RCEM SDEC FRAILTY TOOLKIT

Royal College of Emergency Medicine

BGS British Geriatrics Society Improving healthcare for older people

SDEC for Frailty? Really?

Think SDEC - could this older person be safely discharged?

- Admission avoidance promotes the maintenance of independence and reduces risk of deconditioning
- No hospital admission = no admission associated complications e.g. HAI, less risk of delirium/falls.
- 'Promotes values based person centered care closer to home and has positive impacts on system flow.

NNT for CGA = 33, for one more frail older adult to be alive in their own home at 12m

- 'Comprehensive Geriatric Assessment is MULTIDISCIPLINARY evidence based intervention for frailty. It is a process. not an event, and emerging SDEC models focus on initiating this responsively when an acute need arises.

Identifying Frailty

- Identifying frailty is the first step in providing patient centered evidence based care for older adults.
- The Clinical Frailty Scale is the RCEM/BGS screening tool of choice (see Silver Book - bgs.org.uk/silverbook2)

Tip 1: Remember CFS refers to the patient 2 weeks prior to assessment

Tip 2: to improve accuracy, use the CFS app (scan QR code above to download)

Silver Book II Quality urgent care for older people

Delirium Top Tips

- Delirium is common, under-recognised and associated with a range of adverse outcomes independent of underlying cause...

↑ LOS - extra 10d in hospital
↑ >2 x risk of institutionalisation
↑ 3.5 x risk of falls (and fratures)
↑ risk of death - 11% for every 48h of delirium
↑ risk of readmission
↑ risk of cognitive decline –8 x risk of dementia

- The 4AT is the best validated delirium tool and is recommended by NICE - scan the QR code to download the handy 4AT app

4AT RAPID CLINICAL TEST FOR DELIRIUM

Score 0 = delirium/cog imp unlikely
Score 1-4 = possible delirium
Score 4+ = delirium or cog imp present

Alertness	Normal/fully alert (or mildly sleepy for <10s on waking) Not fully alert as described above	0 4
AMT4- Ask age, DOB, name of hospital and current year	No mistakes 1 mistake 2+ mistakes	0 1 2
Attention- list the months of the year backwards	>7 months of the year correctly <7 months of the year correctly Untestable (too unwell/drowsy)	0 1 2
Acute change or fluctuation in alertness, cognition, or mental status, evident over the last two weeks and present in the last 24h?	No Yes	0 4

Tip 3: Delirium is a symptom of something else...

- Ensure top to toe exam (inc skin/heels/ sacrum!)
- Consider likely underlying cause - use PINCHME mnemonic (see below) and avoid premature closure of thinking!

Tip 4: Collateral is key

- Be a detective - look at ambulance PRF, GP letter, contact family or carers.
- Feels time consuming but saves time later and helps align goals of assessment!

Pain
Infection
Nutrition
Constipation
Hydration
Medications
Electrolytes (and environment)

Tip 5: Management - Pearls and Pitfalls

- Non-pharmacological approaches = mainstay; think regular reassurance/reorientation, remember glasses/hearing aids, encourage normal circadian rhythm.
- INVOLVE the patient, and those important to them.
- Use meds only if severe agitation/safety risk (oral 1st):

HALOPERIDOL 0.5-1mg PO/IM 1°(max 4mg/24h) 1st line OR if PD/Lewy body dementia/QTc>470ms use LORAZEPAM 0.5mg-1mg PO/IM 1° (max 5mg/ 24h)

- Consider admission alternatives – e.g. H@H
- Reassure family/carers - consider delirium leaflet

Polypharmacy Pearls

- Defined as >5 medications (though note sometimes this is appropriate!)
- Take a careful drug history, think about indication for treatment and weigh up whether still required...

Try the STOPP-START tool: https://www.cgakit.com/m-2-stopp-start

- Potential wins to stop = prochlorperazine, long term anti-histamines, longterm anticholinergics (adverse impact on cognition), antihypertensives if symptomatic postural BP drop or recurrent falls.
- Be mindful with hypnotics/sedatives - though these increase falls risk, patients are often very attached, stopping may produce rebound symptoms and careful discussion is required!
- Similarly, antidepressants/antipsychotics should be withdrawn gradually to avoid precipitating delirium!
- Careful consideration should be given to the risk-benefit ratio of ongoing anticoagulation (esp if patient is falling)

Ensure all/any medication changes are clearly documented and communicated to primary care!

Focus on Falls

- A fall from standing height is the commonest MOI causing major trauma (ISS>15) in patients aged >60.

THINK - could this be SILVER TRAUMA?

- Consider need for C-spine immobilisation - if required ensure patient is gently immobilised in a position of comfort (traditional ATLS 3 point immobilisation can be detrimental to this group.)
- Consider how best to minimise transfers/log rolls until imaging obtained and be mindful of vulnerable skin/pressure areas - minimise time immobilised as far as possible!

Tip 6: History...Break it down!

- Consider consequences of falls but possible causes too...
  - **What happened before/during/after fall?**
  - **Any consequences/injuries?**
  - **Any witness history?**
  - **Any previous falls or workup?**
  - **Any falls risk factors present?**

Tip 7: Examinations and Initial Investigations

- Examine top to toe for causes of fall and injuries.
- Ix minimum – ECG, L+S BPs (lie for 5min, take BP, ask to stand, repeat BPs at 1/3/5 mins), bloods (for most.)
- Have low threshold for imaging - older adults are experts in hiding stealthy traumatic injuries!!

The bedrocks of SDEC for falls and frailty are relationships and SAFE DISCHARGE!

Tip 8: Falls focussed good discharge practice

- If no major injuries or medical causes requiring admission - consider same day therapy review and early supported discharge.
- Ensure clear referral pathways exist to local virtual frailty wards, emergency OP clinics, Day Hospital or local equivalents to facilitate ongoing proactive MDT management/CGA if required.

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