

# Geriatric Emergency Department Guidelines

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# Background

- 2 years of consensus-based work.
- Representatives from



**AGS**

THE AMERICAN GERIATRICS SOCIETY  
Geriatrics Health Professionals.  
Leading change. Improving care for older adults.



# Background

- **The growth in the number and proportion of the older population challenges the US healthcare system.**
- **The emergency department is especially challenged to care for this population.**
- **Geriatric EDs began to appear in the US in 2008 and have expanded in number and scope.**

# Evolution of Geriatric EM

1974	First EM Residency
1982	Initial EM studies on geriatric populations
1991	Hartford GSI grant awarded to SAEM
1996	Geriatric EM textbook
2001-2003	SAEM Geriatric Task Force and ACEP Geriatric Section formed
2009	Initial geriatric EM quality improvement metrics published
2010	EM residency geriatric core competencies published
2013	Geriatric ED Guidelines published and approved by ACEP, AGS, ENA, and SAEM

Adapted from:

<http://www.ahcmedia.com/articles/21640-geriatric-emergency-medicine-guidelines-for-staffing-training-protocols-infrastructure-and-quality-improvement#table3>

# Senior ED Holy Cross, 2009

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## An Emergency Room Built Specially For Seniors

FEBRUARY 19, 2009 10:00 PM ET



JOSEPH SHAPIRO



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Only infants go to the emergency department at a higher rate than people 75 and older, according to a recent federal government survey. For years, many hospitals have set up separate emergency rooms just for kids. Now, Holy Cross Hospital in Silver Spring, Md., has set up an ER specifically for patients 65 and older.

The ER opened last November and takes older patients, unless they're considered trauma patients. When the



Dr. James Del Vecchio is medical director of the

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Saturday morning's auction at the closed stadium will offer an opportunity to take home part of Akron's sports history



The new owners of the Rubber Bowl, Team 1 Market

### Fans can't get enough of the Rubber Bowl

By Carol Billecky  
Akron Journal Staff Writer

If you were watching Sunday's auction and 16-foot-tall wreath iron gates that an auctioneer is the former Rubber Bowl is for you.

Akron auctioneer Glenn Wintchey will sell the contents of the stadium to the Akron University of Akron versus meeting at 11 a.m. "It's not concrete, it's probably much going to go," Wintchey said.

UA sold the football stadium in May to Team 1 Marketing for \$85,000.

The Canton company also to run the 75-year-old, horseshoe-shaped bowl into an entertainment center for mixed-consumers.

### Indian officials say massive evacuations save lives, 17 deaths reported; millions in crops destroyed

By Kay Johnson  
Associated Press

BEHARAPUR, INDIA: Mass evacuations spared India the widespread deaths many had feared from

### ER

Continued from Page A1

geriatric emergency medicine services for the region's aging population.

"In emergency medicine, we're recognizing that older patients have different needs than younger patients," said Dr. Steve Wilber, medical director of the Senior Emergency Department at SummaCare.

#### Health complications

Unlike many of their younger counterparts, older emergency department patients often have other health problems and complications along with the issue that brings them to the hospital.

Even something as common as a sprained ankle can be a quick fix for younger patients but a red flag for falls, balance and coordination issues and other underlying problems for older patients, Wilber said.

The goal of the geriatric emergency department is to address not only the medical emergency but also those other health problems, said Dr. Michelle Haines, SummaCare's chair of emergency medicine.

"For the elderly patients and for their caregivers, they don't know what the resources are," she said. "We're doing more things, trying to integrate things like a more comprehensive way to look at the patients."

#### Follow-up care

The senior emergency department at City Hospital — which opened last year — has private rooms and slip flooring and other design features that benefit all patients, particularly those 65 and older, Wilber said.

Within the Senior Emergency Department, nurses known as "transitional care coordinators" work with the patients and their families to schedule follow-up care and coordinate recommended services, such as home care or short-term rehabilitation.

"The goal is to try to keep you out of the hospital," said Dr. Haines, who serves as a transitional care and health-care management coordinator in the Senior Emergency Department.

