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White Paper on the Care of Older People with Acute illness and Injury in the Emergency Department

Geriatric Emergency Medicine Special Interest Group

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Executive Summary

This White Paper is the product of the Geriatric Emergency Medicine Special Interest Group (GEMSIG) of the International Federation of Emergency Medicine (IFEM). It highlights that older people are the fastest growing demographic in most countries; that they access emergency services for many different reasons; and that it is essential to consider their multiple needs when developing emergency care systems. Addressing the needs of the whole person, even at times of acute illness or injury, offers a great opportunity to improve older people's lives. This paper provides guidance to health care systems by stating general principles and giving practical examples that can be modified across all income and resource settings.

Excellent health care for older people during acute episodes of illness or injury is important for the well-being of individuals and the economic viability of societies. To ensure that the care needs of older people are met effectively and appropriately, Emergency Departments (EDs) and health care systems must address their multiple needs and those of the communities in which they live. Older ED patients are different from younger adults not only anatomically and physiologically, but also in terms of mechanisms of injury, presentation of symptoms, function, cognitive changes, social needs, goals of care, complexity, and heterogeneity. Successful care of older patients requires more than episodic care of illness and injury. It also requires attention to their social, psychological, functional needs, and to effective transitions across the health care system.

Experience in many settings demonstrates that simple changes in the approach to care of older people in the ED can have a profound impact on outcomes. However, it requires deliberate clinical and infrastructure changes. IFEM member organizations are encouraged to use this White Paper to influence local and national decision makers.

Introduction and Background

Older people are the fastest growing demographic in almost all countries of the world – high-, middle- and lower-income. In any country, "old" is best defined not by age alone, but by a combination of factors: the need for increased physical and social support; increased physiological and social vulnerability to stressors; the possibility of cognitive impairment; the presence of multiple medical conditions associated with increased age. This interplay of factors – not necessarily confined to old age – is described as frailty. People with frailty often present to EDs with a complex interplay of factors that contribute to the acute illness or injury

on which EDs tend to focus. EDs need to take a broader view of older patients and see not just an illness or an injury but *the whole person* who has that illness or injury. This means considering the person in their family, social, religious and cultural context, as well as the effects of illness on function, cognition and psychosocial well-being.

EDs function as an intersection point in the continuum of care for people of all ages and offer real opportunity to improve lives. It is understood that EDs cannot provide all services to all people or correct health system deficiencies; ongoing efforts to improve primary and preventative care are needed. Nonetheless, for older people, the ED is an important and, sometime, the only access point to the health care system. ED care represents a unique opportunity to influence outcomes, particularly during episodes of acute illness or injury which, for older people, are critical moments with an even greater risk of adverse outcomes. Integrated evaluation and management in the ED can lead to improved outcomes through optimal care, including early and effective recognition and treatment of disease, a focus on the prevention of morbidity and decline in the ED and through transitions of care, and early initiation of rehabilitation.

In some lower-income countries, older people currently may represent a small proportion of the population. Their challenges may be less visible, even hidden, to the society as a whole. There may also be limited integration between the ED, inpatient care and the community, leaving older patients particularly vulnerable at the point of ED discharge. Local traditions for care in the final years of life may range from almost exclusively family-based care to exclusively institutional or state-delivered care. EDs must have a heightened awareness of these realities when assessing older people both clinically and socially. Vulnerability is a leading risk factor for abuse and neglect in any setting: addressing it should be a part of ED care. Assessment and management of frailty needs to be as much a part of ED care as attending to illness and injury. Funding limitations in all income settings may lead health systems to focus on the high-visibility areas of emergency care – trauma, cardiovascular disease, infectious diseases – and to leave the needs of the older population unaddressed.

For the well-being of patients, their families, and societies, continued improvements in the care of older people in EDs must be a priority for both clinical and social care and health policy. It is important to state that most of the recommendations in this White Paper are neither costly nor technologically sophisticated. They are in fact basic and practical. They consist mostly of simple changes that come from a heightened awareness of the needs of this increasingly large group of ED patients. IFEM member organizations can support improvement in their country's health care system by providing leadership and guidance which recognises the importance of timely and appropriate care of older people and sensitivity to their unique needs.

Current Practice

Emergency care for older people has improved in many settings over the last decade. While significant opportunities for improvement still remain, it is important to catalogue some examples of current good practice models in EDs and health care systems here:

1. Geriatric Emergency Department Intervention guidelines, for example, the Geriatric ED Guidelines (2013) co-developed by the American College of Emergency Physicians, the Society of Academic Emergency Medicine, the Emergency Nurses Association, and the American Geriatrics Society; and the Australasian College for Emergency Medicine Care of older persons in the emergency department policy (2020);
2. Creation of educational resources specific to ED clinicians; for example the Acute Geriatrics series in EM Australasia or Geri-EM.com or the European Curriculum on Geriatric EM (Conroy et al, 2016).
3. Geriatric considerations in triage systems, for example, the Canadian Triage Acuity Scale (CTAS) modifiers (Bullard et al, 2017);
4. ED screening for common ED conditions and ED-based care pathways, for example, delirium, pain, falls assessment, frailty, pressure injuries, abuse and neglect;
5. Enhanced geriatric trauma principles and modifications to trauma guidelines;
6. Geriatric consultations in the ED and geriatric short stay units, sometimes called frailty units;
7. Interdisciplinary care in the ED, for example, nurse-led geriatric ED care coordination; mobility and functional assessment by physical and occupational therapists; management of polypharmacy by pharmacists; coordination of social support by social workers;
8. Improved transitions of care for older people following ED discharge, including follow up in the community or residential aged care/nursing homes.
9. Accreditation programmes that define and recognize EDs providing exemplary geriatric care, for example, the American College of Emergency Physicians Geriatric Emergency Department Accreditation program.

