Ten Best Practices for the Older Patient in the Emergency Department

Don Melady, MSc(Ed), MD[a,*], Adam Perry, MD[b,c]

KEYWORDS

• Geriatric emergency department • Best practices • Older patients
• Processes of care • Geriatric principles • Geriatric emergency medicine
• Emergency department transitions

KEY POINTS

- Older adults challenge the traditional linear emergency department (ED) paradigm. Applying geriatric principles to ED practice creates safer, more comprehensive, patient-centered emergency care.
- Guideline-driven modifications to ED processes improve geriatric emergency care. These include geriatric-specific provider education, protocols, and screening; tailored staffing; and timely access to community resources.
- Older adults, their caregivers, and the health care system benefit from transition strategies that incorporate the ED into the patient's continuum of care.

INTRODUCTION

It comes as a surprise to most emergency department (ED) clinicians that older people, defined by an arbitrary age of over 65 years, represent a minority of patients in most EDs, ranging from 10% to 35%. Due to the complexity of presentations by older people and that they belong outside the usual ED paradigm of 1 patient with 1 problem, EDs and the clinicians who work in them have traditionally found older patients among the most challenging patient subgroups to work with.[1] Given the rapidly aging population in North America, it is essential that EDs develop more older person–appropriate approaches to care of this vulnerable population to

Disclosure Statement: The authors have nothing to disclose.
[a] Department of Emergency Medicine, Mount Sinai Hospital, Schwarz/Reisman Emergency Medicine Institute, Room 206, 600 University Avenue, Toronto Ontario M5G 1X5, Canada; [b] Department of Medicine, The Geisinger Commonwealth Medical College, 525 Pine Street, Scranton PA 18509, USA; [c] Wilkes Barre General Hospital, 575 North River St Wilkes Barre, PA 18764, USA
* Corresponding author.
E-mail address: don.melady@sinaihealthsystem.ca

Clin Geriatr Med ■ (2018) ■–■
https://doi.org/10.1016/j.cger.2018.04.001 geriatric.theclinics.com

avoid being overwhelmed by the rising silver tide and, more importantly, to ensure that older people are receiving the acute care that prioritizes their well-being and function. Various efforts have been made in this regard, including the rapid expansion of older person–appropriate EDs, both purpose-built separate departments[2] and general EDs that integrate processes of care appropriate for older people.[3] This article proposes 10 best practices that can be implemented in any ED, regardless of size. These best practices represent a synthesis of work done by various groups in the United States, Canada, and the United Kingdom to formulate the preferred components of a senior-friendly or geriatric ED.[4–6] The case of Mrs BP illustrates these best practices and demonstrates how they can be used to improve the ED care of a complex case of an older person (**Box 1**).

Use Geriatric Principles to Address Complexity

The core task of the emergency physician is rapidly determining "sick" from "not sick" patients. With older adults, this task is complicated by age-related physiologic changes, multiple medications, cognitive impairment, multimorbidity, and functional decline. Compounding the emergency clinicians' challenge is that evaluation and treatment occur rapidly and simultaneously, without benefit of complete information, in a crowded, fast-paced, highly distracting practice environment on an unscheduled basis.

EDs are designed to rapidly diagnose and treat acute illness or injury using a focused, single-complaint–driven paradigm. As EDs have evolved to become the center for acute geriatric assessment and care coordination, this narrow mandate

Box 1
Mrs BP

Mrs BP, 87-years-old, arrives by ambulance from a skilled nursing facility after vomiting twice. The paramedics report "decreased oral intake" over 2 days and a recent diagnosis of urinary tract infection. She denies complaint, besides feeling "queasy."

Past medical history: Dementia. Hypertension. Appendectomy. Urosepsis with bacteremia 1 year ago.

Social history: Lived with daughter until last year. Her son, the POA (power of attorney), visits daily.

Medications: Lisinopril 10 mg daily. Metoprolol XL 50 mg daily. Nitrofurantoin 100 mg twice daily.

Physical examination: Weight 42 kg. Awake and alert; oriented to person and place. Abdomen soft and nontender with normal bowel sounds. Remainder of examination is noncontributory.

ED evaluation: Metabolic panel normal, except urea 22 mg/dL, Creatinine 1.4 mg/dL. Catheterized urinalysis normal; electrocardiogram normal sinus rhythm 68 with T wave inversion in anterior leads; computed tomography abdomen: gallstones with no inflammatory changes and substantial colonic stool.

Over 4 hours in the ED she becomes increasingly confused and agitated, wondering why she is not in her home. She walks out of her room and vigorously resists care.

At this point the ED team considers physical restraint, sedation with a small dose of haloperidol, intravenous antibiotics, and arranging admission. Before initiation, her son arrives and her behavior settles significantly. She has no further vomiting, has 400 mL of water and some fried chicken. She ambulates easily in the department with her son who reports she is her usual self. A call to the facility physician corroborates she is at baseline status. She is discharged with a plan for an evaluation the next day.