Summa's insurance arm, SummaCare, also has care coordinators and emergency department navigators in the unit to help patients who are enrolled in the insurer's Med-



Dr. Steve Wilber is medical director of the Senior Emergency Department at Summa Akron City Hospital on Thursday.

icare Scott Taylor prepares to get the vital signs from Florida Lee Steadman, 72, of Akron in the Senior Emergency Department at Summa Akron City Hospital on Thursday.

care manager-care plans to determine what services are needed after they leave the ER.

Patients can be referred to a chronic program, an at-home visit from a doctor, home care or other services, said registered nurse Pam Merrill, a care coordinator and emergency department navigator for SummaCare. She also follows up with patients after discharge with a phone call to make sure they understood their discharge plan.

Steadman's grandson, Larry Steadman, said he liked the fact that there was an area of the emergency department dedicated to older patients when he recently brought her to the hospital for pain.

"We got size service," he said. "I like that."

#### Keeping patients healthy

The concept fits into an exposed shift in the coming years: the hospital reduced the percentage of ER patients of 65 and older from being hospitalized by 4.3 percent within the five-year timeframe of operation compared to the same time period last year.

Slightly more patients (4.4 percent) also went able to go home after visiting the ER than before the geriatric unit opened.

Wilber, who also serves as Summa's medical director of

### GOP pans Democratic spending proposal

Republican senators say deal to end shutdown less likely

By Anita Kumar  
Nashville Newspress

WASHINGTON: Several Republican senators said Sunday that a new Democratic request to increase government spending is hurting chances of a deal to end the 35-day-old shutdown.

Leaders of the Democratic-led Senate were dismissive of a proposal Sunday to pass, because it helps to place the 100 long, the automatic spending cuts that will be in effect this year.

Another round of those decade-long cuts — known as the sequester and approved by Congress and the White House in 2010 — is expected in January.

The Republican complaint came as Senate Majority Leader Harry Reid, D-Nev., and Minority Leader Mitch McConnell, R-Ky., spoke briefly Sunday afternoon but failed to reach a deal to end the shutdown or find common

Photo 500 Shutdown, AP



Dr. Scott Wilber is medical director of the Senior Emergency Department at Summa Akron City Hospital.

### Seniors get closer look in own ER

By Cheryl Powell  
Akron Journal Staff Writer

Summa Akron City Hospital is taking a new approach to caring for older patients with medical emergencies.

Wanda Runk Lee Steadman recently went to the emergency department with debilitating hip pain, the 75-year-old Akron woman was immediately whisked into a section of the ER dedicated to patients from her generation.

The hospital has been operating a Senior Emergency Department within the ER for patients 65 and older since earlier this year.

A total of 16 of the ER's 54 beds are dedicated to providing specialized ge-

Photo 500 ER, AP

# Geriatric ED Guidelines



- **Purpose**
  - Goals
  - Benefits
- **Staffing and Administration**
  - Background
  - Recommendations:
    - Geriatric Emergency Department Medical Director
    - Geriatric Emergency Department Nurse Manager
    - Staff Physicians
    - Staff Nurses
    - Medical Staff Specialists
    - Ancillary Services

# Geriatric ED Guidelines

- **Follow up and Transition of Care**
  - Background
    - Recommendations
- **Education**
- **Quality Improvement**
  - Geriatric Program Quality Improvement Plan
  - Sample Geriatric ED Quality Assessment Instrument (Dashboard)

- **Equipment and Supplies**
- **Policies, Procedures, and Protocols**
  - Sample Policies & Procedures:
    - The Screening of Geriatric Patients
    - Guidelines for the Use of Urinary Catheters
    - Geriatric Medication Management
    - Geriatric Fall Assessment
    - Delirium and Dementia
    - Palliative Care

- **Why Geriatric ED Guidelines?**
  - Improve care of the geriatric ED population
  - Recommendations feasible to implement in the ED
  - Focus attention and resources to optimize care
  - Marketing tool for hospitals

# Purpose

- **Recognize those that require inpatient care.**
- **Effectively implement outpatient care to those who don't require admission.**
- **Dangers of hospitalization:**
  - Functional decline
  - Increase in dependency
  - Increased morbidity

