Care of the Older ED Patient: Triage, Systems, and Accreditation

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Champlain LHIN
Senior Friendly Hospital Symposium

Disclosure

- I have no financial or other conflicts of interest to disclose

Learning objectives

1. Describe key variables of older people in the ED triage process
2. List three innovative changes to make in the ED for older person care
3. Compare your own ED to the three levels of Geriatric ED accreditation.

Guidance when Applying the Canadian Triage and Acuity Scale (CTAS) to the Geriatric Patient: Executive Summary

Michael J. Bullard, MD*; Don Melady, MD[†]; Marcel Emond, MD[‡]; and members of the CTAS National working group: Erin Musgrave, MN, RN[§]; Bernard Unger, MD[¶]; Etienne van der Linde, MD[‖**]; Rob Grierson, MD[††]; Thora Skeldon, RN, BSN[‡‡]; David Warren, MD[§§]; Janel Swain, ACP, BSc, BEd[¶¶]

Bullard, Melady, et al. CJEM 2017 Sep;19(5):415.

The older person at Triage

Canadian Triage and Acuity Scale **allows** ED nurses and physicians to:

- Triage patients based on the **type and severity of their presenting signs and symptoms**
- Ensure that the **sickest patients are seen first** when ED capacity has been exceeded due to visit rates or reduced access to other services
- Ensure that a patient's need for care is **reassessed** while in the ED

The older person at Triage

Canadian Triage and Acuity Scale **does not allow** ED nurses and physicians to:

- Establish a **diagnosis**
- Start **disposition** planning

- Level 1 - Resuscitation
- Level 2 - Emergent
- Level 3 - Urgent
- Level 4 - Less Urgent
- Level 5 - Non-Urgent

CTAS: 4-step Process VERY brief (< 2 minutes)

1. Quick look
2. Presenting complaint from a standardized CEDIS list (17 categories/167 complaints)
3. Apply 1st order modifiers to all: Vital Signs; level of consciousness; pain; mechanism of injury
4. Apply 2nd order modifiers to some depending on complaint: blood glucose, dehydration, quality of pain, localized weakness, visible deformity, duration of symptoms . . . Wait for it!

Mechanism of Injury

MOI	CTAS Level 2
General Trauma	**MVC**: **MCC**: **Pedestrian or bicyclist:** **Fall:** From >18 ft (>6 m) **Penetrating injury:** To high risk anatomical regions
Head Trauma	**MVC**: **Pedestrian:** struck by vehicle **Fall:** from >3 ft (>1 m) or 5 stairs **Assault:** With blunt object
Neck Trauma	**MVC**: **MCC**: **Fall:** From > 3ft (1 m) or 5 stairs **Axial load** to the head

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Sinai Health System

Your turn . . . .

1. Quick look
2. Presenting complaint from a standardized CEDIS list (17 categories/167 complaints)
3. Apply 1st order modifiers to all: Vital Signs; level of consciousness; pain; mechanism of injury
4. Apply 2nd order modifiers to some depending on complaint: blood glucose, dehydration, quality of pain, localized weakness, visible deformity, duration of symptoms

What challenges does this process pose for the older patient presenting to triage?

Quick look

1st order modifiers

- Vital Signs; level of consciousness; pain; mechanism of injury

2nd order modifiers

- blood glucose, dehydration, quality of pain, localized weakness, visible deformity, duration of symptoms

What’s your number?

- 74-year-old female presents a 3 day hx of increasing weakness and easily short of breath doing her daily activities but was not SOB at rest.
- Does not complain of pain but does give a history of type 2 DM on oral hypoglycemics, and hypertension well controlled on an ACE-I.
- RR 17, HR 94, BP 108/72, Temp 36.8C, O2 Sat 96%, GCS 15

CTAS 3 or 4

CEDIS Presenting Complaint:

General Weakness OR Shortness of breath

During her ED workup, an ECG showed acute inferior wall ischemic changes and her troponin was significantly elevated. She was admitted to Cardiology and managed medically prior to angiography due to her delayed presentation.

What's your number?

