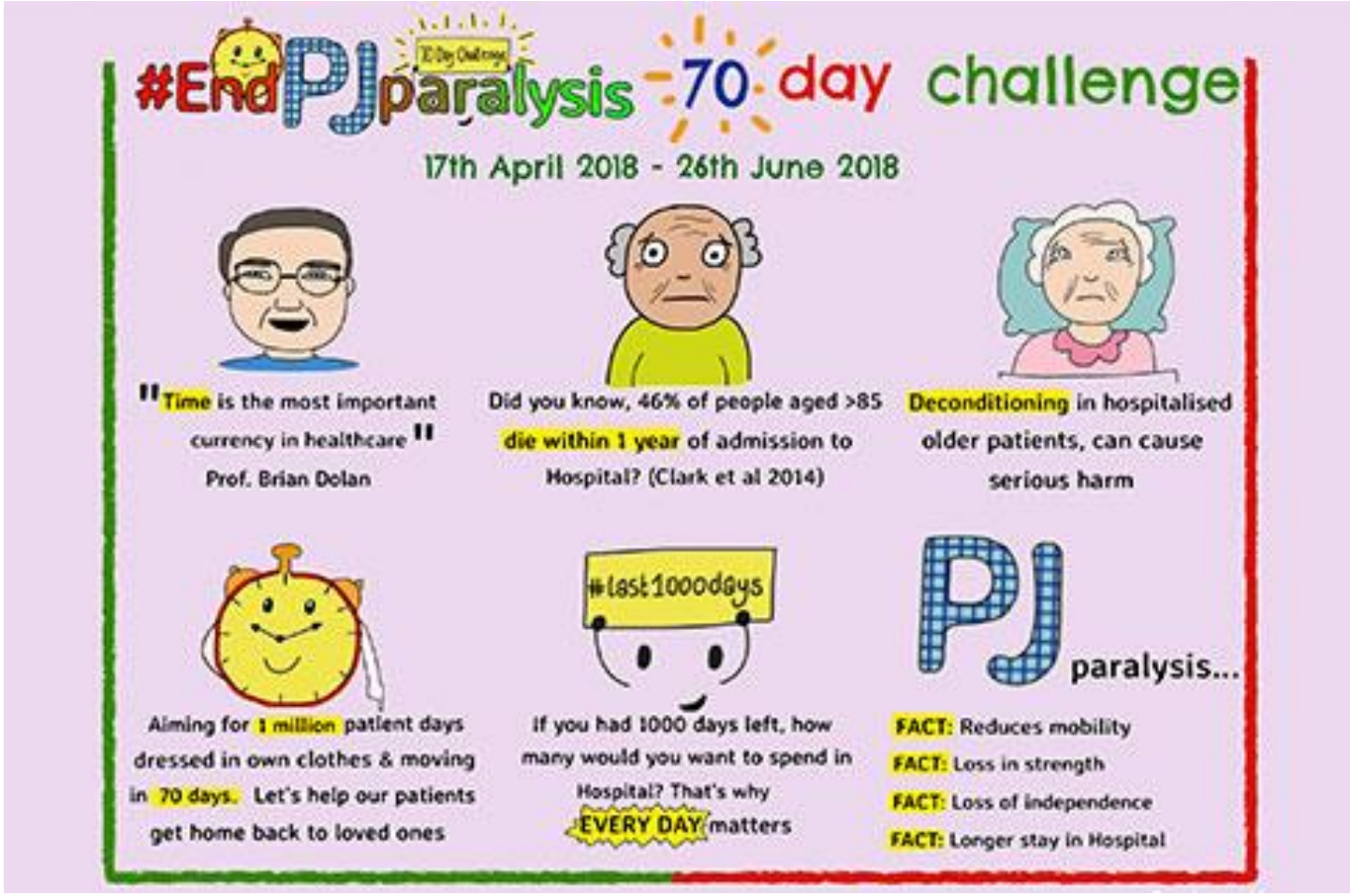
#EndPJparalysis
70 day challenge
17th April 2018 - 26th June 2018
"Time is the most important currency in healthcare"
Prof. Brian Dolan
Did you know, 46% of people aged >85 die within 1 year of admission to Hospital? (Clark et al 2014)
Deconditioning in hospitalised older patients, can cause serious harm
Aiming for 1 million patient days dressed in own clothes & moving in 70 days. Let's help our patients get home back to loved ones
#last1000days
If you had 1000 days left, how many would you want to spend in Hospital? That's why EVERY DAY matters
PJ paralysis...
FACT: Reduces mobility
FACT: Loss in strength
FACT: Loss of independence
FACT: Longer stay in Hospital

