



**RCEM**

Royal College  
of Emergency  
Medicine

# CARE OF OLDER PEOPLE IN THE EMERGENCY DEPARTMENT

**NATIONAL QUALITY IMPROVEMENT PROGRAMME**

*Information Pack*

*2023 - 2025*

Published: October 2023  
(Jul 2024 update)



## Quick guide to running an awesome QIP



### Form your QIP Team

RCEM recommends a multidisciplinary QI team



### Standards

[Click here](#) to find the standards.



### Questions

[Click here](#) to find the questions.



### Inclusion criteria

1. Patients aged 75 years and older
2. Presenting to a type 1 ED
3. NEWS2 score of 4 or under (or your department's equivalent for low or low-medium clinical response if NEWS2 is not used)



### Sample size

Recommended sample size: Please collect data on a minimum of 5 eligible cases per week.



### Data entry portal

Log into the data entry site at <https://rcem.casecapture.com>



### Data frequency

**Recommended:** enter cases each week.

**Alternative:** If your ED will find weekly data entry difficult enter data fortnightly/monthly instead.



### Data Collection Period

Data should be collected on patients attending **from 05 May 2023 to 03 October 2025**

\*For the interim reports data collection period, please see the [Data collection period](#) section for details.

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# Introduction

## The Context

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 will focus 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.

Delirium is an acute deterioration in mental functioning arising over hours or days that may have many triggers, including acute medical illness, surgery, trauma, or drugs. It is linked with poor outcomes including medical complications, falls, increased length of hospital stay and mortality.

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.

Assessing the risk of falling on attendance to ED and then implementing falls reduction measures can reduce the risk of falling in the department or as an inpatient, as well as guide assessments to reduce further falls risks on discharge. Assessing older patients that have presented with falls in a standardized way may lead to diagnosis of underlying pathology and recognition of injuries. It can also guide assessments and interventions to reduce further falls, thus reducing the risks of morbidity, mortality, injuries and institutionalisation.

The assessment for falls should include screening for frailty and delirium, so that targeted interventions by appropriate professionals, such as a CGA (comprehensive geriatric assessment) can be commenced.

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.

The College is also committed to assessing health inequalities relating to patient ethnicity in supporting departments to provide high quality care to all. We will be collecting ethnicity data and monitoring for systemic inequalities and reporting this at a national level.

## The Evidence

This information pack contains in the appendices a narrative evidence review, summarising current clinical guidelines and research literature concerning the care of older people in emergency departments. It has been structured to incorporate each stage of an older person's admission with the view to providing a robust research summary as a backdrop for the wider National QIP.

The review has highlighted the importance of a Comprehensive Geriatric Assessment upon admission to an emergency department. The design of NHS emergency departments scored poorly in catering to the privacy and dignity of older people due to the architectural design of hospitals in the UK. Advanced care planning was shown to benefit both older people and their families although clinicians can feel reluctant to initiate advanced care planning with varied prevalence of advanced care plans across a recent audit of UK hospitals.

Effective screening and management of delirium and frailty in emergency departments was shown to improve outcomes for older people. Both delirium and frailty are prevalent in older people, particularly those who have been admitted to hospital. Assessment of each should be carried out upon admission as part of a multifactorial assessment. A multidisciplinary approach to the care of older people was supported by evidence in the literature with doctors specialising in geriatrics, physiotherapists, occupational therapists, pharmacists, and case managers identified as crucial members of an older person's care team.

## How to Use This Information Pack

This information pack has been designed to support you and your teams in taking part in this QIP.

It contains useful information about taking part such as the inclusion and exclusion criteria for patients, when to collect the data, and how to collect the data. The pack also includes useful information about the objectives and known quality and safety issues for this patient population.

For the first time, there is included a narrative review of the evidence underpinning the quality standards, which goes into more detail the rationale as to why RCEM has selected them.

Another novel feature for National QIP information packs is the inclusion of guidance on how to approach bringing about improvements. There is a general introduction to QI methodology, including the principal steps of conducting a QI project. There is also a 'how-to' section which explains in some more detail, which external links, some of the key interventions described in this QIP, and how these may be implemented in practice.

The COP QIP should act as a springboard to drive improvements. Where the data identifies specific areas for improvement, these should trigger discrete QI projects to address them. The online QIP portal contains intuitive features which allow recording and tracking of specific change ideas using the PDSA format. This will allow measurement and change management to work hand in hand rather than consecutively.

# Objectives

## General National QIP Objectives

Objective	How RCEM is supporting you
1. To identify current performance in EDs against clinical standards and previous performance	<ul style="list-style-type: none"><li>• Expert teams of clinicians and QIP specialists have reviewed current national standards and evidence to set the top priority standards for this national QIP</li><li>• RCEM have built a bespoke platform to collect and analyse performance data against the standards for each ED</li></ul>
2. To show EDs their performance and improvement by measuring, analysing, and reflecting data	<ul style="list-style-type: none"><li>• If they wish, EDs have the flexibility to select the most appropriate comparator to their data, whether this is national or only EDs in their country</li><li>• The RCEM platform includes a dashboard with graphs that track your ED's performance over time. This allows you to use your own ED's performance as a benchmark to drive continuous improvement.</li></ul>
3. To empower and encourage EDs to run quality improvement (QI) initiatives based on the data collected, and track the impact of the QI initiative on their weekly performance data	<ul style="list-style-type: none"><li>• The RCEM platform includes a dashboard with graphs showing your ED's performance as soon as data are entered</li><li>• The dashboard graphs are SPC charts (where applicable) with built in automatic trend recognition, so you are able to easily spot statistically significant patterns in your data</li><li>• The portal has built in tools to support local QI initiatives, such as an online PDSA template</li><li>• Once you have completed a PDSA template with your team, this is overlaid onto your dashboard charts so you can easily see the impact of your PDSA</li><li>• RCEM have also published a QI guide to introduce you to a range of excellent QI methodologies and enhance your QI knowledge and skills</li></ul>
4. Driving improvement at an organisational level for individual patients and encouraging collaboration between departments to share best practice	<ul style="list-style-type: none"><li>• For the first time, the organisational audit is designed as a scorecard to be run on a 4-monthly basis, so that departments can track improvement on an organisational level.</li><li>• RCEM is introducing new information about EDs who have shared examples of initiatives where they have demonstrated outstanding care. You are welcome to make contact and learn from their improvement journey.</li><li>• We see quality improvement as a continual journey. Excellent care is not about being perfect, but more about a commitment towards continuous improvement for our patients.</li></ul>

## Specific Objectives

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.

## Quality Standards

The COP QIP has set out an array of care standards, both for individual patients and for EDs and their Trusts as a whole. These are associated with metrics which will describe how well the standards are being met. As the emphasis is on a QI approach as opposed to Quality Assurance (also known as clinical audit), they will refer to median scores rather than % compliance.

This section describes these standards, the associated metrics and the rationale behind their inclusion in this QIP. Further information about sampling strategy and specific data entry questions can be found in the Data Entry section.