- 85-year-old-male was observed suddenly falling on the sidewalk, with no obvious trip, and had difficulty getting up so EMS were called.
- Complains of left sided chest and hip pain, has no obvious deformities. He is able to give his name, address and phone number, but isn't sure why he is at the hospital or how he got here. No friends or family are with the patient.
- He is well groomed but doesn't know the date and cannot spell WORLD backwards. He has equal strength in all 4 limbs.
- From his electronic health record he is prescribed: metformin, lisinopril, metoprolol, warfarin, and l-dopa-carbidopa (Sinemet©).
- A finger stick glucose reads RR 22, HR 76, Temp 36.9° C, BP 108/82,

  BS 15.8 mmol/L
- O2 Sat 95%, GCS 14

CTAS 2

CEDIS Presenting Complaint:

Multisystem trauma, blunt OR

Syncope/pre-syncope

Issues: VS; medications (beta-blocker, anti-coag); cognitive status (acute vs. chronic); head injury?

Challenges

1. Atypical presentations of disease
2. Cognitive impairment
3. Falls and trauma
4. Co-morbid conditions
5. Polypharmacy
6. End-of-life care

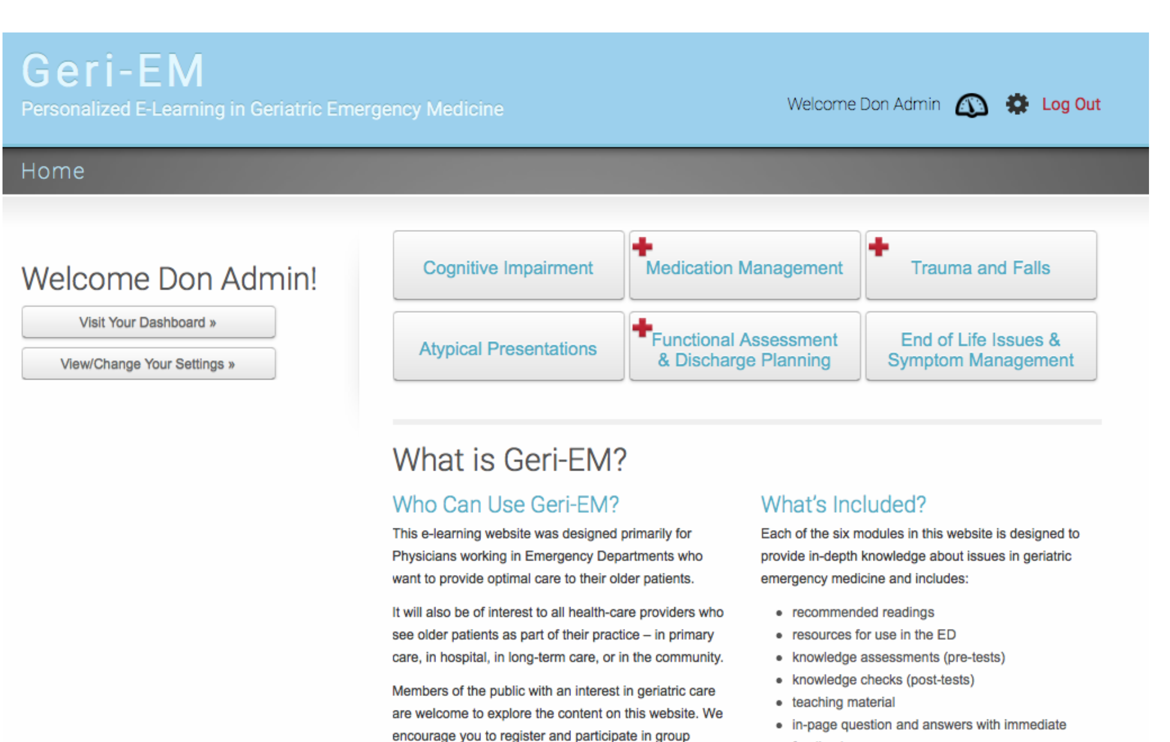
How to address the challenges?

Education:

enhanced awareness

of geriatric realities

Focussed supplementary geriatric education for triage nurses



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How to address the challenges?

Frailty:

a multidimensional syndrome

of loss of reserves

(energy, physical ability, cognition, health)

that gives rise to vulnerability

How to address the challenges?

Addition

of a new

2nd order modifier:

Frailty

Frailty modifier

- allows triage nurses to up-triage patients normally rated as a CTAS level 4 or 5 to a CTAS 3

Frailty modifier

Any patient who is

- completely dependent for personal care;
- wheelchair-bound;
- suffers from cognitive impairment that limits their awareness of their surroundings or ability to appreciate time;
- is in the late course of a terminal illness;
- shows signs of cachexia and general weakness;
- over 80 years of age unless obviously physically and mentally robust.

"if you would not feel comfortable putting the patient in a room alone and not checking on them for more than 30 minutes, they should be at least a CTAS 3."

Frailty:
How to identify – or measure – it?