A Campaign For Deconditioning Awareness – "Sit up… Get dressed… Keep on moving…"

PREVENTING DECONDITIONING AND ENABLING INDEPENDENCE FOR OLDER PEOPLE

Older people can be more at risk of:
- Reduced muscle strength
- Reduced mobility and falls
- Confusion due to changes in environment
- Demotivation

When an older person goes into a hospital or care home…

… and lies in bed, it can further affect their wellbeing and physical function

THIS IS KNOWN AS 'DECONDITIONING SYNDROME'

- Increased risk of falls due to muscle weakness
- Increased confusion or disorientation
- Further immobility due to inactivity
- Constipation and incontinence
- Lying in bed can affect appetite and digestion
- Increased risk of swallowing problems leading to pneumonia

This is often made worse by multiple medications, sensory impairment, dementia and current illness

Prolonged bed rest in older people can lead to substantial loss of muscle strength and physical activity

Assess

Comprehensive Geriatric Assessment

A Comprehensive Assessment should be completed to determine normal capabilities

A risk assessment should be completed

Glasses, hearing aids, clock and calendar should be accessible

Support

Are there appropriate mobility aids available. Is it the right size and reachable?

Walking to the toilet helps to prepare for going home. Is the catheter really needed?

Sitting out of bed helps (when possible). Can you get out of your chair?

Encourage

Feed or take fluids independently

Wash and dress independently in own clothes

Keep moving arms and legs even in a bed or chair

Thinking about how to support and encourage movement helps to:
- Reduce the risk of harm from falls, infection, thrombosis and delirium
- Reduce length of stay in hospital
- Reduce the likelihood of having an increase in their future care needs

