RCEM
Royal College of Emergency Medicine

Care of Older People

2023

RCEM National Quality Improvement Programme
Year 1 Interim Report

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Contents

Foreword

Dr Adrian Boyle, RCEM President

I am pleased to report on the Year 1 Interim results of the RCEM Care of Older People QIP. This report contains the national performance against the RCEM standards of this QIP, which looked at the care for elderly patients aged 75 and older, presenting with a NEWS2 score of 4 or under to EDs from May 2023 to October 2023.

Older people account for a large proportion of the attendances to emergency departments and, the data captured during this QIP provides a valuable opportunity to gain the first insights into the level of care being given to older and frail patients at the National level.

The initial results reported have already provided a good overview of the National performance and, this has helped highlight the first areas where change should be taking place. The first recommendations from the interim analysis are focused on key areas such as Delirium, Falls, Comprehensive Geriatric Assessment and Safety Rounds. The interim analysis of the results also suggests that areas of focus for Year 2 should be in the detection and management of delirium, post-falls assessment, mitigating risk of falls and initiating safety round interventions for long-staying patients.

As we look forward to the National performance report for the second year of this QIP, I would like to thank all the participating EDs for submitting their data and making this analysis possible, your contribution to this project is invaluable. We welcome your feedback, ideas, and experiences to help us. The College and The RCEM Quality Assurance and Improvement Committee are committed to continually evaluating the QIPs and improving them to best support you and improve patient care.

Dr Adrian Boyle

RCEM President

Dr Dale Kirkwood

Co-Chair of Quality Assurance & Improvement Subcommittee

Dr Fiona Burton

Co-Chair of Quality Assurance & Improvement Subcommittee

Dr James France

Chair of Quality in Emergency Care Committee

Topic Team

Anu is a Consultant in Emergency Medicine at Charing Cross Hospital, Imperial College Healthcare NHS Trust, in London. Locally he oversees a prolific multi-professional improvement in the ED. He is the QI Lead for the London School of Emergency Medicine, having developed an education and assessment programme in the region. He also has a great interest in sustainable healthcare, and is a member of the RCEM Environmental Special Interest Group, which seeks to promote greater sustainability in UK Emergency Departments using vehicles such as QI methodology.

Anu Mitra
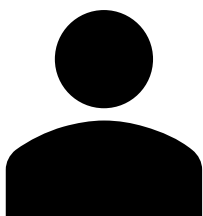
Hannah is currently an LTFT ST5 in EM and Chief Registrar at Royal Bolton Hospital. She is the one of the co-chairs of the EMTA committee, alongside currently Vice-Chair of the Academy of Medical Royal Colleges Trainee Committee. She has previously completed the FMLM National Medical Directors Fellowship. She has a keen interest in medical leadership and medical education having recently completed a Masters in medical leadership and a PGCert in Medical Education. She currently sits on the QI committee as the Trainee Representative. She is passionate about Quality Improvement, having previously completed a QI fellowship and set up regional QI training programme for junior colleagues.

Hannah Baird

Claire is an EM consultant at St Mary's Hospital, Imperial, London. She is the departmental lead for frailty, QI, adult safeguarding and SHO teaching. She teaches on the regional QI and QI 'train the trainers' days in London. She has completed the Diploma in Geriatric Medicine and is involved in several local and regional projects in frailty and older persons' medicine. Claire is dedicated to improving care for older people in the ED, with particular interests in managing delirium, falls and trauma in older people.

Claire Bronze
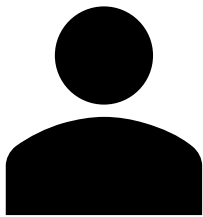
I am an Advanced Nurse Practitioner currently working in Urgent Care. Initially I was on the RCEM credentialling pathway working in an acute ED seeing patients across the breadth of the lifespan, and in all areas of ED including Paediatrics and Resus patients. I am currently working in an Integrated Urgent Care Hub seeing minor illness and injury and have used the skills gained on this project to develop and improve how we manage and treat elderly patients within our area.

I have a keen interest in QI, auditing, and Frailty/elderly care and feel very grateful to have been chosen to work on this project.

Andrea Linehan

Eduard is a trainee ACP in UCLH ED.

We are an urban ED in central London and see an average of 400,000 patient per year. Eduard has been working in ED for last 11 years with specialist interest in trauma and orthopaedics. Eduard is interested in education for improved patient outcomes. The opportunity to work with RCEM and their wonderful QI project team was a wonderful way of understanding the structures and methodology that underpins our safety concerns on a daily basis with patient care.

Eduard Deda

Rachael is a Consultant in Acute Frailty. She is the Clinical Lead of the Geriatric Emergency Medicine Service (GEMS) in Weston General Hospital, Weston-Super-Mare and also in the community NHS@home frailty pathway. This interface role between community and acute, and working in both settings, provides a unique opportunity to help unite frailty services spanning hospital front door and the community to work together to best serve patients. Rachael is Chair of the Royal College of Emergency Medicine, Older Person in Emergency Medicine (OPEM) special interest group.

Rachael Morris

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Executive Summary - Interim Report Year 1 (2023)

RCEM would like to thank all **118** Emergency Departments (ED) that participated in **Year 1** of this Quality Improvement Programme (QIP).

Overview

Older people account for a large proportion of the attendances to emergency departments, but the evidence shows that this cohort of patients often do not receive a good standard of care. The national QIP intends to capture the standard of care delivered in EDs across the country whilst signposting to solutions and methodology for improvement. This report is an evaluation of the nationwide data from the 5th of May 2023 to the 3rd of October 2023.

Key Findings

The findings are based on data entry from 9155 Type 1 ED attendances for older patients meeting inclusion criteria for the national QIP.

Standard 1: Older People (75 years and older) in Emergency Departments should be: Screened for delirium using 4AT, Assessed for falls risk and, Screened for frailty.

- **1a**: The chart above shows that 14.98% of patients were screened for delirium using the 4AT
  - Of the patients that were screened for delirium (n=1997) 31.7% failed to meet the standard because of the screening tool used
- **1b**: 43.79% patients had a falls risk assessment done.
- **1c**: 53.06% of patients have been screened using a recognised frailty scoring system

Standard 2: Action is taken based on the findings of screening processes; Delirium management plan initiated, Post-fall assessment, Falls mitigation and, Comprehensive geriatric assessment initiated.

- **2a**: Of the small number of patients who were found to have delirium (n=467), 28.76% had a complete delirium management plan initiated
- **2a**: Of those with complete or partial delirium management plans, most-frequently done were blood tests and least-frequently were medication review, and assessment for urinary retention and constipation
- **2b**: 37.25% of patients presenting after a fall had a dedicated post-fall assessment. This may be clouded by the fact that separate 'Silver Trauma' pathways may incorporate components of the post-fall assessment
- **2b**: blood tests and ECG were performed frequently (75%) but postural blood pressure less often (25%)
- **2c**: 32.58% of patients identified as being at-risk of falling, had a full falls mitigation plan put in place.
- **2c**: of these at-risk patients most often the falls risk was flagged up (89%), and least often the patient was offered non-slip footwear (45%)
- **2d**: 35.46% of patients had a CGA initiated, as directed by the frailty score

Standard 3: Patients should have their basic care needs met whilst in the ED via a safety round.

- 55.8% of all patients had an ED length of stay of more than 6 hours
- Of these patients, 31.5% had a full safety round initiated

Discussion

Year 1 of this national QIP provides a valuable opportunity to capture the 'baseline' level of care of older people in EDs. There is room for improvement across the board, in all the standards. Particular areas of focus for Year 2 should be in the detection and management of delirium, post-falls assessment, mitigating risk of falls and initiating safety round interventions for long-staying patients.

Key Recommendations

General

- Emergency departments should plan and implement improvement initiatives for specific areas in the RCEM COP standards eg., delirium, using QI methodology. Guidance may be found in the RCEM COP QIP Information Pack, and the RCEM Quality Improvement Guide
- RCEM will share examples of good practice from some of the best-performing departments from Year 1

Delirium

- Emergency departments should provide training to relevant staff
  - Demonstrating ease of using the 4AT
  - On the importance on patient outcomes of early detection of delirium
- Introduction of delirium care bundles or clinical pathways may motivate staff to screen for delirium
- A universal delirium assessment plan should be used in Emergency Departments to ensure standardised care. A suggested assessment tool that is evidence based is the 'PINCHME' tool, which acts as an aide-memoire
- There should be specific emphasis on improving medication review, urinary retention and constipation assessment

Falls

- All patients attending emergency departments over 75 years should be assessed for falls risk in order to put a falls mitigation pack in place for those at risk.
- Improve accuracy of data by ensuring that post-fall assessments are not already being done elsewhere in the patient journey eg., within a 'silver trauma' pathway
- Departments should develop and implement falls mitigation policies for all identified at-risk patients
- Falls mitigation packs should be always made-up and available in departments. These should always include non-slip footwear.

CGA

- Identify barriers to CGA initiation, such as resource constraints, staff training needs, or workflow inefficiencies

Safety Rounds

- Consider alerts / reminders on the EPR to initiate safety rounds for patients once they have reached ED LOS of 6 hours
- Implementation of checklist-style safety round care bundles which focus on patient comfort, basic nursing care and regular medications
  - Involvement of nursing and ancillary staff to lead improvement initiatives in this area

We plan to share this report widely with stakeholders out with the immediate departments. As we embed this in our routine practice, we seek to get the support that EDs require to help them in their QI activities.

Feedback

We want to thank everyone who has participated and congratulate you on what you've achieved. If all teams share their thoughts and feedback, we would have a wealth of learning to share with each other and improve future programmes. Please email us on rcemqip@rcem.ac.uk with any comments you can share regarding this programme or its reports. You may also access the feedback form via the QR Code below:

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Introduction

Rationale

Older people account for a large proportion of the attendances to emergency departments and an even larger proportion of inpatient admissions, but the evidence shows that this cohort of patients frequently do not receive a good standard of care. The rationale for this National QIP is to assess and improve the quality of care given to older and frail patients and to ensure that recommended interventions that can make a meaningful difference to mortality, morbidity and quality of life are implemented where feasible. The QIP focused on key conditions which affect outcomes primarily in older people, and define a broad range of standards with the aim of improving holistic medical and nursing care in ED.

Background

Delirium is among the most common medical emergencies, with a prevalence of approximately 20% in adult acute general medical patients. Despite this, delirium is underdiagnosed and investigation and treatment of it is variable. Undiagnosed delirium with or without dementia is a contributor to significant morbidity and mortality, especially in EDs and hospitals. The assessment for delirium is often missed or carried out unreliably in EDs.

Falls are a common presentation to Emergency Departments (EDs), accounting for 17% of ED attendances in older people. They are the leading cause for people over 65 years losing their independence or requiring long-term placement. Falls may be the first presenting feature of serious underlying pathology, such as cardiac syncope, and may lead to significant injury in older and frail people. These injuries may present atypically, leading to delays in recognition and management.

In the national picture of worsening crowding and increasing length of stay, any solutions require a strategic, whole-systems approach which isn't within the power of EDs to deliver alone. However, there is the need to maintain the basic elements of care and comfort for those older patients who do have to spend longer in the department. The National QIP aims to capture this activity with a view to driving improvement.

Question description

The review conducted prior to this QIP[†], has highlighted the importance of key elements in the care of older people that have been shown to improve the quality of care for this patient group. The findings from the review have been used to formulate the standards and metrics used in this QIP.

Supporting Evidence:

Please see, Appendix 4: Evidence Review, from the COP QIP Information pack for more information.

National Drivers

To improve the quality of care for patients 75+ and older in EDs by:

• Improving screening for delirium, screening for frailty, and falls risk assessments,

• Ensuring actions are taken based on the findings of those screenings and assessments,

• Ensuring patients have their basic care needs met whilst in the emergency department.

To empower and encourage EDs to run QI initiatives based on the data collected to drive improvement and track the impact of the QI initiative on their weekly performance data. Show EDs their performance relative to their own baselines to focus on improvement. EDs can also compare themselves to other participating departments to gauge how much resource may be required to perform as high-performance peers.

[†] Please see, Appendix 4: Evidence Review, from the COP QIP Information pack for more information

Methodology

For a detailed description of the methodology used in the QIP, please see the [information pack.](#)

Care of older people: Year 1 Interim Report

This report presents data collected for year 1 of this QIP. Data was collected on patients aged 75 and older that presented to the ED with a NEWS2 score of 4 or under during the 5th of May 2023 to the 3rd of October 2023.

This programme will continue to run from October 2023 to October 2025, with the second year of the QIP collecting data from October 2023 to October 2024.

Data Excluded Post-Validation

The data used to create the charts in this report contains only the cases that have been submitted within the data entry period. The records submitted were also validated to ensure poor quality data was excluded to prevent distortion of the means and charts. Some of the cases submitted during the data collection period have been removed due to incomplete information and data entry errors that were not identified by the data entry system. Other specific exclusion criteria is mentioned under the results section for each analysis.

Questions and Standards

Please see Appendix 2 for the full question set used to collect data.

Clinical Standards

Standards	
1	Older People (75 years and older) in Emergency Departments should be:
1a	Screened for delirium using 4AT
1b	Assessed for falls risk
1c	Screened for frailty
2	Action is taken based on the findings of screening processes
2a	Delirium management plan initiated
2b	Post-fall assessment
2c	Falls mitigation
2d	Comprehensive geriatric assessment initiated
3	Patients should have their basic care needs met whilst in the ED via a safety round

Organisational Standards

Standards
Screening
Emergency Departments should have systems or processes in place to screen for: a) Frailty   b) Delirium   c) Cognitive impairment   d) Falls risk   e) Elder abuse   f) Polypharmacy   g) Pressure areas and incontinence   h) Functional status / mobility   i) Social support

Discharge Summaries
Emergency Departments should have systems or processes in place to screen for: a) Emergency Departments should have systems in place to record the above information in discharge summaries   b) There should be a system in place to ensure that patients could be provided with a paper copy if requested, including upon discharge to a care home   c) There should be regular quality assurance of discharge summaries
Physical Resources
a) The overall design and layout of the Emergency Department should consider the needs of frail older patients   b) The Emergency Department should have a dedicated area for people with cognitive impairment   c) The Emergency Department should have timely access to dedicated equipment to support the care of those living with frailty, cognitive and/or sensory impairment
Additional Services
Emergency Departments should have timely access to the following services, either within the department, on-site or remotely: a) Real-time language interpreting   b) Geriatrician   c) Acute Frailty   d) Therapies   e) Older Adults Mental Health   f) Community Admission Avoidance   g) Third Sector Support   h) Palliative Care   i) Pharmacist   j) Pastoral / religious support   k) Meal provision

Advance Care Planning
a) Emergency Departments should have timely access to previously completed Advance Care Plans b) Emergency Department staff should be trained to ask patients routinely about their wishes regarding resuscitation decisions and end of life care c) Emergency Departments should have timely access to services or pathways that can support the discharge of people at end of life, to their preferred place of death
Patient Experience
There should be a framework in place whereby feedback from patients and users is sought, analysed and acted-upon in a systematic way, with a focus on older people.

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Performance Against Clinical Standards

Standard 1

Standard 1a – delirium screening using 4AT

(For the time period: 1364 records conforming to standard; from a total of 9155 eligible.)

Assessed for delirium
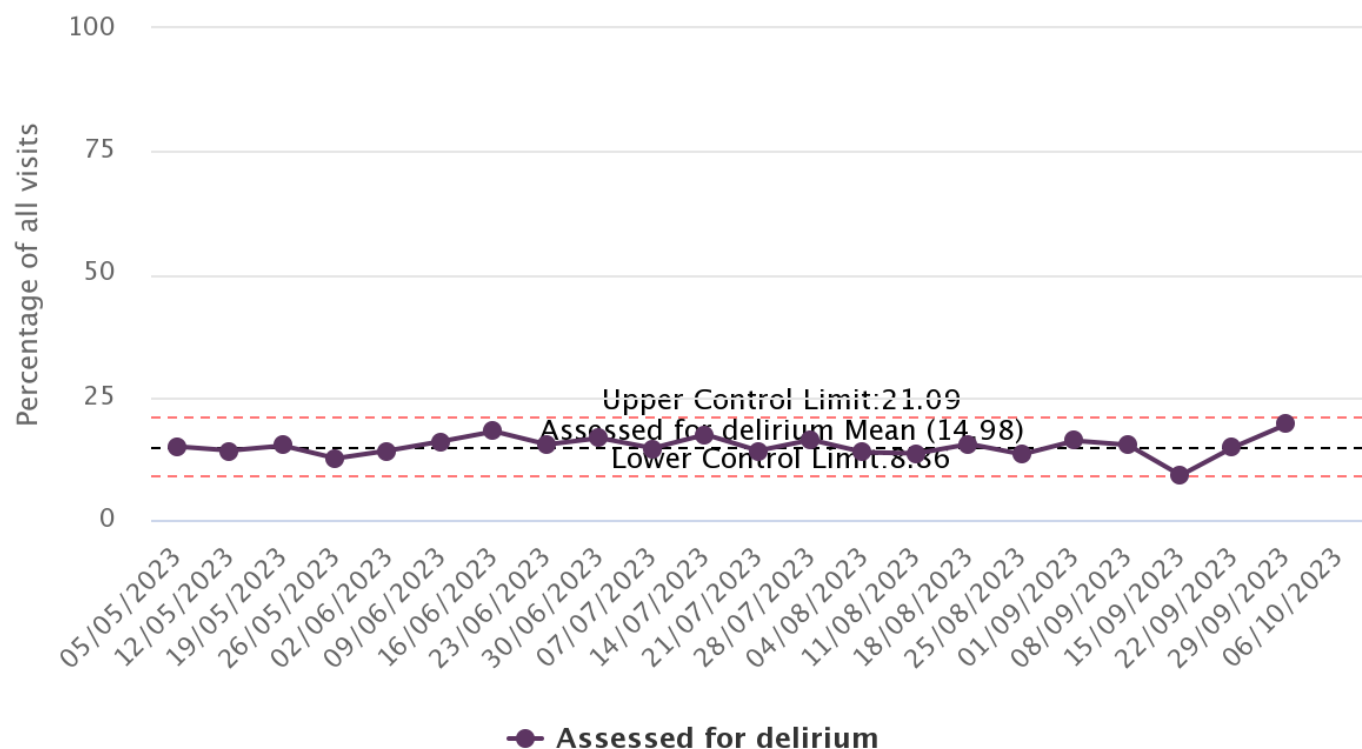
netsolving.com

Understanding SPC Charts

N= 9155 (Patients 75+ years old)

Site Performance

Standard 1A: % of patients (75+) who received a delirium screening using 4AT
Split by Site

Overall Performance by Site (Year 1)
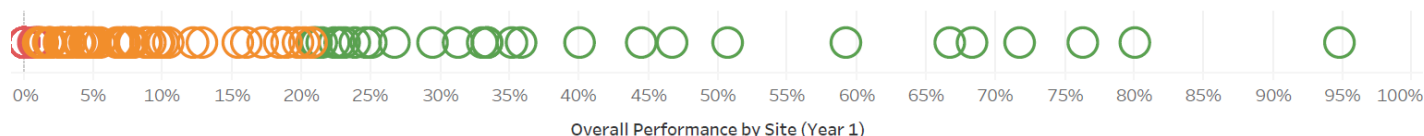
Standard 1A: 27 of the 121 sites did not record any patients conforming to this standard. This includes 3 sites that did not record any records at all for this standard.