### Individual Patient Standards

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

## Organisational Standards

<b>SCREENING</b>
<p>Emergency Departments should have systems or processes in place to screen for:</p> <ul style="list-style-type: none"><li>a) Frailty</li><li>b) Delirium</li><li>c) Cognitive impairment</li><li>d) Falls risk</li><li>e) Elder abuse</li><li>f) Polypharmacy</li><li>g) Pressure areas and incontinence</li><li>h) Functional status / mobility</li><li>i) Social support</li></ul>
<b>DISCHARGE SUMMARIES</b>
<ul style="list-style-type: none"><li>a) Emergency Departments should have systems in place to record the above information in discharge summaries</li><li>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</li><li>c) There should be regular quality assurance of discharge summaries</li></ul>
<b>PHYSICAL RESOURCES</b>
<ul style="list-style-type: none"><li>a) The overall design and layout of the Emergency Department should consider the needs of frail older patients</li><li>b) The Emergency Department should have a dedicated area for people with cognitive impairment</li><li>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</li></ul>

### **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.

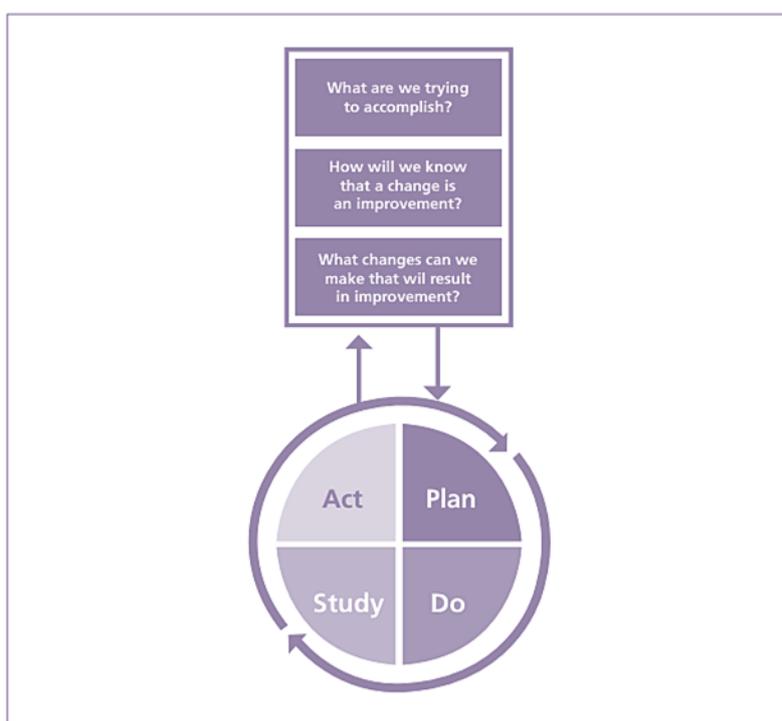
## Methodology

### QI Methodology

We encourage departments to take a Quality Improvement (QI) approach to this national QIP. This places more emphasis on project planning, team working, idea generation and implementation of changes, alongside continuous measurement. [The RCEM Quality Improvement Guide](#) contains a more detailed overview of some widely used approaches to QI. For simplicity, and because it is perhaps the most well-known methodology, we recommend using the Model for Improvement.

### The Model for Improvement, IHI

The Model for Improvement is a simple approach which is structured around asking the three questions below at the outset of a project and undertaking a series of change ideas using the Plan-Do-Study-Act (PDSA) as a framework.



### Generating Change Ideas

What changes are you going to make as part of this work? You will probably have a few ideas of your own already and some of these will have a high chance of success. However, it is important to engage in some form of brainstorming to ensure that a diverse range of improvement ideas is considered.

A tool which is very useful in generating change ideas is the driver diagram. We work in complex systems, with many factors influencing clinical care. Identifying the main factors that feed into your aim allows us to come up with different improvement ideas to address them. There is rarely a 'silver bullet' idea that on its own solves everything and so using the driver diagram exercise to generate a range of improvement ideas is crucial to eventual success.

A driver diagram seeks to identify the primary contributing factors to the aim: primary drivers. In turn, feeding into the primary drivers are secondary drivers and these are often a great way to generate thought about specific change ideas. Examples of driver diagrams can be found in Appendix 3.

There are other tools that can be used to brainstorm ideas and to spark team creativity, such as 'De Bono's 6 thinking hats'. These can be found in [this resource](#) at the [NHS England Improvement Hub](#).

Once you have identified improvement ideas, an impact vs effort matrix is a good way to identify where to start. This may help you identify quick wins (high impact but low effort on the grid) and things that maybe of less impact but take considerable effort.

## Forming your QIP Team

RCEM recommends forming a multidisciplinary QI team; to include consultants, trainees, advanced care practitioners (ACPs), specialty and associate specialist (SAS) doctors, geriatric specialists, frailty specialists, nursing and patient representatives and others to suit your local set up.

## Engaging with Stakeholders

The term 'stakeholder' refers to anyone who could be affected or have an interest in your project. It is important that you spend time thinking right at the outset who your key stakeholders are. Remember to think outside the ED and remember that patients themselves are key stakeholders.

A quick, useful tool to help decide whom you might need to 'get on side' with your project is a Stakeholder Map. This tool is based upon the fact that all stakeholders will have a level of both *interest* and *influence* in your project: identifying who has high influence, high interest, or both; will indicate how engaged you need them to be. See Appendix 3 for an example.

Then think about what motivates each stakeholder. Everyone is busy and has many competing priorities, so think about how you will make this important to your stakeholders. Revisit your stakeholders throughout this process to make sure they continue to be engaged.

## Implementing Change

Improvement initiatives driven by the National QIP should follow an iterative process. PDSA cycles, as detailed above, or equivalent methodology should be used to assess and implement or reject changes based on the data collected. The RCEM QIP portal has intuitive features (the 'My PDSA' section) which allow improvement ideas to be recorded and prospectively tracked using the PDSA format.

The project should use data prospectively to identify problems and inform change, rather than starting with a solution and using data to justify it. Implementing change within a project will involve engaging with staff, disseminating information, education and changing behaviours. Advice on how to address these subjects is given in the [RCEM QI guide](#).

## Data Entry

### Inclusion criteria

1. **Patients aged 75 years and older**
2. **Presenting to a type 1 ED**
3. **NEWS2 score of 4 or under** (or your department's equivalent for low or low-medium clinical response if NEWS2 is not used)

### Exclusion criteria

1. **Any patient 74 years of age or under**
2. **NEWS2 score greater than 5** (or your department's equivalent for medium-high clinical response if NEWS2 is not used)

The questions for individual cases should only refer to activity in the ED undertaken by ED staff, not inpatient areas.

RCEM recognises that many guidelines and clinical standards define 'older people' as over 65. However, the decision has been made to set the age inclusion criterion at 75 for the purposes of this QIP. This aligns with a more pragmatic, real-world approach, reflecting the greater probability of frailty and associated conditions at this age bracket.

In acutely unwell patients, the focus on managing immediate risk to life and limb may give priority to making decisions about a patient quickly without formally assessing their cognitive state. Patients with a NEWS2 score of 5 or over (or equivalent for a medium/high clinical response) are excluded for this reason.

### Data Sampling Strategy

A key difference between the traditional audit and Quality Improvement approaches to gathering data, is that the latter encourages continuous measurement alongside planning and implementing interventions. In this way, the 'story' of the QI project can be told over time, across numerous data points. Pragmatically speaking this data should be gathered in small, frequent samples rather than exhaustive data entry on infrequent occasions.

Without such a data sampling strategy, it will not be possible to track the performance of your QI project, be it due to natural variation or the effect of specific events such as implementation of an improvement idea.

As a general rule, RCEM recommends sampling **5 cases per week or 10 cases every two weeks**. Alternatively, data entry could take place monthly, at **20 cases every month**, but the spread of patients should nonetheless still be across both two-week periods in the month.

