



Urgent Care Pathways for Older People with Complex Needs

Best Practice Guidance

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Prepared by

The Urgent Care Pathway Working Group

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Foreword

From the National Director for Emergency Access, Professor Sir George Alberti, and the National Director for Older People, Professor Ian Philp.

We welcome the recommendations of this report prepared by the Urgent Care Pathway Group, chaired by Professor John Young, suggesting detailed advice on how to improve urgent care for older people.

Older people are high users of urgent and emergency care services, particularly ambulance services and A&E departments, and many of these older people will have complex needs and multiple conditions.

Where hospital admission is being considered it is important to identify those older people who need specialist involvement as a result of frailty. Specialist involvement is known to improve outcomes, reduce length of stay and identify those who would benefit from intermediate care rather than hospital admission (i-v).

The key markers of frailty during emergency response are the presence of confusion or a history of recent falls and or loss of mobility.

For this reason, it is important that these frailty markers are identified during emergency response.

This paper provides advice about how to adapt emergency response systems for older people presenting with falls, confusion or hip fracture with the introduction of simple screening tools and provides the basis for audit of practice. An in-depth assessment by front line staff may be unrealistic, but at risk older people can be identified and referred for specialist assessment and care.

In particular, we would like to emphasise the importance of the following points.

A&E professionals and ambulance clinicians consider routinely:

- ask all older people if the emergency is related to a fall or blackout
- assess gait and balance by observation of standing and walking (using usual walking aids)
- assess for confusion using a cognitive assessment instrument, such as the abbreviated mental test (AMT) 4

The AMT 4 simply records the response to:

1. what year are we in?

2. what do we call this place you are in?
3. how old are you?
4. what is your date of birth?

An incorrect answer to any of the four questions suggests cognitive impairment may be present.

It is our hope that by using this pathway services will be able to ensure patients identified as having falls or blackouts, patients with impaired gait, or with confusion are offered referral for specialist assessment and receive multi-disciplinary specialist care in the hospital, or through intermediate care services in the community.

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Contents

Foreword.....	4
Contents.....	6
Introduction	7
Background	7
Purpose	7
Falls and Older People.....	8
Ambulance Service Response to Falls	8
The A&E Department and Falls	9
Falls Care Pathway	9
Confusional States and Older People	11
Hip Fracture and Older People.....	12
Suggested A&E and Ambulance Service Urgent Care Pathway for Older People Presenting with Falls, Confusion or Hip Fracture	13
Audit Topic 1.....	13
Audit Topic 2.....	13
Audit Topic 3.....	14
Audit Topic 4.....	14
Suggested Audit Indicators for the A&E and Ambulance Service Urgent Care Pathway for Older People with Complex Needs	16
(i) A&E	16
(ii) Ambulance Service.....	16
References.....	18
Working Group Members	20

Introduction

Background

Older people comprise a large proportion of urgent care responses involving ambulance services and A&E departments. There are over three million A&E attendances in England for older people each year (or an estimated 18% of all A&E attendances (1)). Many of these patients will be older people with complex needs – that is older people with multiple chronic conditions such as visual, hearing, mobility and cognitive impairment. For both these front line services, an in-depth assessment of physical, mental and social issues is unrealistic. Increasingly, ambulance service and A&E practitioners are able to commence the assessment of an older person and act as a conduit to ensure that selected older people are referred on for more detailed, comprehensive assessment. To do so effectively these staff need to be supported by well designed care systems that link readily to specialist comprehensive assessment for older people.

Purpose

With these points in mind, a project has been jointly established between the National Director for Emergency Access and the National Director for Older Peoples' Services. The aim has been to develop a suggested practical ambulance service and A&E urgent care pathway for older people with complex needs that will drive up the quality of assessments for older people in line with the expectations described in the National Service Framework for Older People (NSF) (2). Members of the Urgent Care Pathway Group are listed in the appendix. The following common conditions were selected to be the focus of the Ambulance Service and A&E Urgent Care Pathway for older people with complex needs:

1. Falls
2. Confusional states
3. Hip Fracture

Our approach has been to identify best clinical practice in these three areas and construct a clear and auditable clinical care pathway.