- **Multidisciplinary team**
  - Trained staff in the ED
  - Readily available staff for inpatient and outpatient care

- **Endorsement for staffing changes**
  - Dedicated person to coordinate services (91%)
  - Social workers (88%)
  - Specialized nurses (85%)
  - Geriatric consults (79%)
  - Pharmacists (74%)
  - Physical therapy (59%)
  - Occupational therapy (53%)

- **Geriatric consult services in the ED**
  - Mixed results
    - Yuen et al:
      - Admission avoidance in 85% of consults
    - Foet al:
      - 72% had unrecognized needs
      - Fewer ED visits and hospitalizations at follow up
    - Sinoff et al:
      - Higher admission rate (64%)
      - 2 year mortality 34%
      - Institutionalization rate 52%

## ■ Recommendations

- The Geriatric ED will have staffing protocols in place to provide for geriatric-trained providers, including physician and nurse leadership and ancillary services. These protocols should include plans for times when such services may not be available.
- Staff members of the Geriatric ED will participate in educational/training to ensure high-quality geriatric care.
- Although departments may differ in the availability of staffing resources, departments should have available the following positions either as part of a hospital-based Acute Care of Elders (ACE) team or specific for the ED:

# Geriatric ED Medical Director



## ■ **Qualifications**

- Best practiced by a board-certified emergency physician with training in geriatrics.
- Completion of eight hours of geriatric appropriate CME every two years.

# Geriatric ED Medical Director



## ■ Responsibilities

- Member of hospital ED and Medicine committee.
- Oversight of geriatric performance improvement program.
- Liaison with Medical Staff for geriatric care concerns.
- Liaison with outpatient care partners including Skilled Nursing Facilities (SNFs), Board and Care facilities, home health providers, etc.
- Identify needs for staff education and implement educational programs when appropriate.
- Review, approve, and assist in the development of all hospital geriatric policies and procedures.

# Geriatric ED Nurse Manager



## ■ **Qualifications**

- At least two years of experience in geriatrics (or in an ED that sees geriatric patients) within the previous five years.
- Experience with QI programs is recommended.
- Completion of eight hours of Board of Registered Nursing (BRN) approved continuing education units (CEU) in geriatric topics every two years.

# Geriatric ED Nurse Manager



## ■ Responsibilities

- Participate in the development and maintenance of a geriatric performance improvement program.
- Liaison with outpatient care partners including, but not limited to SNFs, Board and Care facilities, home health providers, etc.
- Member of selected hospital-based ED and/or medicine committees.
- Identify needs for staff education and implement educational programs when appropriate.

- **Staff Physicians**

- Provide twenty-four hour ED coverage or directly supervised by physicians functioning as emergency physicians. This includes senior residents practicing at their respective hospitals only.
- Staff physicians are encouraged to participate in geriatric specific education with a goal of 4 hours of CME annually specifically focused on the care of geriatric patients.

- **Staff Nurses**

- Nursing staff is encouraged to participate in geriatric specific education.

# Medical Staff Specialists

- **Specialists will be available for consultation either by established medical staff policies or by pre-arranged transfer arrangements. Although each hospital's medical staff will support different specialist services, it is recommended that the Geriatric ED have access to:**
  - Geriatrics
  - Cardiology
  - General Surgery
  - GI
  - Neurology
  - Orthopedics
  - Psychiatry, preferably with a geriatric specialty
  - Radiology

# Ancillary Services

- **Case management and social services**
- **Mid-level provider/physician extenders (optional, but recommended)**
- **Occupational/Physical therapists**
- **Pharmacists**

# Follow Up and Transition of Care

- **Acute hospitalization is associated with:**
  - Delirium
  - Nosocomial infections
  - Iatrogenic complications
  - Functional decline
  
- **Thus, one important goal of a geriatric ED is to decrease *potentially avoidable* hospital admissions.**

# Follow Up and Transition of Care

- **Discharge to the community presents challenges.**
- **Facilitating timely intervention with community resources should be beneficial.**
  - Most studies demonstrate little effect of these interventions on ED utilization or prevention of complications.
- **Lack of understanding of discharge instructions is a dissatisfier and increases the risk of bad outcomes.**

# Follow Up and Transition of Care



- **Recommendations**

- The Geriatric ED will have discharge protocols in place that facilitate the communication of clinically relevant information to the patient/family and outpatient care providers, including nursing homes.