Sit up… Get dressed… Keep on moving…

YOUR MUSCLES / YOUR STRENGTH / YOUR ABILITIES - USE THEM OR LOSE THEM

BGS British Geriatrics Society
Improving healthcare for older people

University Hospitals of North Midlands NHS
Department for Older Adults

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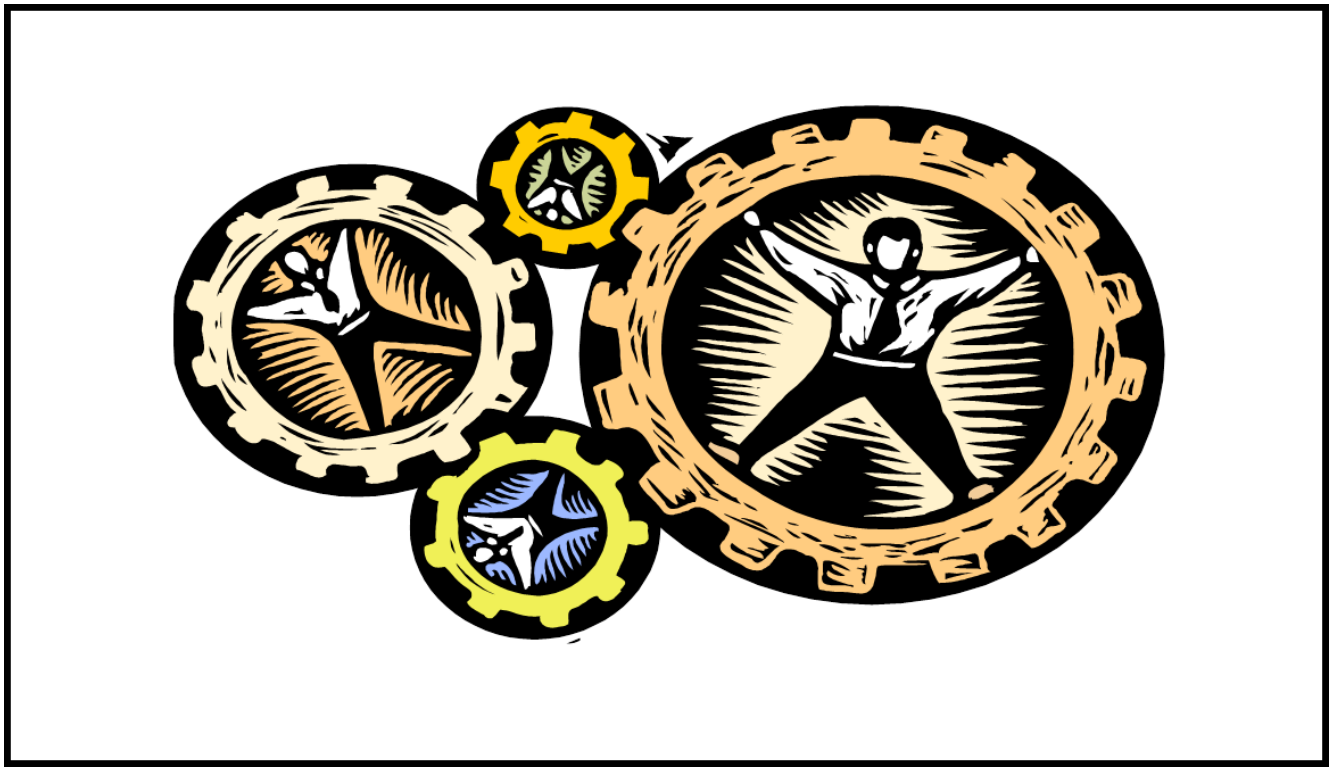
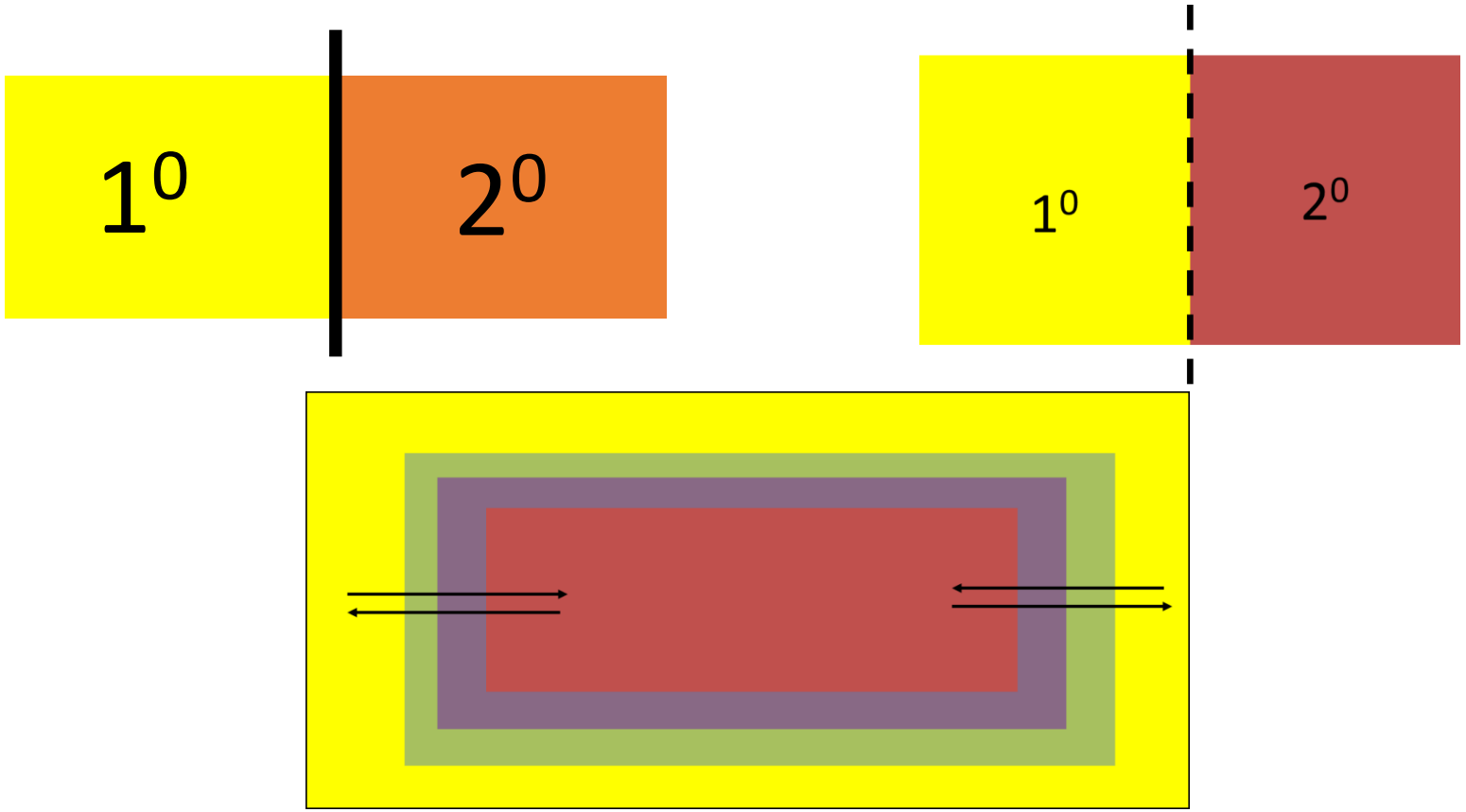
RACE Clinic