RCEM recommends that you designate specific members of your QIP team to gather and upload data to the online portal. This can either be one person, or for greater consistency, you could institute a rota so that there is always someone performing that role at any time. It is important to ensure that the other key steps in the programme continue.

If your department relies on information analysts to produce data report for QI / audit / research, it will be more efficient if you can request them to produce reports for you on a rolling basis.

## Data Collection Period

Data should be collected on patients attending from **05 May 2023 to 03 October 2025**

Specific QIP Year reporting period:

Year 1 Interim report period: 05 May 2023 – 03 Oct 2023

Year 2 Interim report period: 04 Oct 2023 – 03 Oct 2024

Year 2 Final report period: 04 Oct 2024 – 03 Oct 2025

## Data submission period

Data can be submitted [online](#) between **05 May 2023 to 03 October 2025**

Data submission period per QIP year:

Year 1 Interim report period: 05 May 2023 – 03 Oct 2023

Year 2 Interim report period: 04 Oct 2023 – 03 Oct 2024

Year 3 Final report period: 04 Oct 2024 – 03 Oct 2025

Each year's patient data must be entered within the same year's submission period. For example, all patient data collected in year 1's collection period must be submitted in the Year 1's submission period to be valid.

Any patient data submitted outside the submission period for its collection year will be invalidated and the patient data may not contribute towards reporting.

It is recommended to enter data as close to the date of patient attendance as possible, and to review progress regularly. This will help you QI team spot the impact of intervention more promptly for refinement or disposal depending on the changes observed.

## Data Entry Questions

Anonymised Unique ID			
Date and time of arrival or triage – whichever is earlier		dd/mm/yyyy	HH:MM
Date and time of disposition from the ED		dd/mm/yyyy	HH:MM
Age of patient on attendance			
Ethnic Origin		A	White British
		B	White Irish
		C	Any other White background
		D	White and Black Caribbean
		E	White and Black African
		F	White and Asian
		G	Any other mixed background
		H	Indian

Ethnic Origin Cont.	J	Pakistani
	K	Bangladeshi
	L	Any other Asian background
	M	Caribbean
	N	African
	P	Any other Black background
	R	Chinese
	S	Any other ethnic group
	Z	Not stated e.g, unwilling to state
99	Not known e.g, unconscious	

## Case mix

### Screening of older people in Emergency Departments

#### **Should only refer to activity in the ED undertaken by ED staff**

1. Has this patient had a delirium screening test performed in the ED?	Yes/No
(If yes) 1a. Select the tool from this list	4AT/CAM/DSM-V/ other
(If yes) 1b. Was delirium identified?	Yes/No
(If yes) 2. At what time did the patient have the screening done?	Date/time
3. Has the patient had a falls risk assessment?	Yes/No
(If yes) 3a. Was the patient identified as being at risk of falls?	Yes/No
4. Has this patient been screened for frailty using a recognised frailty scoring system?	Yes/No

#### Actions taken based on screening

#### **Should only refer to activity in the ED undertaken by ED staff**

Delirium management plan	(If yes to 1) 5 - Has this patient had a delirium management plan initiated?	Complete / Partial / No
	(if yes) Which parts of the delirium management plan have been initiated?	
	5a. Medication review	Yes / No
	5b. Pain assessment	Yes / No
	5c. Assessed for constipation	Yes / No
	5d. Assessed for urinary retention	Yes / No
	5e. Bloods	Yes / No
5f. ECG	Yes / No	
Post-fall assessment	6 - Has this patient presented with a fall?	Yes / No
	(if yes) 7- Has this patient had a dedicated assessment after their fall?	Complete / Partial / No
	Has the patient had:	
	7a. An ECG?	Yes / No

	7b. Bloods?	Yes / No
	7c. A postural blood pressure?	Yes / No
	(if yes) 8 - Has this patient had a screening assessment for major trauma (aka 'silver trauma'?)	Yes / No
Falls mitigation	9 - If the patient has been identified as being at risk of a fall, has a plan been made to mitigate the risk of further falls?	Complete / Partial / No
	Which actions have been taken to mitigate the risk of further falls?	
	9a. Risk flagged up	Yes / No
	9b. Non-slip socks	Yes / No
	9c. Cot sides up	Yes / No
	9d. Level of observation documented	Yes / No
Comprehensive Geriatric Assessment	9e. Walking aids in reach	Yes / No
	10- (if yes to 4) If indicated from the frailty score, has a CGA been initiated and/or frailty score communicated with GP?	Yes / No

## Basic care needs

### ***Should only refer to activity in the ED undertaken by ED staff***

Safety Round	11- Has a safety round been documented for patients present in ED after a specified time?	Complete / Partial / No
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## Organisational audit

These questions are designed to be answered for your organisation, not individual patients. It is suggested that the department clinical lead, lead nurse or service manager will be best placed to help answer these questions.

### Part One – Screening

Does the department have systems or processes in place to facilitate screening of the following? This means a specific screening process which is outside what would be expected in a basic nursing or medical assessment. These refer to screening done in the ED, by ED staff only.

- Frailty Yes / No (drop down box)
- Which score?
- Delirium Yes / No (drop down box)
- Is one of the following tools used: 4AT, CAM, DSM-V, other: as recommended by NICE (MCQ). We recommend 4AT

- Cognitive impairment Yes / No (drop down box)
- Falls Yes / No (drop down box)
- Elder abuse Yes / No (drop down box)
- Polypharmacy Yes / No (drop down box)
- Pressure areas & Incontinence Yes / No (drop down box)
- Functional status/Mobility Yes / No (drop down box)
- Social Support Yes / No (drop down box)
- If yes, please briefly describe the systems/processes: (mandatory free text box opens up only if yes is clicked)

## Part Two – Discharge Summaries

***These refer to ED discharge summaries, not those completed after an inpatient admission***

- Does the department have systems in place to record the above information in ED discharge summaries?  
Yes / No (drop down box)
- If yes, please briefly describe the systems/processes:  
(mandatory free text box opens up only if yes is clicked)
- Does the department have systems in place to ensure patients are provided with a paper copy of the letter when requested, or when discharged to a care home? <sup>[OBJ]</sup>  
Yes / No (drop down box)
- Does the department undertake regular quality assurance audits of discharge summaries?  
Yes / No (drop down box)

## Part 3 – Physical Resources

- These should describe physical resources, including dedicated spaces, within ED and / or the observation unit
- Has the overall design and layout of the department taken into account the needs of frail older patients as an overriding principle?  
Yes – details; no
- Does the department have a dedicated area for people with cognitive impairment?  
Yes / No (drop down box)
- If yes, please briefly describe the systems/processes: (mandatory free text box opens up only if yes is clicked)
- Does the department have timely access to dedicated equipment to support the care of those living with frailty, cognitive and/or sensory impairment? (this refers to fiddle mats, hearing aids and batteries, soft toys, mittens)  
Yes / No (drop down box)

## Part 4 – Additional Services

Is there a real-time language interpreting service in ED available?