# Follow Up and Transition of Care

## ■ Recommendations

- Essential information to optimize continuity of care at the time of discharge should include the following data elements:
  - Presenting complaints
  - Test results and interpretation
  - ED therapy and clinical response
  - Consultation Notes (in person or via telephone) in ED
  - Working discharge diagnosis
  - ED physician note, or copy of dictation
  - New prescriptions and alterations with long-term medications
  - Follow-up plan

# Follow Up and Transition of Care



## ■ Recommendations

- Clinical information will be presented in a format in a way best suited for elder adults:
  - Use large font discharge instructions.
  - Health Insurance Portability and Accountability Act (HIPAA) compliant copied discharge instructions should be provided to family and care providers.

# Follow Up and Transition of Care



## ■ Recommendations

- The Geriatric ED will have a process in place that effectively provides appropriate outpatient follow up either via provider-to-patient communication or the provision of direct follow up clinical evaluation.
  - Although telephone follow up is the most commonly used, the use of newer technology, including telemedicine alternatives is recommended.

# Follow Up and Transition of Care

## ■ Recommendations

- The Geriatric ED will maintain relationships and resources in the community that can be used by patients on discharge to facilitate care:
  - Medical follow up
  - Primary MD or “medical home”
  - Case managers to assist with compliance with follow up
  - Safety assessments
  - Mobility

# Follow Up and Transition of Care

## ■ Recommendations

- The Geriatric ED will maintain relationships and resources in the community that can be used by patients on discharge to facilitate care:
  - Access to care and medical transportation resources
  - Medical equipment
  - Prescription assistance and education
  - Home health, including outpatient nursing resources
  - ADL resources including meal programs, etc.
  - Nursing homes
  - Rehabilitation facilities

- **Initial “go-live” implementation sessions**
  - Involvement of multi-disciplinary teams including hospital-based leadership and outpatient resources.
  - Geriatric emergency medicine didactic sessions for physician, nursing, and multi-disciplinary staff focused on geriatric care issues to be assessed and managed in the Geriatric ED.
  - In-service education on geriatric-specific equipment.
  - Program introduction for community based organizations caring for geriatric patients with opportunity for input.

- **Community awareness, involvement, and outreach**
  - Emergency Medical Services (EMS) personnel perceive a deficit in their training as it relates to care of older patients, particularly in the areas of education and psychosocial issues. The Geriatric ED should provide training for EMS personnel who rescue and transport older persons to their facilities.
  - The Geriatric ED should also provide educational self-management materials for older adults and their families.

- **Regular educational assessment and implementation of site-specific educational needs.**
  - QI data review with process improvement implementation.
  - Periodic education/re-education of disease specific presentations with updates on policy/procedure changes, community care programs, etc.
  - An important educational goal is to provide familiarity with use of quick, bedside assessment tools.

# Education

- Atypical presentations of disease.
- Trauma, including falls and hip fracture.
- Cognitive and behavioral disorders.
- Modifications for older patients of emergent interventions.
- Medication management.
- Transitions of care and referrals to services.
- Pain management and palliative care.
- Effect of comorbid conditions.
- Functional impairments and disorders.
- Management of the group of diseases peculiar to the geriatric adult, including conditions causing abdominal pain.
- Weakness and dizziness.
- Iatrogenic injuries.
- Cross-cultural issues involving older patients in the emergency setting.
- Elder abuse and neglect.
- Ethical issues, including advance directives.