- Team of 6 full-time ANPs cover 7 day service (07.00 – 19.30)
- RACE Ambulatory Emergency Clinic (AEC) opened April 2015
- ANP led, with Consultant / Registrar review and support
- Typically see 6- 8 patients per day, referred from General Practitioners, Emergency Department or other
- Undertake Comprehensive Geriatric Assessment
- Prescribing, ordering x-rays, discussing resuscitation status and formulating advance care plans, “Silver Phone”
- Preferential access to diagnostic radiology and pathology
- Access to interprofessional services

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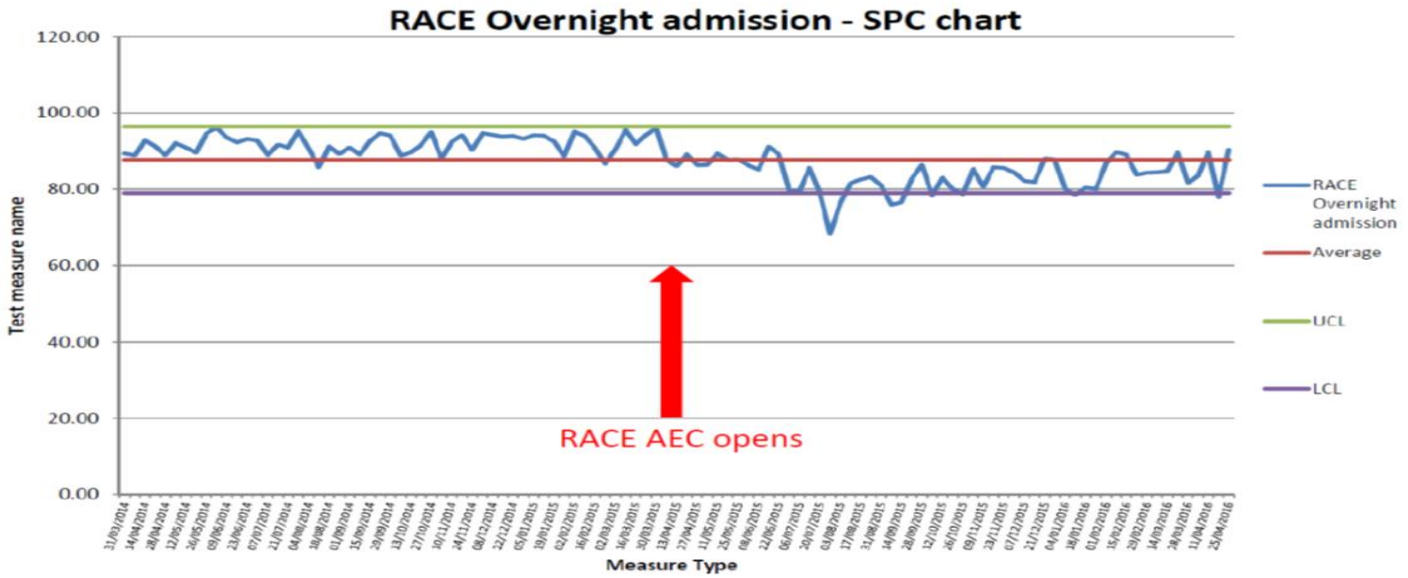

