Dementia Training Australia

How to best care for older people with cognitive impairment in ED

Dr Linda Schnitker

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Overview Content Presentation

People with cognitive impairment in EDs:

1. Background
2. Quality Indicators
3. Care Challenges
4. Best Practices
5. Conclusion

1. Background

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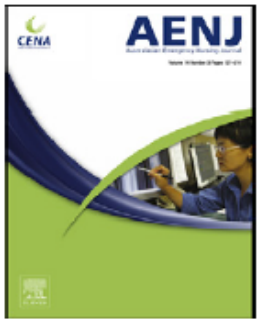


LITERATURE REVIEW

Negative health outcomes and adverse events in older people attending emergency departments: A systematic review

Linda Schnitker[a,*], Melinda Martin-Khan[a], Elizabeth Beattie[b], Len Gray[a]

[a] *The Centre for Research in Geriatric Medicine, School of Medicine, The University of Queensland, Woolloongabba, Queensland, Australia*

[b] *School of Nursing and Midwifery, Queensland University of Technology, Kelvin Grove, Queensland, Australia*

[1] Schnitker et al. 2011

How to best care for older people with cognitive impairment in ED

1/5 Background

Functional Decline:

- Increased risk compared to younger ED patients[1]
- The oldest are at highest risk[2]

FUNCTIONAL DECLINE ED PATIENTS ≥ 65 YEARS			
Time since ED visit:	3 weeks	3 months	6 months
Results:	10% – 52%[3]	6% (ADL) & 20% (IADL)[4]	16%[5]

[1] Denman et al. 1989
[2] Bloch et al. 2009, Grossman et al. 2003
[3] Currie et al. 1984, Rowland et al. 1990, Sayers et al. 1997.
[4] Shapiro et al. 2001
[5] McCusker et al. 1999.

1/5 Background

ED Readmission:

- No significant differences between 65+ and 75+ group

ED- READMISSION PATIENTS 65+ AND 75+				
Time since ED visit:	14 days	1 month	3 months	6 months
Results 75+:	5.6%[1]	12% - 17.1%[2]	6% - 24%[4]	
Results 65+:		10.3% - 19.3%[3]	17.2% - 26%[5]	42.9%[6]

[1] Rowland et al. 1990
[2] Bentley et al. 2004, Caplan et al. 1998
[3] Friedmann et al. 2001, Hastings et al. 2008, McCusker et al. 2000, 2009, Ferrera et al. 1999.
[4] Richardson, 1992, McCusker et al. 1997
[5] Friedmann et al. 2001, Hastings et al. 2007, 2008.
[6] McCusker et al. 2000

1/5 Background

Hospitalisation:

HOSPITALISATION RATE ED PATIENTS ≥ 65 YEARS DISCHARGED HOME				
Time since ED visit:	7 – 14 days	1 month	3 months	6 months
Results:	3% - 10.2%[1]	10.9% - 14%[2]	13.3 – 18.3%[3]	17.6% [4]

[1] McCusker et al. 2000, Sayers, 1997.
[2] Hastings et al. 2008, McCusker et al. 2000.
[3] Hastings et al 2008 & 2007.
[4] McCusker et al. 2000

1/5 Background

Institutionalisation:

INSTITUTIONALISATION RATE OLDER ED PATIENTS			
Time since ED visit:	1 month	3 months	6 months
Results 75+:		7.5%[1]	13%[1]
Results 65+:	1.4%[2]	2.6%[2]	3%[3]

[1] Bloch et al. 2009, Richardson, 1992.
[2] Hastings et al. 2008, McCusker et al. 2000.
[3] Carpenter et al. 2009, McCusker et al. 1999.

1/5 Background

Mortality:

MORTALITY RATE OLDER ED PATIENTS			
Time since ED visit:	1 month	3 months	6 months
Results 75+:		12.4%[1]	1% -14.8%[2]
Results 65+:	1% - 2.2%[3]	2.4% - 10%[4]	10.2%[5]

[1] Bloch et al. 2009, Richardson, 1992.
[2] Bloch et al. 2009, Bently et al. 2004. Richardson, 1992.
[3] McCusker et al. 2009, Hastings et al. 2008, Friedmann et al. 2001.
[4] Hastings et al. 2008 & 2007, Friedmann et al. 2001,Chin et al. 1999
[5] McCusker et al. 1999

1/5 Background

Adverse Events[1]:

1. Adverse medication-related events
2. Under triage of illness severity
3. Adverse communication-related events
4. Lack of recognition of geriatric syndromes

Princess Alexandra Hospital, Brisbane

[1] Schnitker et al. 2010

1/5 Background

Adverse medication-related events:

- No routine screening[1]
- Discordance medication lists[2]

SUB-OPTIMAL PHARMACOTHERAPY[3] OLDER ED PATIENTS (≥ 65 Y)	
In ED	3.6% - 19.9%[3]
Upon discharge	5.6% - 31.8%[4]

[1] Beers et al 1990.
[2] Nixdorff et al 2008.
[3] Chen et al. 2009, Carter et al. 2008, Nixdorff et al. 2008, Caterino et al. 2004, Heininger-Rothbucher et al. 2003, Chin et al. 1999
[4] McCusker et al. 2009, Hastings et al. 2007, Hustey et al. 2007, Chin et al. 1999.

