Australasian College for Emergency Medicine

Australian & New Zealand Society for Geriatric Medicine

Care of older persons in the emergency department

Policy P51

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Document Review

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Version	Date	Pages revised / Brief explanation of revision
02	Jul-07	
03	Mar-13	• Formatting changed. Wording relating to ED funding and staffing simplified.
04	Jul-15	• Purpose and scope separated. Changes made to content under the policy subheading – Clinical, administration, education and training and research subheadings added. Additional supporting content relating to general entitlements, assessment and management, transitional communication on discharge, ED design, staffing and funding, information and reporting systems, disaster management, assessment and management principles and education programs added. • Changes made to the content under the procedure and action subheading – Clinical, assessment and treatment and transitional communication subheadings added. Additional supporting content relating to general clinical information, clinical pathways, multidisciplinary assessment, vulnerable patients discharge and risk assessment, patient requirements and residential aged care facilities added.
05	Nov-19	• Name change and references to “elderly patients” changing to “older persons”. Structural and formatting changes to document. • Definition section added. Quality indicator section added.
06	April-20	• Feedback from Australian and New Zealand Society for Geriatric Medicine (ANZSGM) incorporated • Co-branded with ANZSGM

Related documents

- *ACEM Policy on End of Life Care and Palliative Care in the ED*
- *ACEM Emergency Department Design Guidelines*
- *National Safety and Quality Health Service Standards*

Related links

- Advance Care Planning Australia
- Advance Care Planning New Zealand
- End of Life Directions for Aged Care
- End of Life Law in Australia
- Geriatric Emergency Department Accreditation

1. Purpose and scope

This document is a Policy of the Australasian College for Emergency Medicine (ACEM) and relates to the recommended standards of care for older persons in the Emergency Department (ED). It has been developed in consultation with and endorsed by the Australian and New Zealand Society for Geriatric Medicine.

The Policy is applicable to Australian and New Zealand EDs.

In Australia and New Zealand older persons are generally defined as persons aged 65 years and over. Older Aboriginal and Torres Strait Islander peoples are able to access aged care services from 50 years of age in Australia, and Māori and Pacific Islanders are able to access services from 50 years of age in New Zealand. However, it is recognised that physiological function is more important than chronological age.

Where older persons are referred to in this policy and the older person does not have cognitive capacity to make health related decisions, it is assumed that the ED team will involve the appropriate substitute health decision maker, as determined by jurisdictional law.

2. Definitions

Frailty

A 'condition or syndrome which results from a multi-system reduction in reserve capacity to the extent that a number of physiological systems are close to, or past, the threshold of symptomatic clinical failure. As a consequence, the frail person is at increased risk of disability and death from minor external stresses.' [1]

Carers

Family members, friends, whānau and aiga who provide informal, unpaid personal care, assistance, and physical or psychological support to an older person. This is different to people who provide care to a person as part of a contract or form of employment.

Substitute decision makers

A person appointed or identified by law to make decisions on behalf of a person whose decision making capacity is impaired. Substitute decision makers have legal authority to make these decisions; the relevant legislation varies between jurisdictions (countries, states and territories).

Advance Care Planning

Involves planning for future health decisions in the event that a person may not be able to express their goals and wishes regarding their treatment and care. It is important that these preferences are discussed with family, carers or next of kin. Advance Care Planning can involve preparing an Advance Care Directive and appointing a substitute decision maker.

Advance Care Directives (Australia) and Advance Directives (NZ)

A legal document which states a persons' preferences for treatment and care when they are unable to express their wishes. An Advance Care Directive (ACD) or Advance Directive (AD) also enables a person to appoint a substitute decision maker. More than one substitute decision maker may be appointed under an ACD (depending on the jurisdiction). ACD and AD documentation differs between jurisdictions.

3. Policy

3.1 General

Older persons have the right to high quality, timely, person-centred acute care in the setting that best meets their needs and wishes. ACEM is committed to ensuring that:

1 Emergency Departments offer a safe and welcoming environment for older persons and their families or carers.

2 Emergency physicians are expert in provision of high-quality holistic emergency care for older persons including assessment and management, identification of vulnerable older persons and supporting safe discharge.