Fried phenotype model

1. Unintentional weight loss
2. Self-reported exhaustion
3. Weak grip strength
4. Slow walking speed
5. Low physical activity

Frailty: yes or no?

Fried et al Frailty in older adults: evidence for a phenotype. J Gerontol A Biol Sci Med Sci 2001

Rockwood Accumulated Deficits model

Measured by a Frailty Index =

How many things *are* wrong with you?

How many things *could be* wrong with you?

Frailty:
how frail?

Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173(5):489-495.

Clinical Frailty Scale

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Recommendations and Implications

- Introduction of e-CTAS in Ontario
- Impact of CTAS 4 and 5 in an ED – flow, metrics
- Value of implementing both supplementary education and the frailty modifier to improve processes

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Geriatric ED Guidelines

Staffing

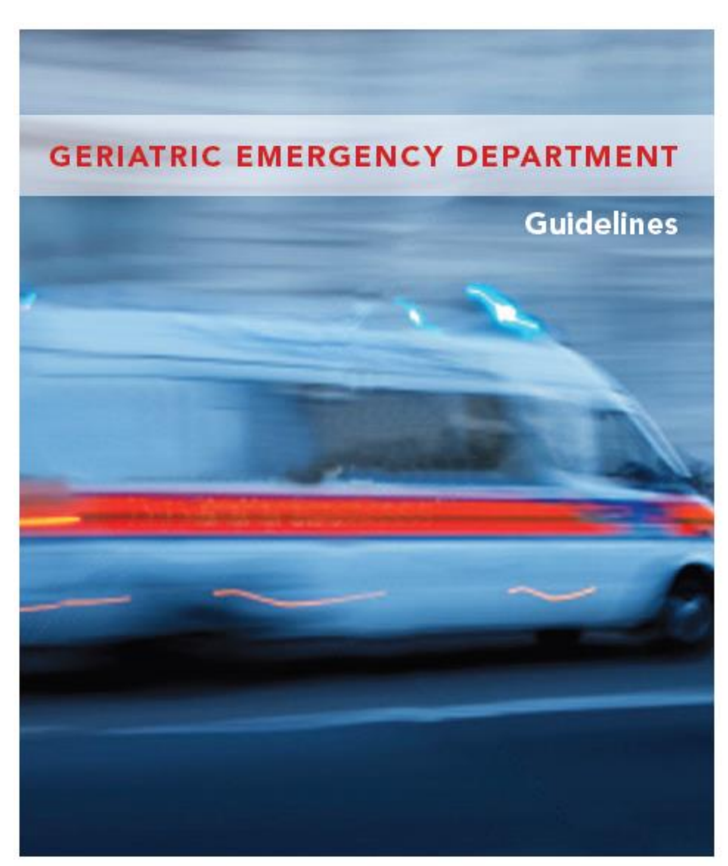
Education

Processes of care

Transitions of Care

Quality Improvement

Physical environment



2013

How do we know who is providing good ED care?

How can we promote good ED care?

How can we ensure good ED care?

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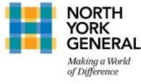
American College of Emergency Physicians

Geriatric ED Accreditation

To ensure that a Geriatric ED
is an ED verified by a trusted agent
that meets the needs of older adults



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Three Levels

All levels promote improvements in:

Staffing
Education
Processes of care
Transitions of Care
Quality Improvement
Physical environment

Three Levels

Level 3

Good
older adult ED care
achievable by *any* ED

$1,000

Level 2

Extensive enhancements of
older adult ED care
requiring focussed commitment

$5,000

Level 1

Excellent and uniform
older adult ED care
requiring whole system
enhancements and commitment

$10,000

Level 3

1. One MD with some focussed education in geriatric Emergency Medicine
2. One RN with some focussed education in geriatric ED nursing care
3. One initiative that focussed on care of older ED patients (e.g., a catheter utilization policy, a functional assessment tool, a process for transitions of care)
4. Access to mobility aids and food and drink

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Level 2

Staffing

1. A physician champion or medical director
2. A geriatric nurse case manager for at least 56 hours/week
3. Access to 2 members of an interdisciplinary team (PT/OT/SW/Pharm)
4. Executive level supervision

Level 2

Education

1. Focussed education of all staff MDs in domains of geriatric EM
2. Focussed education of all staff RNs in geriatric ED nursing

Level 2

Policies and Procedures (10 out of 27 options)

1. Screening process for delirium; for dementia;
2. Standardized assessment of function; of fall presentations; of suspected abuse; of medication use
3. Order sets for pain management; for common presentations; for avoiding PIMs; to promote mobility

