1 CPD CREDIT

Ref Talks

Autumn Series 2023

EDINBURGH COMMUNITY GERIATRICS SERVICE

Community Geriatrics aims to support expert care for the frail elderly within community settings whether at home, or in a care home and includes the interface between home and hospital. We will discuss the referral pathways available using case based examples.

WELCOME

NHS Lothian

SPEAKERS

Dr Andrew Coull
Consultant Geriatrician & Physician, NHSL

Dr Carolyn Armstrong
Consultant Geriatrician & Physician, NHSL

DATE
30th Oct, 2023

TIME
7:30 PM - 8:30 PM

REFHELP@nhslothian.scot.nhs.uk

Edinburgh Community Geriatrics Service – how can we help you?

Dr Andrew Coull

Dr Carolyn Armstrong

Consultant Physicians in Medicine of the Elderly

October 2023

Why cover this topic?

- The ‘alternatives to admission’ agenda is a key priority for Scottish Government.
- We should avoid acute hospital admission for frail elderly if at all possible.
- To get feedback on new information and pathways on RefHelp.
- Update on significant changes to the South Edinburgh and Midlothian ‘offer’.

A few caveats...

- The ‘offer’ is different between H&SCPs.
- In Edinburgh the ‘offer’ is different but complementary between south and north.
- There has been substantial change in the South Edinburgh and Midlothian ‘offer’.

The ‘offer’ is different between H&SCPs

MoE West Lothian

Current services for Medicine for the Elderly in West Lothian

- SCI gateway single point of contact referral for non-urgent
- REACT for urgent 01506 524149
- Referral should be based on patient’s postcode, **not** GP Practice

REACT Hospital at Home (H@H)	Acutely unwell frail, older peopleAlternative to hospital admissionShort term (few days)Comprehensive geriatric assessment at home (inc care home) in the acutely decompensated	Phone call to REACT hub 01506 524149 if urgent (sa… day/next day) visit required – clinical conversation i… usefulNot an alternative to a GP visit.SCI gateway ref…al if able to wait 2-3 days for assessment.
REACT Rehab (AHPs)	AHPs only – physio and OTFull assessment at home (inc care home for physio)	Phone call to REACT hub (01506 524149) if urgent (sa… day/next day) visit requiredSCI gateway referralSt Johns Hospital > REACTH@H will often refer during/ on discharge

The ‘offer’ is different between H&SCPs

MoE East Lothian

Information

For patients with frailty, dementia or delirium, avoidable admission to hospital can be detrimental to both physical and mental health. Patients loose 10% of their body mass per week on bed rest or with minimal activity as is common in hospital. In addition, change of environment can worsen cognitive and behavioural issues in those with dementia or delirium. For some patients admission to hospital is still the most appropriate course of action but this document outlines alternatives sources of support and treatment available to prevent this where possible.

Referral Guidelines | **Resources and Links**

Patient need/ type of service required:	*Team to refer to:*	*Who can refer:*	*How to refer:*
PT and OT requirement where urgent assessment, equipment and support could	**Integrated Rehabilitation Team**	Any health professional	East Lothian Rehabilitation Service Point of Contact 01620 642834

The ‘offer’ is different between H&SCPs

MoE Edinburgh

Information

MoE Edinburgh specialise in Comprehensive Geriatric Assessment for the frail elderly. We recommend you use the Rockwood Clinical Frailty Scale **(Rockwood Clinical Frailty Scale April 2020-1.pdf)** in all referrals and your clinical practice. There are a range of community based services that provide assessment for frail elderly and offer alternatives to admission or alternative admission pathways for suitable patients.

Community Services

Team / service	Patient need/ type of service required:	How to refer:
Social care Direct	Non urgent PT / OT / Social Care advice or intervention	0131 200 2324 Email: socialcaredirect@edinburgh.gov.uk

The South Edinburgh 'offer'

Care Home Polypharmacy Reviews

- To meet and discuss with GP practices
- To proactively support you and your pharmacist to carry out care home polypharmacy reviews
- We have also done joint reviews with Old Age Psychiatry

Email: LibertonDayHospital@nhslothian.scot.nhs.uk

The South Edinburgh 'offer'

Advice, outpatients or day hospital

Urgent: Flow centre 03000 134 000 Option 1 & 4 and ask for Duty Geriatrician on for HaH. Appt within 2 days

Advice: Email LibertonDayHospital@nhslothian.scot.nhs.uk

Routine (or urgent): SCI gateway Via Liberton MoE

Case 1: Urgent advice

66 year old with recent severe (>20%) weight loss.