Falls and Older People

Falls has been selected because the condition represents a major national public health issue. Falls are the commonest cause of serious injury in older people and the commonest reason for hospital attendance. There is reliable research evidence that between a quarter and one third of falls can be prevented in older people (3). The NSF has described the appropriate service response based on an integrated falls prevention service (2) and the National Institute for Health and Clinical Excellence (NICE) has produced guidance on important components of such a service (4).

Ambulance Service Response to Falls

The importance of the ambulance response to older people who have fallen has historically been poorly recognised within the wider NHS. Ambulance clinicians are in a unique position of attending this group of patients in their own home and as a result are able to observe, not only the condition of the patients, but also their living conditions (hygiene, food etc). Moreover, ambulance clinicians are now acknowledged as important partners in the implementation of local falls prevention services and it has become clear that ambulance services can play an important role in case finding and, if suitable routine systems are in place, offer a major opportunity for falls prevention. For example, in the former Hampshire Ambulance Service, there were over 21,000 '999' responses for falls in the year commencing April 2005 representing 18% of annual demand at an approximate cost of £200 each.

Over a third of the patients involved in these emergency responses are “not-conveyed” to a hospital (5) because the patient is not injured, or because another referral pathway is more appropriate, or because the patient refuses to attend the A&E department. However, these patients have a high risk for further falls (5) and/or the development of a behavioural response characterised by ‘fear of further falls’ such that they become housebound with features of anxiety/depression. Ideally, these ambulance patients should be positively identified and made known to the local primary and community care services. Early intervention can be expected to reduce the need for future health and social care services. At present, routine engagement of primary and community care services with this group of vulnerable older people who have “fallen but not-conveyed” does not always occur and needs rectification. Often no other healthcare professional is made aware that the ambulance service has attended this group of patients and there is therefore a missed opportunity to utilise the valuable information collected about the person and the fall (5).

The A&E Department and Falls

Older people presenting with falls is a major issue for A&E departments. In 1999 there were nearly 650,000 falls related A&E attendances in the UK for people over 65 years (6). Studies suggest nearly a half of A&E attendances for people aged over 65 years can be the result of a fall (7) and 50% of those who fall will have another fall within the next 12 months (8,9). There is evidence that falls prevention initiated in A&E can be effective (9,10). However, there is considerable under-reporting of falls and blackouts in older people because the consequence of the fall (namely, the injury or fracture) becomes the diagnosis, the sole focus of attention and the subsequent code for the episode of care. Thus, the primary event, the fall/blackout, is often not acknowledged either clinically or in the coding and goes unreported. Over a third of falls go unreported in computerised A&E records (11). In practice this results in the wider issue of falls prevention becoming overlooked. This issue has become increasingly important with the more widespread introduction of district wide, integrated falls prevention services currently being established by primary care trusts in accord with the NSF. It is therefore important that A&E departments and ambulance services become fully integrated with their local falls services, building on the integrated services being developed in a number of areas.

The recent (Jan. 2006) National Sentinel Falls Audit (12) reported that this required integration is lacking: *“There is striking evidence of inadequate involvement of the specialist falls service in critical components of the hospital service. In A&E there is inadequate screening for risk of falls. The majority of A&E Departments do not have any mechanism for involving the specialist falls service on site. Specialist falls services have limited involvement in developing protocols with A&E to patients with osteoporotic hip fracture.”*

UK research evidence has shown that improving integration of A&E departments with falls services can reduce hospital attendances and admissions for recurrent falls and these systems of care can be implemented in day-to-day practice (12).