Lower Quartile Performance <1.01%   Interquartile Range: 1.01% - 20.8%   Upper Quartile Performance: >28%   (Median Performance 5.3%)

Commentary

The chart above shows that about 15% of patients were screened for delirium using the 4AT tool. Of the patients that were screened for delirium (n=1997) 31.7% failed to meet the standard because of the screening tool used but, when looking at all patients eligible for this analysis, 7156 out of 9155 failed to meet the standard solely because they were not screened for delirium, meaning that the lack of screening accounted for 78% of the reason why patients have failed to meet the standard.

Despite setting an age cut off as over 75 years, in order to capture the cohort of patients most likely to benefit from delirium screening, this standard had very low numbers of patients screened in most participating departments. Recording delirium screening appears to be a significant challenge across emergency

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departments with no real improvement in performance as the QI has progressed so far. There needs to be a focus on why delirium screening is proving to be consistently challenging in the emergency department environment in order to address the underlying causes of this.

Recommendations

- Emergency departments should provide training to relevant staff
    - Demonstrating the ease of using the 4AT
    - On the importance on patient outcomes of early detection of delirium
- Introduction of delirium care bundles or clinical pathways may motivate staff to screen for delirium
- A prompt or mandatory field on the paper or electronic records to perform the 4AT may help to improve the numbers screened.

Delirium screening tools

netsolving.com
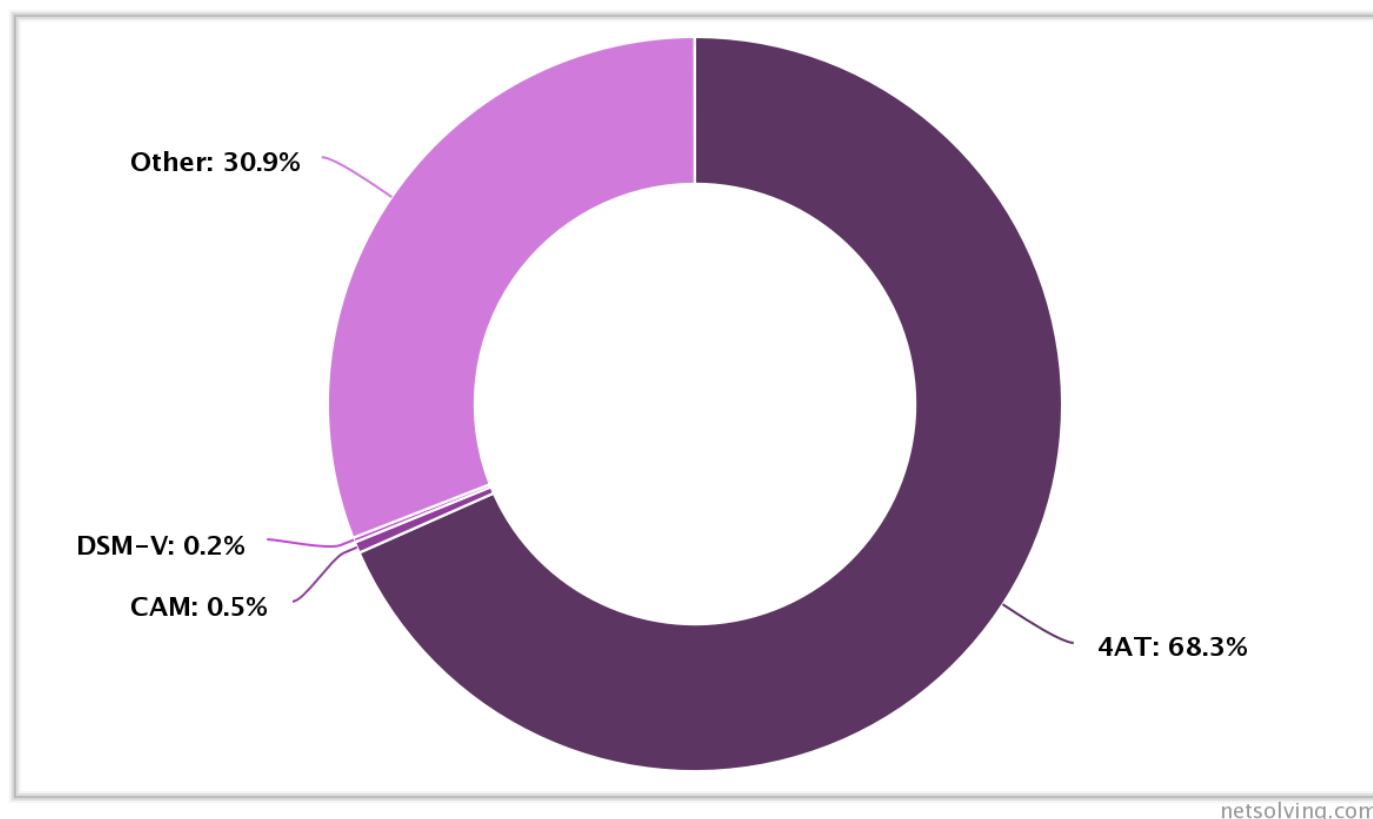
N= 1997 (Patients 75+ years old that had a delirium screening test performed in the ED)

Exclusions:

All records of patients that did not had a delirium screening test performed in the ED have not been included in this chart.

Commentary

The breakdown of screening tools used shows that the 4AT tool is the most used screening tool, accounting for 68.3% of all records eligible for this analysis. 30.9% of the eligible records were screened using other tools- the top 3 most popular screening tools reported by participants under 'Other tools' were: GCS, AMTS and SQiD. The 4AT has been validated for use in the emergency department environment and is therefore the tool recommended for this QI project. The majority of patients across most of the departments involved in this project did not have any delirium screening documented.

Recommendations

As above (see 'Delirium screening using 4AT').

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Standard 1b – Falls risk assessment

(For the time period: 3986 records conforming to standard; from a total of 9155 eligible.)
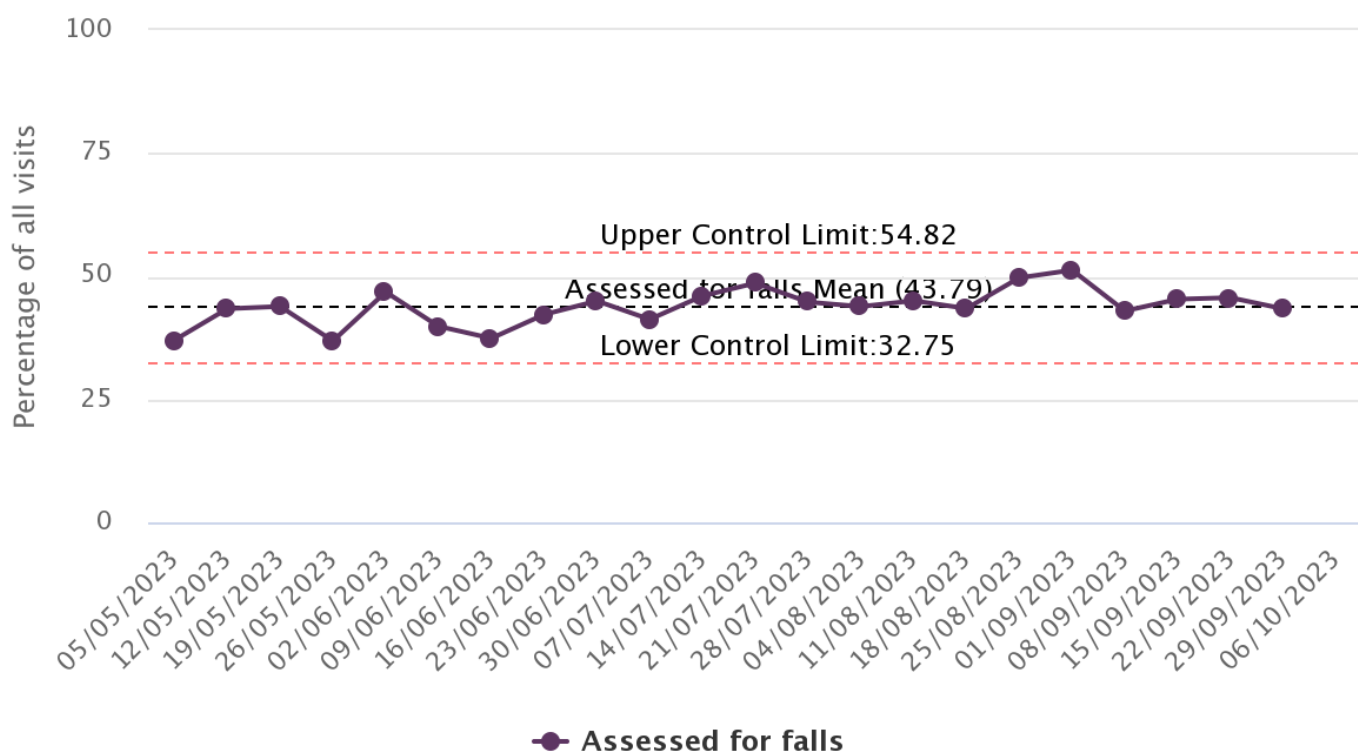
N= 9155 (Patients 75+ years old)

Site Performance

Standard 1B: % of patients (75+) who received a Falls Risk Assessment
Split by Site

Overall Performance by Site (Year 1)
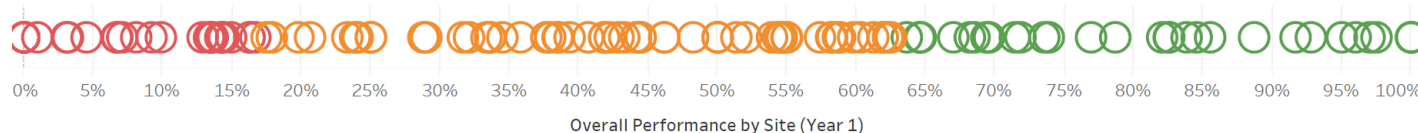
Standard 1B: 11 of the 121 sites did not record any patients conforming to this standard. This includes 3 sites that did not record any records at all for this standard.

Lower Quartile Performance <16.7%   Interquartile Range: 16.7% - 63.4%   Upper Quartile Performance: >64%   (Median Performance 43.7%)

Commentary

The SPC chart above shows an average of about 44% patients had a falls risk assessment done. The proximity of the control limits indicates that the current performance is stable. Given that the compliance rate is nearing the upper control limit, significant increases in compliance beyond 55% may require systemic changes or national interventions. Whilst this demonstrates better performance than for Standard 1a, there is still scope for improvement.

Recommendations

- Provide targeted education to staff on identifying and assessing falls risk and mitigation strategies in elderly patients.
- Establish documentation protocols for falls risk assessment eg., option for risk assessment tool could automatically appear in initial nursing documentation for all older patients.

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Standard 1c – Frailty Screening

(For the time period: 4811 records conforming to standard; from a total of 9155 eligible.)
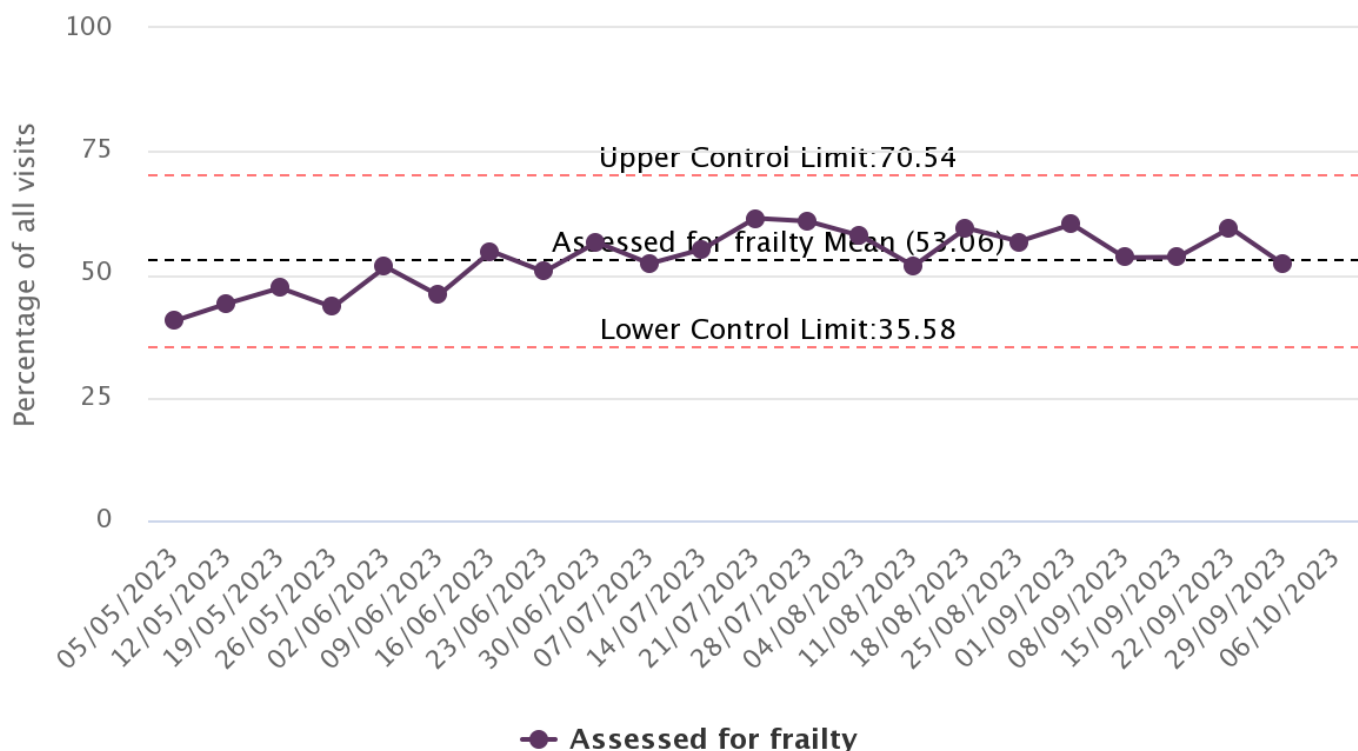
N= 9155 (Patients 75+ years old)

Site Performance

Standard 1C: % of patients (75+) who received a Frailty Screening
Split by Site

Overall Performance by Site (Year 1)
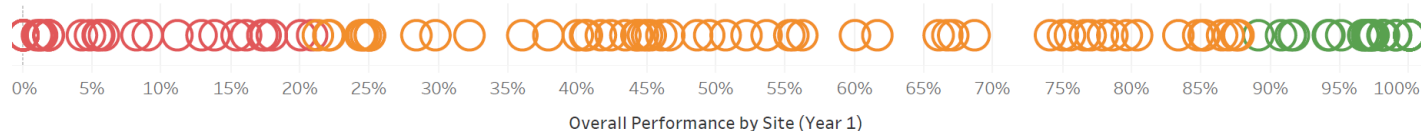
Standard 1C: 10 of the 121 sites did not record any patients conforming to this standard. This includes 3 sites that did not record any records at all for this standard.

Lower Quartile Performance <21.0%   Interquartile Range: 20.1% - 88.7%   Upper Quartile Performance: >88.7%   (Median Performance 50.1%)

Commentary

The data shows that on average, 53.06% of patients have been screened using a recognised frailty scoring system. The upper control limit of 70.5% shows that the current systems are capable of achieving a higher mean performance but, very unlikely to go beyond 70% unless there is a change in the current systems.