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J. C. BROCKLEHURST, MD, FRCP (Edin).
Professor of Geriatric Medicine
University of Manchester

Day centres and day hospitals

ONE of the most interesting features in the development of geriatric care in this country over the past 20 years has been the realisation of the important part that geriatric day hospitals have to play in medical services for old people. The first purpose-built day hospital was opened at Cowley Road Hospital, Oxford, in 1958, and by the end of 1970 there will be at least 120 day hospitals attached to different de-departments of geriatric medicine. Geriatricians, often struggling to develop first class services in worn out buildings and with limited inpatient facilities, have realised that the presence of a day hospital adds immeasurably to the spectrum of care which can be offered to elderly people. The day hospital as a focus of optimism and therapeutic activity has almost always been found to add lustre to the whole department.

Geriatric day hospitals must be clearly distinguished from day centres for elderly people. The day hospital is entirely a hospital in that if offers medical, nursing and medical ancillary services, and it is because of the need of one or more of these that patients attend. Almost without exception day hospitals form part of a general or geriatric hospital. Day centres, on the other hand, are social in their content, their purpose is to provide companionship, communal meal and personal facilities, such as laundry and bathing. Both day hospitals and social day centres (as they are probably best called) are complementary to each other. Two things they have in common are that each provides a midday meal and occupies the major part of an old person's day, and secondly, that each requires the provision of special transport for the majority of those who attend.

Day hospitals

The services which day hospitals provide may be summarised:

1. Physical rehabilitation of patients disabled by diseases such as stroke, osteoarthritis, Parkinsonism and others. This physical rehabilitation may be a continuation of treatment begun when the patient was an inpatient, or it may be started with attendance at the day hospital without previous inpatient admission.

2. Physical maintenance — since the disability suffered by many elderly people and referred to above is by its nature not completely curable, it is often important to provide regular periods of physical treatment, perhaps by attendance at a day hospital once a week, so that the maximum amount of independence which the patient has gained during the period of rehabilitation may be maintained.

3. The social care of physically disabled people may be offered for one of two reasons. Firstly, to allow a person completely housebound by his physical disability, the opportunity of social companionship, perhaps once a week. It is understood, of course, that such a patient requires some degree of nursing and for this reason could not attend a social day centre. Secondly, it may be possible in occasional cases to arrange the discharge from hospital of a physically disabled elderly person only if such form of day hospital care can be provided every day to allow the relative on whom the patient is dependent to carry on with his or her work. The day hospital may provide similar care for patients who, because of mental confusion, cannot safely be left at home alone, and whose relatives must go out to work. They may also

Eight-seater ambulance brings patients to the day hospital

Table I

	Proportion of patients in five day hospitals in south east England attending primarily for these reasons	Proportion of geriatricians in charge of day hospitals who regard these functions as very important
Physical rehabilitation	% 27	% 90
Physical maintenance	41	78
Social care of physically disabled	26	50
Social care of mentally confused		22
Medical or nursing procedure	6	37
Total	465 patients	90 physicians

Future prospects

There can be no doubt that the day hospital is now firmly established as a normal and necessary part of a geriatric service. It is the intention of the Department of Health and Social Security that geriatric departments should be provided within the structure of future general district hospitals, and this would appear to be the appropriate site for the day hospital. Medical cover will then always be easily available and the day hospital may contribute in many ways to the life of the district general hospital. It has an important part to play in the education of nurses and medical students. It provides a link with the community services. This may be particularly successful if health visitors are attached to the day hospital to follow-up patients who are discharged, and to investigate causes of breakdown in those who have given up attending.