# Quality Improvement

- **A geriatric program shall be developed and monitored by the Geriatric Medical Director and Geriatric Nurse Manager.**
- **Will include**
  - Identification of quality indicators
  - Methods to collect data
  - Results and conclusions
  - Recognition of improvement
  - Action(s) taken
  - Assessment of effectiveness of actions and communication process for participants

# Quality Improvement

- Geriatric volume
- Admission rate
- Readmission rate
- Deaths
- Suspected abuse or neglect
- Transfers to another facility for higher level of care
- Admissions requiring upgrading of level of care to ICU within 24 hours of admission
- Return visits to the ED within 72 hours
- Completion of at-risk screening tool
- Completion of follow up reevaluation for discharged patients

# Quality Improvement

- **Falls**
  - Polypharmacy screening
  - Risk screening
  - Physical therapy evaluations
  - Referrals

- **Catheter use and catheter associated UTIs (CAUTIs).**
  - Foley insertion and indication checklist usage data
  - Days of catheter use in hospital
  - Automatic discontinuation orders utilized
  - Total catheter days
  - ED CAUTI prevalence

# Quality Improvement

- **Medication reconciliation / pharmacy oversight**
  - Documentation of high-risk medications
  - Usage of high-risk medication in ED.
  - Percentage of revisits for medication adverse reaction or noncompliance
  
- **Restraint**
  - Indication documented
  - Chemical restraint attempted and with which medication



# Equipment and Supplies

- **Physical plant changes**
  - Improve care not just for geriatric patients, but for everyone.
  - Separate space or a separate ED may be beneficial.
  - Most hospitals will be more capable of implementing a program in which any ED bed can be made “geriatric friendly”.

# Furniture Improvements

- **Exam / reclining chairs.**
- **Sturdy armrests on chairs**
- **Pressure redistributing mattresses**
- **Upholstery that is soft, moisture proof, easily cleaned**
- **Enhanced signage**
- **Doors with handles, not round knobs**

# Special Equipment

- Body warming devices/warm blankets
- Fluid warmer
- Non-slip fall mats
- Bedside commodes
- Walking aids/devices
- Hearing aids
- Monitoring equipment
- Respiratory equipment
- Restraint devices
- Urinary catheters including condom catheters



# Visual Orientation Improvements

- **Lighting**
  - Soft light
  - Natural light
  - Indirect light
  - Light colored walls with matte sheen
  - Light flooring with low-glare finish



# Visual Orientation Improvements

## ■ Patterns

- Contrast sensitivity in aging vision:
  - Confusing
  - Hinders movement
  - Patterns with dominant contrasts may cause vertigo or appear to vibrate.
- Misperceptions of patterns as obstacles or objects.



# Visual Orientation Improvements

## ■ Colors

- Color can enhance visual function and depth perception.
- Avoid monochromatic color schemes.
- Contrast between horizontal and vertical surfaces.
- Decreased ability to differentiate cool colors.
  - Greens, blues.
- In a poorly lit area, yellow is the most visible.
- Orange and reds grab attention.
- Blues appear hazy and indistinct and may appear grey.

# Acoustic Orientation Improvements

- **Private rooms or acoustically enhanced drapes**
  - Better communication and less delirium
- **Sound absorbing materials**
  - Carpet, curtains, ceiling tiles
- **Portable hearing devices**
- **Music reduces anxiety, heart rate, and blood pressure**

# Policies, Procedures, Protocols



- **Triage and initial evaluation**
  - Family/care provider presence/participation in the triage process is highly encouraged.
- **Initial screening tool to recognize and evaluate at-risk seniors**
- **Patient safety**
- **Suspected elder/dependent adult abuse and neglect**

# Policies, Procedures, Protocols



- **Sedation/analgesia in the geriatric patient**
- **Assessment and evaluation of delirium/agitation**
  - Restraint policies
- **DNR/POLST/palliative care**
- **Patient Death.**
  - Inclusion of the grieving family in the “code” situation is encouraged.

# Policies, Procedures, Protocols

- **Urinary catheter placement guidelines**
- **Fall risk assessment and clinical guideline for the evaluation of the “geriatric adult fall”**
- **Wound assessment and care**
- **Transitions of care and follow-up**
- **Medication reconciliation and pharmacy review**

# Sample Policy: Screening

- **Policy:** It is the policy of the Geriatric ED to screen all geriatric patients for high-risk features. Those patients screened to be at risk will be referred to health care resources, both inpatient and outpatient, to help improve overall health and functional outcomes.
  