Recommendations

- Build in mandatory frailty screening tool in the EPR / paper record for all older patients
- Training for relevant staff
    - o On the clinical importance of identifying frail patients
    - o On how to score patients correctly using the frailty scoring system in place locally

Standard 2

Standard 2a – Delirium management plan initiated for patients with delirium

(For the time period: 129 records conforming to standard; from a totoal of 467 eligible.)
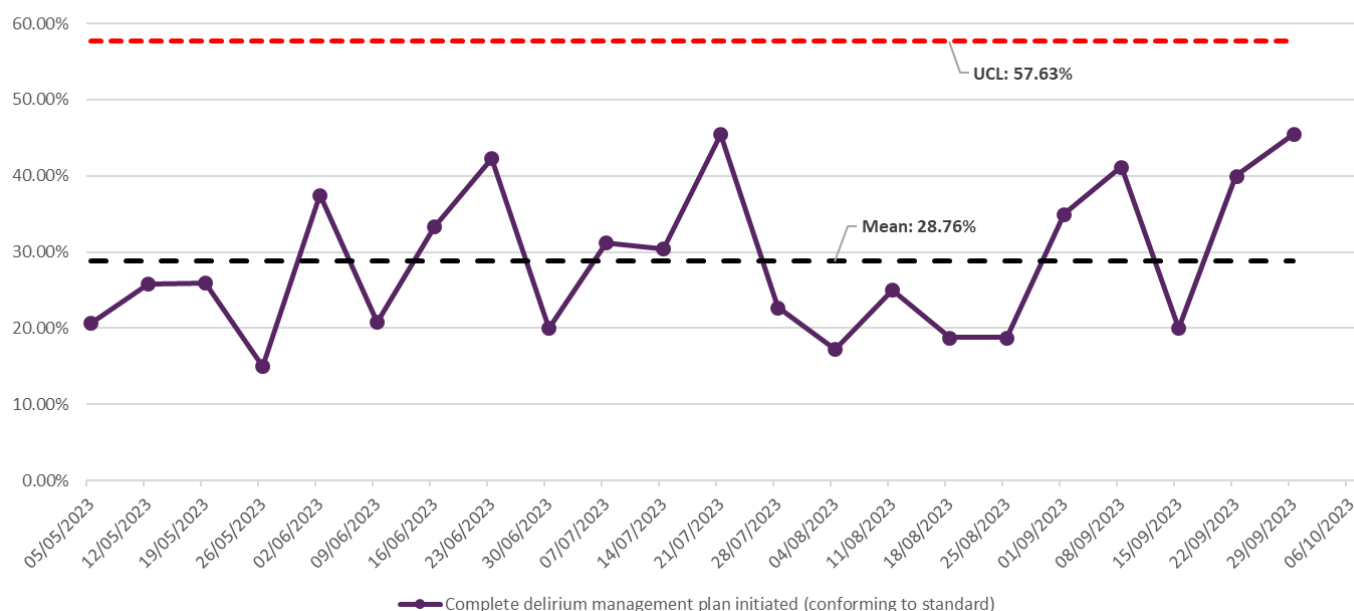
[Understanding SPC Charts](#)

N= 467 (Patients aged 75+, with delirium identified after screening)

Exclusion

Patients that have not been screened for delirium have been excluded from this analysis and, patients that did not have delirium identified after screening have also been excluded.

Site Performance

Standard 2A: % of patients identified with Delirium having a Delirium Management Plan initiated
Split by Site

Overall Performance by Site (Year 1)
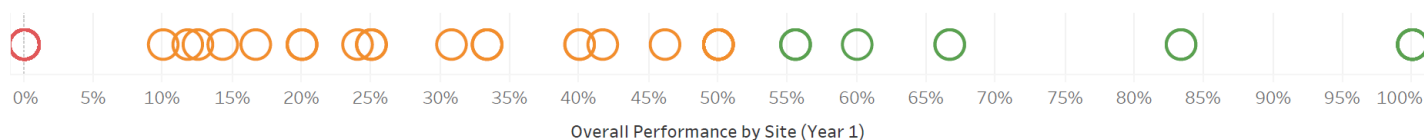
Standard 2A: 75 of the 121 sites did not record any patients conforming to this standard. This includes 38 sites that did not record any records at all for this standard.
Note IQR Calculations exclude the sites with no records recorded for this standard. (38 sites in this instance). Only 10 sites recorded 10 or more records for this standard.

Lower Quartile Performance 0%   Interquartile Range: 0.01% - 50.0%   Upper Quartile Performance: >50%   (Median Performance 16.7%)

Commentary

When looking at the chart above, it is important to keep in mind that the small sample size (n=467) is a result of the results shown on Standard 1a where 78% of patients were not screened for delirium- Due to the exclusion criteria of this analysis, where only patients with identified delirium following screening are eligible, 78% of patients that could have had delirium identified after screening have been left out of this analysis for this reason.

When considering the results shown in the chart above, the mean compliance to this standard was about 28.76%, meaning that out of all patients with delirium identified following screening, nearly one third on average had a complete delirium management plan initiated. The chart above also shows considerable level of variation with performance changing from about 40% to 20% and back to 40% compliance within a matter of 3 weeks (see weeks 08/09/2023 to 22/09/2023)

Recommendations:

- For a delirium plan to be initiated delirium, as a condition, needs to be identified (see recommendations for Standard 1a)
- An effective delirium management plan benefiting the patient, their relatives, staff and hospital flow pathways can motivate staff to screen for delirium in the Emergency Department. This may take the form of a checklist of key interventions and assessments.

Standard 2a – Delirium management plan initiated (Components)
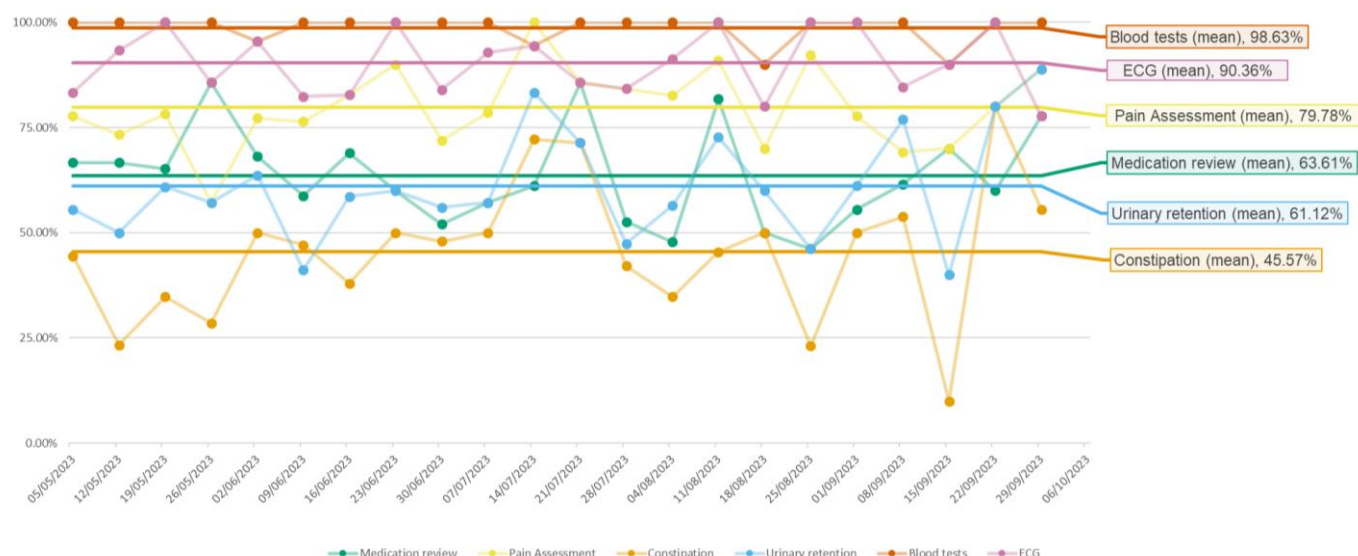
N= 368 (Patients aged 75+, with delirium identified after screening where a complete or partial delirium management plan was initiated)

Exclusion

Patients that have not been screened for delirium have been excluded from this analysis and, patients that did not have delirium identified after screening have also been excluded. Patients where a delirium management plan was not initiated have also been excluded.

Commentary

The chart above shows the individual components of the delirium screening from all records where a complete or partial delirium management plan was Initiated. Blood tests rank as the most consistent and most common component in all delirium management plans, with an average of 98.6% of all plans having a blood test. Constipation is the least common component with less than 50% of all plans having this component included, this specific component has also been consistently the least common component as it ranked lower than any other component for 17 out of the 22 weeks data was collected for. Blood tests, ECGs and pain assessment score highly because they are common features of the wider assessment of ED patients. However, medication review, urinary retention and constipation are not universally done in ED patients and therefore staff must remember to include as an 'extra'.

Recommendations

- A universal delirium assessment plan should be used in Emergency Departments to ensure standardised care
- A delirium assessment plan should be based on nationally recognised evidence. This prevents missing recognised causes of delirium such as constipation that can be treated. A suggested assessment tool that is evidence based is the 'PINCHME' tool, which acts as an aide-memoire
- There should be specific emphasis on improving medication review, urinary retention and constipation assessment

Standard 2a – Delirium management plan initiated – Breakdown
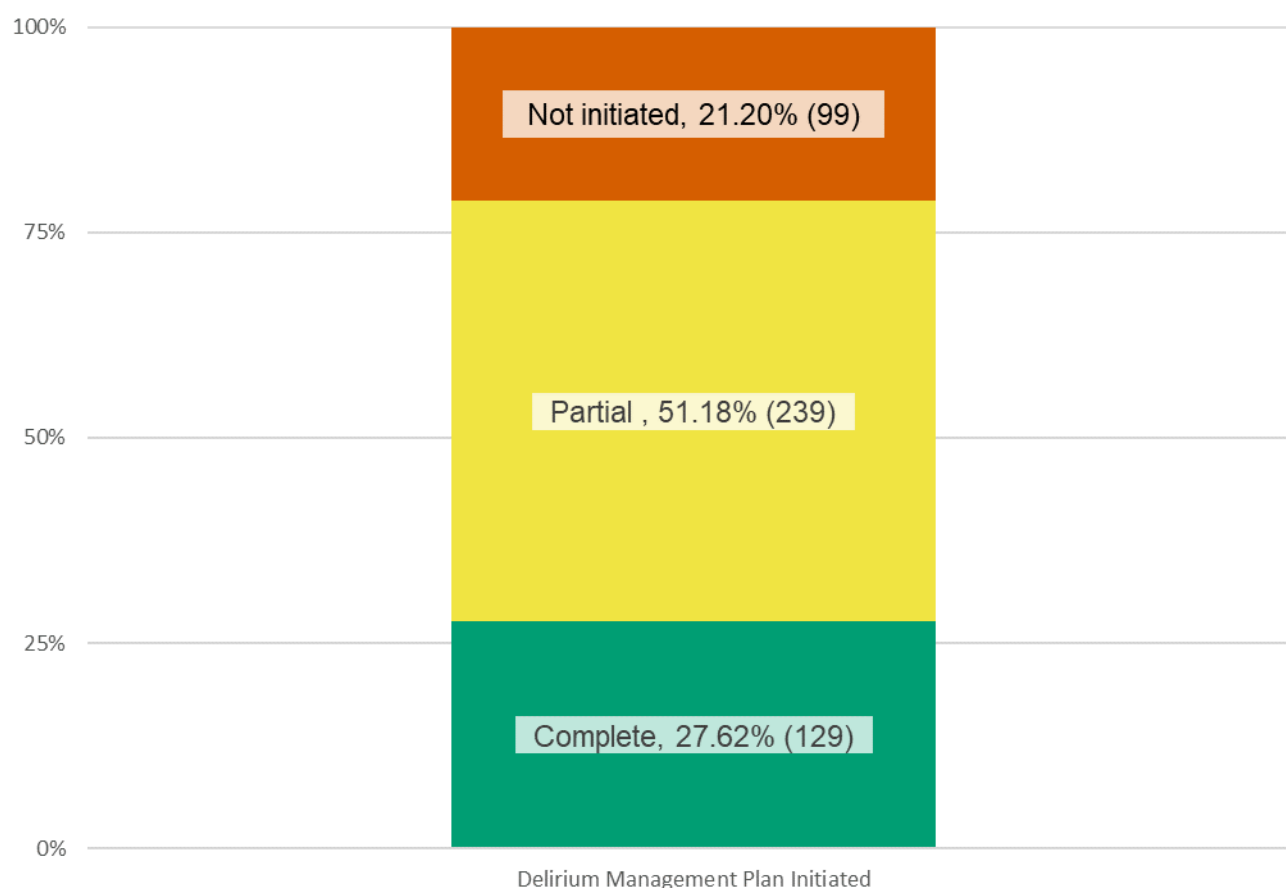
Not initiated, 21.20% (99)

Partial , 51.18% (239)

Complete, 27.62% (129)

Delirium Management Plan Initiated

N= 467 (Patients aged 75+, with delirium identified after screening)

Exclusion

Patients that have not been screened for delirium have been excluded from this analysis and, patients that did not have delirium identified after screening have also been excluded.

Commentary

As it was for Standard 2a, the low sample size is explained by the results shown in Standard 1a where 78% of patients were not screened for delirium, meaning that the 78% of patients that could have had delirium identified after screening have been left out of this analysis for this reason.

The majority of delirium management plans initiated (51.2%) did not feature all components as they were partial plans. When looking at partial delirium management plans, on average, management plans will contain at least 4 out of 6 components. Similar to the component breakdown chart on the previous page, assessment for constipation was the least featured component on partial management plans, with only 27.6% of the management plans containing this component.

Recommendations

As above

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Standard 2b – dedicated assessment after a fall

(For the time period: 1075 records conforming to standard; from a total of 2884 eligible.)

Upper Control Limit:49.47

Dedicated assessment after a fall Mean (37.25)

Lower Control Limit:25.03

→ Dedicated assessment after a fall
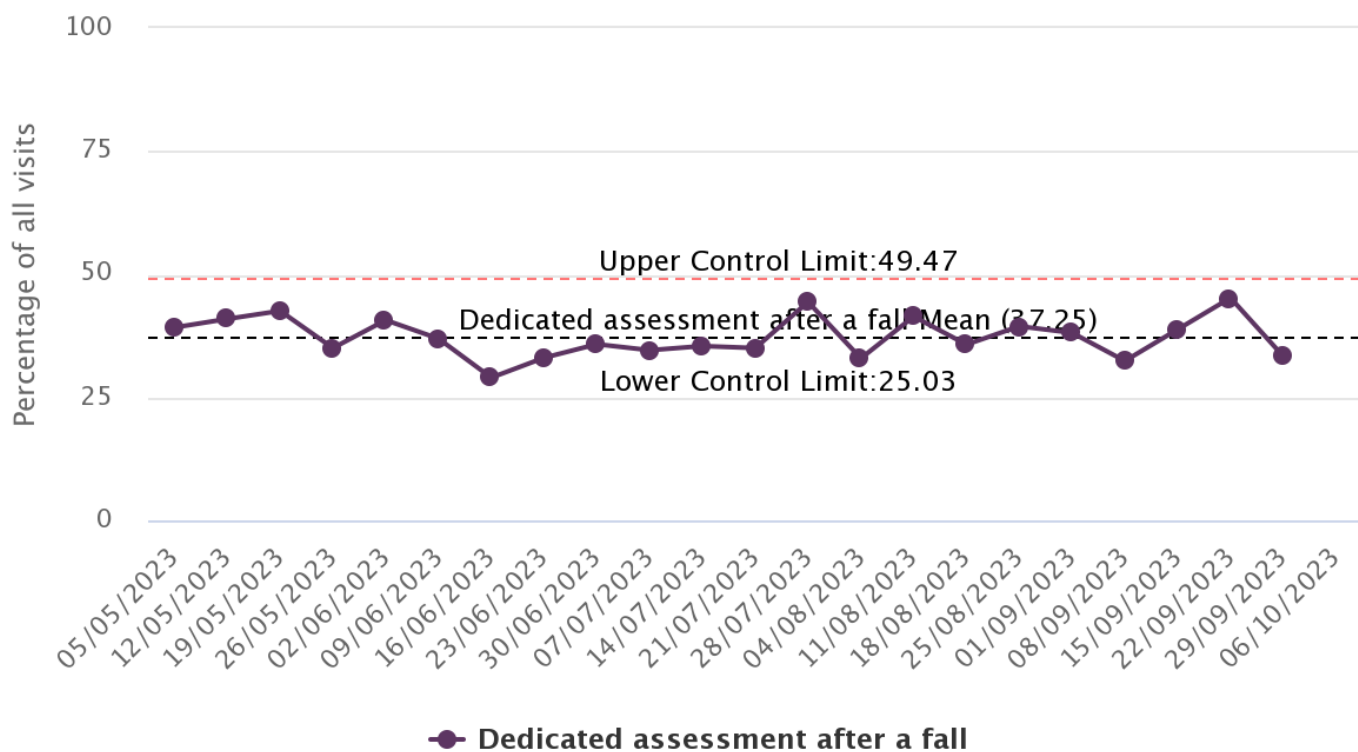
netsolving.com

N= 2884 (Patients 75+ years old, presenting with a fall)

Exclusion

All patients that did not present to the ED with a fall have been excluded from this analysis.

Site Performance

Standard 2B: % of patients receiving a Dedicated Assessment after a Fall
Split by Site

Overall Performance by Site (Year 1)

Standard 2B: 12 of the 121 sites did not record any patients conforming to this standard. This includes 4 sites that did not record any records at all for this standard.

Lower Quartile Performance >19.4%   Interquartile Range: 19.4% - 51.0%   Upper Quartile Performance: >51.0%   (Median Performance 36.7%)

Commentary

The current mean for a dedicated assessment post fall is 37.25%, there appears to be consistent variation around this mean with little outliers currently. We would hope that as the project continues and more interventions are put into place we will start to see improvement in the data. 'Silver Trauma' is a priority for many emergency departments and therefore the assessment maybe recorded in different documents which are not reviewed as part of the QIP.

Recommendations

- Improve accuracy of data by ensuring that post-fall assessments are not already being done elsewhere in the patient journey eg., within a 'silver trauma' pathway
- Educate staff to ensure that an elderly patient with a fall requires consideration of a delirium screen.

- Identify sites where this is done well and learn from this.

Standard 2b – dedicated assessment after a fall (components)

N= 2884 (Patients 75+ years old, presenting with a fall)

Exclusion

All patients that did not present to the ED with a fall have been excluded from this analysis.

Commentary

When looking at the breakdown of the dedicated assessment after a fall, a postural blood pressure is the least featured component of assessments in every single week that data was collected. This contrasts with blood test, which was the most featured component on assessments for all weeks data was collected. Indeed, blood tests and ECG scored at around 75% of patients. This represents good performance.

Recommendations

- All patients presenting to an emergency department with a fall should be assessed for the cause of that fall. For those over the age of 65 years or where a clear mechanism is not apparent, this should include the investigations recommended in this QI project as standard.

- A proforma or aide memoire for the components of a falls assessment could be instigated in order to ensure all components are included.