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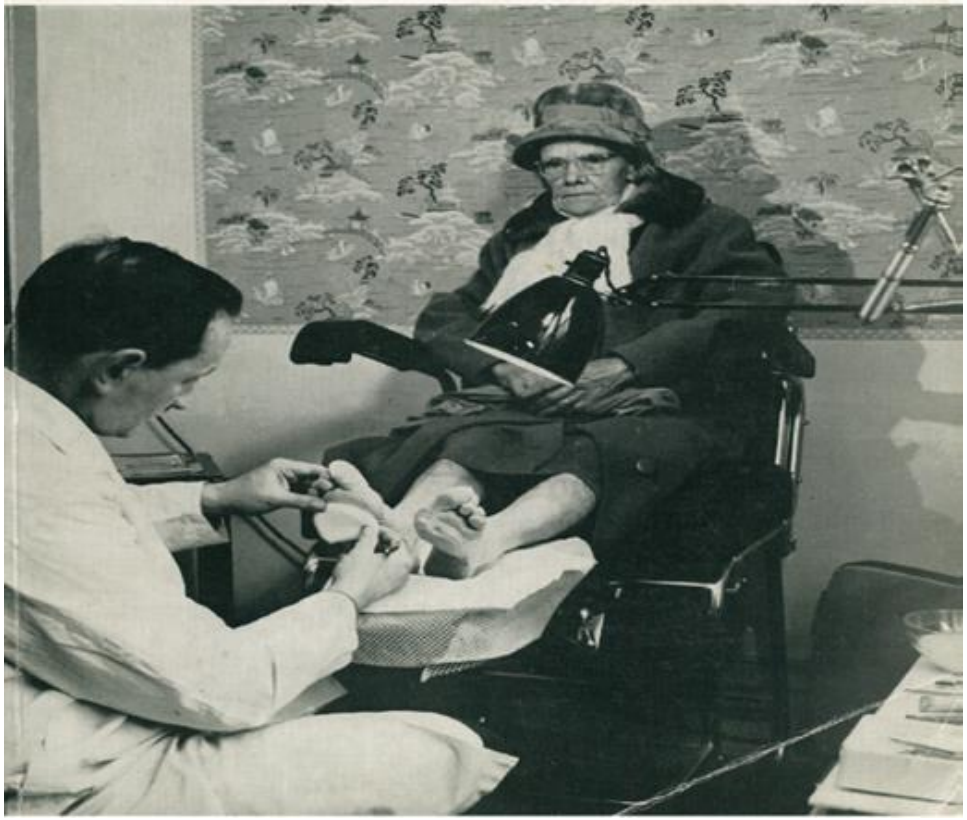

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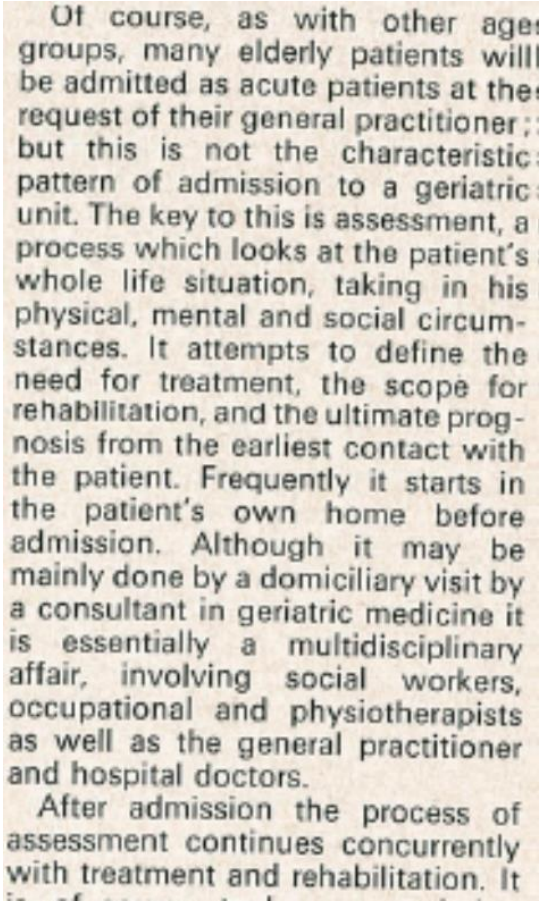
- “At the end of the consultation you should know more about your patient as a person”