Outcome

- We ordered urgent CT CAP
- Will send / discuss result with GP
- Offered urgent OP

The South Edinburgh 'offer'

Routine or urgent outpatients or Day Hospital

SCI gateway via Liberton MoE

Case 2: Unexplained falls

75 year old previously fit lady with recurrent falls.

O/E No murmurs. No postural drop. Mild impaired balance. Neuro NAD.

Bloods: Raised calcium and PTH and MGUS. CT CAP showed multiple renal lesions. ECG, 24 hour tape, echo normal. MRI head showed large pituitary adenoma.

We can see older people who are not frail (falls, fatigue, sweats, syncope, weight loss, dizziness, anaemia) and get other specialty support as needed.

The South Edinburgh 'offer'

Routine or urgent outpatients or Day Hospital

SCI gateway via Liberton MoE

Case 3: Falls and frailty

85 year old frail lady with recurrent falls. Previous stroke, glaucoma, hearing impairment, arthritis and diabetic neuropathy. Polypharmacy. POC bd. Uses zimmer.

O/E CFS 7. Postural drop. High risk of falls.

Bloods: Unremarkable.

Please use Clinical Frailty Scale in referral.

We may review patients medically at Sighthill or Liberton (or MCH for Midlothian).

Our triage process identifies those already known to PT/OT in hubs.

Otherwise our AHPs will see patient as indicated.

We do NOT see people automatically for 6 weeks.

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.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY
Inspiring Minds

Ageing Well

Resilience to Stressors

The healthiness of ageing can be thought of in terms of **resilience.**
Resilience is the capacity to **recover quickly** from an event or stressful situation. Stressor events can be:

- **physical** (e.g., falls, viruses) or
- **non-physical** (such as the loss of a spouse).

Healthy people recover quickly from stressor events, without lasting



Less resilient people are more prone to real setback or stress.



Frailty is the opposite to resilience

Frailty is the **a lack of resilience** in bouncing back from stressor events.
It is a medical term used to describe **a loss of fitness** that occurs as a result of natural ageing, combined with the outcomes of multiple long-term conditions.
In later life, **multiple conditions combined** can have a greater effect than each condition alone.
For example, diabetes in combination with heart disease and depression **can be more severe** than only diabetes or heart disease.

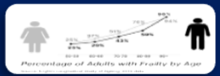
Healthy vs accelerated ageing

People age in different ways and at different rates

VS

Frailty is common

Most adults who live long enough will experience frailty
Frailty **increase with age**
Frailty affects **women** more than men



What are the indicators of frailty

Frailty can be measured in different ways

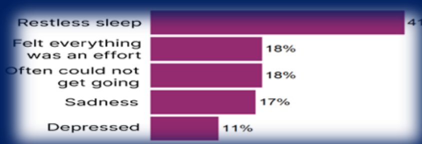
By a doctor assessing:

- Weakness
- Slow walking speed
- Low physical activity
- Exhaustion
- Unintentional weight loss

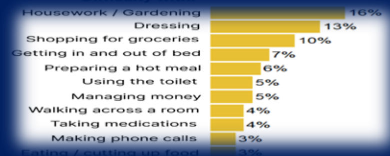
By counting the number of health issues someone has. The burden of frailty grows as people accumulate more health issues

Common Health Issues In Frailty

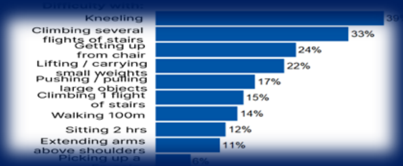
Psychological Wellbeing



Lifestyle



Mobility



What Health Issues can be reversed?

How Can I Improve Frailty

Although frailty does increase with age it is not **inevitable**
Certain behavioural and lifestyle changes can help **prevent** or even **reverse frailty** in its early stages.