Recommendations

In recognition of the rapidly expanding demographic and the gaps in its care, IFEM developed its GEMSIG in 2015. In 2018 the group published a Consensus Statement highlighting eight minimum standards of care for older people in EDs around the world. For

this White Paper, we have used that framework in consultation with our members in all regions of the world to develop the following recommendations to improve care of older people in ED.

STANDARD 1. The right **approach**: EDs should recognise that older people are a core population of service users.

- Develop leaders in geriatric emergency medicine to drive clinical improvement, education, research and policy relating to emergency care of older people. Leaders can be ED physicians, nurses or allied health professionals trained in the care of older people.
- Identify and collect data on quality improvement metrics relating to emergency care of older people.
- Lead quality improvement and/or research initiatives relating to emergency care of people.
- National emergency medicine organisations should identify leaders and support the development of groups focused on improving emergency care of older people.
- Governments should identify and provide appropriate resources for improving emergency care of older people.

STANDARD 2. The right **personnel**: EDs should identify that adequate care of older people often involves an interdisciplinary and multi-specialty approach.

- Develop a team which is available for interdisciplinary care and assessment for older people in the ED. The team could include physicians and nurses trained in care of older people, physiotherapists, occupational therapists, pharmacists, social workers, and volunteers.
- Establish relationships and referral pathways with providers who have special training and skills in caring for older people. This could include geriatrics, psychiatry, rehabilitation and palliative care.
- Enhance knowledge, skills and attitudes in the care of older people among ED clinicians; clinicians who focus on fast pace and immediate results may need support to develop a more age-appropriate approach.

STANDARD 3. The right **environment**: EDs should address safety and accessibility issues for older people with the design of the physical environment and available equipment.

- Modify the physical environment to support older people in the ED, and optimise mobility, independence and safety. Where possible this includes orienting features (clocks and signage); temperature and lighting control; access to toileting, hydration and nutrition; call bells; and noise reduction.

- Support individuals of varying levels of mobility both within the department and at discharge. This includes access to mobility aids (canes and walkers), accessible beds, chairs, commodes, toilets, and removal of fall hazards.

STANDARD 4. The right **decision making**: EDs should ensure that the needs and goals of older people are considered at all levels of decision making.

- Ensure that the older person's values, preferences, and prognosis are incorporated into all decisions as is medically, socially and culturally appropriate.
- Every care policy or program introduced to the ED should consider the impact it will have on emergency care of older people, for example, programs and care centred on mental health and substance use, homelessness, and communicable disease.
- Decisions regarding admission or discharge should consider the risks of hospitalisation, including loss of independence and hospitalisation-associated disability; and should attempt to balance the value of inpatient care with these risks.
- ED care providers should include the needs and opinions of carers when preparing a discharge plan for older ED patients.

STANDARD 5. The right **processes**: EDs should establish policies and procedures that guide holistic person-centred management of problems common to older people.

- Ensure triage assessment recognises the unique ways older people present to the ED.
- Screen for common conditions affecting older people including delirium, falls, frailty, dementia, pain, abuse and neglect, food insecurity, polypharmacy and potentially inappropriate medication use, carer burden.
- Consider the potential impact of physiological, physical and psycho-social changes associated with aging, such as hearing, vision, cognition, and functional independence.
- Enhance mobility by implementing standardised processes for the use of cardiovascular monitors, physical and pharmacologic restraints, intravenous lines, and urinary catheters.

STANDARD 6. The right **support**: EDs should facilitate education about issues common to older people.

- Ensure providers working in the ED receive interdisciplinary training in geriatric concepts and best practice as part of their continuing education. This includes adequate training, resources and time; and should include education for students, trainees and continuing professional development. Core topics would include delirium, cognitive decline, falls, frailty, elder abuse, pain, incontinence, pressure injuries, medication assessment and prescribing for older people.

- ED care providers should recognise, plan for, and communicate the likely clinical trajectory; they should participate in discussions about patient-centred goals of care and care at the end of life

STANDARD 7. The right **results**: EDs should actively support patient-centred care to optimise outcomes.

- Provide older patients with access to care and rehabilitation services that meets their needs, including in facilities outside of the hospital such as the patient's home.
- Health care provided during and after an acute health event should include recognition and planning for the likely clinical trajectory; care should be provided in line with the older person's care goals, needs, values, and preferences.
- Caregiver dependency affects many older people. EDs should have methods for identifying caregiver dependency and burnout, and for supporting caregivers.

STANDARD 8. The right **system**: EDs should include strategies for safe and effective transitions of care.

- Ensure sharing of information between care facilities (including long term care, rehabilitation, respite care and other forms of supported housing), and between clinicians involved with the older person's care.
- Provide written discharge instructions which are clear and contain information regarding results and outcomes of ED visit, medication changes, follow-up instructions, and indications for returning to the ED.
- Ensure appropriate communication of information to primary care providers, family members, long-term care and community caregivers to improve transition of care.

Conclusion

Aging of populations around the world will continue in the coming decades. Improvements in their care are possible, most of them occurring at the local ED level. However, they require leadership and direction from national and international organisations. The IFEM Geriatric Emergency Medicine Special Interest Group calls on the institutions of international emergency medicine to ensure that emergency health services are designed to optimally manage the health and social care needs of older people during and after acute illness or injury. IFEM encourages its member organisations to recognise and address the needs of this core user group, and to engage and collaborate across disciplines and across systems. Creating change and driving improvement will benefit patients, staff, health care systems, economies and our societies.

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