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Standard 2b – dedicated assessment after a fall (breakdown)
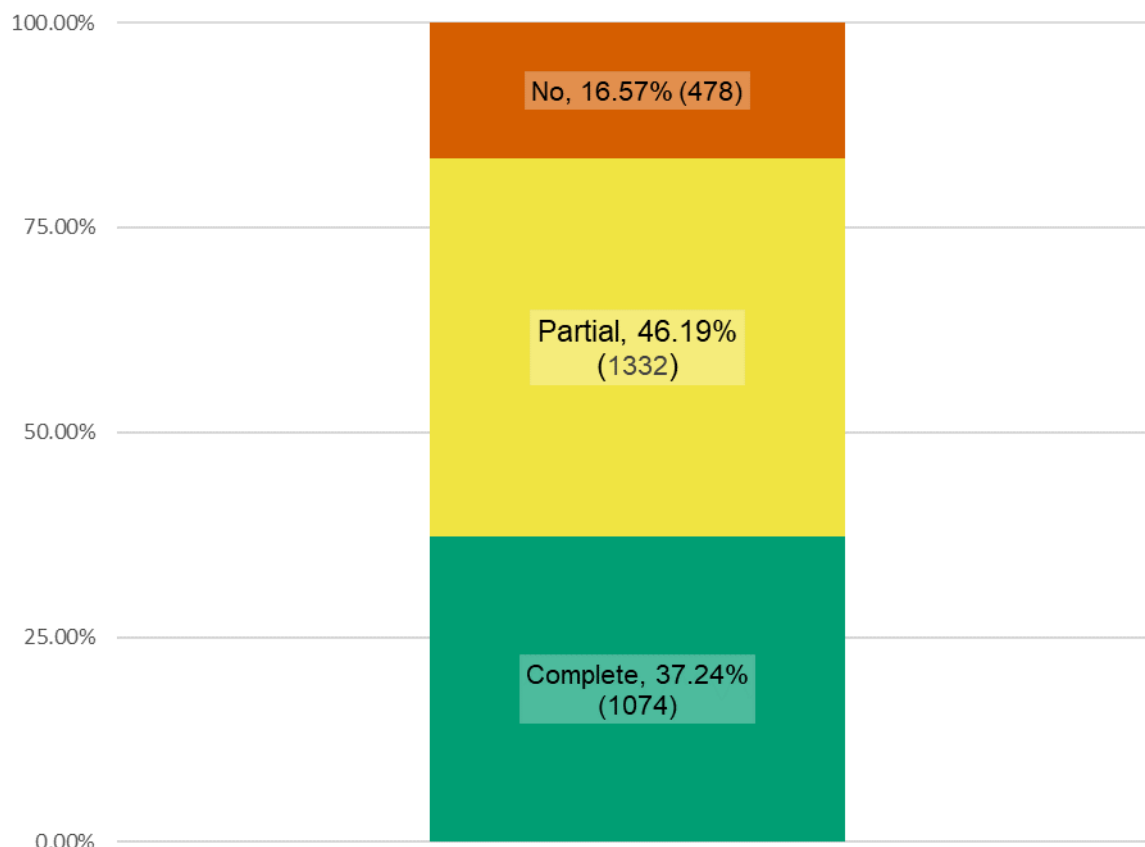
N= 2884 (Patients 75+ years old, presenting with a fall)

Exclusion

All patients that did not present to the ED with a fall have been excluded from this analysis.

Commentary

The stacked bar chart above shows that of the 2844 patients who presented because of a fall, 83.43% had some form of assessment undertaken. However only 37.24% had a full post-fall assessment of ECG, blood tests and postural BP. The following run chart illustrating the breakdown of the individual constituent parts of the assessment highlights the main area for improvement

Recommendations

- A proforma or aide memoire for the components of a falls assessment could be instigated in order to ensure all components are included.

Standard 2c – Falls mitigation plan

(for the time period: 893 records conforming to standard; from a total of 2751 eligible)
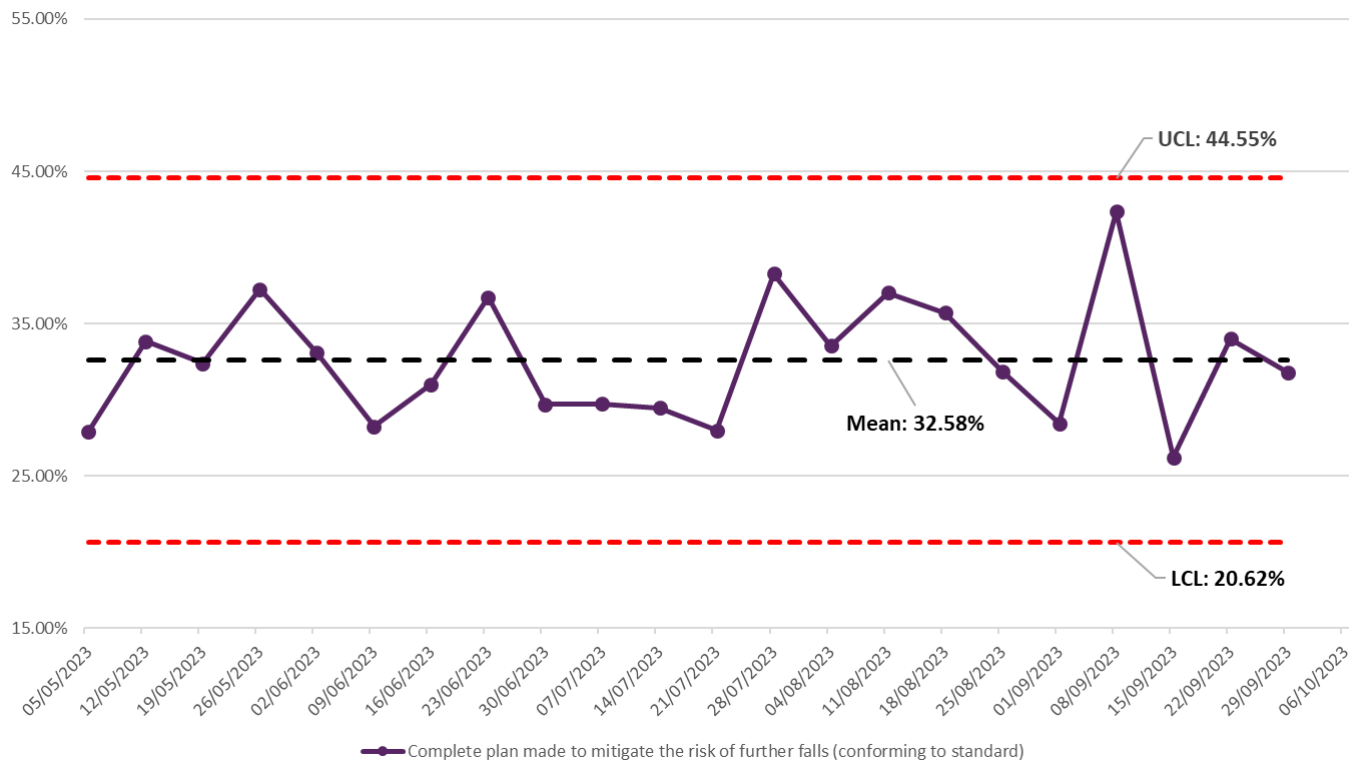
Complete plan made to mitigate the risk of further falls (conforming to standard)

N= 2751 (Patients aged 75+, identified to be at risk of falls following a falls risk assessment)

Exclusion

All patients that were not risk assessed for falls and, patients that were risk assessed for falls but were not identified as being at risk of falls were excluded from this analysis.

Site Performance

Standard 2C: % of Patients identified to be at risk of Fall receiving a Falls Mitigation Plan
Split by Site

Overall Performance by Site (Year 1)
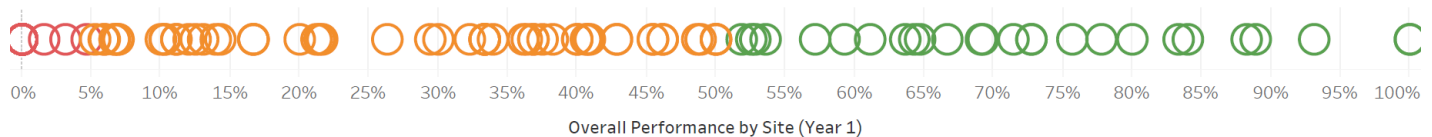
Standard 2C: 37 of the 121 sites did not record any patients conforming to this standard. This includes 13 sites that did not record any records at all for this standard.
Note IQR Calculations exclude the sites with no records recorded for this standard. (13 sites in this instance).

Lower Quartile Performance >5.1%   Interquartile Range: 5.1% - 50.0%   Upper Quartile Performance: >50%   (Median Performance 31.1%)

Commentary

When analysing the results of the chart above, it is important to keep in mind that patients that were not risk assessed for falls have been removed from this analysis. Considering the results of Standard 1b, where 3986 out of 9155 patients had a falls risk assessment, this means that 5169 patients (56.5% of all patients) have not been subjected to this analysis solely due to the fact that no falls risk assessment was performed. This means that 56.5% of patients in this QIP had their fall risk undetermined and could potentially be included in this analysis had an assessment been done.

The chart above also shows that on average 32.58%, about one-third, of patients with an identified risk of falling had a complete falls mitigation plan made to mitigate their risk of further falls. The upper control limit

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also shows that the current system could perform better but, without a change in the system, performance is very unlikely to reach 50% compliance and over.

Recommendations

- All patients attending emergency departments over 75 years should be assessed for falls risk in order to put a falls mitigation pack in place for those at risk.
- Departments should develop and implement falls mitigation policies for all identified at-risk patients
- Falls mitigation packs should be always made-up and available in departments. These should always include non-slip footwear.
- Falls mitigation policies should include as a minimum: walking aids, non-slip footwear, level of observation and cot sides.

Standard 2c – Falls mitigation plan (components)
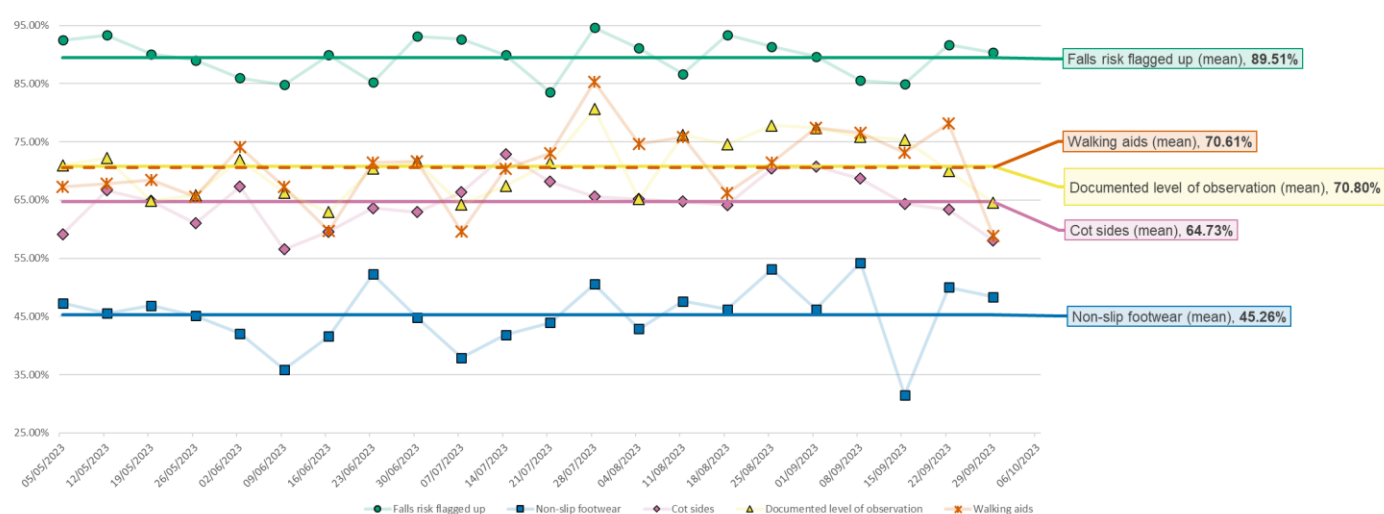
N= 2033 (Patients aged 75+, identified to be at risk of falls following a falls risk assessment, where a complete or partial plan to mitigate the risk of further falls was made)*

(*) For the Walking aids n = 1189 as records where it was indicated that walking aids were not applicable have been removed for this specific percentage calculation.

Exclusion

All patients that were not risk assessed for falls and, patients that were risk assessed for falls but were not identified as being at risk of falls were excluded from this analysis. Records where walking aids in reach were marked as not applicable have also been excluded from the percentage calculation for walking aids in reach but were used to calculate the percentage for other components.

Commentary

The chart above shows the breakdown of each component of the falls risk mitigation plan. The most featured component in each mitigation plan was the 'risk flagged up' component, which was on average included in 89.5% of all mitigation plans and was also the most featured component in every week data was collected. This contrasts with the 'non-slip footwear' component, which was on average included in 45.3% of mitigation plans and was also the least featured component in each week data was collected. Patients that may have had some falls mitigation elements in place but did not have a falls risk assessment are not included here.

Recommendations

- Staff should be trained on how to identify falls risk and how to instigate a falls mitigation pack.

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- Documentation of falls mitigations put into place (or reasons for deviation from this) should be recorded in all cases. This could be done with a proforma in either written notes or on the electronic patient record in order to ensure standardised documentation and all relevant data being captured.
- In any cases where a patient has fallen in the ED, the falls risk assessment, falls mitigation tasks and documentation of these should be reviewed, with areas for learning and improvement identified.

Standard 2c – Falls mitigation plan (breakdown)
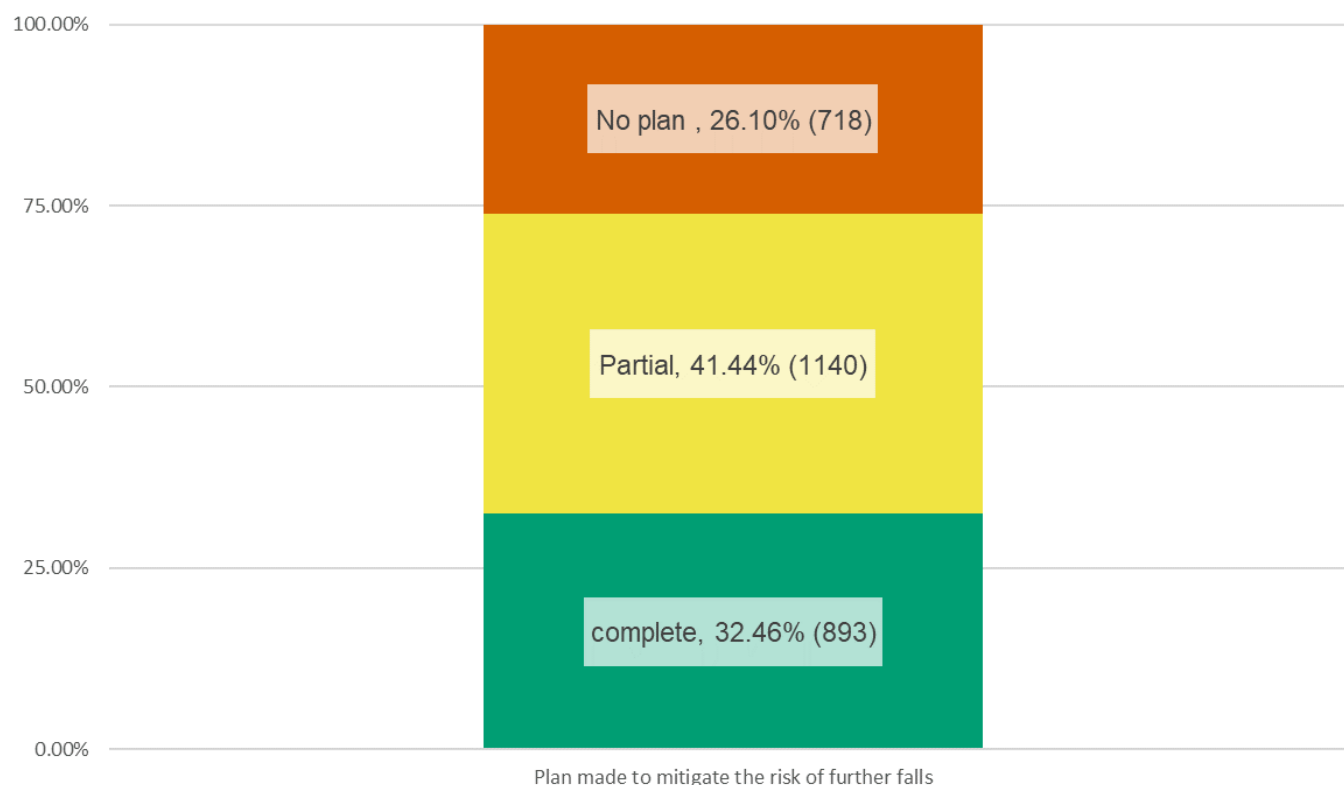
Plan made to mitigate the risk of further falls

N= 2751 (Patients aged 75+, identified to be at risk of falls following a falls risk assessment)

Exclusion

All patients that were not risk assessed for falls and, patients that were risk assessed for falls but were not identified as being at risk of falls were excluded from this analysis.

Commentary

The chart above shows the breakdown of the falls mitigation plans, as well as the percentage of records where a plan was not done for patients known to be at risk of falls following assessment.

When looking at the partial plans, the least featured component was 'non-slip footwear' which was included on 21.4% of all partial plans. 'Risk flagged up' was the most featured component on partial plans with 84.4% of partial plans including this component. On average, partial plans where walking aids were not applicable featured 2 out of 4 components; plans where walking aids were applicable on average featured 3 out of 5 components.

Recommendations

As above

Standard 2d – Comprehensive Geriatric Assessment

(For the time period: 1716 records conforming to standard; from a total of 4811 eligible.)