Acknowledgements and references
Banks, J., Batty, G.D., Breedvelt, J.J.F., Coughlin, K., Crawford, R., Marmont, M., Nazroo, J., Olfield, Z., Steel, N., Steptoe, A., Wood, Martin., Zaninotto, P., (2021)
English Logitudinal Study of Ageing: Waves 0-9, 1998-2019 [data collection]. 36th Edition. UK Data Services. SN:5050, Hoogendijk, E,O., Afialo, J., Ensrund, K, R., Kowal, P., Onder, G., Fried, L, P. 2019 Frailty: implications for clinical practice and public health.
The Lancet. 394, 1365-1375: Niederstrasser, N, G.< Rogers, N, T., Bandelow, S. 2019. Determinants of frailty development and progression using a multidimensional frailty index: evidence from the English longitudinal study of ageing. Plos One:

The South Edinburgh 'offer'

Routine or urgent outpatients or Day Hospital

SCI gateway via Liberton MoE

Case 4: Anaemia

80 year old frail lady symptomatic with iron deficiency anaemia secondary to colorectal cancer not for further intervention. Cannot tolerate oral iron. Significant impact in quality of life. Hb 70. MCV 69. Ferritin 10.

Agreed with GP that patient needs targeted treatment ie not full medical assessment

Liberton team cross match patient.

Patient attend for ferrinject and RCC x 2

GP monitors Hb for further intervention as needed.

We offer ECGs, X-Rays, iv zoledronic acid, ABPIs, synacthen test.

The South Edinburgh 'offer'

Step up care for complex Care

Patient requiring community bed for complex health / nursing / end of life care and cannot stay at home and has had referral discussion with SCD.

Speak to Duty Geriatrician for HaH via Flow Centre or

Email:
aahdischargehub@nhslothian.scot.nhs.uk

Case 5: Complex care step up

78 year old man with severe leg ulceration and pressure sores. PVD and amputee. Self-neglect. Non compliant with DN input and carers for personal care.

Discussion with Duty Geriatrician. Agreed no need for acute hospital intervention.

Admitted to Hawthorn Ward at Ellens Glen Community Hospital. Edinburgh has three community hospitals. They are not nursing homes. They are covered by MoE consultant during day and LUCS overnight.

The South Edinburgh 'offer'

Routine or urgent outpatients or Day Hospital

SCI gateway via Liberton MoE

Case 6: Falls and cognitive impairment

82 year old frail lady with multifactorial and gait balance disorder with recurrent falls with concerns raised about cognition.

O/E CFS 7. Symptoms of cognitive impairment. MOCA 17/30. IQCODE 62.

PT/OT home visit

Brain imaging: Global atrophy. Mild Small vessel disease. No major stroke.

AHPs will do HV as indicated.

PT will see at Liberton if specific intervention indicated (vestibular and BPPV, parallel bars).

We have a Liberton Memory Clinic.

We can offer dementia counselling, treatment and get access to post diagnostic support.

We also have a Continence Assessment Clinic.

The South Edinburgh 'offer'

Referral from SE/SW hubs Prevention of Admission or Discharge to Assess Teams

Weekly meeting on Microsoft Teams. Future plans to work with Community ANPs.

Case 7: Frail and housebound

93 year old frail lady house bound from Previous stroke. Recent admission to acute hospital with urosepsis.
Discharge with support of D2A.
Significant concerns raised about functional decline, cognition, continence and skin issues.
SW hub team bring to discussion with Liberton MoE team at weekly meeting.
Request made for patient information from GP practice.
MoE complete domiciliary visit to contribute to CGA.
Weekly meetings with IMPACT.
Alternate weekly meetings with Primary Care Pharmacists.
pc.prescribing@nhslothian.scot.nhs.uk