3 Emergency physicians practice shared decision making with older persons, ensuring that emergency care is aligned to the older person's healthcare goals. They have a right to receive this care in the presence and support of their families and carers, where desired.

4 Transition of care to support optimal outcomes for older persons through timely, high-quality communication of current issues, emergency management, ongoing care needs, referrals and suggested follow-up.

5 Where required, older persons receive person-centred, end-of-life or palliative care in the ED.

Emergency Departments (EDs) are available 24 hours a day, 7 days a week to provide emergency care. In determining the most appropriate location for the delivery of acute care it is important that the older person's wishes are respected, while communicating to that person the risks and benefits of presenting to an ED.

Older persons often have complex medical needs which should be accounted for in all aspects of their care. In particular, older persons are at increased risk of delirium, falls, pressure sores, nosocomial infections, and medication errors. Older persons are more likely to be on multiple medications, increasing the risks associated with polypharmacy and may experience heightened vulnerability, due to cognitive impairment or frailty.

ACEM is committed to ensuring that Aboriginal and Torres Strait Islander and Māori as tangata whenua, their families/whānau and carers receive culturally safe emergency care and ensuring equity of access and outcomes. In addition, the specific needs and wishes of culturally and linguistically diverse older persons and their families should also be incorporated into all aspects of the care that person receives.

3.2 Assessment and management

Assessment and management of older persons in the ED should adhere to the following principles:

- The potential impact of physiological, behavioural and physical changes of ageing on presentation of disease should be accounted for.
- Atypical and subtle presentations of disease are common in older persons and may result in increased risk of diagnostic error.
- Access to multi-disciplinary assessment and care planning should be available and tailored to individual requirements.
- Older persons with heightened vulnerability, such as cognitive impairment, frailty, polypharmacy, or at risk of elder abuse should be identified and their specific needs addressed.
- Systems are in place to identify and manage older persons at high risk of deterioration due to delirium, falls, pressure injuries, frailty.
- Risk and benefit should be assessed before an older person is admitted to hospital or discharged from the ED.
- ACEM supports the use of Advance Care Plans and Advance Care Directives and encourages the development of systems whereby all persons complete and regularly update these directives to ensure their wishes are known and able to be respected in the event of a life-threatening illness. This is particularly important in instances when an older person does not have capacity to express their wishes.

3.3 Transitional communication on discharge

Transitional communication on discharge of older persons from ED supports safe discharge. Special provisions should be in place for the unique transitional care needs of residents of residential aged care homes. Clinical handover documents, including discharge summaries, should include information regarding the acute emergency problem, treatment or other issues identified (e.g. frailty or recent weight loss) and document why any medication changes were made. This supports safe follow up by all the health care professionals involved in the older person's care, such as general practitioners, community nurses, physiotherapists, dieticians or residential aged care homes. Where urgent medications are required this should be clearly communicated.

It is important that EDs have systems in place to manage such communication, including paper and electronic clinical handover documents, to an older person's general practitioner, substitute decision maker and the residential aged care home (where required).

Consider the risks of discharging an older person from the ED late at night, especially when they live alone. Local guidance may be needed to specify the timeframe for the discharge of at-risk patients without sufficient support from relatives or carers.

3.4 Administration

Emergency department design and facillities

In recognition of the principle that ED design potentially poses a risk to older persons, the physical ED environment should be designed to be older person-centred with consideration for their safety and comfort. In particular, attention should be paid to limiting the risk of complications such as delirium, falls and pressure injuries and maximising the ability of older persons to safely and easily navigate and mobilise within the environment.