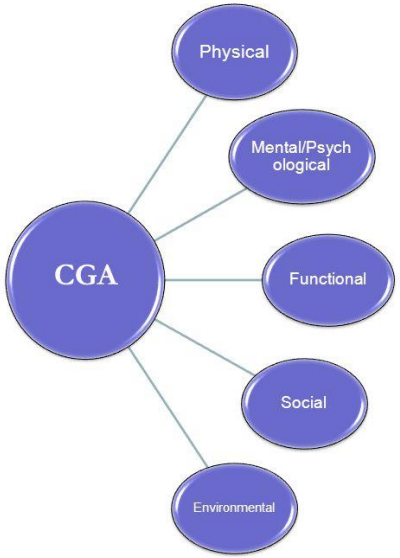
Of course, as with other age groups, many elderly patients will be admitted as acute patients at the request of their general practitioner; but this is not the characteristic pattern of admission to a geriatric unit. The key to this is assessment, a process which looks at the patient's whole life situation, taking in his physical, mental and social circumstances. It attempts to define the need for treatment, the scope for rehabilitation, and the ultimate prognosis from the earliest contact with the patient. Frequently it starts in the patient's own home before admission. Although it may be mainly done by a domiciliary visit by a consultant in geriatric medicine it is essentially a multidisciplinary affair, involving social workers, occupational and physiotherapists as well as the general practitioner and hospital doctors.

After admission the process of assessment continues concurrently with treatment and rehabilitation. It

Comprehensive Geriatric Assessment (CGA)

"a multidimensional and usually interdisciplinary diagnostic process designed to determine a frail older person's medical conditions, mental health, functional capacity and social circumstances in order to provide a coordinated and integrated plan for treatment and follow up."

British Geriatric Society (BGS)2015



But we cant do all that in clinic.

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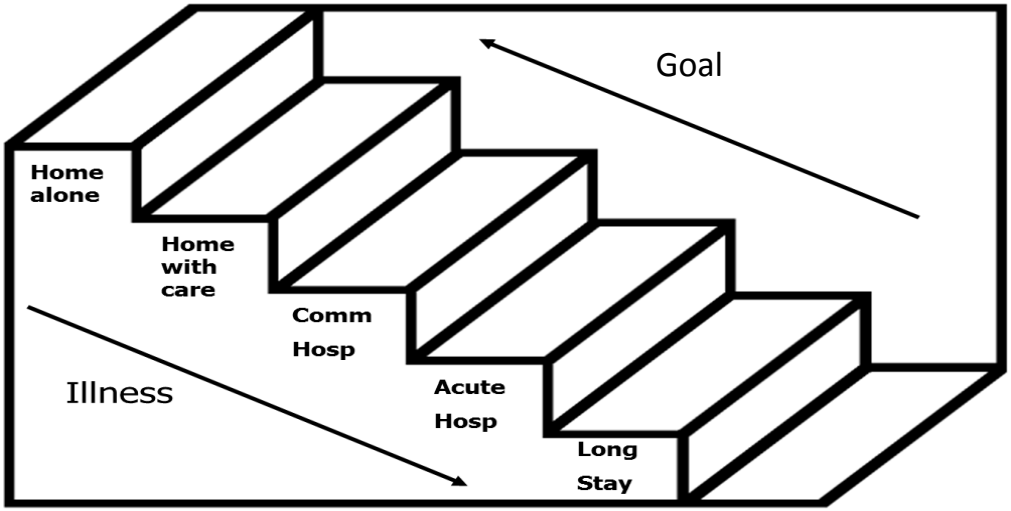
Collaboration



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