1/5 Background

Under triage of illness severity:

- ‘Age’ independent factor influencing the process of care[1]

UNDER TRIAGE OF ILLNESS SEVERITY IN OLDER ED PATIENTS (≥65 Y)	
Missed diagnosis / unrecognised health issues	20% - 28%[2]

[1] Montout et al. 2008, Magid et al. 2005, Lane et al. 2003, Grant et al. 2000.
[2] Ray et al. 2006, Khan et al. 1996

1/5 Background

Adverse communication-related events:

- Missing essential patient information[1]
- Emergency physicians experience communication problems[2]

[1] Schumacher et al. 2006, Stiell 2003
[2] McNamara et al. 1992

1/5 Background

Lack of recognition of geriatric syndromes:

- Cognitive Impairment:

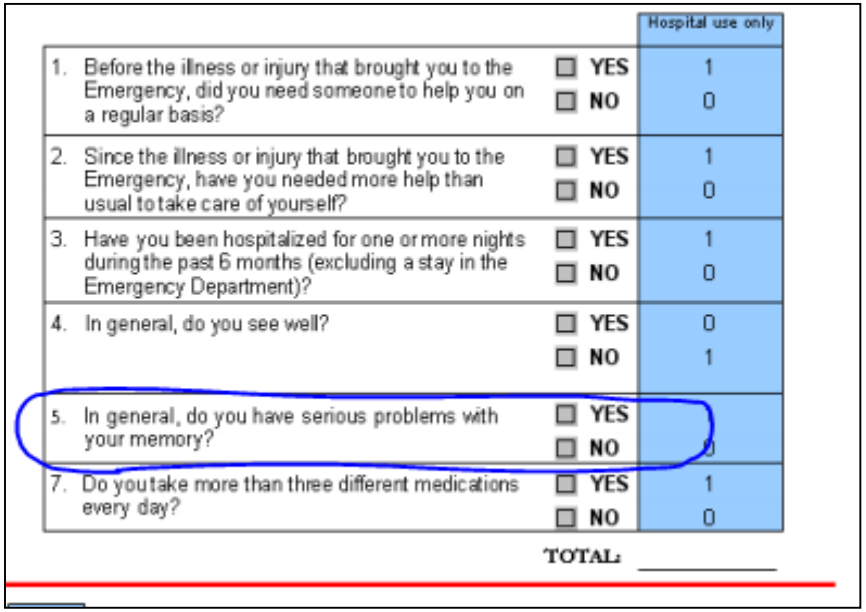
- No routine screening
- Poor documentation[1]

RECOGNITION OF CI IN OLDER ED PATIENTS ≥ 65.		
	Not detected:	Not documented:
Delirium:	43.3% - 76%[2]	40% - 83%[3]
Cognitive functioning		88%[4]

[1] Hustey, 2002.
[2] Han et al. 2009, Hustey et al. 2003, Kakuma et al. 2003,Elie et al. 2000.
[3] Elie et al. 2009, Lewis et al. 1995.
[4] Press et al. 2009

1/5 Background

The Identification of Seniors at Risk (ISAR) tool: (ISAR)[1]:



		Hospital use only
1. Before the illness or injury that brought you to the Emergency, did you need someone to help you on a regular basis?	☐ YES ☐ NO	1 0
2. Since the illness or injury that brought you to the Emergency, have you needed more help than usual to take care of yourself?	☐ YES ☐ NO	1 0
3. Have you been hospitalized for one or more nights during the past 6 months (excluding a stay in the Emergency Department)?	☐ YES ☐ NO	1 0
4. In general, do you see well?	☐ YES ☐ NO	0 1
5. In general, do you have serious problems with your memory?	☐ YES ☐ NO	
7. Do you take more than three different medications every day?	☐ YES ☐ NO	1 0
	TOTAL:	

The Triage Risk Screening Tool (TRST)[2]:

- History or evidence of cognitive impairment (poor recall or not oriented)
- Difficulty walking/transferring or recent falls
- Five or more medications
- ED use in previous 30 days or hospitalization in previous 90 days
- RN professional recommendation*

[1] McCusker et al.1999
[2] Meldon et al. 2003

1/5 Background

People with dementia compared to older adults [1,2]

- More frequent ED visits
- More frequently admitted
- Increased re-presentations
- Increased mortality rate

- LaMantai MA, Stump TE, Messina FC, Miller DK, Callahan CM. Emergency Department Use Among Older Adults with Dementia. *Alzheimer Dis Assoc Disord,* 2016.
- Australian Commission on Safety and Quality in Health Care. Evidence for the safety and quality issues associated with the care of patients with cognitive impairment in acute care, 2013.

2. Quality Indicators

2/5 Quality Indicators

Measuring Quality of Care of Older ED Patients with Cognitive Impairment: ‘the EDQI cognition Project’

2/5 Quality Indicators

Research Question

- What data reflects quality of care of older ED patients with cognitive impairment?