Important elements of an older person-friendly environment include attention to the following in ED design:

- Ensuring privacy for the older person and their family (wherever possible).
- Way-finding that supports safe and timely navigation:
    - Signage that facilitates navigation.
    - Toilet facilities that are easily identifiable and that provide contrasted colours of toilet door and toilet seat from walls and floor respectively.
- Lighting:
    - Access to natural lighting.
    - Lighting that supports navigation particularly at night for access to bathroom/toilet facilities.
- Hearing and noise:
    - Attention to noise levels and implementation of noise-reduction strategies.
    - Use of hearing-loop technology.
- Support surfaces:
    - Availability of pressure reducing surfaces.
    - Availability of reclining chairs that offer an alternate to ED trolleys where clinically appropriate.
- Falls risk reduction:
    - Removal of safety hazards such as loose cords and clutter.
    - Glare reduction.
    - Flooring that minimises falls risk or injury from falls.
    - Ensure that trolleys can be lowered enough for older persons to safely get on and off.
    - Where appropriate, encourage regular walks and toileting.
- Temporal orientation cues within treatment cubicles and waiting areas.
- Visible wall clocks.
- Call bells that are within reach and functional.
- Where indicated, provision of food and fluids appropriate to the older persons needs including texture-modified food and fluids.
- Ensuring access to physical and functional aids and distraction therapies.
- White communication boards for each bed which display the patient journey of the older person, their likes and dislikes and if they have special needs or requests.
- Family/whānau rooms that are inviting and comfortable.

It should be noted that an older person-centred environment is a suitable environment for younger patients. Conversely, an ED environment tailored to younger persons may not be fit for purpose for older persons.

Information and reporting systems

ED information and reporting systems should facilitate an operational understanding of the patients who are presenting to their ED as well as the broader Local Hospital Network, Primary Health Network or District Health Board (NZ). Accurate identification of residents from residential aged care homes assists in assessing risks and benefits for admission to inpatient wards, supports discharge summaries and any changes of medication or management plans for aged care homes to be aware of.

Where a patient has an Advance Care Plan and/or Advance Care Directive this should be documented in a manner that is able to be referenced at future ED visits. The preferences and wishes identified in these documents should be upheld.

Funding and staffing

EDs should be appropriately funded and staffed (both from a perspective of levels and skill-mix) to reflect the increased medical complexity and the specific needs of older persons. Hospitals should understand the demographics of the population presenting and consider additional resourcing in areas with increased presentations of older persons.

Where possible, a multidisciplinary team should be available to support the quality assessment and management of older persons in the ED. Ideally staffing levels should include an emergency physician, emergency nursing, and access to allied health professionals. This will ideally include access to physiotherapy, occupational therapy, speech therapy, social workers, pharmacists as well as Aboriginal Liaison Officers or Māori health workers.

Specialist gerontic nursing and/or community-hospital interface practitioners have significant knowledge, particularly related to transitions of care, packages and programs available in the community and what they are able to provide.

Disaster management

Disaster management plans should incorporate specific management contingencies for vulnerable older persons.

3.5 Education and training

ACEM is committed to ensuring that all Fellows and trainees are equipped with the skills to assess and manage common emergencies and presentations of older persons. In particular, ED staff are required to recognise atypical and subtle presentations of disease and identify geriatric syndromes and incidences of elder abuse. In addition, all Fellows and trainees are supported to provide patient goal-focussed end-of-life and palliative care for patients of all ages.

Geriatric assessment and management principles form core topics of the ACEM curriculum as well as other ACEM training activities including the Emergency Medicine Certificate and Diploma.

ED education programs should ensure that Fellows and trainees are aware of local alternate programs available to avoid hospitalisation like community nursing, early supported discharge and hospital in the home.

ACEM encourages emergency physicians to participate in ‘Communities of Practice’ that promote integration of evidence-based care for older persons across the care continuum, recognising the complexity of care for acutely unwell older persons.

3.6 Advocacy and research

ACEM acknowledges and supports the need for high quality research into the assessment and management of older persons in the ED. ACEM recognises that further research is needed regarding the delivery of emergency care to older persons. ACEM will advocate to ensure that older persons including residents of residential aged care homes receive timely and appropriate emergency care.

