Care of Older People in the Emergency Department

Authors

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Introduction

All older people have the right to a health and social care assessment and should have access to treatments and care based on need, without an age-defined restriction to services1. Health services should not be ‘ageist’.

Standards

1. Hospitals must provide an Acute Frailty service for at least 70 hours a week, with the aim to complete a clinical frailty assessment within 30 minutes of a patient’s arrival in the Emergency Department or SDEC unit.
2. Pain scores must be obtained in all older aged patients at triage.
3. The ED staff must support patients to remain as independent as possible whilst they remain in the ED.
4. Each Emergency Department must have a Geriatric Emergency Medicine/Frailty lead.
5. All staff working in the Emergency Department must complete dementia and delirium training.
6. All EDs must have ready access to time critical medication used commonly by older people, such as Parkinson’s Disease medication, insulin and anti-epileptic medicines.

Recommendations

1. All EM staff should have protocols for the management of ‘silver trauma.’

2. ED staff should undertake Clinical Frailty Scale (CFS) scoring if it will make a meaningful difference to their ED management.

3. Skin integrity and pressure area review should be assessed and documented using a reliable tool such as the Waterlow score.

4. EM staff should adapt their environments to the needs of the older person.

5. ED staff should be mindful that older aged patients are disproportionately affected by ED crowding (including delayed ambulance offloads) and endeavour to mitigate against this including the use of documented 6hrly ‘care rounds’ and trying to avoid corridor care for those with cognitive impairment.

6. EM staff should adhere to hospital specific guidelines for safeguarding of older people, in addition to the multi-agency policies and procedures [1].

7. Comprehensive Geriatric Assessments are an evidence based intervention that promotes health and prevents readmission, however they should be best completed after, not during, an emergency department stay.

8. The 4AT tool should be used for the assessment of delirium

9. Early discussion with the patient and any nominated family members to determine their treatment priorities including alternatives to admission eg. frailty Same Day Emergency Care (SDEC) are strongly encouraged.

10. Accurate discharge information, including any medication changes is essential, as well as ensuring any treatment plans are communicated with carers in the event of the patient not being able to remember fully.

Background

The Clinical Frailty Scale (CFS) is recommended by NHS Improvement, NHS England, the Ambulatory Emergency Care Network and the Acute Frailty Network2 to identify the individual's level of frailty two weeks prior to presentation1. The CFS is a tool for those aged 65 years and older. Many Emergency Departments use 75 years and older as the recommended age for frailty scoring. ED staff should only undertake CF scoring if it will make a meaningful difference to their ED management.

Identifying frailty as soon as the patient arrives into the Emergency Department, or earlier by the ambulance crew which can then be handed over at triage, allows the patient to be immediately seen and cared for by the appropriate frailty team such as a Geriatric Emergency Medicine Service or Acute Frailty Team, or streamed directly to an Older Persons Assessment Unit or GEM area. Knowing the patients baseline frailty state (rather than how they are acutely presenting at time of arrival into the ED), allows for pragmatic conversations regarding response to therapy, rehabilitation goals, initiation of frailty pathways and being seen by appropriate teams in the hospital, consideration of alternatives to admission if safe and appropriate.

Pain is often under recognised in the Emergency Department especially in older aged patients and those with a cognitive impairment such as dementia. If the patient is unable to communicate verbally, non-verbal cues should be looked for such as agitated behaviour and facial grimacing. The Abbey Pain Tool may be useful to use with patients who are unable to verbalise their pain score. It is important to ask the patient's carer / family member if they believe the patient to be in pain and how the Emergency Department team may be able to identify pain if unable to verbalise.

'Silver trauma' assessment should take into account the differing injury patterns and physiological responses (co-existent morbidities and polypharmacy) of the older person. Lower thresholds for CT scanning and high suspicion for occult injuries are central to safe and effective care; traumatic brain injuries and chest wall injuries are the most common cause of death. Departments must have clear protocols for common clinical scenarios eg. anticoagulation reversal, as well as admission pathways whether isolated injuries (eg. pubic rami fracture) or multi-system involvement.

Environmental considerations for older patients living with frailty and those living with dementia include a quieter assessment area away from the noisy and over stimulating main Emergency Department, enough room for family members or carers to accompany the patient and close access to toilet facilities. The Emergency Department should be 'age-friendly', with signs in large font accompanied by pictures as a visual aid. Signs to toilets should be bold, visible and multi-cue i.e. a picture of a toilet beside a toilet sign. All signage should be at eye level 1. Consideration of floor and wall colourings along with breaks in patterns should be taken into account to support those with Parkinson's Disease. Orientation aids such are large font clocks and calendars displaying the day, month and year to help orientate the patient to their new environment.