Conclusion

RefHelp

Home | Educational | News & Events | WaitingTimes | About Us

Search Results

Your Results for: MoE

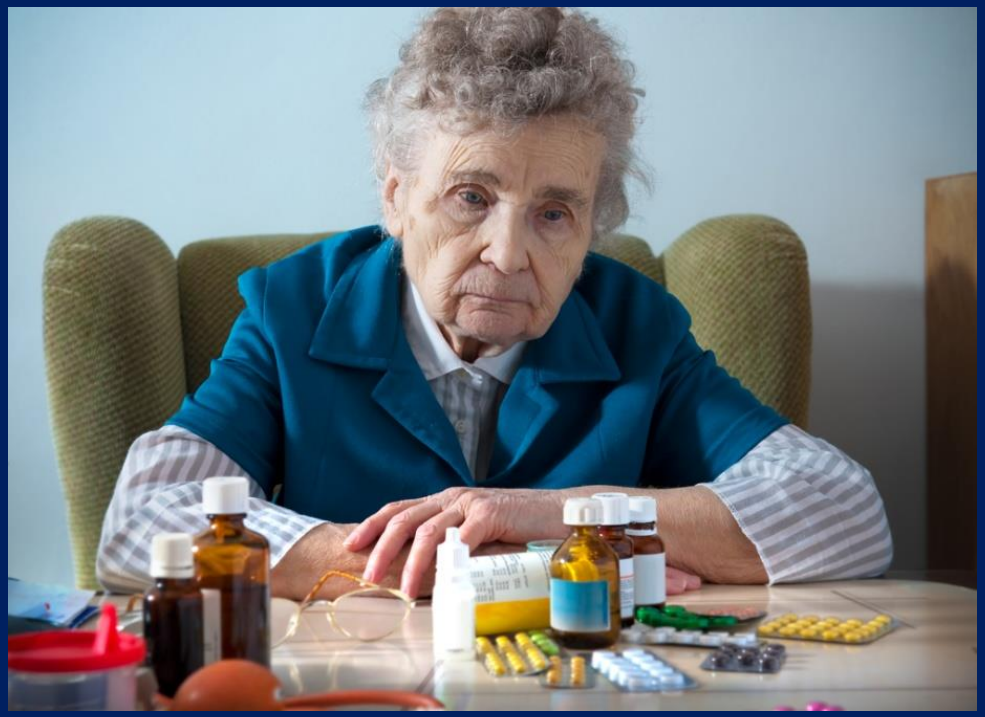
MoE Edinburgh

https://apps.nhslothian.scot/refhelp/guidelines/medicineoftheelderlyservices/moe-edinburgh/

Information MoE Edinburgh specialise in Comprehensive Geriatric Assessment for the frail elderly. We recommend you use the Rockwoo
Scale April 2020-1.pdf) in all referrals and your clinical practice. There are a range of community based services that provide assessment f
alternative

WGH-MoE Outpatient Clinics

Any questions or comments?



If you have any questions about Older Peoples Pathways in Edinburgh then Follow us on Twitter and send us a DM

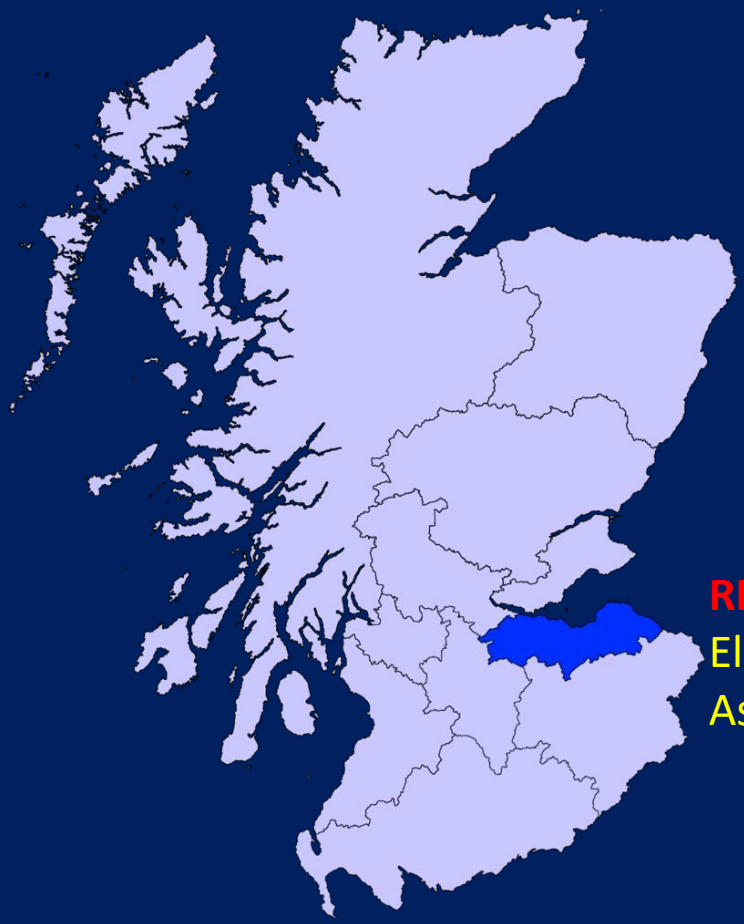
Edinburgh Community Geriatrics Service (ECGS)

