RCPE Medicine of the Older Person Symposium

Friday 05 March 2021

Comprehensive geriatric assessment (CGA) for the non-geriatrician - Dr Simon Hurding

Q. Impressed with number of CGAs! After doing CGA, How was the decision made to add patient onto palliative register?

A. Great and challenging question. As a practice we believe that many more patients should be on the palliative care register than actually are. The conversation when someone has an aggressive cancer is relatively straightforward and even then we try to provide clarity behind what we mean by palliative care versus terminal care. Discussions with the patient and family promote the benefits that once on the register care tends to be fast tracked by the practice and out of hours service. In considering suitable patients we tend to start with the consideration that 'I would not be surprised if this person does not live for more than six months' or 'I would not be surprised if this patient died in the next 6 months'. Having considered this then I would look to their current medical problems (cancer, end-stage chronic disease, very old, degree of organ failure) and make a judgement. I suppose the time to consider discussing the palliative register is when therapeutic aims become solely about relieving suffering rather than life prolongation.

Q. Do you use CGA in primary care to prioritise patient for advanced care planning in the future?

Q. Did you look at the correlation between eFI scores and clinical frailty scores?

A. The CGA is and excellent way to identify unmet need in a holistic and patient centred manner. Increasingly I find that in primary care it is not a one off event, but often the start of a therapeutic process. Writing the detailed Key Information Summary is a fantastic way for me to reflect on the patient and what the next steps are. I try to allow the therapeutic process to be driven by the patient, so there may be one patient who has a very high frailty index, with a lot of medical, social, psychological needs who have a way of just getting on with life. Conversely, another patient may have a much lower frailty index but a lot of demands on the service. My frequent fliers are not necessarily those with greatest need, thought there may be a better correlation than in wider general practice. Answering that question would require some sort of audit. Interestingly part of Helen Jones' research demonstrated that my frequent fliers are younger, and most under the age of 80. This doesn't actually surprise me as this group will include those with long term disabilities and complicated care packages.

Q. How do suggest GP practices set up a similar process? What are the barriers that need addressing?

A. Part of our cluster of general practices is looking at different models of care focussed around the use of the CGA. For example Penicuik use a far more MDT model and do one CGA a week followed by the MDT meeting. The Newbattle model is in part based on the size of the practice (9th largest in Scotland) and our approach to managing patient demand (majority initiating consultation using eConsult). There are other models in between what are perhaps two extremes. Once we are back to more normal times (post-pandemic) there is a great need to spend time reflecting on the differing models and the benefits and problems with each one. I would be very against a recommendation for 'one size fits all', which general practice has been guilty of attempting too many times in the past, especially when forms of patient care becomes contractual (I can show you the scars....)

Q. It sounds like a lot of work largely because all the CGA reviews were NEW patients to you. Do you think this would get more sustainable overtime (so does the work done on NEW patients mean that later consultations are quicker)?

A. I find that completing the CGA for new patients is completely invaluable to how I care for them. It completely speeds up subsequent consultations, though I always have to be sensitive to taking the time to listen. Due to the pandemic there have been around 20 patients who I am caring for, but have not yet done a CGA. Though I am now catching up with doing these outstanding CGAs I have definitely been on the back foot with their care. Of interest, although perhaps concerning, is that there are two patients where a colleague did the CGA to help me out, and I have never managed to get my head round these patients. Having said that colleagues often feedback how helpful the detailed key information summaries are if they have to provide any care for Mid Med patients. I think the CGA reveals how complex these patients often are.

Q. Really impressive work. Are you aware of other GP practices that have dedicated doctors for their frail population? The reduction in hospital re-admissions suggest this would be very useful.

A. Thank you and please refer to answer 3. There is UK wide work around frailty, which is why the eFI is now integrated within the GP computer systems. I understand that in England there is the requirement to maintain a frailty register, but I don't know how that is then used by practices. We are not aware of another quite so comprehensive model as Mid Med. I am in touch with a Swedish GP who provides similar care to the elderly population of a single island. She cycles to visits, which I also tried to do until I became too busy. There are going to be debates around the affordability of this model, though from Helen Jones' data, it looks like it may be at least cost neutral to the health board. One issue is that reduced hospital admissions only saves imaginary money (apart from food and drugs) as the main costs are staff and infrastructure. (No I don't want reduced hospital admissions to lead to staff losing their jobs....) Overall, and a key point I was trying to make, is that this is the sort of worthwhile role that a GP of my experience should be doing and that as it is very much about being an expert generalist this should be funded by the new GP contract.

<u>Bladder and bowel dysfunction: the BASICS - Ms Anne Sanderson</u>

Q. How important is a rectal examination to assess and exclude constipation as a contributing factor? Is it essential? Is it negligent to avoid doing a rectal examination?