Comprehensive geriatric assessment
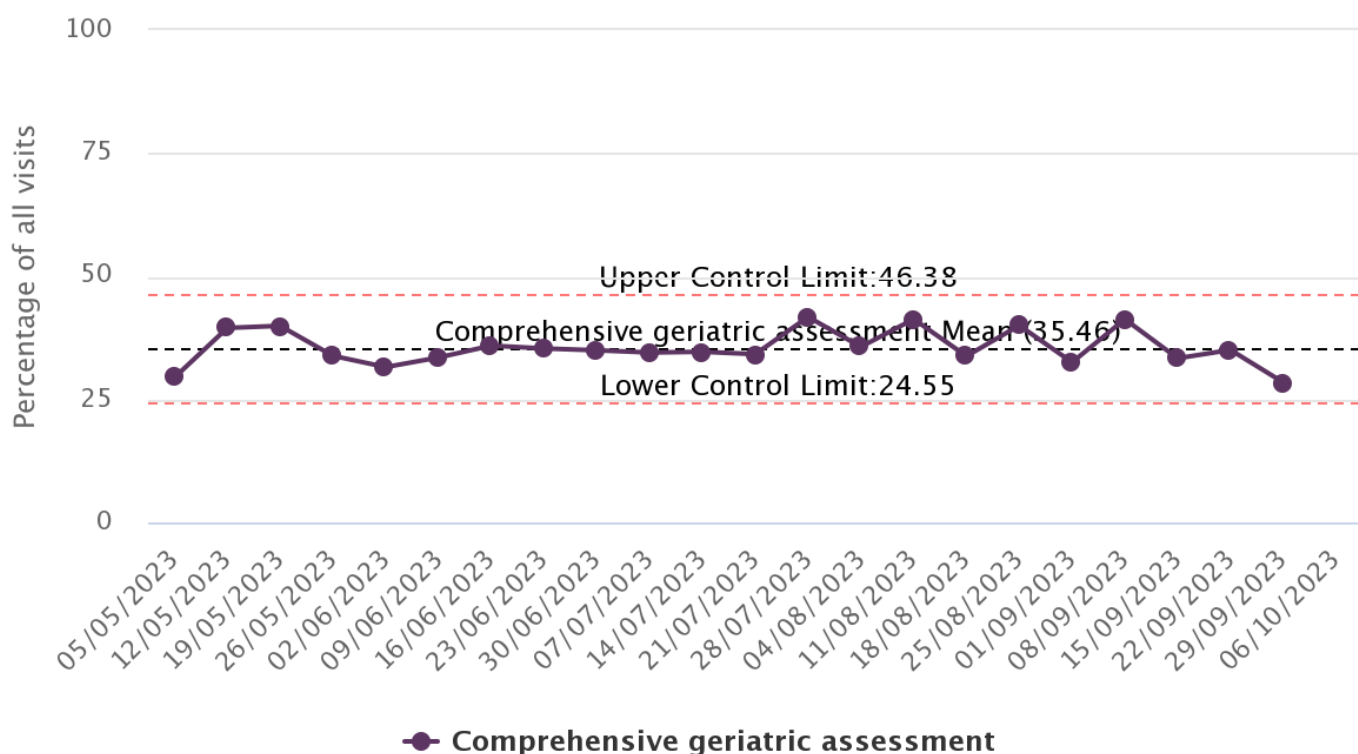
netsolving.com

N= 4811 (Patients 75+ years old, that have been screened for frailty)

Exclusion

All patients where a comprehensive geriatric assessment was not indicated have been excluded from this analysis.

Site Performance

Standard 2D: % of relevant Patients undergoing a Comprehensive Geriatric Assessment
Split by Site

Overall Performance by Site (Year 1)
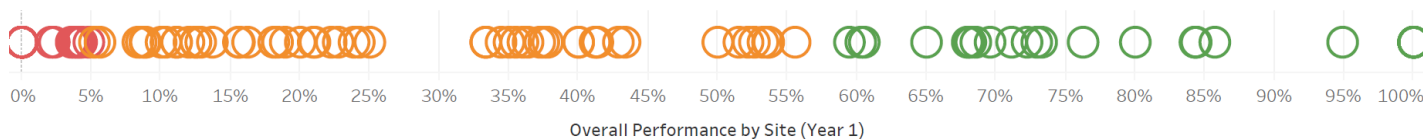
Standard 2D: 29 of the 121 sites did not record any patients conforming to this standard. This includes 10 sites that did not record any records at all for this standard.
Note IQR Calculations exclude the sites with no records recorded for this standard. (10 sites in this instance).

Lower Quartile Performance >5.0%   Interquartile Range: 5.1% - 57.5%   Upper Quartile Performance: >50%   (Median Performance 24.2%)

Commentary

The chart above shows the weekly average percentage of patients where a Comprehensive Geriatric Assessment (CGA) was initiated if indicated from their frailty score. Based on the results, on average, 35.5% of patients will have a CGA initiated if indicated from their frailty score. The control limits also show that the process is relatively stable but, unlikely to reach beyond 50% compliance unless there is a change in the system.

When considering the results above, it is important to keep in mind that the sample size is a direct result of the results shown in Standard 1c (Frailty Screening) as only patients that have been screened for frailty have been included in the analysis of the chart above.

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Recommendations

- Identify barriers to CGA initiation, such as resource constraints, staff training needs, or workflow inefficiencies
- Implement targeted interventions to streamlining processes for CGA initiation

Standard 2d – Comprehensive Geriatric Assessment (breakdown)
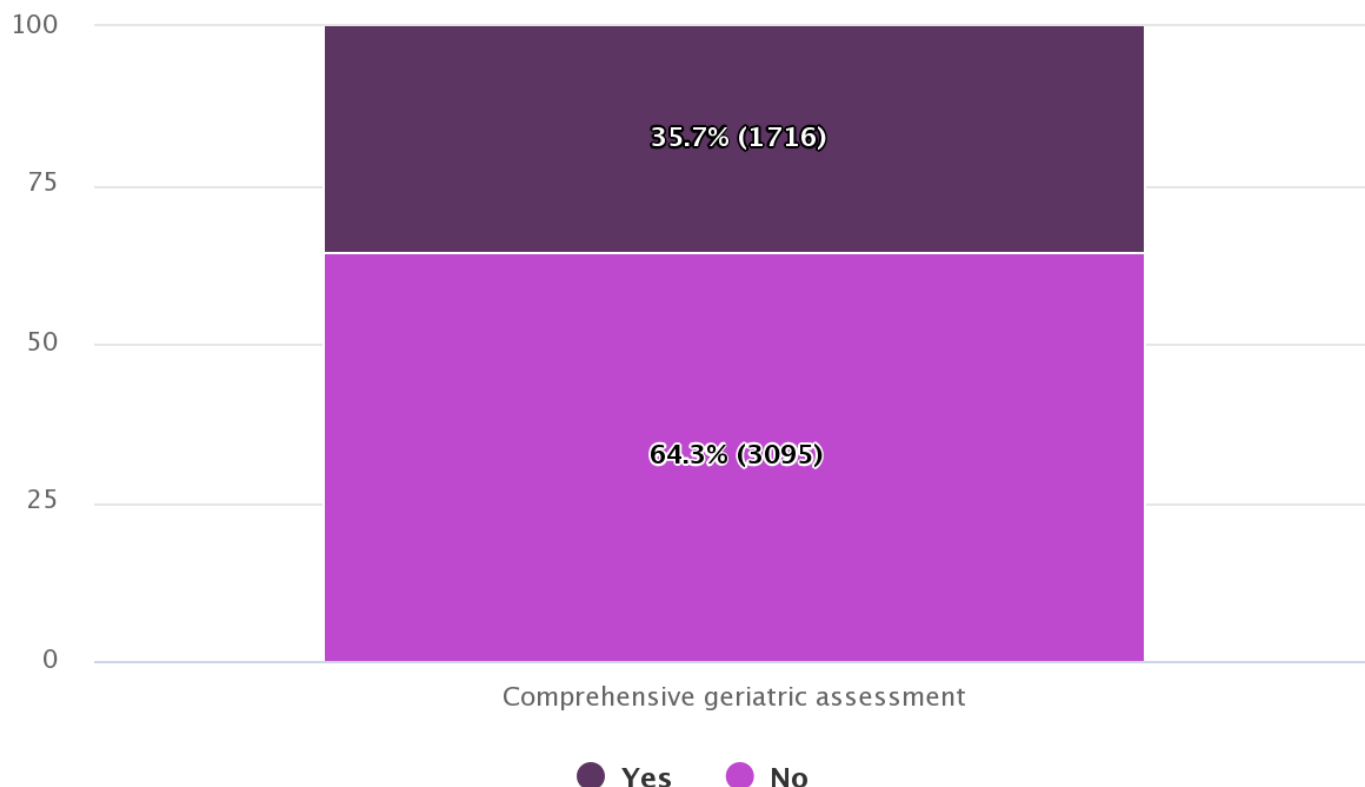
N= 4811 (Patients 75+ years old, that have been screened for frailty)

Exclusion

All patients where a comprehensive geriatric assessment was not indicated have been excluded from this analysis.

Commentary

The Chart above shows the total number CGAs initiated if indicated from the patients frailty score. This percentage represents a proportion of patients who received a CGA. When considering patients where a CGA was not initiated (64.3%), it is important to remember that only patients that have been screened for frailty and a CGA was indicated from the frailty score have been included on the chart above. This means that the screening and frailty score were not factors determining why a CGA was not initiated.

Recommendations

As above

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Standard 3

Standard 3 – Safety round documented

(For the time period: 1631 records conforming to standard; from a total of 5110 eligible)

[Understanding SPC Charts](#)

N= 5110 (Patients 75+ years old, with a length of stay in the ED of over 6 hours)

Site Performance

Standard 3: % of relevant Patients with a Safety Round Documented
Split by Site

Overall Performance by Site (Year 1)
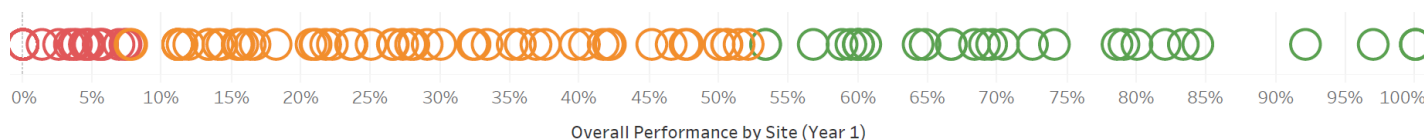
Standard 3: 19 of the 121 sites did not record any patients conforming to this standard. This includes 6 sites that did not record any records at all for this standard.

Lower Quartile Performance <=7.5%   Interquartile Range: 7.51% - 53.3%   Upper Quartile Performance: >53.3%   (Median Performance 26.6%)

Commentary

The chart above shows the average percentage of patients in each week that had an ED Length of Stay (ED LOS) for over six hours and had a complete safety round documented. As indicated by the sample size, 5110 patients stayed in the ED for over six hours and, on average 31.5% of those patients had a complete safety round documented during their stay. The upper control limit shows that the system is capable of achieving a higher compliance but, without a system change, performance is very unlikely to go beyond 50% compliance.

The denominator of 5110 represents 55.8% of the 9155 patients included, which means that more than half of older patients in the national QIP had a protracted ED length of stay, more than two hours longer than the national performance standard of four hours. This supports the rationale for including Standard 3.

However the relatively poor mean performance in this standards also highlights that basic care for patients spending extended periods in the ED needs more attention.

Recommendations

- All departments should have a policy in place to maintain ongoing care of patients who spend extended periods of time in the ED
- Consider alerts / reminders on the EPR to initiate safety rounds for patients once they have reached ED LOS of 6 hours

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Standard 3 – Safety round documented (components breakdown)

Observations documented (within 4hrs)
Offered food and drink (or reasons for NBM)
Regular medications charted
On a hospital bed
Pressure areas checked
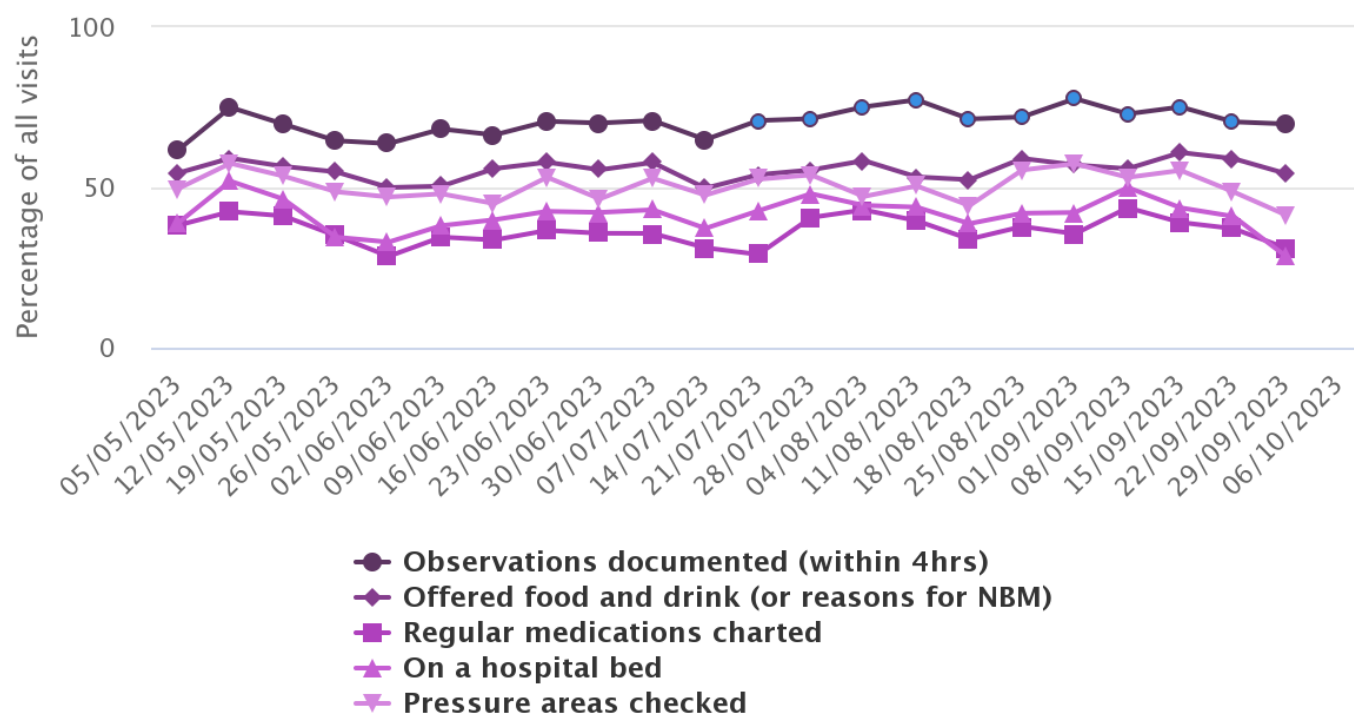
netsolving.com

N = 5110 (Patients 75+ years old, with a length of stay in the ED of over 6 hours)

Exclusion

Records where the patient length of stay was less than 6 hours have been excluded from this analysis

Commentary

The Chart above shows the breakdown of individual components of the documented complete and partial safety rounds and, for each week, the average percent of safety rounds that featured each component.

From the results above, 'observations documented within 4 hours' was the most common component on safety rounds for each week of data collected. That this component is less than 100% is of some concern, and also begs the question of the accuracy of data collection. The least common component was 'regular medications charted', where it was only surpassed by the 'on a hospital bed' component as the least featured component in safety rounds for only 1 out of 22 weeks of data collected.

Recommendations

- Implementation of checklist-style safety round care bundles which focus on patient comfort, basic nursing care and regular medications
- Involvement of nursing and ancillary staff to lead improvement initiatives in this area

Standard 3 – Safety round documented (breakdown)
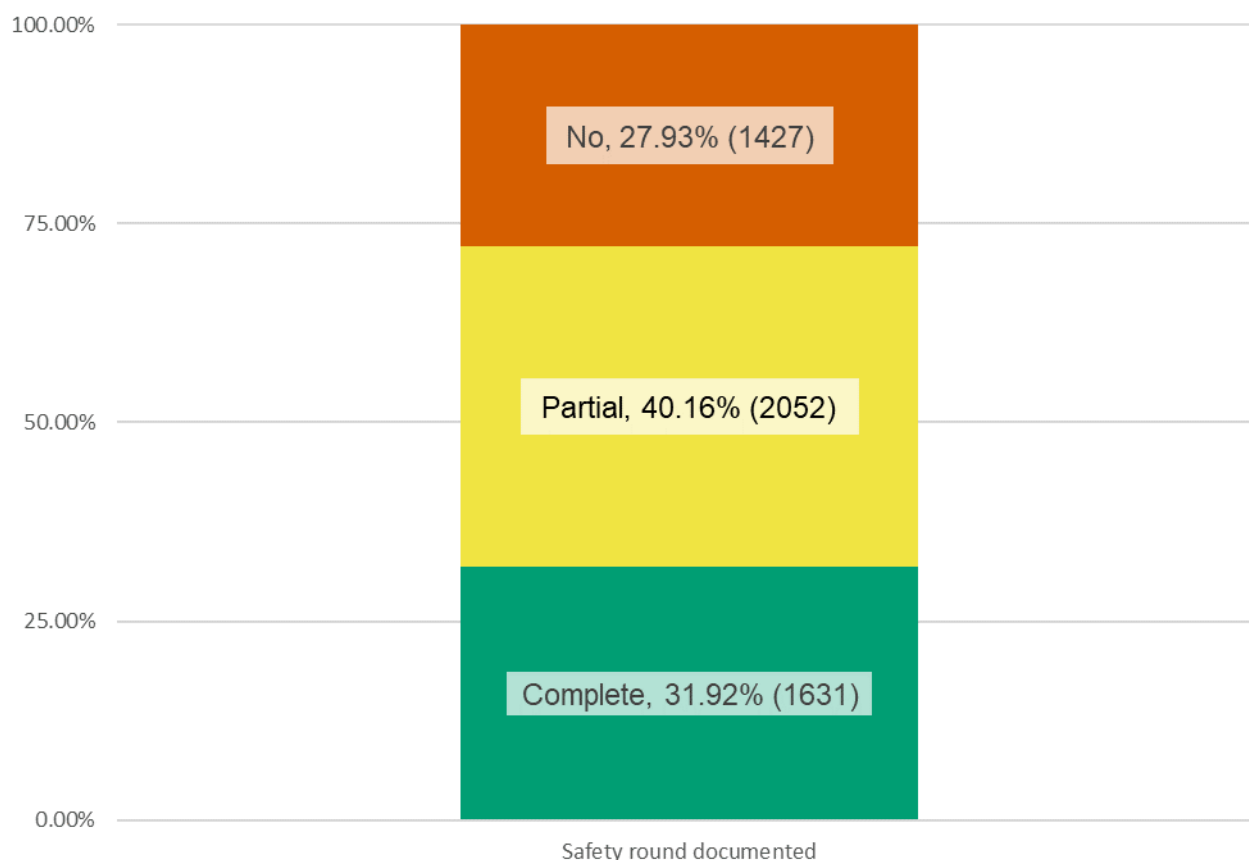
No, 27.93% (1427)

Partial, 40.16% (2052)

Complete, 31.92% (1631)

Safety round documented

N = 5110 (Patients 75+ years old, with a length of stay in the ED of over 6 hours)

Exclusion

Records where the patient length of stay was less than 6 hours have been excluded from this analysis.
Records where no discharge time provided were excluded from this analysis.
Records where no answer was provided regarding the details of the safety round were also excluded.