Yes / No (drop down box)

Does the department have timely access to the following, and if yes, during which hours?  
(specify HIGHEST level of cover, and then click on checkboxes for in-hours / OOH)

### Geriatrician

	Every day (7 days)	Mon-Fri	Some days
In-hours (8-5)			
Out of hours (5pm-8am & weekends)			

### Acute Frailty Service

Physically in ED/available to come to ED/remote advice/No (drop-down)

	Every day (7 days)	Mon-Fri	Some days
In-hours (8-5)			
Out of hours (5pm-8am & weekends)			

### Therapies

Physically in ED/available to come to ED/remote advice/No (drop-down)

	Every day (7 days)	Mon-Fri	Some days
In-hours (8-5)			
Out of hours (5pm-8am & weekends)			

### Older Adults Mental Health

Physically in ED/available to come to ED/remote advice/No (drop-down)

	Every day (7 days)	Mon-Fri	Some days
In-hours (8-5)			
Out of hours (5pm-8am & weekends)			

### Community Admission Avoidance Service

Yes / No (drop down box)

	Every day (7 days)	Mon-Fri	Some days
In-hours (8-5)			
Out of hours (5pm-8am & weekends)			

### Third Sector Support Service (e.g. British Red Cross / Charities)

Yes / No (drop down box)

	Every day (7 days)	Mon-Fri	Some days
In-hours (8-5)			
Out of hours (5pm-8am & weekends)			

**Access to Palliative Care Service**

Yes / No (drop down box)

	Every day (7 days)	Mon-Fri	Some days
In-hours (8-5)			
Out of hours (5pm-8am & weekends)			

**Access to Pharmacist**

Yes / No (drop down box)

	Every day (7 days)	Mon-Fri	Some days
In-hours (8-5)			
Out of hours (5pm-8am & weekends)			

**Access to Pastoral / religious support**

Yes / No (drop down box)

	Every day (7 days)	Mon-Fri	Some days	OOH * 5pm-8am & weekends
In-hours 8-5				

**Meal provision**

Yes / No (drop down box)

	Every day (7 days)	Mon-Fri	Some days	OOH * 5pm-8am & weekends
In-hours 8-5				

**Part 5 – Advance Care Planning**

Does the department have timely access to previously completed Advance Care Plans?

Yes / No (drop down box)

Are ED staff trained to ask patients routinely about their wishes regarding resuscitation decisions and end of life care?

Yes / No (drop down box)

Does the department have timely access to services or pathways that can support the discharge of people at end of life, to their preferred place of death?

- Yes / No (drop down box)

**Part 6 – Patient Experience**

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

Yes / No (drop down box)

## Definitions

Note: these definitions are also accessible as pop-up tips in the data entry portal adjacent to the relevant question. Just hover over the question mark to view.

- **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, a 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 programme 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 and a 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.

## Guidance on care of Older People

This is a reference section which aims to guide you to finding solutions for improvement. If your performance in one or more of the metrics has identified a need for improvement, you will find guidance and advice on change ideas to drive that improvement.

### Delirium Screening

Delirium is a diagnosis based on clinical judgement and can be difficult to distinguish in patients with existing cognitive impairment ([NICE 2023](#)). Over 49,000 patients were admitted into ED with delirium in 2021/22 (NHS Digital), reflecting the need for robust and accurate clinical guidance. There are multiple risk stratification scores available, the most commonly used and widely recommended being the 4AT score. 4AT is a quick and easy tool with only 4 components. Alertness, Abbreviated Mental Test 4, attention and acute change. Further information on how to assess patients using the 4AT tool can be found [here](#).

<p><b>Standard 1:</b> validated national or locally developed tool</p>	<p>Validated national tools are:</p> <ul style="list-style-type: none"> <li>• 4AT – Arousal, Attention, Abbreviated Mental Test 4</li> <li>• 6-CIT – Six Item Cognitive Impairment Test</li> <li>• AMT – Abbreviated Mental Test</li> <li>• CAM – Confusion Assessment Method</li> <li>• DSD – delirium superimposed on dementia</li> <li>• DRS-98-R – Delirium Rating Scale</li> <li>• DOS - Delirium Observation Screening Scale</li> <li>• ICDSC – Intensive Care Delirium Screening Checklist</li> <li>• Nu-DESC – Nursing Delirium Screening Scale</li> <li>• MMSE – Mini Mental State Examination</li> <li>• RADAR – Recognising Acute Delirium As part of your Routine</li> <li>• mRASS – Modified Richmond Agitation-Sedation Scale</li> <li>• SQiD – Single Question to Identify Delirium</li> </ul>
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## Falls Screening

Any patient over 75 presenting either with a fall, or a history of recent falls should be risk assessed. [NICE](#) provides clear and concise guidance on the management of patients with falls. Falls screening is useful in the implementation of safety and prevention of falls during admission. Screening for falls also includes preventative elements such as assessing footwear of patients, use of cot sides, polypharmacy and use of walking aids. Use of EPRs has made falls screening simpler as it can easily be added to the admission/triage template. Implementation of effective falls screening is a multidisciplinary effort and use of in-house therapy teams and frailty services can benefit departments greatly.

## Frailty Screening

Frailty screening is useful in determining if there has been a decline in function since previous attendance/admission, especially when assessing post trauma/illness as these can greatly affect a patient's frailty. Early discharge planning and support is greatly benefited by the use of frailty assessment. RCEM recommends the use of screening tools including the [Clinical Frailty Score](#). This can be used initially on admission and re-evaluated on each admission. The tool is also available as an app for ease of use.

## Delirium Management Plans

Delirium is a complex and multifactorial condition; management can be difficult and encompass many elements. Management should include diagnosis and treatment of the underlying cause. Collateral history should be obtained from next of kin/family member/carer. A thorough physical exam should be completed including skin and neurological examination. Baseline bloods and appropriate radiological investigations should be gained. Urinalysis should also be gained to rule out UTI, however catheters should be avoided where possible. Management of pain and other precipitating factors for agitation is essential. [Further reading](#) on the topic is available from the British Geriatric Society (BGS).

## Frailty Trauma

Frailty Trauma (aka., 'Silver Trauma') is complex and multifactorial. Comprehensive and systematic assessment is needed to ensure that injuries are not overlooked. Assessment can be made more difficult by factors such as dementia/cognitive impairment, infection, conditions such as osteoporosis and polypharmacy. [BGS Guidance](#).

The London Trauma Network provides a detailed guide on management of patients presenting with traumatic injury, it can be accessed [here](#). RCEM recommends the use of the [Silver Book II](#), a comprehensive guide on management of older patients in ED, including trauma, this can be accessed here. RCEM also provides teaching modules via the [RCEM learning portal](#) specifically on Frailty trauma.

[TARN guidance](#) on management of trauma in older patients is very comprehensive and offers specific guidance on criteria for imaging and management of the complex older adult.

## Safety Rounds

The term “safety round” is interchangeable in each trust, but essentially refers to the process of ensuring the needs of older patients are met if in the ED for longer than 6 hours. Administration of regular medication and analgesia, offering of food and drink if appropriate, toileting needs, and pressure area care attended to are some of the basic interventions carried out during a safety round. Provision of a hospital bed and/or pressure relieving mattress along with up-to-date observations are other interventions that can be added.

## In-House Frailty Teams

Local in-house frailty and therapy teams can provide much needed assessment and support to elderly patients in the ED. Therapy teams can offer assistance with mobilising post falls, and often can liaise with community teams to discuss increased package of care needs, at home assessments for interventions and provide mobility aids if required.

Frailty teams can support the patient by completing a more thorough and comprehensive assessment of the patient during their ED stay. Frailty specialists can help assess common issues such as polypharmacy and frequent falls and offer solutions such as assessment by therapies and pharmacists. The wider multidisciplinary team of pharmacists and specialist nurses have a very active role in assessing and evaluating patient’s needs and are a huge asset in helping to provide care for the older person in ED.