Older patients living with frailty are one of the most vulnerable patient groups presenting to the Emergency Department. They will often not vocalise their care needs and instead Emergency Department staff must seek to identify them. This includes, nutrition and hydration with some patients presenting after a period of time when they have not eaten or drunk for many hours. Emergency Departments should have a range of cups, plates and cutlery with adaptations to support the patient to independently eat and drink for themselves. A range of drinks and snacks should be on offer and ideally hot food. Patients may have reduced mobility and need quick and easy access to the toilet.

The Geriatric Emergency Medicine/Frailty lead should work collaboratively with relevant specialities such as Care of the Elderly, Stroke, Trauma and Orthopaedics and where possible, community colleagues such as General Practice frailty leads, NHS@home teams, carers support teams, voluntary sector. The GEM lead should lead engagement in local and national audits, Quality Improvement Projects relating to best care of older adults in the Emergency Department. Learning from these projects should be shared with wider ED teams to help upskill all members of the Emergency Department in best care for older patients.

Older patients living with frailty presenting to the Emergency Department are most often best cared for by a multi-disciplinary team, made up of Doctors, Nurses, Therapists, pharmacists and other allied health professionals. The NHS Long Term Plan states that ‘all hospitals with a 24 hour A&E will provide an Acute Frailty service for at least 70 hours a week, with the aim to complete a clinical frailty assessment within 30 minutes of a patients arrival in the Emergency Department or SDEC unit’ 4. Frailty teams can be Emergency Medicine led by those with a special interest in GEM or any other specialty with a ‘front door’ frailty interest. Geriatric Medicine led. A dedicated GEM service is able to provide all care for patients at the time of their arrival into the ED, regardless of level of acuity of illness or injury. Other frailty services may ask that patients are seen by ED first, to exclude certain conditions such as fractures and the need for acute care.

Comprehensive Geriatric Assessment (CGA) is a structure for the thorough assessment and management of a person’s medical, psychological, functional, social and environmental circumstances and needs. It improves patient and service outcomes 5 and increases the likelihood that patients survive and are back home 3 to 12 months after discharge6. The frailty service / GEMs teams working with the ED should provide appropriate criteria (from routinely collected ED information) to determine which ED patients should receive a CGA. Given the time constraints the ED has to work within (4hr emergency access standard) and the iterative nature of CGA, careful consideration needs to be given as where this assessment takes place; the ED is not necessarily always the most appropriate place.

ED staff should be adept at recognising common frailty syndromes including, Frailty Delirium, Falls, Polypharmacy, suspected fracture neck of femur(#NoF) and end of life (EoL) care. It should be recognised that delirium is a medical emergency with associated high rates of mortality and morbidity7. Following identification of delirium, pathway should be initiated to help identify precipitants and provide appropriate acute management eg. TIME bundle8. Consider referral to community based teams if the patient has had two or more falls in the last 12 months or has problems with walking or balance9. For older aged patients a medication review is suggested, to include medication reconciliation, identification of polypharmacy, anticholinergic burden, drug interactions and side effects, compliance with medication and understanding of use. For older aged patients the STOPP/START tool is an example of a medication review tool. Any medication changes must be conveyed to the patients General Practice team and in writing to the patient.

Patients who have a clinical suspicion or confirmation of a hip fracture should have the Big Six interventions/treatments before leaving the ED10 (pain relief, delirium screen, NEWS2 score, bloods & ECG, pressure area assessment and IV fluids started). EDs should have ready access to Treatment Escalation Plans (TEPs) and Recommended Summary Plan for Emergency care and Treatment ReSPECT information. If there is an acute necessity for a ReSPECT conversation, i.e. it is thought the patient will die in the Emergency Department, effort should be made to include the patient and their nominated family members in the conversation. Rapid access to 'just in case' medications should be available for use in the department and as a TTO for patients requesting a rapid discharge home if their wish is to die at home. In this case a community prescription chart should also be kept in the department. Psychological and spiritual support should be available for the patient and their loved ones, often provided by the Chaplaincy Service.

An accurate and meaningful discharge letter and telephone handover is particularly important for patients who are unable to retain the information themselves or communicate it to care providers, such as those living with dementia. It is also useful to document the time last medications were given and any medication changes.

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