An Approach to the Older Patient in the Emergency Department

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KEYWORDS

- Geriatric emergency department • Cognitive impairment • Atypical presentation
- Functional assessment • Geriatric medication reconciliation
- Emergency department palliative care

KEY POINTS

- Older adults are a rapidly growing, high-risk, unique emergency department (ED) patient population. ED provider perspectives and ED processes must evolve to better serve their complex care requirements.
- A more comprehensive approach to older ED patients requires routine, standardized assessment of cognitive impairment, atypical presentations, functional impairment, medication management, trauma, and end-of-life issues.
- A senior-friendly approach enhances patient safety, quality of care, and patient, caregiver and provider satisfaction.

INTRODUCTION

Most emergency physicians (EPs) would agree that during a busy shift of trauma presentations, resuscitations, breaking bad news, multitasking, and constant interruptions, the most challenging part of the shift can be providing care to older patients. Here is the issue: older individuals in an emergency department (ED) often present with multiple acute and chronic problems and sometimes cognitive impairment, accompanied by either no or many carers, often with many health care professionals

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involved in their care, and rarely with one simple solution or endpoint to their care.[1] Providing care to this rapidly growing population can seem overwhelming unless EPs have some core skills, knowledge, and attitudes that inform an approach. This article outlines the unique needs of older adults and approaches to address those needs. Many of the topics are addressed in detail in additional chapters of this issue.

Older adults are particularly vulnerable when they are acutely ill: they are more likely to experience adverse health outcomes due to depleted physiologic reserves; to have multiple comorbidities; and to be at risk for adverse events related to medications. The early identification of this particular vulnerability and awareness of geriatric syndromes, such as frailty, cognitive impairment, falls, delirium, sensory impairment, and polypharmacy, is crucial. Addressing the unique needs of older adults earlier while in an ED allows appropriate care for this vulnerable population.

High-risk ED presentations, such as trauma, sepsis, and cardiac arrest, trigger a standardized bundle of diagnostic and therapeutic interventions. Older adults in the ED are also a high-risk cohort and benefit from a similar comprehensive approach. A standardized approach to the unique vulnerabilities of older adults will have a significant impact on both the quality of care a patient receives and the efficiency of EPs and department work flow. This article outlines 6 key commonalities among older patients and demonstrates how increased geriatric awareness shapes an approach to older ED patients.

COGNITIVE IMPAIRMENT

An overriding issue for older ED patients is assessment of mental status and cognitive impairment. Dementia is the most common disease of old age and affects as many as 25% of people over age 80. Furthermore, dementia is the principal risk factor for delirium, often the principal presenting symptom of serious life-threatening disease in older ED patients. EPs must have a clear approach to both of these issues.

Ideally each ED system will develop a process of care for delirium management that involves standardized screening and a protocol-driven approach to investigation and treatment of its cause(s), once identified, and symptoms. Various screening tools have been developed for the identification of delirium. They are all some modified version of the Confusion Assessment Method[2] and incorporate the principal features of delirium:

- Acute and fluctuating course
- The presence of inattention
- Either disorganized thinking and/or altered level of consciousness (hyperalert or hypoalert)

Han and colleagues[3] have proposed a 2-step process that can be built into the ED work flow of nurses and doctors and is time-efficient enough to recommend completing on all patients over a specified age. It uses a highly sensitive and simple screen—the Delirium Triage Screen—to rule out delirium followed by a highly specific 4-question tool—the brief Confusion Assessment Method—to rule it in. The Delirium Triage Screen consists of establishing a Richmond Agitation and Sedation Scale number, a familiar ED tool routinely used for intubated patients and in conscious sedation. If that number is anything other than zero (alert and normal), then a simple test of attention (eg, spell "LUNCH" backwards) is used. If the patient rules in on this screen, completed in approximately 15 seconds, then the protocol proceeds to a series of standard questions assessing the 4 domains of delirium. This process can be completed by a nurse or potentially a nonclinician (because it involves limited clinical ability) and is integrated into the electronic health record to trigger a delirium