The British Geriatrics Society provide guidance on setting up a Frailty services [here](#).

## Design of Emergency Departments and Specialised Equipment

Equipment such as oxygen tubing/cardiac monitoring should be assessed for each patient, if not essential then patient interventions should be kept to a minimum to reduce agitation.

Noise levels and crowds should also be reduced as much as possible, using screens and curtains safely to occlude visual factors can help in reducing agitation. Use of cot sides and appropriate positioning of the call bell to ensure safety is recommended. Safe storage of equipment and close monitoring of mobile agitated patients is also recommended. Falls risk assessment and appropriate adjuncts are recommended also. More information is available [here](#).

Several Frail-Friendly departments have adapted the layout and design of their departments to become more appropriate for the older person. These can be as simple as large clearly visible signage for toilets and exits, to more significant changes such as changing flooring and room lay out. Further information is available [here](#).

## Appendices

### Appendix 1: Analysis plan for standards

This section explains how the RCEM team will be analysing your data. You are welcome to use this analysis plan to conduct local analysis if you wish. Analysis sample tells you which records will be included or excluded from the analysis. The analysis plan tells you how the RCEM team plan to graph the data and which records will meet or fail the standards.

Standard	Relevant questions	Analysis sample	Analysis plan – conditions for the standard to be met
Standard 1: Older People (75 years and older) in Emergency Departments should be: <ol style="list-style-type: none"> <li>screened for delirium using 4AT</li> <li>assessed for falls risk</li> <li>screened for frailty</li> </ol>	Q1 - Has this patient had a delirium screening test performed <b>in the ED</b> ? 1a - Select the tool from this list.	All patients  All patients	Chart: SPC <b>Title:</b> Standard 1a – delirium screening using validated tool Analysis: <b>Met:</b> Q1 = Yes AND Q1a = 4AT  Additional Chart: <b>Chart:</b> Stacked bar chart <b>Title:</b> Delirium screening tools Analysis: % breakdown answers from Q1a
	Q3 - Has this patient had a falls risk assessment?	All patients	Chart: SPC <b>Title:</b> Standard 1b –falls risk assessment Analysis: <b>Met:</b> Q3 = Yes
	Q4 - Has this patient been screened for frailty using a recognised frailty scoring system?	All patients	Chart: SPC <b>Title:</b> Standard 1c – frailty screening Analysis: <b>Met:</b> Q4 = Yes
Standard 2: Action is taken based on the findings of screening processes <ol style="list-style-type: none"> <li>Delirium management plan initiated</li> <li>Post-fall assessment</li> <li>Falls mitigation</li> <li>Comprehensive geriatric assessment</li> </ol>	Q5- Has this patient had a delirium management plan initiated? Which elements were completed: <ol style="list-style-type: none"> <li>Medication review</li> <li>Pain assessment</li> <li>Constipation</li> <li>Urinary retention</li> <li>Blood tests</li> <li>ECG</li> </ol>	Only include: Q1 = yes AND <sup>1</sup>  Q1b = yes	Chart: SPC <b>Title:</b> Standard 2a – delirium management plan initiated for patients with delirium. Include breakdown of each component of the delirium management plan as outlined on the left  Analysis: <b>Met:</b> Q5 = Complete  Additional Chart: <b>Chart:</b> Stacked bar chart <b>Title:</b> Delirium management plan initiated

<sup>1</sup> **Correction:** Please note that this is an amendment to the initially published information pack, where the inclusion criteria Q1b = Yes was not stated.

			Analysis: % breakdown answers from Q5
Q6- Has this patient presented with a fall?  Q7- Has this patient had a dedicated assessment after their fall? Have they had: a) Blood tests b) ECG c) Postural BP?  Q8- Has this patient had a screening assessment for major trauma (aka 'silver trauma'?)	Only include: Q6 = yes   Q6 = yes	Chart: SPC <b>Title:</b> Standard 2b – dedicated assessment after a fall Include breakdown of each component of the post-fall assessment as outlined on the left  Analysis: <b>Met:</b> Q7 = Complete  Additional Chart: <b>Chart:</b> Stacked bar chart <b>Title:</b> Dedicated assessment after a fall Analysis: % breakdown answers from Q7	
Q9- If the patient has been identified as being at risk of a fall, has a plan been made to mitigate the risk of further falls?  Which components of the falls mitigation plan have been completed?  a) Falls risk flagged up b) Non-slip footwear c) Cot sides d) Documented level of observation e) Walking aids	Only cases where Q3 = 'Yes' AND <sup>2</sup>   Only cases where Q3a = 'Yes'	Chart: SPC <b>Title:</b> Standard 2c – falls mitigation plan Include breakdown of each component of the falls mitigation plan as outlined on the left  Analysis: <b>Met:</b> Q9 = Complete  Additional Chart: <b>Chart:</b> Stacked bar chart <b>Title:</b> Falls mitigation plan Analysis: % breakdown answers from Q9	
Q10- (if yes to 4) If indicated from the frailty score, is there documented evidence of a Comprehensive Geriatric Assessment (CGA) initiated?	Only include: Q4 = yes Q10 = yes or no Exclude: Q10 = not indicated	Chart: SPC <b>Title:</b> Standard 2d – comprehensive geriatric assessment Analysis: <b>Met:</b> Q10 = Yes  Additional Chart:	

<sup>2</sup> **Correction:** Please note that this is an amendment to the initially published information pack, where the inclusion criteria Q3a = Yes was not stated.

		Q4 = yes	<b>Chart:</b> Stacked bar chart <b>Title:</b> comprehensive geriatric assessment <b>Analysis:</b> % breakdown answers from Q10
Standard 3: Patients should have their basic care needs met whilst in the ED via a safety round	11- Has a safety round been documented for patients present in ED more than 6 hours?  Which components of the safety round have been completed? a) Repeat vitals b) Food & drink c) Regular medications d) Hospital bed e) Pressure areas	If ED LOS >6 hours  If ED LOS >6 hours	<b>Chart:</b> SPC <b>Title:</b> Standard 3 – safety round documented Include breakdown of each component of the safety round as outlined on the left  <b>Analysis:</b> <b>Met:</b> Q11 = complete  <b>Additional Chart:</b> <b>Chart:</b> Stacked bar chart <b>Title:</b> comprehensive geriatric assessment <b>Analysis:</b> % complete within 6 hours, complete over 6 hours, partial within 6 hours, partial over 6 hours, not done

## Appendix 2: Data retention and security

We will endeavour to hold accurate and up-to-date information. Some information can be amended by you, and some can be amended by RCEM. If you are aware of an inaccuracy, you can inform RCEM who will correct or delete it promptly. We will never collect sensitive personal data without your explicit consent.