A. DRE is essential part of assessing bowel dysfunction. All registered nurses should be competent in DRE unless contraindicated see NHS Lothian Protocol or RCN Bowel care (2019).

Q. Are you amazed that people in their 80s do not seem to be able to manage their own bowels?

A. Patients of all ages may have problems managing their own bowels for various reason e.g. acute illness, post op, neurological dysfunction, cognitive impairment.

Q. Thank you, a very useful talk. I find a big problem is encouraging ward staff to complete bowel charts, especially with electronic documentation. Do you have any advice about this?

A. I would suggest that wards use paper bowel charts as electronic recording doesn’t allow you to look back and evaluate bowel pattern. If patients can complete their own chart they should be requested to do so. Accurate

documentation is essential and the responsibility for both registered and non reg nursing staff. I think any ward rounds and MDT bowel charts need to be consulted to reinforce how essential this is when caring holistically for any patient.

Q. Is digital stool evacuation still in practise for those who are severely constipated?

A. DRF can be required as part of neurogenic bowel management care plan, often in SCI patients. DRF may also be required if patient is acutely constipated and rectum is so loaded it is impossible to insert supps and enema. Aim being to avoid recurrence.

Q. How important is it to use a flip flow valve on a short-term catheter to retain the sensation of bladder filling? Does this impact on continence after catheter removal?

A. Not a huge amount of evidence for using valve before TWOC, really depends on individual and ability to manage valve independently etc. I would say if IDC required we should always consider a catheter valve as opposed to free drainage to maintain bladder capacity.

Q. When meeting an older frail patient with incontinence for the first time in hospital, how far do we go to investigate/exclude urological causes when that is the 'only' red flag? Have come across multiple patients who may not be fit for more invasive measures of Ix/Mx but not cause really found.

A. Incontinence alone is not a red flag so I would say once you have completed BASICS assessment, have diagnosis of type of dysfunction and if treatment/management has not been effective you may want to discuss with urology/urogynae colleague if felt appropriate.

Q. Can we use BBNT services for younger patients also who have difficulties with B and B function due to morbid obesity?

A. Absolutely, following completion of BASICS, diagnosis and treatment BB dysfunction remains a problem or if advice required re treatment/management.

BBNT are available for advice for patients, staff. Avoiding delayed discharge from hospital and recurrent admissions related to BB is a priority.

<u>The doctor will see you now (virtually) - Dr James Woods</u>

Q. Is there any data on patients' and doctors' preference on virtual clinic?

A. There is a recent public engagement report for NHS Near Me which shows that overall 87% of public respondents felt video consulting should be offered where appropriate and 94% of health care professionals. In the over 75s group there was a slight reduction to 75% in favour. (Near Me Public Engagement Full report September 2020 published by Technology enabled Care, Scottish Government).

Q. Experienced consultants may have adapted well to virtual clinics, but if trainees have not learnt clinic skills in "real life" first is there a danger they never will now? Clinical exam skills already in jeopardy!

A. In general, trainees feel more comfortable with technology than some of their senior colleagues. Whilst physical examination skills are important, there are ample opportunities in day to day practice to develop these and face to face clinics will always be required. Virtual consultations also offer an excellent opportunity to focus on history taking for example.

Q. Could you explain a little more about how you involve trainees in clinic? Can they be an additional participant on Near Me?

A. Trainees can attend as an additional attendee. They have their own NearMe Log in and access to our waiting area. They can either select patients to review on their own if they have the relevant experience or alternatively can join a consultation with the Consultant present.

Q. Whilst many of the consultants have offices/laptops to enable telephone/video consults, as a trainee this is often not the case. In addition, our clinic space has been taken over for Covid-related use. Have you had any issues with this side of technology?

A. Access to equipment can be a challenge. Especially towards the start of lockdown trainees were not, in my experience, prioritised for digital equipment especially if needing to work from home, this has improved latterly in my experience. In general at present, we do have some spare physical space for trainees to use but a limiting factor is many of the desktop computers do not have web cameras to allow video calls and this is an issue.

Digital health - tools to modernise healthcare? - Professor Lynn Rochester

Q. Any data on patient opinion of these products?

A. There will be anecdotal comments – in product development formal evaluations have taken place and may be published on the manufacturer's website – along with anecdotal comments

Q. Thanks, a really interesting talk. Have these devices led to changes in medication management, i.e. trying to personalising patient's management?

A. Some changes have been reported in respect to the PKG – I referenced papers on slides – that suggest changes in patient management occurred on the basis of feedback.

In terms of other apps that have become available – I am not sure as they are not formally evaluated – it would be interesting to carry out a survey of what is happening in the clinic and how this is bringing about change – especially after the last year. Would be happy to discuss this proposal!