Commentary

The Chart above shows the total number of complete and partial safety rounds, as well as the number of records where no safety round was documented. Partial safety rounds was the most common with 40.2% of records of patients with a length of stay over six hours containing a partial safety round documented.

When looking at the partial safety rounds, the most common component featured was 'Observations documented' with 97.2% of partial safety rounds featuring this component. The least common component was 'medications chartered' with only a quarter of partial safety rounds featuring this component. When looking at the number of components per partial safety round, on average, partial safety rounds will have 3 out of 5 components.

Recommendation

- As above

Organisational Audit Results

Screening section

Commentary

Frailty, Falls and Pressure areas & Incontinence screening perform best, with systems in place in over 90% of departments. This contrasts with polypharmacy where only 20% of Departments have systems or processes in place to facilitate this screening. Polypharmacy screening is often undertaken by pharmacists, which may explain this

When considering delirium screening, 98% of departments that have a system in place use 4AT, CAM, DSM-V, or other screening tool as recommended by NICE.

Systems or processes in place to facilitate screening
n = 50

Category	No	Yes
Social Support	42% (21)	58% (29)
Functional status/Mobility	18% (9)	82% (41)
Pressure areas & Incontinence	4% (2)	96% (48)
Polypharmacy	80% (40)	20% (10)
Elder abuse	40% (20)	60% (30)
Falls	8% (4)	92% (46)
Cognitive impairment	30% (35)	70% (15)
Delirium	18% (9)	82% (41)
Frailty	4% (2)	96% (48)
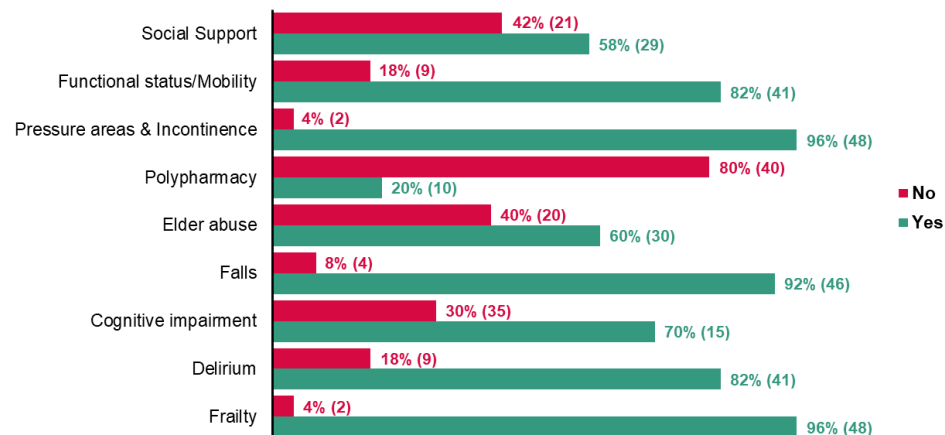
Screening section - scores per ED
(Maximum score = 10) n = 50
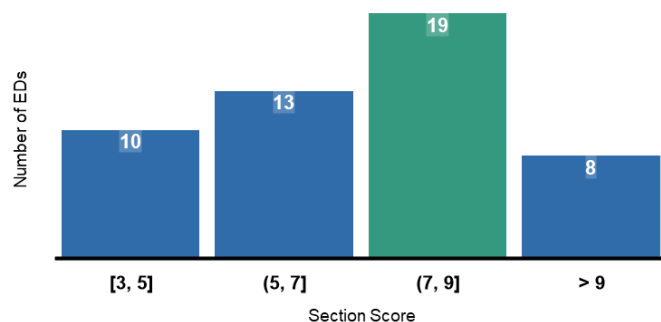
Number of EDs by Section Score:
- [3, 5]: 10
- (5, 7]: 13
- (7, 9]: 19
- > 9: 8

Systems or processess in place to facilitate screeng of Delirium

No, 18% (9)
Yes, 82% (41)

One of the following tools used: 4AT, CAM, DSM-V, other as recommended by NICE (MCQ)

No, 2% (1)
Yes, 98% (40)
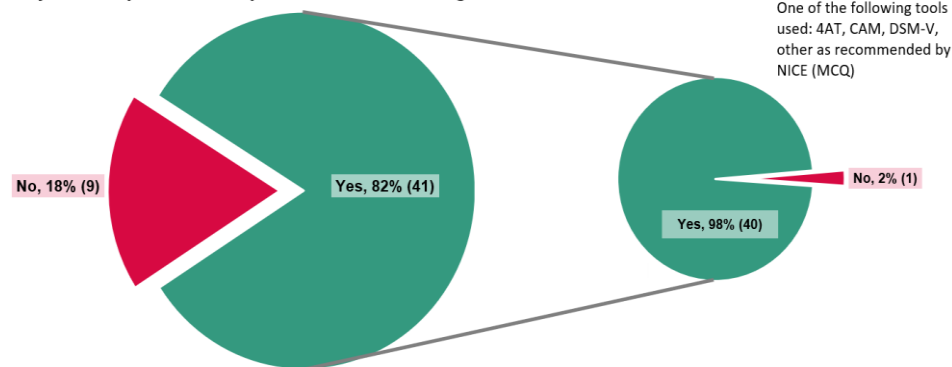
ED discharge summary section

Commentary

The results of this section reveal shortcomings in the provision and quality of discharge summaries. Results indicate that there are more departments with no system in place to provide ED discharge summaries (56%). In addition, nearly ¾ of Departments (74%) also reported not having regular quality assurance audits of discharge summaries.

ED discharge summaries
n = 50

Regular quality assurance audits of discharge summaries: 74% (37) No, 26% (13) Yes

System in place to provide paper copy of discharge letter to patient: 10% (5) No, 90% (45) Yes

System in place to provide ED discharge summaries: 56% (28) No, 44% (22) Yes

■ No
■ Yes

ED discharge summary section - scores per ED
(Maximum score = 3) n = 50

Number of EDs

- Score 0: 3
- Score 1: 21
- Score 2: 19
- Score 3: 7

Section Score
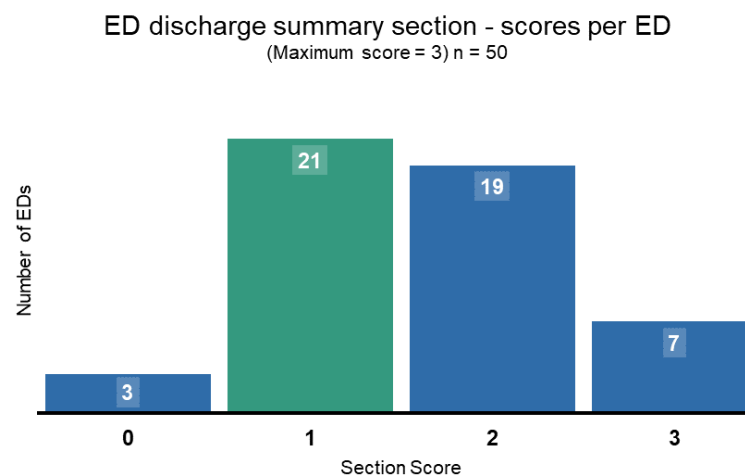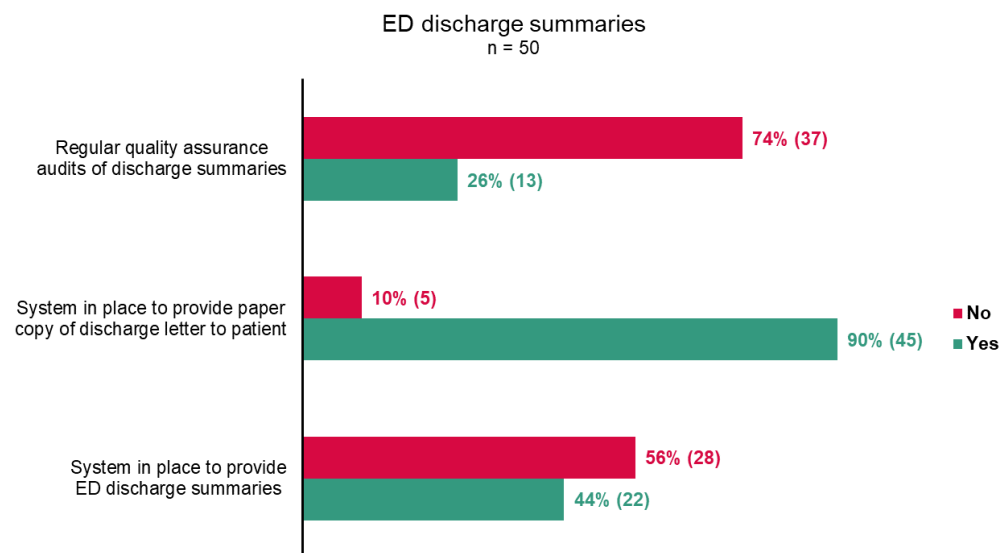
Physical resources section

Commentary

When looking at the results of the physical resources section, more than ¾ of departments report that the needs of older patients have not been taken into consideration in their overall design and layout. Data further reveals that out of these departments, 84% do not have a specific area dedicated to frail older patients. The same appears to be true for patients with cognitive impairment, with only 16% of departments reporting having an area dedicated to this patient group.

ED Physical Resources
n = 50
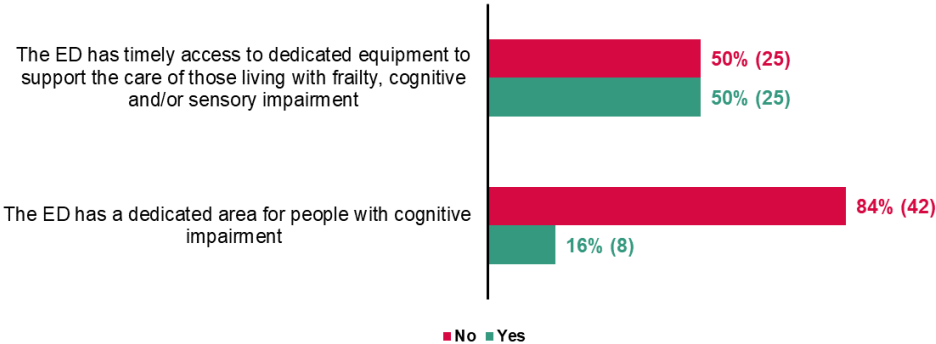
The ED has timely access to dedicated equipment to support the care of those living with frailty, cognitive and/or sensory impairment
- 50% (25) No
- 50% (25) Yes

The ED has a dedicated area for people with cognitive impairment
- 84% (42) No
- 16% (8) Yes

■ No ■ Yes

Physical Resources section - scores per ED
(Maximum score = 3) n = 50

Number of EDs

Section Score	Number of EDs
0	16
1	23
2	5
3	6
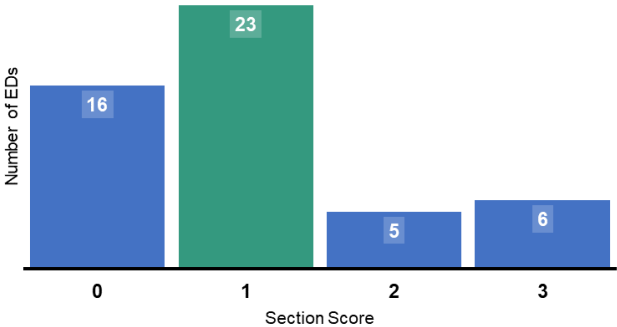
Needs of frail older patients reflected in the design and layout of the department

Yes, 24% (12)
No, 76% (38)

If not reflected, there is a dedicated area

Yes, 16% (6)
No, 84% (32)
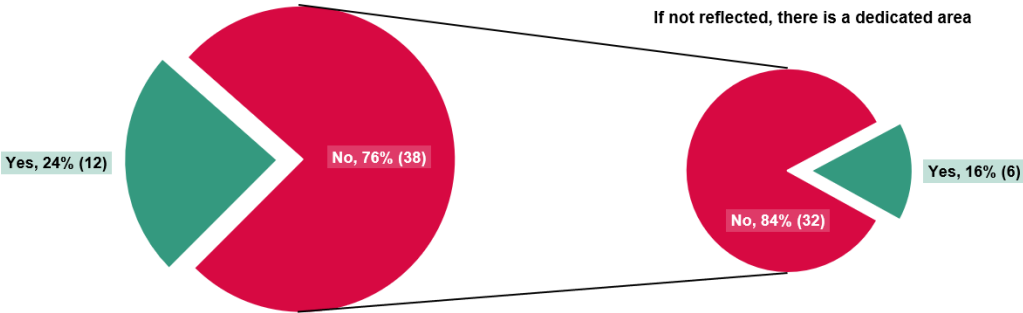
Additional services section

Geriatrician

Geriatrician
n = 50

No, 14% (7)   Yes, 86% (43)

Geriatrician
Service availability
n = 43

- Every day (7 days): 35% (15)
- Mon-Fri: 56% (24)
- Some days: 9% (4)

In hours 8am-5pm

- Every day (7 days): 2% (1)
- Mon-Fri: 2% (1)
- Some days: 95% (41)

Out of hours (5pm-8am & weekends)

Number of EDs

Community admission Avoidance Service

Community Admission Avoidance Service
n = 50

No, 38% (19)   Yes, 62% (31)

Community Admission Avoidance Service Availability
n = 31

- Every day (7 days): 48% (15)
- Mon-Fri: 45% (14)
- Some days: 6% (2)

In hours 8am-5pm

- Every day (7 days): 13% (4)
- Mon-Fri: 6% (2)
- Some days: 81% (25)

Out of hours (5pm-8am & weekends)

Number of EDs

Third Sector Support Service

Third Sector Support Service
n = 50

No, 72% (36)

Yes, 28% (14)

Third Sector Support Service Availability
n = 14

Number of EDs

In hours 8am-5pm
- Every day (7 days): 21% (3)
- Mon-Fri: 50% (7)
- Some days: 29% (4)

Out of hours (5pm-8am & weekends)
- Every day (7 days): 7% (1)
- Mon-Fri: 7% (1)
- Some days: 86% (12)
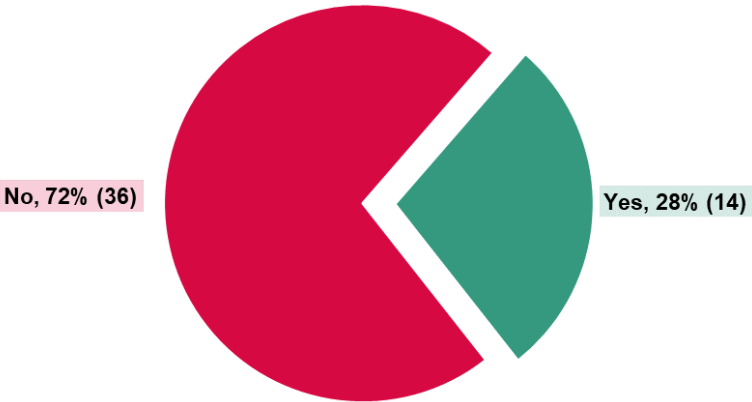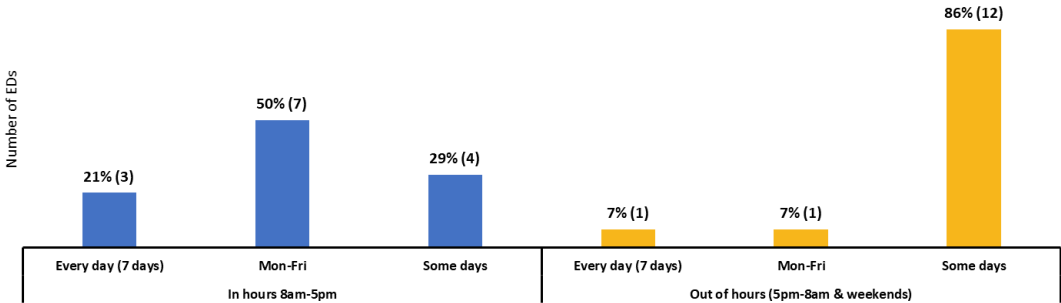
Palliative Care Service

Access to Palliative Care Service
n = 50

No, 16% (8)

Yes, 84% (42)
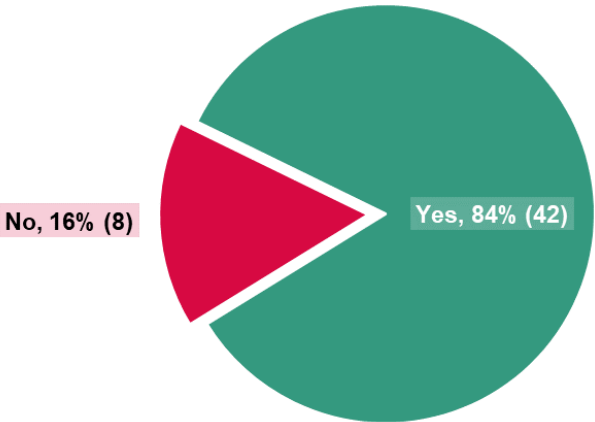
Palliative Care Service Availability
n = 42

