

The Silver Book

Improving urgent care for older people

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The silver book

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- Hon Sec BGS



The silver book

- Matthew Cooke
Emergency Medicine
Czar
- Alistair Burns
Dementia Czar
- David Oliver
Older People Czar

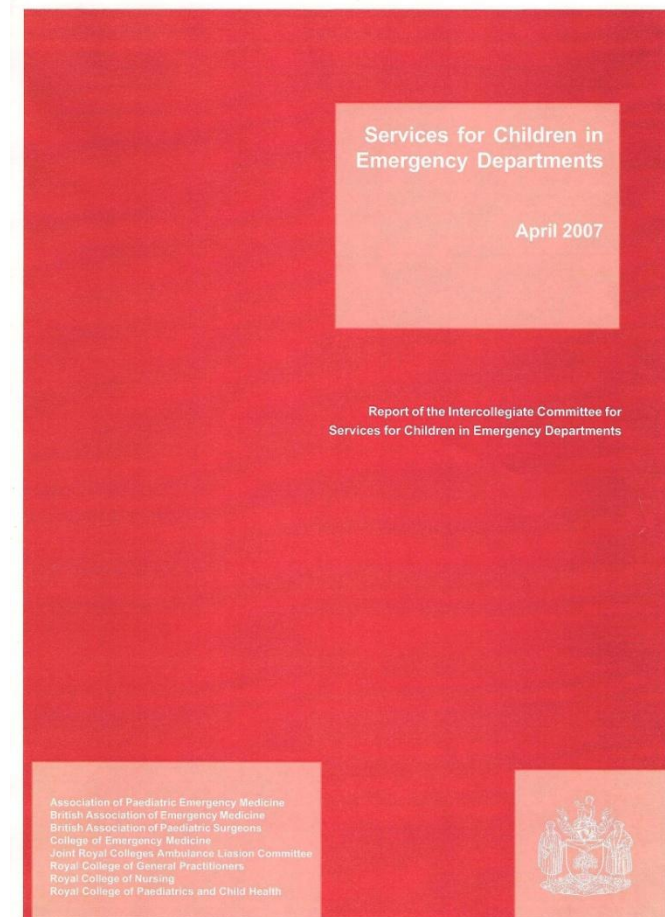


Membership

- Age UK
- Ambulance Service Medical Directors Association
- Association of Directors of Social Services
- British Geriatrics Society
- Chartered Society of Physiotherapists
- College of Emergency Medicine
- College of Occupational Therapists
- Society for Acute Medicine,
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Physicians
- Royal College of Psychiatrists

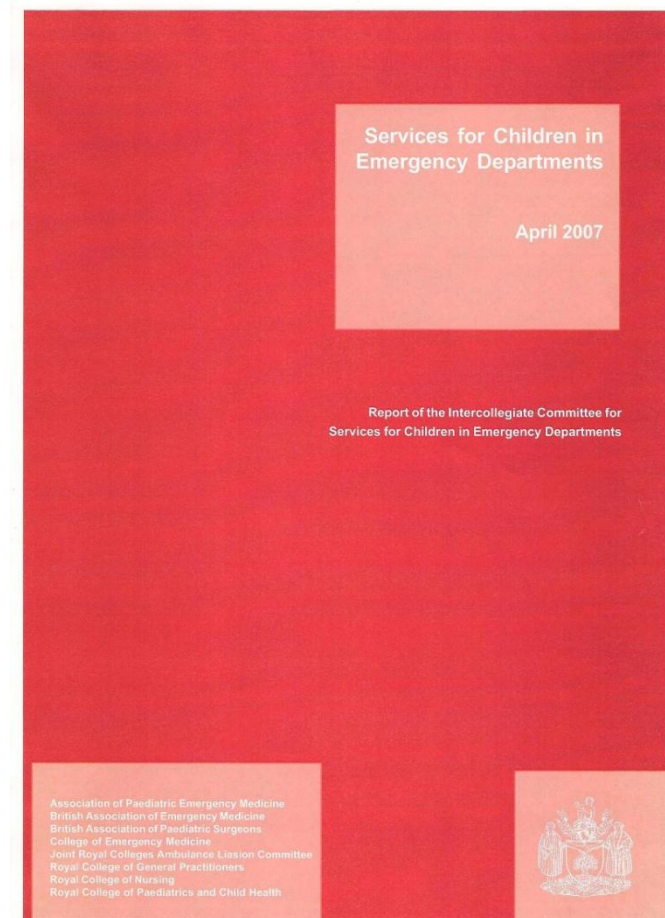
The red book

- Accident & emergency services for children (1999)
- Recommendations for services & skills needed by EDs
- By 2007 not fully implemented



Red book contents

- Challenges
- Service Design
- Assessment
- Treatment
- Staffing
- Training
- Major incidents
- Child protection



Extremes of life

- Children
- 3.5 million attendances at ED / year (30%)
- 90% discharged with no involvement of in-patient team
- People over 85
- ~ 600 000 attendances / year (5%)
- 62% admitted
- Most likely to be re-admitted
- Most likely to require long term care

Silver book recommendations

- 6 principles
- 20 standards
- 92 recommendations

Principles 1

- All older people should have access to treatments and care based on need, without an age-defined restriction to services
- Older people have a right to a health and social care assessment and should have equal access to specialist advice when needed
- Urgent care service responses to older people must be person-centred, driven by the person's needs and provided in a dignified and respectful manner