4. Procedure and action

4.1 General

The assessment and management of patients are concordant with the older persons' expressed wishes (including prior advance care planning documentation and confirmation with substitute decision makers where appropriate), where these are in keeping with the principles of relevant law; all older persons with serious, life-limiting illnesses are given the opportunity to discuss prognosis and advance care planning. Early access to palliative care services is facilitated where indicated.

4.2 Assessment and treatment

Physiological, behavioural and physical changes of ageing will guide the ED team in:

- Triage.
- Trauma team activation.
- Assessment and management.

Multidisciplinary assessment

A process is available to facilitate older persons' access to multi-disciplinary functional assessment, geriatric medicine assessment and care planning where indicated. A falls risk management plan should be considered prior to discharge for all older persons presenting to the ED with a fall. Multidisciplinary assessment will ideally occur in the ED or arrangements made for this to occur in the community.

- Quality use of medications:
  - A best possible medication history is documented for each older person presenting to the ED according to the National Safety and Quality Health Service standards.
  - A medication review and reconciliation of the older person's medication list should be conducted in all cases. As an alternative, a patient's GP could be requested to arrange a Home Medication Review.
- Pain assessment and management:
  - All older persons are screened for pain on arrival, and regularly during the ED episode of care, utilising a cognition- and communication-appropriate pain assessment tool such as Pain Assessment in Advanced Dementia Scale (PAIN AD).
  - Opioid sparing modalities of analgesia (e.g. nerve or regional blocks) are utilised, where appropriate.
  - If patients are being discharged on opiates, arrangements need to be made for safe follow up and bowel management.

Clinical pathways

Clinical pathways should be applied in the assessment of older persons and should acknowledge and address the atypical presentation of disease in older persons and encompass the need for ED providers to consider difficult to discern problems, such as elder abuse and depression, as potential contributors to clinical presentations.

4.3 Vulnerable older persons

Vulnerable older persons are identified by ED staff and their specific needs addressed including:

- Cognitive impairment:
  - All older persons aged over 75 should be screened for cognitive impairment and delirium using

tools validated for use in the ED (such as 4AT or an appropriate alternative). If screening results in an abnormal result this should trigger further action and be communicated as part of clinical handover or discharge summaries.

  - Older persons with cognitive impairment have strategies implemented to reduce the risk of delirium, or if present, reduce the impact of delirium.

  - When delirium is identified, assessment is undertaken to determine the underlying cause, allowing this to be treated.

- Elder abuse

  - Older persons with suspected or known elder abuse are reviewed by a social worker and admitted to hospital or an alternate place of safety until further assessment can be made.

- Frailty

  - Frail older persons are recognised as having high risk associated with hospitalisation and prolonged ED stays.

  - Validated tools such as the Clinical Frailty Scale can support multidisciplinary assessment and identification of frailty.

  - Where an older person is identified to be frail, strategies are implemented to reduce the risk of prolonged ED stays and to minimise iatrogenic complications and harms (e.g. pressure injuries, falls, delirium and infection).

  - Invasive devices, such as indwelling catheters or intravenous cannulas, are used only where it is critical to safely care for the older person and where use is concordant with the individual's healthcare goals.

4.4 Discharge risk assessment

Older persons should have a discharge risk assessment performed prior to discharge, including documentation of the level of independence, the need for home health services and an assessment of carer stress. All older persons presenting to an ED with a fall should have a falls risk management plan at discharge.

Older persons should not be discharged until appropriate support in their usual or proposed environment is confirmed to be available. The ED should have an established process to identify and manage older persons with high discharge risk.

Discharge communication for residents of residential aged care homes should, in addition to usual discharge communication, include:

- Outcomes of discussions with older persons or their substitute decision maker regarding advance care planning.

- Nursing care summary including findings of skin integrity check, dietary intake in ED, changes required to the resident's usual nursing care and medications dispensed during ED stay.

- Where appropriate, an interim medication administration record (IMAR) or ED medication administration record (EDMAR) is provided and medication is supplied in accordance with local policy, to allow new medications to be administered for a minimum of 72 hours as a bridge to general practitioner review.