Number of EDs

In hours 8am-5pm
- Every day (7 days): 57% (24)
- Mon-Fri: 40% (17)
- Some days: 2% (1)

Out of hours (5pm-8am & weekends)
- Every day (7 days): 24% (10)
- Mon-Fri: 2% (1)
- Some days: 74% (31)
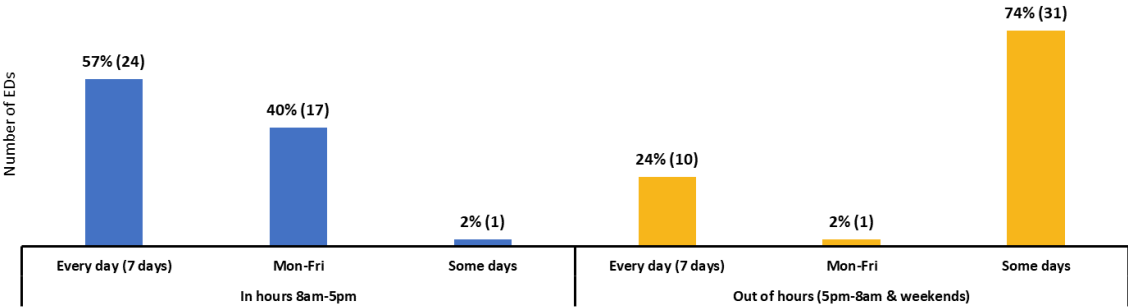
Pharmacy Service

Access to Pharmacist
n = 50

No, 22% (11)

Yes, 78% (39)
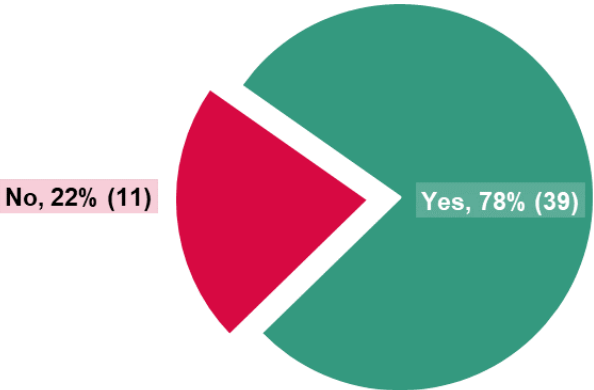
Pharmacist Availability
n = 39

Number of EDs

- 72% (28) — Every day (7 days)
- 26% (10) — Mon-Fri
- 3% (1) — Some days

In hours 8am-5pm

- 67% (26) — Every day (7 days)
- 3% (1) — Mon-Fri
- 31% (12) — Some days

Out of hours (5pm-8am & weekends)
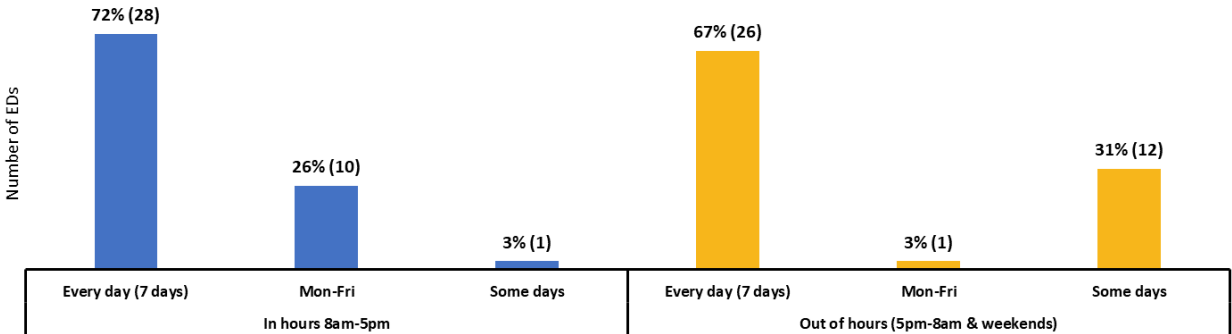
Pastoral/Religious Support Service

Access to Pastoral / religious support service
n = 50

No, 6% (3)

Yes, 94% (47)

Pastoral / religious support service availability
n = 47

Number of EDs

- 83% (39) — Every day (7 days)
- 15% (7) — Mon-Fri
- 2% (1) — Some days

In hours 8am-5pm

- 70% (33) — Every day (7 days)
- 0% (0) — Mon-Fri
- 30% (14) — Some days

Out of hours (5pm-8am & weekends)

Meal provision service

Meal provision service
n = 50

No, 2% (1) Yes, 98% (49)

Meal provision service availability
n = 49

Number of EDs

In hours 8am-5pm
- Every day (7 days): 98% (48)
- Mon-Fri: 0% (0)
- Some days: 2% (1)

Out of hours (5pm-8am & weekends)
- Every day (7 days): 84% (41)
- Mon-Fri: 0% (0)
- Some days: 16% (8)
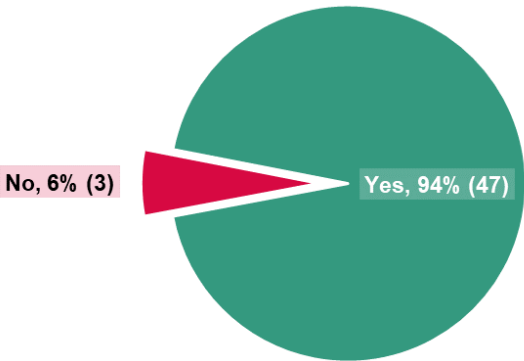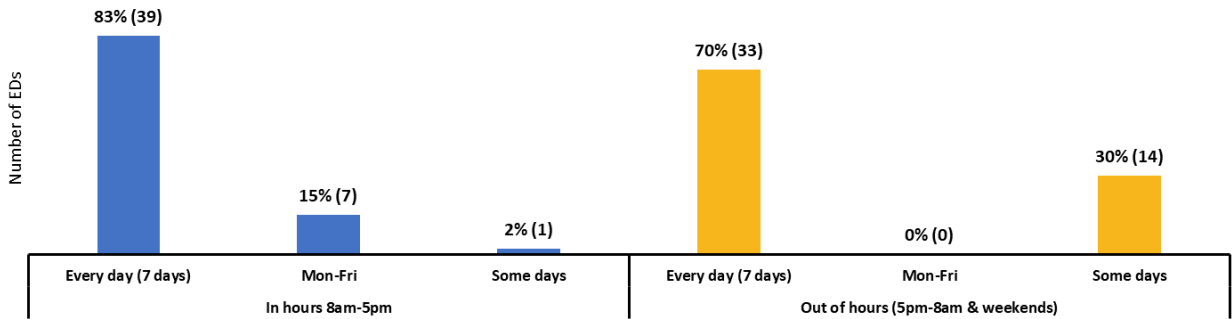
Acute Frailty service

Acute Frailty Service
n = 50

Physically in ED, **32%** (16)
No Service, **6%** (3)
Remote advice, **2%** (1)
Available to come to ED, **60%** (30)

Acute Frailty Service Availability
n = 47

In hours 8am-5pm
- Every day (7 days): 17 (36%)
- Mon-Fri: 29 (62%)
- Some days: 1 (2%)

Out of hours (5pm-8am & weekends)
- Every day (7 days): 2 (4%)
- Mon-Fri: 0 (0%)
- Some days: 45 (96%)

Therapy Service

Therapy Service
n = 50

- Physically in ED, **40%** (20)
- No Service, **4%** (2)
- Remote advice, **2%** (1)
- Available to come to ED, **54%** (27)

Therapy Service Availability
n = 48

	In hours 8am-5pm			Out of hours (5pm-8am & weekends)		
	Every day (7 days)	Mon-Fri	Some days	Every day (7 days)	Mon-Fri	Some days
	39 (81%)	9 (19%)	0 (0%)	6 (13%)	1 (2%)	41 (85%)

Older Adults Mental Health Service

Older Adults Mental Health Service
n = 50

- Physically in ED, **8%** (4)
- No Service, **28%** (14)
- Remote advice, **4%** (2)
- Available to come to ED, **60%** (30)

Older Adults Mental Health Service Availability
n = 36

	In hours 8am-5pm			Out of hours (5pm-8am & weekends)		
	Every day (7 days)	Mon-Fri	Some days	Every day (7 days)	Mon-Fri	Some days
	23 (64%)	12 (33%)	1 (3%)	20 (56%)	0 (0%)	16 (44%)
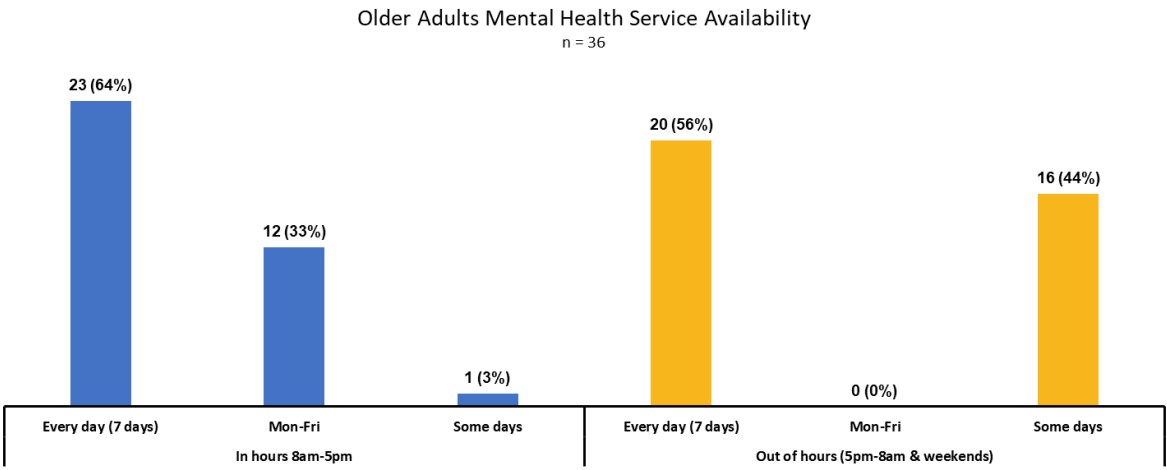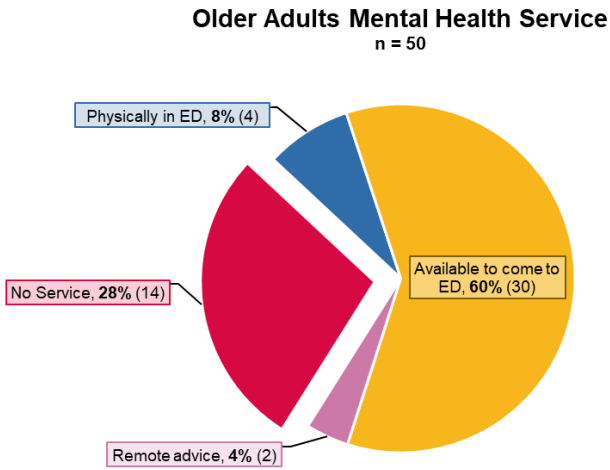
<u>Additional Services Section Scores:</u>

Additional services section - Scores per ED
(Maximum score = 8) n = 50
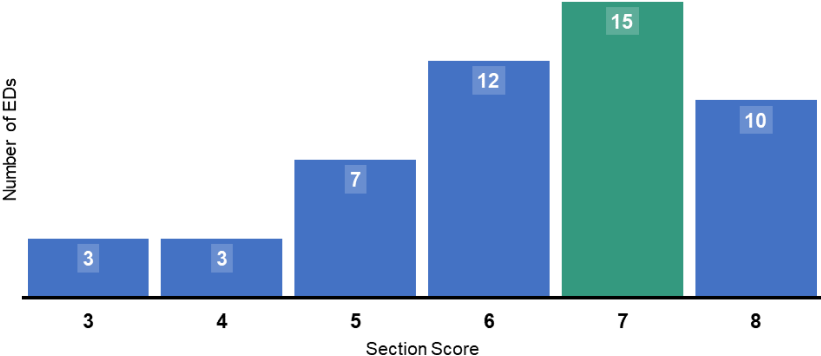
Commentary

When considering the results of the additional services section score, 74% of departments have achieved a score of 6 or more out of 8 in this section. For all services, nearly all of them are available in most EDs. The only service that is lacking in the majority of departments is Third Sector Support Services, with 72% of departments reporting not having this service available. When looking at services that might be provided on/off-site, the majority of those services have been reported to be available to come to the department. The most common on-site service out of those services was Therapy Service with 40% of EDs reporting having this service physically in the ED.

Advance Care section

Advance Care Planning
n = 50

The department has timely access to services or pathways that can support the discharge of people at end of life to their preferred place of death
18 (36%)
32 (64%)

ED staff trained to ask patients routinely about their wishes regarding resuscitation decisions and end of life care
8 (16%)
42 (84%)

The department has timely access to previously completed Advance Care Plans
13 (26%)
37 (74%)

■ No
■ Yes

Advance Care Planning Section - Scores per ED
Maximum score = 3

Number of EDs

Section Score	
0	1
1	11
2	14
3	24
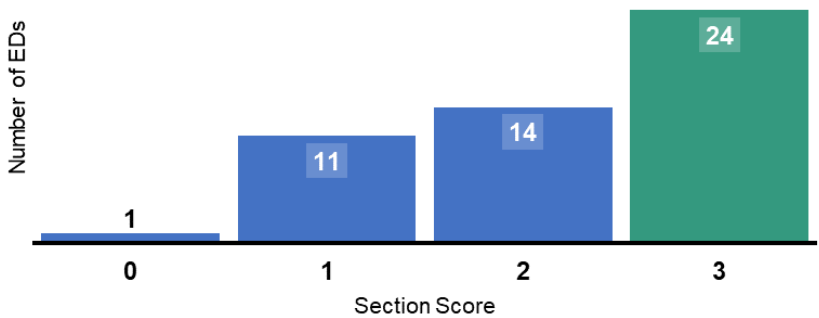
Commentary

The scores for this section show that 48% of departments achieved the highest score and, more than half of the departments that did not achieve the highest score achieved the second-best score. This indicates that most departments are fully compliant and those that are not, are very close to achieving full compliance.

Patient Experience section

There is a framework in place whereby feedback from patients and users is sought, analysed and acted-upon in a systematic way. There is a way of seeking feedback specifically about care of older people.

n = 50

Yes, 68% (34)	No, 32% (16)

Commentary

The results above show that about 2/3 of departments have a framework in place to gather, analyse and act on feedback from patients, with the capability of seeking feedback specifically about care of older people. This aligns with long-established nationwide practice of asking routinely for feedback from NHS patients eg., the Friends & Family Test.

Organisational Data – Total Scores

Organisational Audit - Total Scores
(Maximum Score = 28) n = 50

Organisational Audit Scores
(Maximum Score = 28)
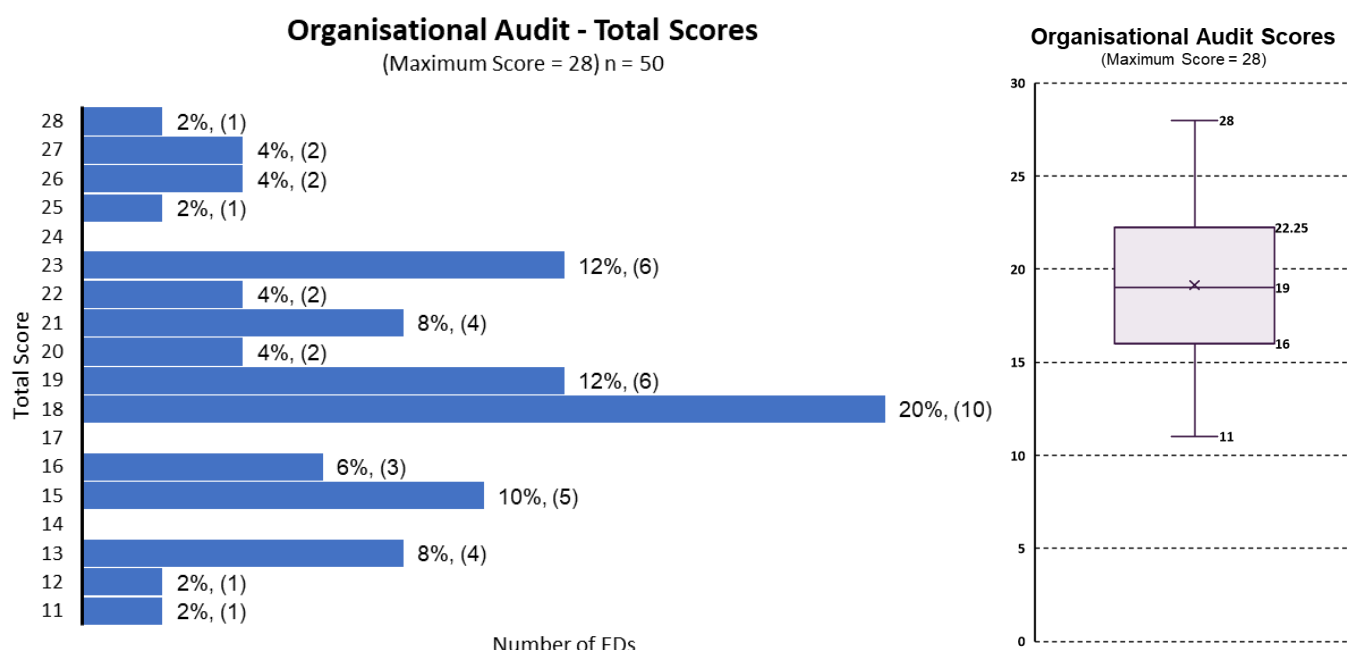
Commentary

When looking at the overall scores for the Organisational Audit, the mean score was 19 out of 28 (68%). The third quartile also shows that 75% of departments have scored a maximum of 22 points out of 28 (79%). When looking at the first quartile, 25% of departments scored a maximum of 16 out of 28 points (57%). When considering the distribution of scores, the majority of departments have achieved more than 50% compliance on the organisational element of this QIP. This is a sound basis for further improvements to be made in Years 2 and 3. It should be noted that only 50 departments have done the organisational scorecard so far.