Falls Care Pathway

The falls care pathway, as described in the NSF and in the NICE guidance, involves primary prevention (environment & lifestyle issues); case finding of people who have fallen or who are at risk of falling; multi-disciplinary assessment for falls risk factors; and an individualised multi-component, multi-agency intervention for falls prevention. It is self-evident that ambulance services and A&E departments can make a contribution to the falls care pathway but that neither services can be expected to undertake the whole pathway, the latter components of which comprise the specialist falls prevention service. Two aspects of the falls care pathway of special relevance to ambulance services and A&E departments are:

Case identification: *“Older people in contact with health care professions should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall(s). Older people reporting a fall or considered at risk of falling should*

be observed for balance and gait deficits and considered for their ability to benefit for interventions to improve strength and balance.” (Reference: NICE guidance 2004).

Multi-factorial Falls Risk Assessment: *“Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or core balance should be offered a multi-factorial falls risk assessment. This assessment should be performed by healthcare professionals with appropriate skills and experience, normally in the setting of the specialist falls service. This assessment should be part of an individualised multi-factorial intervention.” (Reference: NICE guidance 2004).*

It was felt appropriate for ambulance services and A&E departments to consider contributing to the district wide case identification of falls in older people, and to consider initiating (but not undertake) the multidisciplinary comprehensive falls of assessment.

Confusional States and Older People

Confusional states are another common presentation of illness in older people. Estimates suggest that 10 to 30% of older people presenting to A&E departments have delirium (13). Terminology is important but not always well understood. Dementia is a clinical syndrome with several pathological entities (e.g. Alzheimer's' disease, cerebrovascular disease) in which there is a chronic confusional state typically characterised by impaired memory. Acute confusion (often referred to as delirium) develops over a short time period and is typically characterised by fluctuation and periods of drowsiness. The two clinical syndromes can be perplexing because they can co-exist – dementia is the major risk factor for delirium. Research suggests that delirium is frequently under-recognised or misdiagnosed as dementia, or simply recorded as 'a confused elderly patient.' Non-detection of delirium in A&E departments has been shown to be associated with increased mortality (14).

The noise, bright lights, stark and unfamiliar environment of an ambulance or A&E department can be especially threatening to frail older people and often has an adverse effect on cognitive abilities. The Royal College of Physicians has recently reviewed the delirium literature and has produced guidelines to improve delirium management (15). An important aspect of particular relevance to A&E departments is to improve delirium case finding by routinely incorporating a test of cognitive function for older people presenting for emergency care. This improvement in clinical assessment has therefore been addressed in the suggested urgent care pathway.

Hip Fracture and Older People

A hip fracture is the most serious complication of a fall in an older person. It carries a threat to survival and to future independence. Most of these fractures are fragility fractures in which a low impact fall (i.e. from less than head height and not hit by a moving vehicle) has resulted in a fracture in the context of osteoporosis. Most patients with hip fractures, therefore, are older people with complex needs. Hip fractures account for 50% of injury related hospital admissions and 66% of bed days for people aged over 75 years.

There are several well established national guidelines for the management of hip fracture in older people (e.g. SIGN; Royal College of Physicians; Joint Guidance from the British Orthopaedic Association/National Osteoporosis Society (“Blue Book”). There are also several examples of integrated care pathways (e.g. Peterborough, Belfast) in use. The key factor from an A&E department perspective is to ensure rapid diagnosis and rapid transfer to the orthopaedic trauma ward. Widely accepted auditable processes include obtaining an x-ray, commencement of IV fluids, administration of IV analgesia, thromboprophylaxis, and the use of pressure relieving mattresses – the suggested timeframe is for this to be achieved in less than four hours of A&E arrival (16).

Suggested A&E and Ambulance Service Urgent Care Pathway for Older People Presenting with Falls, Confusion or Hip Fracture

Audit Topic 1

Aim: To improve case identification of fallers

Action: Ambulance Services: the details of all ambulance attendances to older people who have “fallen but not conveyed” routinely notified to an appropriate health or social care agency. A copy of the completed Patient Report Form made available to that agency.

Action: A&E Departments: to routinely ask all older people if the attendance is related to fall or blackout (positive response – linked to Audit Topic 4).

