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Acute hospital admission of the frail older person: an opportunity to discuss future care

More than a third of the UK population now lives to the age of 85¹ and the absolute number of older adults in the population is increasing significantly.² Frailty is defined by Clegg et al as “a state of increased vulnerability to poor resolution of homeostasis after a stressor event, which increases the risk of adverse outcomes, including falls, delirium, and disability”.³ The prevalence increases with age, with up to half of adults over the age of 85 estimated to be frail.^{3,4} It is now well reported that increasing frailty is important as a prognostic indicator, with frailty status being strongly associated with both quality of patient outcome and mortality.⁵ A recent NHS Benchmarking Network report suggests that 52% of Trusts in the UK now have a specialist frailty unit⁶ and, in primary care, the new GP contract will require practices to actively identify their frail patients and review them appropriately.⁷

Measurement of frailty can be performed in several ways and there are a number of tools in use. The Comprehensive Geriatric Assessment (CGA), the gold standard for the management of frailty in older people, is an holistic, multidimensional, interdisciplinary assessment of an individual and has been demonstrated to be associated with improved outcomes in a variety of settings.⁸ The CGA can also be used to quantify an individual’s degree of frailty in a Frailty Index (FI-CGA).⁹

In this edition of *Age and Ageing* Hatheway et al present data from secondary analysis of a cohort study, initially reported in 2011, including 409 elderly patients admitted to a tertiary care teaching hospital in Canada.⁹ The current study examines the relationship between the recovery of mobility and balance, initial treatment response and underlying frailty. Patients who were more frail at baseline, as reported by the patient or their family, were less likely to recover their balance and mobility (odds of no or incomplete recovery increased by 1.06 with each 0.1 increment in the FI-CGA at baseline) and this was similarly dependent on age (1.010). Improvement in mobility and balance over the first 48 hours was associated with greater improvement overall and with shorter recovery times. Patients with only mild mobility impairment recovered sooner – by day 5 about 50% with mild impairment had recovered, compared to 25% of those with moderate impairment and 10% with severe impairment. Declining mobility in the first 48 hours represented a relative risk of death of 17.1. The relationship between degree of baseline frailty and recovery was independent of the extent of mobility impairment at admission.

This study has immediate clinical relevance and contributes to the growing evidence base on this important topic. Although secondary analysis of existing data can be problematic, as the available data are not collected to address the particular research question, this study makes appropriate use of routinely collected data with a reasonable sample size. To improve generalisability, it would be helpful to see the analysis of data from a number of hospital sites.

Almost two thirds of people in the UK, aged over 85, die during a hospital admission.¹⁰ The likelihood of dying in the 12 months following a hospital admission

increases with age¹¹, however it is difficult to predict which older patients are at risk of dying during, or soon after, a hospital admission. This study offers one approach to assessing and managing the frail older patient with acute illness to appropriately tailor their ongoing care. If we are able to identify the patients who are most likely to recover, we can target them for intensive rehabilitation and early discharge planning. Equally, those patients who are at greater risk of dying can be offered the opportunity to have advance care planning discussions and palliative care input, ensuring that unnecessary interventions are minimised.

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