Organisational Audit Recommendations

- All participating EDs should perform an organisational scorecard 2-3 times a year to review performance and make targeted plans for improvement
- Pharmacists should be engaged in ED to screen for polypharmacy and support prescribing for older people
- Concise discharge summaries should be available to give to patients in ED
- There should be regular audit of the quality of discharge summary information
- As an ever-growing proportion of NHS patients, the needs of older people should be a core consideration in the design and refurbishment plans of Emergency Departments
- As a bare minimum, there should be dedicated areas or cubicles designed to address the specific needs of patients with cognitive impairment
- Key priorities for the provision of additional services include: third sector support in-hospital or in the community, and acute frailty and therapy services embedded in the ED. Future commissioning should focus on introducing these services to improve the patients journey for older people in ED.

Further Information

Thank you for taking part in this QIP. We hope that you find the process of participating and results helpful.

If you have any queries about the report, please e-mail RCEMQIP@rcem.ac.uk

Details of the RCEM QIP Programme can be found on Quality Improvement page of the RCEM website

Give Your Feedback

We would like to know your views about this report and participating in this QIP. Please email RCEMQIP@rcem.ac.uk

We will use your comments to help us improve our future topics and reports.

Useful Resources

- Guidance on understanding SPC charts
- RCEM Quality Improvement Guide – guidance on PDSA cycles and other quality improvement methods
- RCEM Quality Improvement Guide
- Quality Improvement Zone – TURAS, NHS Education for Scotland
- Quality Improvement Essentials Toolkit

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Excellence in Emergency Care

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Appendices

Appendix 1: Glossary of terms and abbreviations

Term	Definition
CGA	Comprehensive Geriatric Assessment. A multi-disciplinary process evaluating the overall physical, mental and functional health of an older or frail person. The BGS defines 'initiating a CGA' as: assessing current functional ability, assessing for baseline functional ability (2 weeks ago), cognitive assessment, social circumstances assessment and medication review.
Cognitive impairment	Difficulty with cognitive functions such as memory, thinking, attention and reasoning not related to an acute illness or disorder.
Delirium	An acute alteration in one or more of consciousness, cognitive function and attention related to an organic cause. Also known as 'acute confusional state'. There may be more than one cause for delirium present.
Delirium Screening Test	All patients 75 years and older should be assessed for delirium using a validated tool, such as 4AT, CAM or the DSM-V criteria.
Delirium Management Plan	Also known as a delirium care bundle. This should assess for the underlying cause of delirium, aim to manage the symptoms and reduce risk to the patient. Environment and de-escalation should be considered. Further details on assessment and management of delirium can be found in NICE guidelines and the Silver Book 2. **The plan should include as a minimum:** • A thorough history • Complete top-to-toe examination assessing for infection • Dehydration • Pain and neurological abnormalities • Assessment for constipation and urinary retention • Blood tests • ECGs and other tests such as X-rays where clinically indicated. The patient may also need a plan for sedation in line with the NICE guidelines.
Falls risk assessment	To establish whether a person is at risk of falling. This should be performed at initial assessment to determine whether a person may be at risk of falling in the department or on discharge. Patients that should be considered at risk of falls include those presenting with a fall, those with a fall in the last 3 months, a diagnosis of dementia, acute delirium, known or self-reported problems with balance, mobility or gait and alcohol or drug use.

Falls mitigation	In a person assessed to be at risk, steps taken to reduce the likelihood of falling whilst in the ED. **This should include, as a minimum**: • Communicating with other staff that falls risk has been identified (including a flag on electronic notes, a falls wristband or a sign on the bedspace). • Non-slip socks. • Trolley sides/ cot sides up whilst in ED (in line with local policy). • Walking aids nearby if applicable and the patient placed in an area where they can be appropriately observed.
Frailty	A state related to, but separate from, the ageing process, where physiological reserves of multiple body systems are lost. Frailty renders a person vulnerable to dependency on others following insults such as infection and trauma, that would not have the same impact on a person without frailty.
Frail	A patient with a Clinical Frailty Scale score of 5 or above (taken as the level of function at 2 weeks prior to assessment). Other methods of assessing frailty exist, especially in other clinical settings, but the CFS is recommended for routine use in the ED.
NEWS2	Version 2 of the National Early Warning Score in widespread use throughout the NHS, using clinical observations to identify deterioration of a patient's clinical state.
Older people	For the purpose of this QI project this will be defined as people of 75 years and older.
Post-fall assessment	An assessment to establish the reason that a person may have fallen or is at risk of falling in order to prevent further falls. **This should include, as a minimum**: • Blood tests (including FBC, renal profile/ electrolytes, calcium level. Others may be clinically indicated). • ECG. • Postural blood pressure.
Type 1 ED	Provides a 24-hour, consultant led service with full resuscitation facilities.
Safety Round	This may have various names in different trusts, but refers to basic care for patients that have a prolonged stay in ED. This may not be a formal entity in your organisation, but there should at least some documentation that older patients' basic care needs are being met. It should be documented if the patient has been in ED more than six hours, although may be actioned sooner. **This should include, as a minimum**: • Recent observations documented. • Food and drink offered (or reasons for being NBM). • Regular medications charted. • Transfer onto a hospital bed.

	• Documentation that pressure areas have been assessed. It may also include documentation regarding whether help is needed with toileting.
Silver Book II	Publication from a range of experts on Quality Urgent Care in Older People in collaboration with colleges including RCEM and RCP hosted by The British Geriatric Society.

Appendix 2: National Breakdown of Participation

Nationally, **9155** cases from **118** EDs were included in this QIP.

Click here to see a map of all the participating EDs.

Country	Number of relevant EDs	Number of cases *
National total	118	9155
England	109	8687
Scotland	3	172
Wales	5	276
Northern Ireland	1	20
Isle of Man / Channel Islands	0	0
* analysis includes complete cases only		

Appendix 3: EDI Monitoring

Equality, Diversity and Inclusion statement: We have integrated ethnicity data monitoring into our platform to form the start of a data set containing thousands of cases which can then be analysed to detect differences in care quality along sex, race and age lines. We have representation from the EDI committee at our programme development meetings and attend theirs to update this body of work.

Without accurate data, establishing care disparities is more challenging, hampering efforts to target resources and find solutions in priority areas. We have nested these questions to establish the interhospital variability of ethnicity data recording and better understand the barriers to this data set. This exercise will take 15-20 minutes but provides a significant insight into this issue. Please encourage your team locally to input this data and show them how to find it to improve the collection process.

This data is only going to be used nationally however we do encourage local systems to better capture this data so insights and research can be undertaken in this important space.

Standard 1a

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	30	20.00%	80.00%
Any other Asian background	103	16.50%	83.50%
Any other Black background	32	12.50%	87.50%
Any other ethnic group	123	13.01%	86.99%
Any other mixed background	47	8.51%	91.49%
Any other White background	320	16.56%	83.44%
Bangladeshi	36	16.67%	83.33%
Caribbean	83	19.28%	80.72%
Chinese	10	10.00%	90.00%
Indian	161	16.77%	83.23%
Not known e.g. unconscious	143	18.18%	81.82%
Not stated e.g. unwilling to state	1151	10.51%	89.49%
Pakistani	69	11.59%	88.41%
White and Asian	9	11.11%	88.89%
White and Black African	15	6.67%	93.33%
White and Black Caribbean	53	16.98%	83.02%

White British	6625	15.53%	84.47%
White Irish	141	13.48%	86.52%

Standard 1b

Descriptor (Fundamental)

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	30	36.67%	63.33%
Any other Asian background	103	42.72%	57.28%
Any other Black background	32	25.00%	75.00%
Any other ethnic group	123	40.65%	59.35%
Any other mixed background	47	42.55%	57.45%
Any other White background	320	42.19%	57.81%
Bangladeshi	36	25.00%	75.00%
Caribbean	83	33.73%	66.27%
Chinese	10	20.00%	80.00%
Indian	161	32.30%	67.70%
Not known e.g. unconscious	143	35.66%	64.34%
Not stated e.g. unwilling to state	1151	45.26%	54.74%
Pakistani	69	50.72%	49.28%
White and Asian	9	22.22%	77.78%
White and Black African	15	26.67%	73.33%
White and Black Caribbean	53	56.60%	43.40%
White British	6625	43.82%	56.18%
White Irish	141	54.61%	45.39%

Standard 1c

Descriptor (Fundamental)

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	30	73.33%	26.67%
Any other Asian background	103	62.14%	37.86%
Any other Black background	32	59.38%	40.63%
Any other ethnic group	123	60.98%	39.02%
Any other mixed background	47	55.32%	44.68%
Any other White background	320	57.19%	42.81%
Bangladeshi	36	41.67%	58.33%
Caribbean	83	73.49%	26.51%
Chinese	10	70.00%	30.00%
Indian	161	73.29%	26.71%
Not known e.g. unconscious	143	51.05%	48.95%
Not stated e.g. unwilling to state	1151	42.05%	57.95%
Pakistani	69	60.87%	39.13%
White and Asian	9	55.56%	44.44%
White and Black African	15	53.33%	46.67%
White and Black Caribbean	53	77.36%	22.64%
White British	6625	52.80%	47.20%
White Irish	141	49.65%	50.35%

Standard 2a

Descriptor (Fundamental)

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	1	0.00%	100.00%
Any other Asian background	2	0.00%	100.00%
Any other Black background	0	--	--
Any other ethnic group	4	0.00%	100.00%
Any other mixed background	2	0.00%	100.00%
Any other White background	14	35.71%	64.29%
Bangladeshi	3	66.67%	33.33%
Caribbean	5	40.00%	60.00%
Chinese	0	--	--
Indian	5	40.00%	60.00%
Not known e.g. unconscious	10	20.00%	80.00%
Not stated e.g. unwilling to state	64	39.06%	60.94%
Pakistani	4	25.00%	75.00%
White and Asian	0	--	--
White and Black African	1	100.00%	0.00%
White and Black Caribbean	3	33.33%	66.67%
White British	341	24.93%	75.07%
White Irish	9	44.44%	55.56%

Standard 2b

Descriptor (Fundamental)

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	7	57.14%	42.86%
Any other Asian background	23	47.83%	52.17%
Any other Black background	7	42.86%	57.14%
Any other ethnic group	31	41.94%	58.06%
Any other mixed background	10	30.00%	70.00%
Any other White background	91	43.96%	56.04%
Bangladeshi	6	50.00%	50.00%
Caribbean	13	38.46%	61.54%
Chinese	5	20.00%	80.00%
Indian	33	33.33%	66.67%
Not known e.g. unconscious	50	26.00%	74.00%
Not stated e.g. unwilling to state	365	41.92%	58.08%
Pakistani	13	38.46%	61.54%
White and Asian	3	33.33%	66.67%
White and Black African	2	50.00%	50.00%
White and Black Caribbean	10	50.00%	50.00%
White British	2167	36.18%	63.82%
White Irish	48	39.58%	60.42%

Standard 2c

Descriptor (Fundamental)

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	9	44.44%	55.56%
Any other Asian background	23	47.83%	52.17%
Any other Black background	5	20.00%	80.00%
Any other ethnic group	32	40.63%	59.38%
Any other mixed background	10	30.00%	70.00%
Any other White background	86	33.72%	66.28%
Bangladeshi	7	57.14%	42.86%
Caribbean	18	33.33%	66.67%
Chinese	2	0.00%	100.00%
Indian	35	57.14%	42.86%
Not known e.g. unconscious	38	13.16%	86.84%
Not stated e.g. unwilling to state	332	34.34%	65.66%
Pakistani	25	44.00%	56.00%
White and Asian	2	50.00%	50.00%
White and Black African	3	66.67%	33.33%
White and Black Caribbean	21	33.33%	66.67%
White British	2059	31.57%	68.43%
White Irish	45	28.89%	71.11%

Standard 2d

Descriptor (Fundamental)

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	22	31.82%	68.18%
Any other Asian background	64	42.19%	57.81%
Any other Black background	19	31.58%	68.42%
Any other ethnic group	75	32.00%	68.00%
Any other mixed background	26	57.69%	42.31%
Any other White background	183	42.62%	57.38%
Bangladeshi	15	46.67%	53.33%
Caribbean	61	29.51%	70.49%
Chinese	7	42.86%	57.14%
Indian	118	32.20%	67.80%
Not known e.g. unconscious	73	21.92%	78.08%
Not stated e.g. unwilling to state	484	34.09%	65.91%
Pakistani	42	14.29%	85.71%
White and Asian	5	20.00%	80.00%
White and Black African	8	25.00%	75.00%
White and Black Caribbean	41	21.95%	78.05%
White British	3498	36.36%	63.64%
White Irish	70	31.43%	68.57%

Standard 3

Descriptor (Fundamental)

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	19	0.00%	100.00%
Any other Asian background	57	35.09%	64.91%
Any other Black background	13	7.69%	92.31%
Any other ethnic group	62	19.35%	80.65%
Any other mixed background	28	28.57%	71.43%
Any other White background	183	37.70%	62.30%
Bangladeshi	25	24.00%	76.00%
Caribbean	46	28.26%	71.74%
Chinese	6	16.67%	83.33%
Indian	86	32.56%	67.44%
Not known e.g. unconscious	85	29.41%	70.59%
Not stated e.g. unwilling to state	668	33.53%	66.47%
Pakistani	50	38.00%	62.00%
White and Asian	3	0.00%	100.00%
White and Black African	8	25.00%	75.00%
White and Black Caribbean	32	15.63%	84.38%
White British	3654	31.99%	68.01%
White Irish	86	33.72%	66.28%

Appendix 4: Participating Emergency Department

England

Queen's Medical Centre

Furness General Hospital

Whittington Hospital

Queen Elizabeth The Queen Mother Hospital

Lincoln County Hospital

North Middlesex University Hospital

Russells Hall Hospital

University Hospital ff North Tees

William Harvey Hospital

The Royal Oldham Hospital

Bedford Hospital

Pilgrim Hospital

Ipswich Hospital

The Royal Lancaster Infirmary

George Eliot Hospital

Wexham Park Hospital

Leighton Hospital

Queen's Hospital

Royal Berkshire Hospital

Royal Liverpool Hospital

King's College Hospital

Southend University Hospital

Leeds General Infirmary

St George's Hospital

Rotherham District General Hospital

Worcestershire Royal Hospital

Salford Royal

Kettering General Hospital

Southport and Formby District General Hospital

Scarborough Hospital

Barnet Hospital

Hinchingbrooke Hospital

Heartlands Hospital

Tameside General Hospital

Great Western Hospital

Hillingdon Hospital

Medway Maritime Hospital

Cumberland Infirmary

The Queen Elizabeth Hospital

Colchester Hospital

Royal Shrewsbury Hospital

Eastbourne District General Hospital

Royal Cornwall Hospital

Bristol Royal Infirmary

Northwick Park Hospital

Peterborough City Hospital

Northumbria Specialist Emergency Care Hospital

The Princess Royal Hospital

Yeovil District Hospital

Bassetlaw Hospital

Queen Alexandra Hospital

Frimley Park Hospital

Addenbrooke's Hospital

Derriford Hospital

St James's University Hospital

Milton Keynes University Hospital

West Middlesex University Hospital

Sandwell General Hospital

King George Hospital

Royal Victoria Infirmary

Manchester Royal Infirmary

University Hospital Coventry

Ealing Hospital

Good Hope Hospital

Charing Cross Hospital

Kingston Hospital

Stepping Hill Hospital

South Tyneside District Hospital

Watford General Hospital

Warwick Hospital

Southampton General Hospital

Musgrove Park Hospital

North Manchester General Hospital

Basildon University Hospital

Northampton General Hospital

Homerton University Hospital

Salisbury District Hospital

The Royal London Hospital

Birmingham City Hospital

Barnsley Hospital

Northern General Hospital

The Royal Free Hospital

James Cook University Hospital

Darent Valley Hospital

Princess Alexandra Hospital

Royal Bolton Hospital

St Peter's Hospital

University Hospital Aintree

Weston General Hospital

Diana, Princess of Wales Hospital

Norfolk and Norwich University Hospital

Alexandra Hospital

Luton & Dunstable University Hospital

Scunthorpe General Hospital

Royal Surrey County Hospital

University Hospital Lewisham

West Cumberland Hospital

Torbay Hospital

The Tunbridge Wells Hospital

Airedale general hospital

New Cross Hospital

Conquest Hospital

Countess of Chester Hospital

Queen Elizabeth Hospital

Warrington Hospital

Fairfield General Hospital

Walsall Manor Hospital

The Maidstone Hospital

Bradford Royal Infirmary

Scotland

Wishaw General Hospital

Queen Elizabeth University Hospital

University Hospital Monklands

Northern Ireland

South West Acute Hospital

Wales

Glan Clwyd Hospital
Ysbyty Gwynedd
Prince Charles Hospital
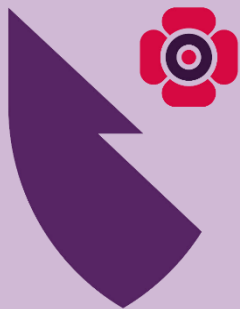Bronglais General Hospital
Royal Glamorgan Hospital

Appendix 5: Understanding your IQR visualisation

Inter-Quartile Range Visualisations:

Although this report is focussing on the overall national picture, it was felt that it would be useful to show the range of performances for the individual sites involved in this Quality Improvement Programme.

These IQR visualisations provide a benchmarked view of how all sites compare to each other across the full time period. It is coloured to show the quartile range for the sites. The bottom 25% performing sites have been coloured red, the top 25% performing sites are green, with the remaining sites orange, (which means they performed within the inter-quartile range).

It is hoped these new views will help generate discussion within the individual sites QIP Team as it means that they will be able to benchmark their performance against all other sites.

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