Principles 2

- Older people, their families and carers should be involved and consulted in all discussions about their health and social care needs, including self-care, wherever possible
- All decision making needs to take account of relevant legislation, for example the Mental Capacity Act in England and Wales
- Teams assessing older people must practice interdisciplinary working across health and social care within a joint governance framework

Standards

- See Handout

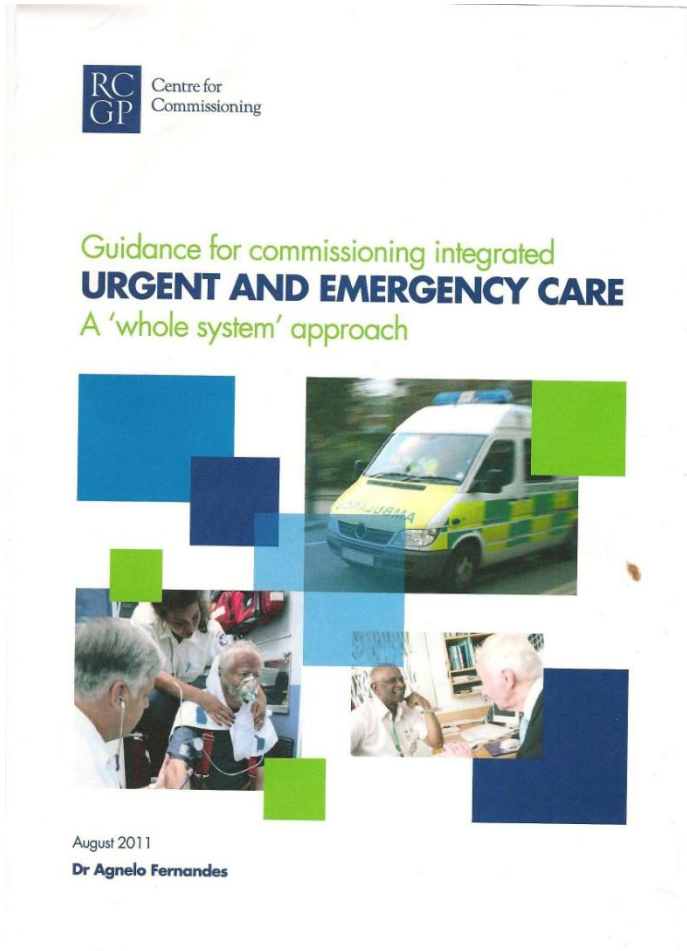
Assessment & Treatment

- Dementia & delirium
- Depression & self-harm
- Falls & fragility fractures
- Incontinence & UTI
- End of life issues
- Discharge planning

Policy context

- Health & Social Care Bill
- Economic situation
- Demography

RCGP Commissioning Guidance



Key principles of a good service

- No confusion of what to do, who to call or where to go
- A joined-up and co-ordinated system
- Safe, responsive and a high quality service
- Self-care, prevention, anticipatory care and patient empowerment
- Patient and public involvement
- Monitoring of urgent and emergency care services
- Knowledge to influence the spend on services
- Integrated mental and physical health care for all.

Summary

- Older people come to emergency care for many reasons and along many pathways
- Where feasible, health and social supports to prevent attendance at emergency departments and admission to hospital should be developed
- Frail people often have complex mental and physical health needs which may require admission to hospital

ISAR screening tool

ISAR screening tool (Identification of Seniors At Risk) ^[2] *Ask carer if patient unable to answer*

Before the illness or injury that brought you to the Emergency Department, did you need someone to help you on a regular basis?

☐ No

☐ Yes

Since the illness or injury that brought you to the Emergency Department, have you needed more help than usual to take care of yourself?

☐ No

☐ Yes

Have you been hospitalised for one or more nights during the past 6 months (excluding a stay in the Emergency Department)?

☐ No

☐ Yes

In general, do you have serious problems with your vision, that can't be corrected by glasses?

☐ No

☐ Yes

In general, do you have serious problems with your memory?

☐ No

☐ Yes

Do you take more than three different medications every day?

☐ No

☐ Yes

A score greater than 1 suggests increased risk of severe functional impairment, frequent hospitalisation and depression over the following six months; in this case please

- *Ask a Primary Care Coordinator to review (if one is available)*
- *Inform GP*

**Number of
questions
answered
with YES**

Rockwood scale

Box 1: The CSHA Clinical Frailty Scale

- 1 *Very fit* — robust, active, energetic, well motivated and fit; these people commonly exercise regularly and are in the most fit group for their age
- 2 *Well* — without active disease, but less fit than people in category 1
- 3 *Well, with treated comorbid disease* — disease symptoms are well controlled compared with those in category 4
- 4 *Apparently vulnerable* — although not frankly dependent, these people commonly complain of being “slowed up” or have disease symptoms
- 5 *Mildly frail* — with limited dependence on others for instrumental activities of daily living
- 6 *Moderately frail* — help is needed with both instrumental and non-instrumental activities of daily living
- 7 *Severely frail* — completely dependent on others for the activities of daily living, or terminally ill

Note: CSHA = Canadian Study of Health and Aging.