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5. Quality indicators

Quality indicators for Emergency Medicine in general, are reported in an age-disaggregated format to ensure equity in quality of care and access to care across all age groups. Particular emphasis should be placed on time to meaningful care and ED length of stay, as older persons are at higher risk of being subjected to access block and its attendant safety risks.

Sentinel events, such as unexpected mortality within 30 days of ED discharge to the community, should be monitored through usual ED morbidity and mortality processes.

Quality measurement and quality improvement activities are recommended for the following quality indicators.

Donabedian indicator type	Domain	Indicator
Structural quality indicators: ED policy	*Registration*	The ED has a policy or procedure defining accountability for collection of accurate patient residential setting data to guide ED provider in the understanding of the care environment to which patients may be discharged [2]
	Trauma	The ED has a trauma team activation policy or procedure that includes increased age as a trigger for trauma team activation [2]
	Multidisciplinary team	The ED has a policy or procedure to facilitate allied health staff assessment of older persons, where indicated, irrespective of time of ED presentation [2]
	Functional aids	The ED has a policy or procedure in relation to patient property with specific reference to functional aids of older persons, ensuring accessibility and minimising loss [2]
Structural quality indicators: ED design	*Pressure injury*	The ED has mattresses designed for pressure redistribution available for use on commencement of an ED episode of care in older persons' pressure ulcer prevention and management [2]
	End of life	The ED's physical environment includes a quiet area for management of older persons at end of life, to enable privacy and dignity for patients and their families [2]
	Call systems	The ED facilitates nursing response to older person's care needs by ensuring call systems are: installed; visible; able to be reached by older persons; and are functional [2]
	Hearing	The ED design incorporates hearing loop technology and signs indicating its availability are visually evident at all points of public entry [2]
	Texture-appropriate diet	Appropriate oral fluid options are available within the ED for older persons with impaired swallow [2] Appropriate food options are available within the ED for older persons with difficulty chewing [2]

Donabedian indicator type	Domain	Indicator
Process quality indicators	*Registration*	Proportion of older persons where ED providers accurately identify the authority and contact details of current nominated substitute health decision makers [3]
	Shared decision making	Proportion of older persons where ED providers ascertain patient or substitute health decision maker treatment preferences [3]
	Delirium	Proportion of older persons where ED providers screen for delirium [4]
		Proportion of older persons with delirium where ED providers document an attempt to attribute the altered mental state to a potential aetiology [5]
	Falls	Proportion of older persons where ED providers screen for previous falls [3, 6, 7]
		Proportion of older persons presenting with a fall, who have an ED service episode end status of discharge, where ED providers develop a risk management plan to prevent further falls [3]
	Medications	Proportion of older persons where ED providers initiate medication reconciliation [3]
		Proportion of older persons where ED providers administer usual medications due during their ED stay, unless these are contra-indicated [3]
	Discharge risk	Proportion of older persons with an ED service episode end status of discharge where ED providers perform an assessment of discharge risk [8]
		Proportion of older persons with an ED service episode end status of discharged where ED providers ascertain that supports are available to ensure safe discharge [3]
	Discharge communication	Proportion of older persons with an ED service episode end status of discharge where ED providers communicate patient-specific discharge information to the older-person or their family [3]
		Proportion of older persons with an ED service episode end status of discharge where ED providers undertake discharge communication with the primary care provider [8]
		Proportion of aged care home residents with an ED service episode end status of discharge where ED providers contact the aged care home staff or primary care or on-call physician prior to discharge from the ED, or document attempts to do so [3, 9]
	Pain	Proportion of older persons with pain during their ED episode of care who, on ED departure, have a final pain rating of severe [10]
	IDC	Proportion of older persons where ED providers placed a potentially avoidable indwelling catheter [10]
	Unplanned return	Proportion of older persons (or residents of aged care homes) with an ED service episode end status of discharge who have an unplanned return to ED within 7 days of ED departure [10]

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