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CAEP POSITION STATEMENT & GUIDELINES

Canadian Association of Emergency Physicians position statement on care of older people in Canadian Emergency Departments: executive summary

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Introduction

Canadian emergency departments (EDs) welcome more patients over the age of 65 than any other population segment between 20 and 40% of all visits depending on the location [1]. This proportion of ED visits by a population marked by increasing complexity is expected to grow significantly [2]. Yet many ED providers and users would say that EDs have been slow to address specific changes that would lead to more efficient department function and better outcomes for this population. This position statement, endorsed by CAEP, aims to provide guidance to EDs interested in making effective changes.

The CAEP Geriatric Emergency Medicine (GEM) Committee developed this position statement. It is the collaborative product of an expert panel of Canadian specialists in GEM, users, advocacy groups, administrators, and other stakeholders. The group represents rural and urban EDs in all regions of Canada. This position statement includes eight recommendations supported by evidence and expert consensus representing good care of older adults in Canadian EDs. Practical examples of changes that can be implemented to address each recommendation are available in the full document. The recommendations should trigger changes to enhance the experience and outcomes of older people and their caregivers in Canadian EDs.

Recommendation 1

Emergency Departments have an explicit policy recognizing older people as core users of ED services and stating that excellent care of older people is a departmental priority

The care that institutions provide and the outcomes they achieve are strongly influenced by what they say matters to them. In Canadian EDs older people need to be seen as a core population and excellent care for them as a priority for every department. An important and effective intervention for every Canadian ED is to formally declare that the optimal care of older people is an essential part of its mission and values. This first step, at the level of the ED or of the hospital, commits the institution to consider and adopt or adapt some or all the recommendations that follow. It sets a clear strategic path that can be integrated into a department's

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5-year plan, demonstrating that excellent care of older people is a priority.

Recommendation 2

Emergency Departments establish a locally appropriate process for interdisciplinary assessment of complex older patients, particularly those likely to be discharged

ED presentations by older adults are often a complex mix of acute and chronic medical problems; adverse drug events; and issues related to functional, social, and cognitive impairment combined with unmet care needs [3]. There is a common dictum in older person care that "geriatrics is a team sport," implying that adequate assessment and care of complex frail older ED patients is beyond the skillset of any single clinician [4]. Evidence suggests that interdisciplinary care of older patients leads to: reduced ED length of stay, decreased ED return visits, decreased hospital admissions, improved functional outcomes, and increased system-level healthcare cost savings [5, 6]. Differently resourced EDs will implement this in different ways, but finding ways to access interdisciplinary assessment in EDs, large or small, is essential.

Various roles are:

- *Care coordination:* obtaining collateral information from multiple sources; expanding the health history; performing extended (functional, cognitive, and social) assessments; coordinating transitions of care and community follow-up; accessing support networks; assessing for possible elder abuse or neglect; assisting with applications for assisted living, acute rehabilitation, or long-term care [7, 8]. This is usually accomplished by a nurse with advanced skill in geriatric assessment.
- *Mobility assessment:* evaluating for causes of pain; ability to transfer and need for specific mobility aids; mobility requirements once discharged [9–11]. This is usually accomplished by a physical and/or occupational therapist.
- *Medication review:* identifying potentially inappropriate medications that may have contributed to the patient's visit; suggesting alternatives or appropriate deprescribing; reviewing compliance and barriers and solutions (e.g. daily medication dispensers); communicating with other primary and specialist care providers; linking with community pharmacist(s) [12, 13]. This is usually accomplished by a pharmacist.
- *Consultant services:* Access to consultative services, for example: geriatric medicine, geriatric psychiatry, palliative care, wound care, or addictions medicine. Access could be in-department consultation or community-based follow-up, in-person or through telemedicine.

Recommendation 3

Emergency Departments involve family members and caregivers in the care of older people during their ED stay

"Caregivers," whoever they may be, are an essential part of the older patient's ED experience and of the ED's ability to provide optimal care. EDs should adopt a policy about the presence of caregivers for older patients in the ED that is unique from the standard visitor policy. ED clinicians should be trained and encouraged to promote and facilitate the presence of caregivers in recognition of their essential role.

Caregiver presence adds value in many ways:

- Source of clinical information. Caregivers provide the ED team with essential clinical information that may not be available from any other source and which supplements history taking from patients, for example, medication changes, functional and cognitive status [14]. Identifying caregiver stress, burnout, unmet needs, and potential older person abuse and neglect all rely on the clinical team's ability to observe the interaction between the patient and their caregivers [15].
- Help with care. Caregivers in the ED should be invited to participate in patient care, while respecting their individual needs as well. Caregivers can help the clinical staff to provide important bedside care; can help with orientation and stimulation, thus preventing incident delirium; and help reduce the severity of behavioural and psychological symptoms of dementia (BPSD) and the need for chemical and physical restraint [16].
- Communication and advocacy. Caregivers usually want to be more involved in communication during and after a hospital visit, as they often are caring for the patient when they are discharged [17].

Role for volunteers. It is frequently the case that older patients do not have caregivers in the ED or in their lives. In that case, volunteers can serve an important role as adjuncts to care of older patients (improved functional recovery, decreased incidence and severity of delirium, decreased length of stay) [18]. Implementing a volunteer programme can benefit older patients in the ED, supporting the clinical team to provide care and improving the experience of the older patient during a long ED stay [19].