- **Recommended Resources:**
  - Nurse screening tool
  - Resource list including, but not limited to:
    - Physical therapy
    - Occupational therapy
    - Home health providers
    - Case managers
  - Outpatient follow up resources

# Sample Policy: Screening

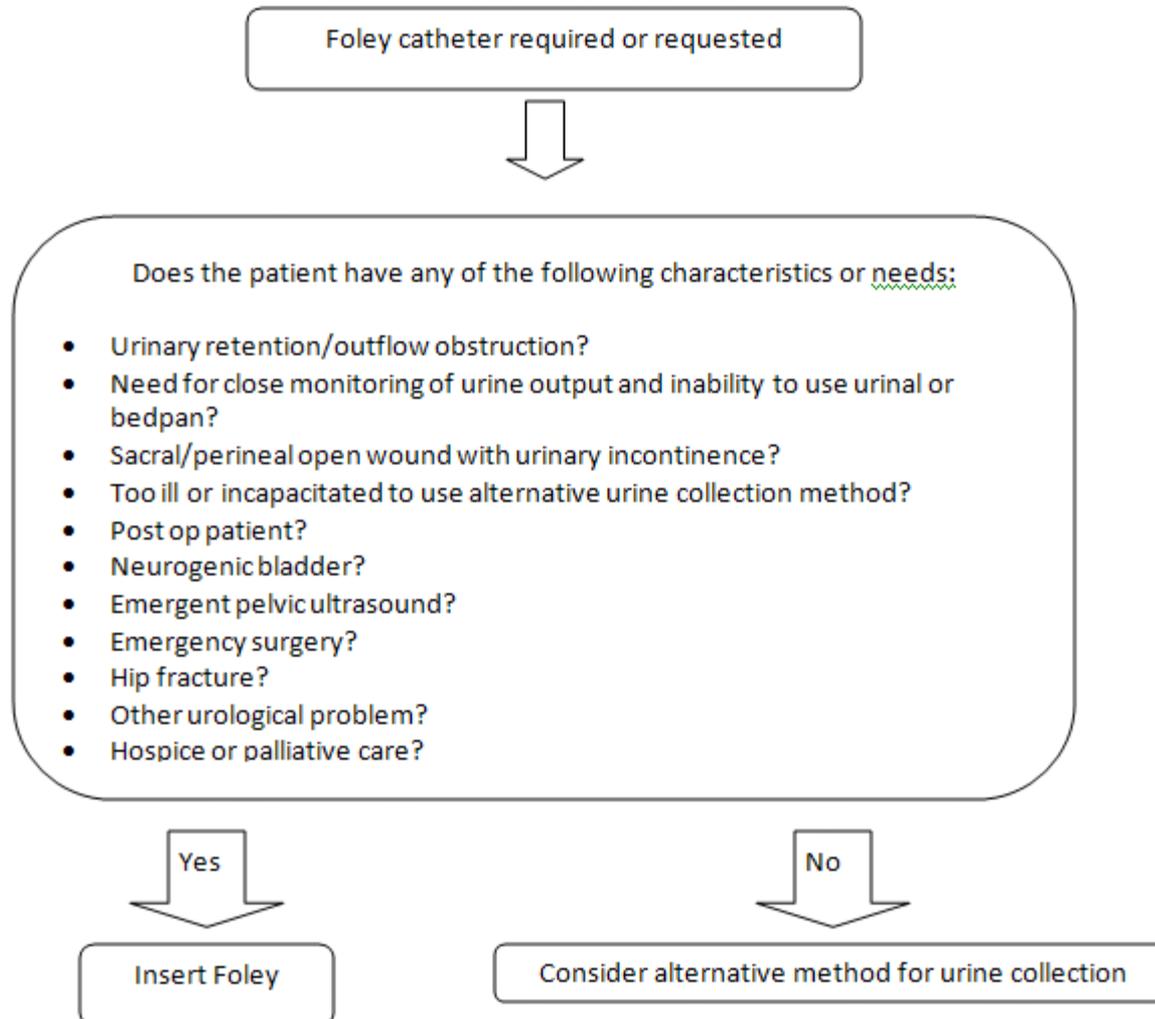
## ■ Procedure:

- All geriatric patients, regardless of the presenting complaint shall be screened (on the initial index visit, not follow up visits) using the “Identification of Seniors at Risk Tool” or a similar risk screening tool. This is a simple, quick screening tool that should be completed by the treating nurse as part of the initial evaluation. Answers to the screening questions can be provided by the patient, family, care providers, or others involved in the patient’s assessment and care.
- The treating physician will review the results of the initial screening during the index visit.
- Any patient noted to be at-risk (on the ISAR that means one or more positive responses on the initial screening tool) will be provided with appropriate resources focused to the individual needs.