X (formerly Twitter) @EdinburghCommu2

Hospital at home

- ***A service that provides acute hospital level care by healthcare professionals in a home context for a condition that would otherwise require acute hospital inpatient care***
- Key features:
  - Senior medical decision maker
  - Urgent access to hospital level diagnostics
  - ‘Hospital type’ interventions
  - High acuity and complexity of patients/conditions managed
  - Short time limited acute episodes of care

NHS Lothian H@H



REACT-Rapid Elderly Care Assessment Team

IOPS-Integrated Older People's Service

MERRIT-Midlothian Enhanced Rapid Response and Intervention Team

ELSIE- Hospital at Home East Lothian


I.V. Antibiotic
Grab box
SM18 TLN
R
DOCTOR


Grab Box 4
for
CATHETER INSERTION
I.V. Antibiotic
Grab Box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ZERO EMISSIONS
I AM ELECT

Edinburgh H@H

GP referral

Flow Centre 03000 134 000 Option 1 & 4 Monday to Friday 8am – 8pm (last referral 5pm)

Then send SCI gateway referral to MoE Liberton marked urgent for HaH

Patients prioritised according to their NEWS

Will be redirected to duty doctor for advice/at 'capacity'

Consider additional discussion with home first navigator if urgent therapy need.

Case 1:

82 year old man with Parkinson's Disease, living at home with wife and QDS POC. Referred by GP with lethargy. Found to have Delirium secondary to CAUTI. Treated with IV fluids, IV Gent, catheter changed, PD meds managed. Recovered and discharged to GP in 6 days with updated ACP.

Wife involved throughout and very grateful.

Can provide bedside tests including ECG, bloods, bladder scan and urgent inpatient tests as needed.

Can provide other treatments including oxygen, Nebs, IV diuretics and will carry out polypharmacy review.

Aim to discuss and update ACP for most patients as appropriate.

If told 'at capacity', please come through for discussion as often alternative options

Edinburgh H@H

OOH referral

Referrals accepted: Sat/Sun 8am -5pm
Care Home resident with any medical condition OR non care home resident known to H@H with the same condition in the last 6 months

Overnight: 2 care home residents can be placed on workbench for review next morning

Referrals made via Flow Centre and call will be transferred to team to discuss.

Please ensure Adastra referral is selected with appropriate H@H team, and 'Referred to H@H' selected in outcome.

Case 2:

72 year old man, lives with wife, supported by TDS POC. Well known to team with COPD, HTN, AF, DM and heart failure. Referred by LUCS with exertional SOB and increasing oedema.
Diuretics titrated up and attends DH for blood transfusion as Hb 72. No improvement, trial of Metolozone but CKD worsening clinical benefit. Discussion around priorities of treatment; now aiming for supportive care at home; ACP meds arranged and discharged back to GP with DN involvement. Died at home 1 week later.
This was 3rd referral in 1 year with HF – many bed days saved and much improved QOL for him and wife.
Do not do transfusions, IV iron or IV Zol at home but arranged at Day Hospital or similar.
If EOL, will discharge back to GP and DN care.

Edinburgh H@H

ED referral

QI work to increase ED referrals.
H@H NP input daily during week.
Can refer 2 patients overnight for review next day.