Recommendation 4

Emergency Departments prioritize training and education of ED staff to develop competence in the emergency care of older people

Educational programmes for ED clinicians have been shown to positively impact knowledge and clinical practice regarding care of older adults [20]. EDs committed to improving care of older people should provide their clinicians with in-house educational opportunities. While the focus of this Statement is on the ED itself, medical and interprofessional learners form a key part of many ED teams, and their geriatrics-focused educational needs should be addressed [21]. Interprofessional education (IPE) including emergency physicians, medical trainees, nurses, physical and occupational therapists, geriatricians, social workers, prehospital providers and pharmacists [22], should be the norm in ED-based geriatrics education.

Educational interventions should focus on the areas in which learners express or demonstrate the least confidence [23]. These often include common geriatric syndromes such as falls, delirium, dementia, as well as geriatric trauma, medications, atypical presentations, end-of-life care, and transitions of care [20]. Various courses and training programmes, live and online, exist to help with geriatric ED education.

Recommendation 5

Emergency Departments develop standardized approaches to common geriatric presentations

Older patients commonly come to EDs with presentations that are nearly unique to this age group [24]. These presentations include the common geriatric syndromes: falls, weakness, acute functional decline, frailty, and delirium. Other geriatric-specific presentations involve trauma and polytrauma from ground-level falls, polypharmacy, end-of-life care, atypical presentations of disease, and dementia. We recommend that individual EDs implement a standard approach to these presentations.

Each institution should develop its own approach based on local resources and needs; but some examples of high-yield areas for standardisation of approach could include:

- Implementing standard practices for ALL older ED patients that would ensure basic care needs are met, with a focus on mobility, hydration/nutrition, sensory optimisation, orientation, and symptom management.
- Developing a structured approach, using an institutionally developed order set or pathway, for older patients who have fallen [11].
- Adding one or more standardized ED-validated screening tools to the primary assessment of all older patients [25–33]. Using one or more of these tools will allow for standardised care and improve the detection of the geriatric syndrome in question when compared to usual practice.
- Establishing geriatric-informed trauma protocols [34].
- Developing order sets to guide standardized approaches to common conditions.

Recommendation 6

Emergency Departments have equipment and modify the physical space to support the needs of older people

EDs should be safe and responsive to the needs of older patients, particularly those with cognitive and mobility impairments. Making efforts to accommodate the basic needs of older people and their caregivers through simple enhancements of the physical environment and equipment can improve the quality of care, as well as the experience of patients, caregivers, and providers. Important changes can be included in major re-designs or new builds. Basic low-cost modifications and equipment can be added to existing EDs. Many of these additions would benefit all ED patients, regardless of age, and improve general patient experience.

Every ED should have easy access to gait aids such as walkers for patients to utilise while present in the ED and upon discharge. Other additions include non-slip socks; bedside commodes and raised toilet seats; a large-face clock and orientation board for the date in each room; access to warm blankets and palatable food and drink; sensory aids like reading glasses, over-the-ear hearing amplifiers, earplugs and eye shields. An ED can bring many of these improvements together in a mobile geriatric cart [35] with an impact on patient well-being and experience.

Recommendation 7

Emergency Departments ensure high-quality transitions of care

It is not adequate to merely provide high-quality care in the ED. EDs must also play a role in successful transitions of care for older patients moving into and out of the department. EDs receive older patients from many different sources and discharge to many different destinations—independent living,

retirement homes, long-term care, community-based care, palliative care, rehabilitative care, and institutions such as hospices, jails, shelters, and psychiatric hospitals. Similarly, many different people are involved in even one individual older patient's care—pre-hospital providers such as paramedics and family physicians; consultant physicians, surgeons, and psychiatrists; community-based nurses and allied health professionals; personal support workers; and the care providers highlighted in recommendation three. The ED is an important interface between all these sites and people. The ED needs to ensure that there is an excellent transition of care between it and all of them to promote safety, continuity and coherence of care. This can be achieved through focusing on changes relevant across the care continuum and based on local needs: before the ED visit, in the ED, at the point of discharge, and after the ED visit. An effectively planned and executed transition of care avoids ED revisits and re-hospitalisations; reduces overall ED length of stay (considering all the avoided visits); and enhances outcomes and improves patient experience for older patients [36].

Recommendation 8

Emergency Departments identify and collect data about key quality indicators about the care of older ED patients

It is essential to identify quality indicators specific to the care of older ED patients to ensure delivery of up-to-date and evidence-informed care. Quality indicators provide objective measures to help define minimum standards of care and serve as the foundation for ongoing improvement. Quality indicators allow EDs to identify areas of success and areas for improvement, to communicate needs and accomplishments to hospital administrators, and to guide future initiatives [37, 38].

Specific quality indicators in any location will differ based on local needs and resources. Several studies have outlined quality indicators relevant to older adults in the ED [37, 39–41]. Such indicators should act as a starting point for EDs as they develop their own specific ones, matching their changing care and needs, as well as those of older adult patients. As EDs learn about the needs of older patients, how they are meeting them, and opportunities for further improvement, they should develop new and more relevant indicators.

Conclusion

CAEP makes eight recommendations that utilise up-to-date evidence and expert consensus. This position statement can be used by providers and ED leaders to elevate the care of older people in EDs across Canada. Older people are core ED users, whose presentations are often complex, and who experience unique challenges in the ED. Nearly every ED struggles to provide quality care to its older patients; but with the spirit of innovation, creativity and positive change, an ED can improve their experience of care. Emerging evidence suggest that aside from improving the quality of care and the older person's experience in the ED, these recommendations can also lead to important cost-savings both for the ED and the health system [42]. As highlighted through these recommendations and examples in the full text document, no ED is too big or small to improve care of older people. The Canadian Association of Emergency Physicians recognises the need for change; and the opportunities that exist; and supports the implementation of all eight recommendations.

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Declarations

Conflict of interest The authors declare that they have no conflict of interest.

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