# Sample Policy: Screening

- All patients noted to be at-risk requiring admission to the hospital will be referred to case management upon admission with the risk assessment results communicated.
- All patients noted to be at-risk that are to be treated as an outpatient will be followed up the following day. Although phone consultation may be adequate, in-person evaluations either in the ED, by the primary physician, or by an RN or mid-level provider is preferable.
- Specific at-risk features will be addressed during the index visit in the ED. Recommendations and referrals will be documented as part of the “Medical Decision Making” and will be addressed along with the case-specific discharge instructions.

# Sample Policy: Urinary Catheters



# Sample Policy: Falls Assessment

- **Policy:** It is the policy of the Geriatric ED to initiate a comprehensive evaluation for geriatric patients presenting after a fall or for those who may be at high risk for a future fall. Patients will be evaluated for injuries, including those injuries that may be “occult” in the geriatric population. Furthermore, patients will be evaluated for causes of and risk factors for falls. Patients will be assessed prior to disposition for safety with the goal to prevent further injury and falls.

# Sample Policy: Falls Assessment

- **Procedure:** All geriatric patients presenting after a fall will be assessed by the attending physician. Although the cause of the fall may be straightforward, a thoughtful assessment begins by answering the question “if this patient was a healthy 20 year old, would he/she have fallen?” If the answer is “no,” then an assessment of the underlying cause of the fall should be more comprehensive and should include:

# Sample Policy: Falls Assessment

- History is the most critical component of the evaluation of a patient with or at risk for a fall. Several studies and authorities have suggested that there are several key elements to an appropriate history in the patients with a fall. These key historical elements are as follows:
  1. Age greater than 65
  2. Location and cause of fall
  3. Difficulty with gait and/or balance
  4. Falls in the previous (XX time)
  5. Time spent on floor or ground
  6. Loss Of Consciousness/AMS
  7. Near syncope / orthostasis
  8. Melena

# Sample Policy: Falls Assessment

9. Specific comorbidities such as dementia, Parkinson's, stroke, diabetes, hip fracture and depression
10. Visual or neurological impairments such peripheral neuropathies
11. Alcohol use
12. Medications
13. Activities of daily living
14. Appropriate foot wear

# Sample Policy: Falls Assessment

- Medication assessment should be performed on all patients at risk or who have suffered from a fall. Special attention should be to those patients currently taking any of the following classes of medications: vasodilators, diuretics, antipsychotics sedative/hypnotics, and other high-risk medications.
- Orthostatic blood pressure assessment.
- Neurologic assessment with special attention to presence/absence of neuropathies and proximal motor strength.
- Although there is no recommended set of diagnostic tests for the cause of a fall, a threshold should be maintained for obtaining an EKG, complete blood count, standard electrolyte panel, measurable medication levels and appropriate imaging.

# Sample Policy: Falls Assessment

- Evaluation of the patient for injury should include a complete head to toe evaluation for ALL patients, including those presenting with seemingly isolated injuries.
- Safety assessment prior to discharge should include an evaluation of gait, and a “get up and go test” (reference). Patients not able to rise from the bed, turn, and steadily ambulate out of the ED should be reassessed. Admission should be considered if patient safety cannot be assured.
- All patients admitted to the hospital after a fall will be evaluated by PT/OT.

# Conclusions

- **Geriatric Emergency Departments may improve the care of older patients in the ED.**
- **Consensus guidelines that discuss the development of geriatric EDs are available at:**
  - <http://www.acep.org/geriEDguidelines/>
  - <http://www.saem.org/education/geriatric-ed-guidelines>
  - <http://geriatriccareonline.org/ProductAbstract/geriatric-emergency-department-guidelines/CL013>