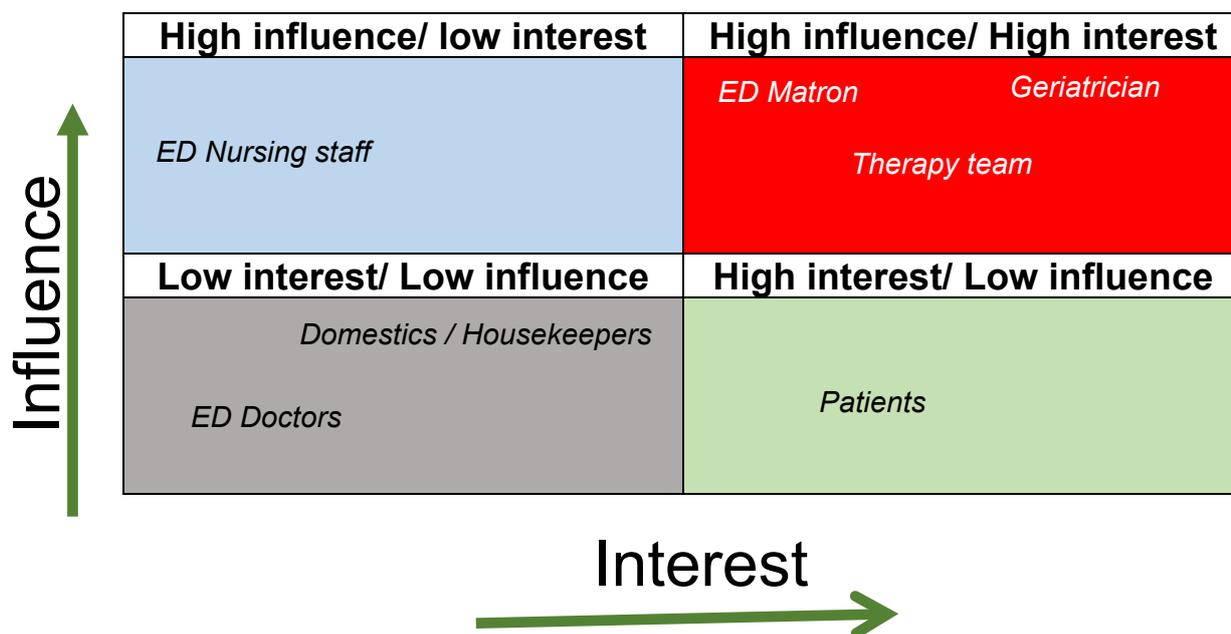
We do not sell, trade or rent personal details to third parties. However, some information is passed to third party suppliers who host the software to enable account creation and activation.

Security measures are in place to secure personal information include encryption technology and firewalls as well as restrictions regarding the storage of sensitive information. The account holder information is password protected as set up by the account holder. The account holder can edit their personal information by logging on and entering a password. Staff access to account holder information is also password protected.

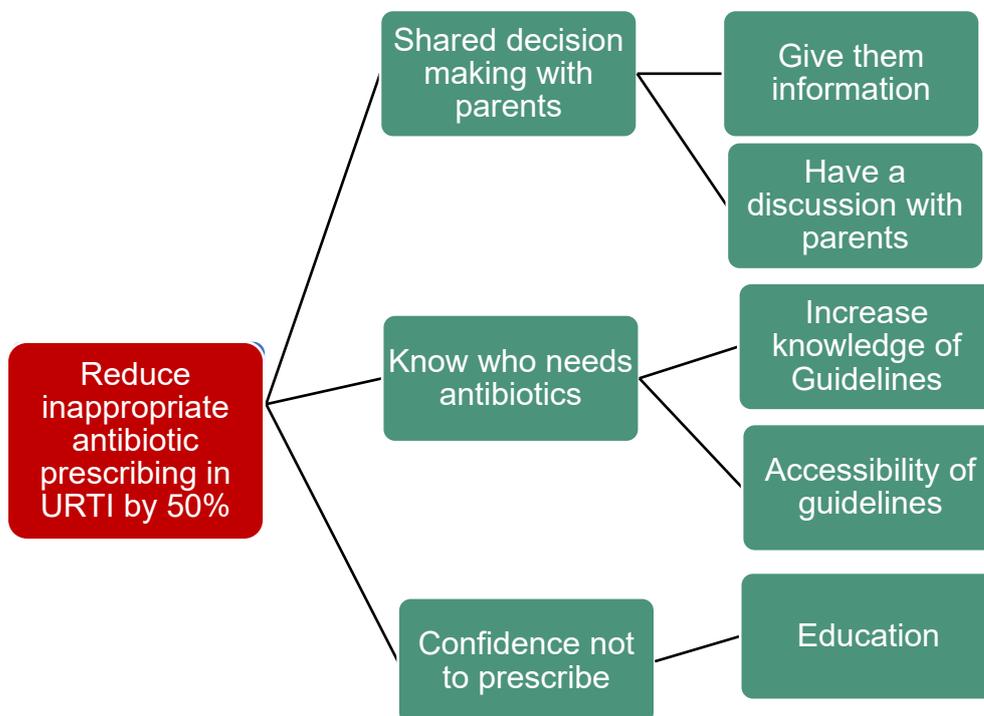
If you have any queries regarding registration, please contact the Quality Team at [quality@rcem.ac.uk](mailto:quality@rcem.ac.uk)

### Appendix 3: Examples of QI tools

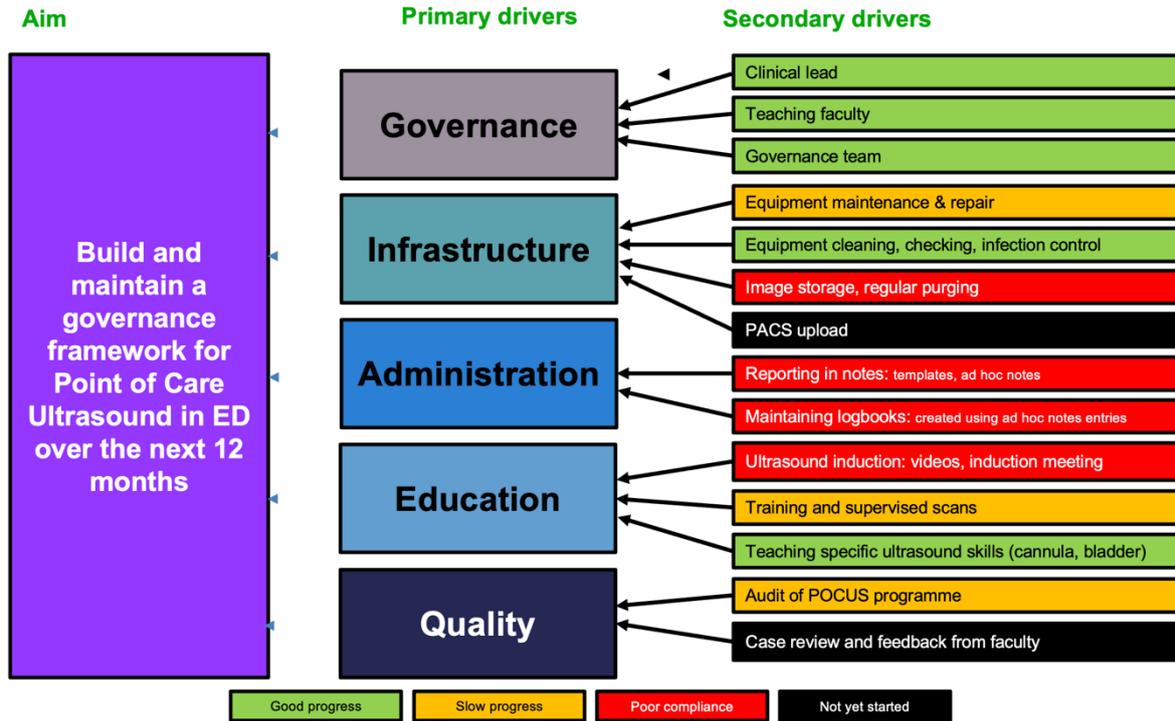
Stakeholder map for a project to reduce the number of Falls in ED