Suggested referrals:

1) All Care Home residents with non-surgical presentations

2) Age >65 or Clinical Frailty Scale > 4, with:

- De-compensated heart failure and Saturations >92%
- Infection requiring ongoing IV antibiotic and NEWS <5
- Fall without fracture when further assessment or analgesia review required
- Delirium requiring further assessment
- Exacerbation of COPD when CRT not available

Case 3:

75 year old lady referred by ED overnight. Presented with uncontrolled back pain and significant weight loss. Being supported at home by daughter.
H@H reviewed next day – increased analgesia and sorted social situation with locality hub input.
Expedited OP CT CAP > showed pancreatic malignancy.
Informed in own living room with family.
Discussed with MDT, for best supportive care, referral made to palliative care for pain management and discharged to GP.

Have 1 physio as part of our team but link with Hub therapists, DNs, SCD and other com teams as needed.
Urgent investigation can be expedited and arranged as 'inpatient'.

Edinburgh H@H

DH referral

Good links with Day Hospitals and other community teams, such as IMPACT, CRT and HF team
- encourage direct referrals to H@H via nurse coordinator 07989170797

Same pathway for supported discharges from ED and hospital wards.

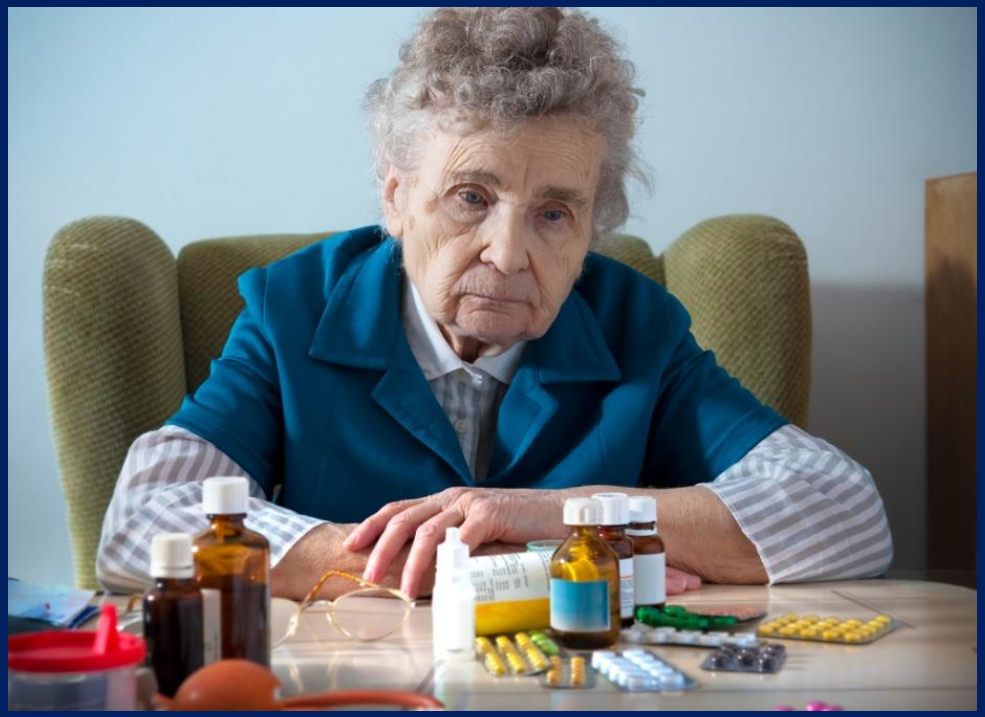
Case 4:

82 year old lady reviewed urgently in Day Hospital with rapidly declining mobility and weight loss with significant functional decline. Felt likely to have undiagnosed dementia but daughter was very anxious and to facilitate rapid investigation was admitted to H@H.
CT head and CAP arranged – no malignancy. Treated for UTI. Reviewed by CPN – ACE 63 and probable depression. Started Mirtazepine. Referred for POC via SCD. CRP remained elevated but stable, discharged to GP with FU in clinic.
1 month later – TC with daughter – ongoing weight loss, not engaging with carers, CRP still elevated. Arranged admission to ICT for nursing care and possible further investigation.
Good links with clinic.
Patients can attend for X-ray.
CPN as part of team to improve mental health assessment and link with RRT/CMHT.
Team can arrange direct admission to ICT beds for rehab & assessment.

Key messages

- Always consider an alternative to admission for frail older adults
- If unsure, please ‘phone a friend’ – FC will put you through
- All details available on Refhelp – search ‘Medicine of the Elderly’

Any questions or comments?



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