It is acknowledged that this positive case identification of fallers, in line with NICE guidance, will potentially increase workloads for primary and community care and falls services. However, experience in the former Hampshire and Berkshire Ambulance Services has demonstrated that the notification rate of non-conveyed falls averages at less than one patient per week per general practice. Moreover, most of these patients are likely to eventually find their way through to the falls services by virtue of future falls. Earlier, more timely referral might be expected to be associated with increased health gain.

Audit Topic 2

Aim: To improve the quality of ambulance service and A&E department routine assessment of older people, where hospital admission is being considered.

Action: a) Assessment of gait and balance by observation of standing and walking (using usual walking aids).

b) Assessment for confusion using a cognitive impairment instrument

Failure on either of these two assessments should link to Audit Topic 4.

It would be regarded as poor assessment if a patient attending an A&E department did not have a recording of temperature, pulse rate and blood pressure. Our intent with Audit Topic 2 is to augment this accepted routinely collected clinical information with two basic assessments that could be considered routine for older people.

There are many formal assessments for gait and balance but the “Get up and go” test has been well researched, is quick and simple and suitable for use by ambulance practitioners and A&E staff. The patient sits in a chair and is asked to stand, walk a few metres (using usual walking aid if relevant), turn round and sit down again. Difficulties in executing the task, including balance problems, can be easily identified.

There are several methods to assess cognitive function. Examples include: a four point test (AMT4 score); the ten point Abbreviated Mental Test Score (AMT score); or the 30 point Mini-Mental State Examination Score (MMSE score). We recommend the AMT4 score as it is quick to use and therefore suitable for clinical environment of the A&E department (17). There is some favourable experience with its use in A&E departments (18). The AMT4 simply records the responses to:

1. What year are we in?
2. What do we call this place you are in?
3. How old are you?
4. What is your date of birth?

An incorrect answer to any of the four questions suggests cognitive impairment may be present (17).

Audit Topic 3

Aim: To improve management of hip fracture in A&E

Action: The diagnosis and immediate management (*X-ray*; commencement of IV fluids, administration of IV analgesia, administration of sub-cutaneous heparin, and the use of pressure relieving mattresses) to be achieved in less than four hours of A&E arrival.

Audit Topic 4

Aim: To improve integration of A&E departments with mainstream older people services offering comprehensive assessment.

Action: Patients identified as having presented with falls or blackouts, patients with impaired gait, or with confusion offered referral for comprehensive specialist assessment.

The most appropriate services for comprehensive assessment will vary between local health and social care communities but is likely to include the following:

- Primary health care team
- Mental health services for older people
- The local falls prevention service
- An intermediate care service
- Day hospital
- Elderly care outpatients
- Elderly care in-patients

Suggested Audit Indicators for the A&E and Ambulance Service Urgent Care Pathway for Older People with Complex Needs

(i) A&E

1. The percentage of all people aged over 65 seen by the ambulance service each month for whom a fall or blackout is recorded as reason for attendance.
2. The percentage of all people aged over 65 presenting to A&E each month, where hospital admission is being considered, who have had an assessment of gait and balance recorded.
3. The percentage of all people aged over 65 presenting to A&E each month, where hospital admission is being considered, who have had an assessment of cognitive state recorded.
4. The percentage of older people presenting to A&E with falls or blackout who have been referred for specialist assessment.
5. The percentage of people presenting with hip fracture who receive an *X-ray*; commencement of IV fluids, administration of IV analgesia, administration of thromboprophylaxis, and the use of pressure relieving mattresses in less than four hours of A&E arrival.

(ii) Ambulance Service

1. The percentage of all people aged over 65 seen by the ambulance service each month for whom a fall or blackout is recorded as reason for attendance.
2. The percentage of people aged over 65 seen by the ambulance service because of a fall or blackout but are “not conveyed.”
3. The percentage of people aged over 65 seen by the ambulance service because of a fall or blackout but are “not conveyed” and referred to a health or social care service.

4. The percentage of all people aged over 65 seen by the ambulance service, where hospital admission is being considered, who have had an assessment of gait and balance recorded.
5. The percentage of all people aged over 65 seen by the ambulance service, where hospital admission is being considered, who have had an assessment of cognitive state recorded.

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