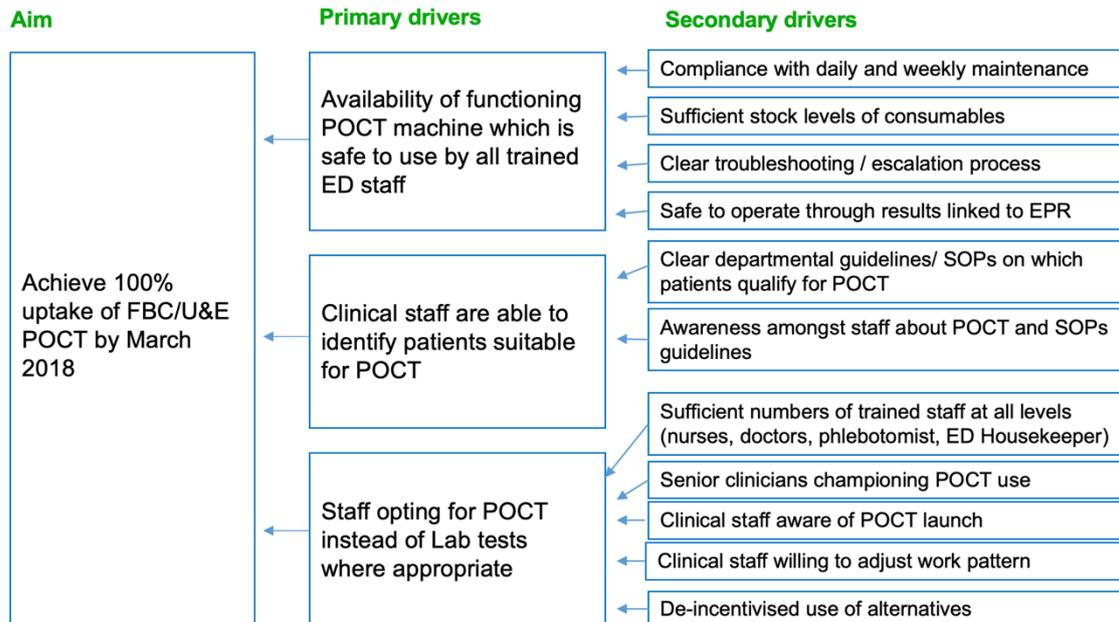
Driver Diagram for a project to improve antibiotic stewardship



### Driver Diagram for a POCUS governance project



### Driver Diagram for a Point of Care Testing project



## Appendix 4: Evidence Review

### Introduction

The below thematic narrative summarises a comprehensive literature review carried out to evaluate the research evidence and current clinical guidelines around the quality of care of older people in emergency departments. The summary begins by reviewing the literature on assessment and ED design upon admission to hospital. From there, the literature is explored around before advance care planning and end of life care is discussed.

Attention is given to how delirium is assessed, managed, and prevented in acute medical contexts with focus given to non-pharmacological interventions. In contrast, the next section reviews the role of pharmacists in emergency departments and the risk of polypharmacy particularly among frail older adults. Frailty is then explored in more detail. Further discussion is given to frailty screening and frailty units embedded in emergency departments and the multidisciplinary team's role in an older person's care. Finally, evidence around the assessment of falls and consequent hospital and community-based interventions is reviewed.

### Methodology

The literature was reviewed using a sensitive search strategy. The research question 'exploring the quality of emergency department care of older people' was established. From here, the question was broken down into key concepts: national guidelines for best practice, supporting evidence from clinical research, clinical outcomes from best practice and gaps between observed clinical outcomes and outcomes from recommended best practice.

From these key concepts, search terms were developed, both free-text and controlled vocabulary terms. The review began with free-text terms used in Google Scholar and the NICE report and guideline databases. Following this initial, wider search, controlled vocabulary terms were used to search the Cochrane Library; BMJ Best Practice; EMBASE, NHS England Open Health Data Project Directory, Office of National Statistics, RCEM Best Practice; British Geriatric Society Resources and NIHR Journals Library.

Search terms were designed to cover key areas of interest and included terms relating to Access to Services; Admission Length and Assessment; Delirium Management; End of Life Care; Preventing Falls and Frailty Screening; Emergency Department Design and Pharmacy and Polypharmacy.

### Increasing demand and adapting design- catering to and improving the experience of older people in emergency departments

The number of people over 60 in the UK is expected to increase to 18.5 million in 2025 (NHS, 2015). Increases of over two-thirds in attendances to Emergency Departments (EDs) for those over 60 have been recorded since 2014 (NHS, 2015). Given these projections, EDs should place more of a strategic focus on meeting the needs of this demographic. The British Geriatric Society (BGS) recommends that admissions start with a Comprehensive Geriatric Assessment (CGA) (BGS, 2019). Older adults are more likely to be alive and living at home a year after a CGA upon hospital admission compared with usual medical care alone (Ellis et al., 2017).

Designing EDs to cater to older adults is crucial to their care and experience. Reviews highlight the importance of dignity and privacy for patient and family satisfaction by avoiding multioccupancy rooms and hallway placements (Barnes et al., 2016; Sloane, 2022). NHS EDs have historically scored poorly in privacy as wayfinding around complex building layouts result in uninvolved parties easily viewing older adults in distress. The importance of light levels in EDs was also noted. Bright light and glare can be as hindering to older adults with sight loss as low lighting (Barnes et al., 2016). Contrasting tones when designing signage and fittings should be implemented as well as avoiding tripping hazards below eye level (Akagi and Adachi, 2015).

## End of Life care: experiences of Older People and families

1 in 5 older adults with an emergency admission to hospital are in the last year of their lives (Bielinska et al., 2021). An emergency admission may therefore be an opportune time to start advanced care planning, with research suggesting people over 70 generally welcomed these discussions in hospital (Bielinska et al., 2021). Advanced care planning involves older people discussing the care they would like to receive up to the final months of their life. These conversations are important for the older person as well as their family. However, this review has identified that healthcare practitioners can feel reluctant or unsure as to when to initiate end of life care planning. Although, qualitative exploration of advanced care planning identified the benefit of contemplation and preparation for the end of life (Bielinska et al., 2021).

A recent review within The Society for Acute Medicine Benchmarking Audit (Lasserson, Subbe, Cooksley & Holland, 2019) found that very few patients had an advanced care plan available. Prevalence varied from 2.9% to 12.6% of patients among 6072 patients in 123 hospitals audited (Knight et al., 2020) despite the national guidelines of advanced care planning as best practice (NICE, 2018).

## Delirium management

Delirium is defined as an acute confusional state, categorised as hyperactive or hypoactive with symptoms varying from agitation and increased psychomotor activity to withdrawal and reduced mobility respectively (APA, 2013, NICE, 2023). Whilst delirium is prevalent, affecting up to 50% of older adults in hospital (NICE, 2010), reporting of delirium was described as poor, suggesting that awareness and screening procedures need improvement (NICE, 2010).

Once delirium develops, hospital stays lengthen, increasing the risk of hospital-acquired complications and receiving a diagnosis of dementia (NICE, 2010). Risk of death within 30 days of an ED admission also increases by a factor of 5.5 compared to patients admitted without delirium (BGS, 2022). To improve outcomes for older people in EDs, identifying and preventing delirium is critical. Preventative measures include providing clear ward signage and a 24-hour clock whilst facilitating regular visits from family to prevent disorientation (NICE, 2023). Promotion of hydration, nutrition, mobility, pain management, and sleep hygiene are also recommended. Those at risk of delirium should be assessed within 24 hours of admission. Risk factors include age  $\geq 65$  years, underlying cognitive impairment, a current hip fracture or a severe and/or deteriorating condition (NICE, 2010). Assessment within 24 hours of admission is recommended as symptoms will fluctuate during an ED admission and establishing a baseline is crucial (McCusker et al., 2003).