Level 2

Policies and Procedures (10 out of 27 options)

4. Access to palliative care consultation; geriatric psychiatry; to rehabilitation beds; to mobility aids; to food and drink; to volunteer support;
5. Standardized approach to discharge planning to the community; to long-term care; to notification of other care providers (PCP, specialists);
6. Standardized access to post-discharge community paramedicine; to phone follow up

Level 2

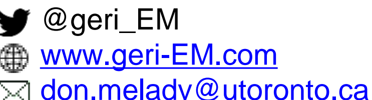
Quality Improvement and Outcome metrics

1. Evidence (e.g. chart audit) of 75% adherence to the policies and procedures
2. Tracking of outcome measures in at least 3 domains (e.g. positive screens, referrals made, LOS, repeat visits, mortality, discharge destination, others)

Level 2

Equipment and supplies

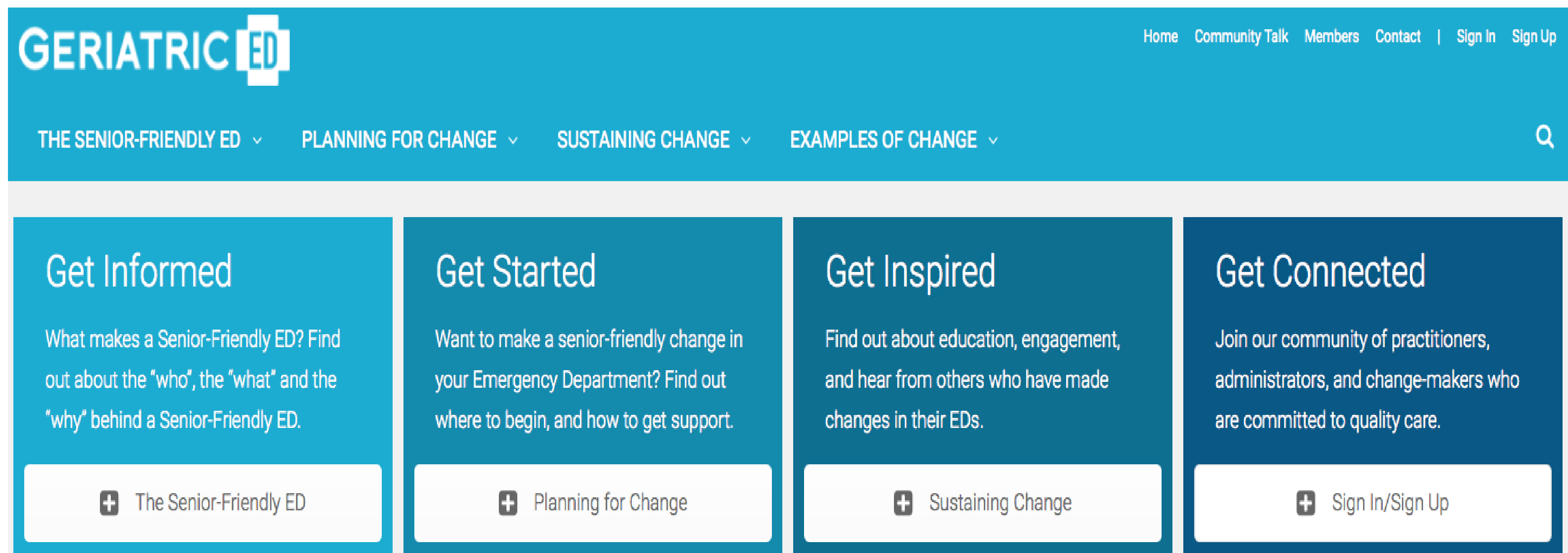
1. Walkers and canes
2. 3 out of: non-slip socks; hearing assists; blanket warmer; low beds; appropriate mattresses/pillows; commodes; condom catheters;



Level 2

Physical environment

1. Required: Two chairs per patient bed; clock in each room; food and drink
2. Recommended: optimal lighting; noise reduction; non-slip floors; hand rails; signage and way-finding; accessible toilets; raised toilet seats



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(Search: checklist)

Motivation to become an accredited Geriatric ED?

- Improved outcomes
- Quality assurance
- Standardization of processes
- Reputation enhancement
- Potential return on investment

Thanks

To:

Stephanie Saraga RN, Mount Sinai Hospital ED

Michael Bullard, MD, University of Alberta Health Sciences Centre

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Questions?

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