The 4AT, CAM-ICU or ICDSC are recommended assessment tools depending on the clinical location of the older adult (NICE, 2023). Scores on the 4AT used at scale in practice are strongly linked with 30-day mortality and length of hospital stay (MacLulich et al., 2019). A recent meta-analysis supported the use of CAM-ICU and ICDSC as screening tools in ICUs (Chen et al., 2020), although their use in EDs was not supported to the same degree, given the speed at which the 4AT can be administered with high sensitivity and specificity without the requirement of specialist training (Gagne et al., 2018, O'Sullivan et al., 2018).

For those older adults who have already developed delirium, non-pharmacological interventions are recommended (Macantonio, 2017) to prevent significant complications (Shenvi et al., 2020). Unless the older person is at risk to themselves or others, providing an unambiguous, reorienting, and supportive environment can help in the management of symptoms (Gower, Gatewood and Kang, 2012). If delirium does not resolve following management, a re-evaluation for underlying causes is recommended alongside assessment for dementia (NICE, 2023).

## ED-based pharmacists, interventions addressing polypharmacy

Two-thirds of older adults admitted to hospital are medicating multiple co-morbidities (Ruiz, Bottle, Long & Aylin, 2015). As this group is at greater risk of adverse drug interactions due to polypharmacy, ED-based pharmacists can play a vital role in advising the care team. In meta-reviews, evidence suggests mechanistic pathways for the benefit observed in wards where a pharmacist was present, including improvements to patient outcomes by minimising prescribing errors and adverse drug interactions (Gillespie et al., 2009).

However, ED-based pharmacists are likely to work concurrently across multiple wards which may limit the degree of detail and consolidation they're able to input into a treatment plan, particularly where there is risk of polypharmacy (NICE, 2018).

Polypharmacy poses an increased risk to frail older adults (Kernick, Chew-Graham & O'Flynn, 2017). A cyclic relationship links polypharmacy and frailty, where, due to the increased risk of side effects of multiple medications, frailty is associated with polypharmacy whilst the severity of frailty concurrently leads to an increase in medication intake (Turner & Clegg, 2014; Nwadiugwu, 2020).

A person-centred approach is recommended, where intervention to prevent polypharmacy acts as a proactive response to frailty (McCormack, 2004). This intervention could include regular medication reviews by an ED-based pharmacist known to the older person alongside continued observation for any sudden changes in mental and physical health alongside new medications (Turner & Clegg, 2014).

## Frailty screening

Frailty is characterised by a decline across multiple body systems, increasing a person's vulnerability to adverse health outcomes (Treacy et al., 2022). A fifth of older inpatients are classified as frail and almost half of all hospitalisation days accounted for are due to frailty (Gilbert et al., 2018). NHS England (NHSE) recommends the Clinical Frailty Scale (CFS) in its acute frailty service provision mandate, describing it as a "quick and simple tool" (NHSE, 2019, p. 5). The CFS is a validated tool designed to identify and assess the severity of an older adult's impairment to function due to frailty (Rockwood et al., 2005). This mandate is not mirrored in Scotland or Wales with the abbreviated CGA, "Think Frailty" (HIS, 2019) and Edmonton Frail Scale (Rolfson et al., 2006) concurrently adopted as alternatives (Knight et al., 2022).

## ED-based acute frailty services and social care provision

The NHS Long Term Plan in 2019 called for all hospital EDs to provide acute frailty services for at least 70 hours a week (NHS, 2019). Frailty services in hospitals should comprise of Acute Frailty Units (AFUs), which provide bed-based care, and mobile 'in-reach' teams responsible for the multidisciplinary team (MDT) administration of CGAs. NHSE guidance states that an AMU MDT should comprise of doctors specialising in geriatrics, physiotherapists, occupational therapists, pharmacists, and case managers (NHSE, 2019). In a recent systematic review of hospital-based intervention and therapies across 1009 older adults, multidimensional interventions were found to be effective in the care of frail hospitalized older adults based on physical, psychological and social outcomes (Rezaei-Shahsavari et al., 2020).

On average, 15% of older people are readmitted to AMUs within 28 days of discharge (BGS, 2023). Reducing the risk of readmission revolves around a robust handover from hospital services to community social care teams for rehabilitation. Rehabilitation goals, where appropriate should be initiated through early mobilisation whilst the older adult is still in hospital (BGS, 2023). Whilst hospital based social workers hold a multidimensional role across education, advocacy and counselling for frail older adults particularly as discharge coordinator (Heenan, 2021, NICE, 2015) peer reviewed analyses of their input on the outcomes of older people and their families in the UK is scarce (McLoughlin, 2016).

## Falls: assessments and interventions

Falls negatively impact an older person's independence and quality of life, both associated with increased mortality and morbidity (Montero-Odasso et al., 2022). Whilst the impact of falls is universally reported in older adults, with 30% of older adults falling annually (Ganz & Latham, 2022), guidelines have been inconsistent across healthcare stakeholders and providers (Montero-Odasso et al., 2022).

Since the publication of the NICE guidelines for falls in 2013, an update was announced in May 2019, expected in 2024 (NICE, 2019). Existing guidelines recommend a multifactorial falls risk assessment in hospital after admission. Assessment includes history of falls; assessment of gait, balance and mobility, sight impairment and muscle weakness (NICE, 2013). Following a multifactorial assessment, a multifactorial intervention is currently recommended, including strength and balance training alongside a medication review (NICE, 2013).

With busy and fast-paced environments being synonymous with EDs, design modifications are recommended by NHS England (NHSE) to reduce the risk of falling including access to visual and hearing aids and non-slip flooring and handrails (NHSE, 2019). Having personal possessions in close reach and providing non-slip socks instead of slippers (Stoeckle et al., 2019) as well as coloured wristbands to identify those at high risk of falling (Kobayashi et al., 2017) have been adopted in American and Japanese EDs respectively, reducing the risk of falling. Some evidence supports gait, balance, co-ordination and strengthening exercises in improving clinical balance outcomes immediately post intervention based on individual risk factors identified during assessment (Lord et al., 2011, NICE, 2013). However, Cochrane Reviews highlighted this evidence was not robust and did not allow for conclusive relationships to be drawn (Lord et al., 2011).

Updates to NICE guidelines in 2024 are expected to include new evidence that indicates that multifactorial interventions may not be effective when based on individual risk factors. Alternatively, offering all interventions irrespective of risk factors may be effective (NICE, 2019). Contradicting evidence around Vitamin D supplements will also be considered in 2024 (Bischoff-Ferrari et al., 2016, Thanapluetiwong et al., 2020).

## Contact Us

If you have a clinical or methodology question regarding this QIP, you can email our QIP Clinical Team directly at the below email address. Your question will be sent directly to the relevant team, automatically sharing on your name and contact email for reply.

[c76464e3.rcem.ac.uk@uk.teams.ms](mailto:c76464e3.rcem.ac.uk@uk.teams.ms)

If you would prefer to send your question anonymously, you can send it to our general QIP email address below. Our team will then pass your question onto the relevant team and email you back from our general account.

[RCEMqip@rcem.ac.uk](mailto:RCEMqip@rcem.ac.uk)

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