2/5 Quality Indicators

Methodology EDQI project – 3 phases

2/5 Quality indicators

Results Phase 2

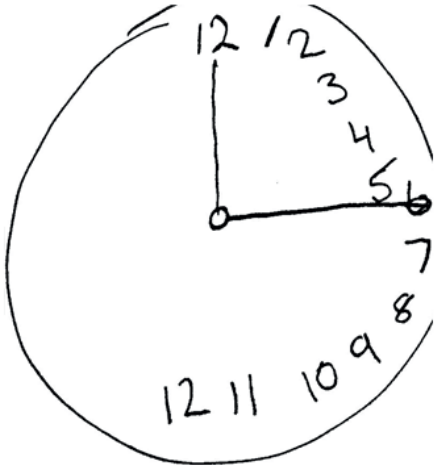
- Process and outcome data of 544 older ED patients
- Structural data of 8 Australian ED sites

ED Population Characteristics (N=544):	
Mean age	80.5 (SD 6.7) (Range, 70 – 99)
Female	277 (51%)
Service urgency according to a five-level triage instrument	Level 1: n=0 (0%) Level 2: n=92 (17%) Level 3: n=318 (58%) Level 4: n=124 (23%) Level 5: n=10 (2%)
Subsequent hospital admission:	314 (58%)

2/5 Quality indicators

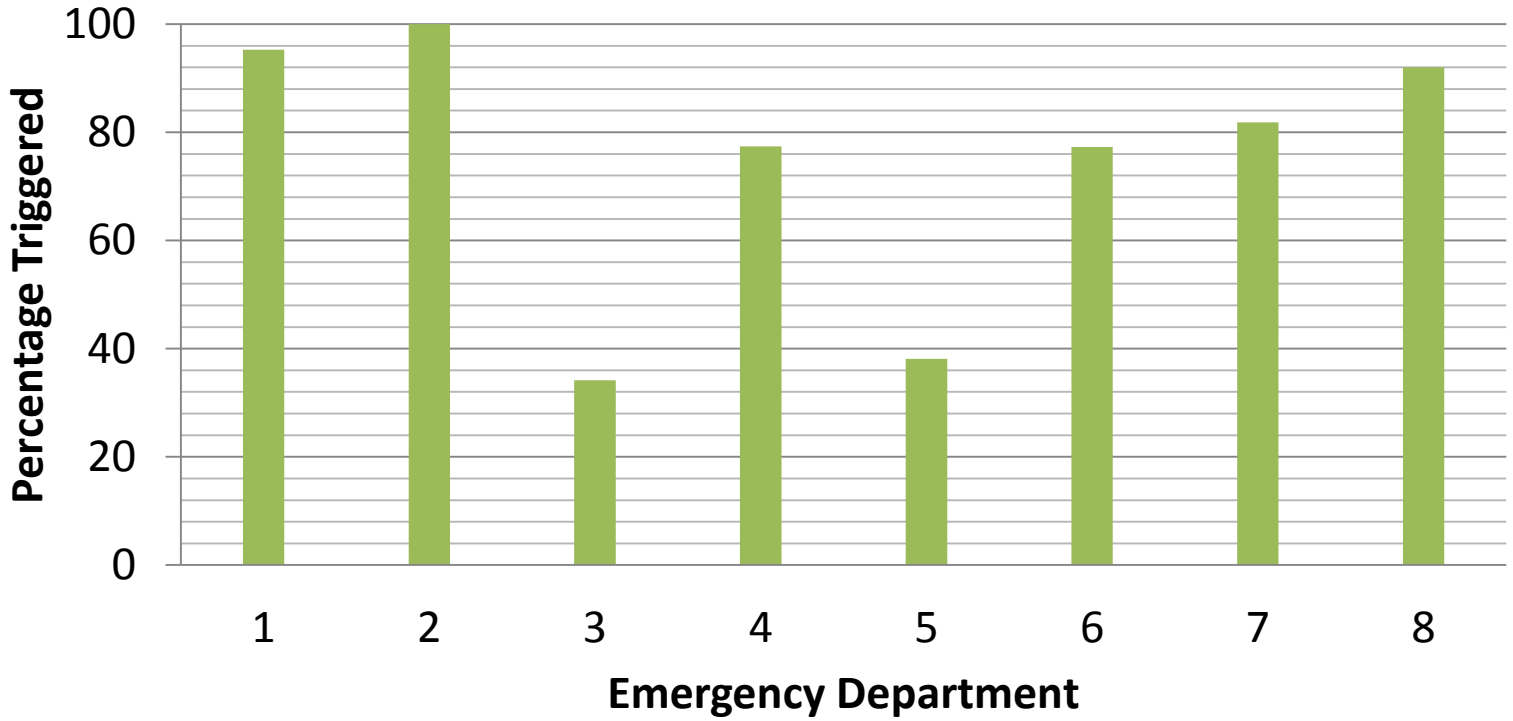
1) Process Quality Indicator: Cognitive screening

Proportion of older people who received cognitive screening in ED



2/5 Quality Indicators

- *Proportion of older people who received cognitive screening in ED*



2/5 Quality Indicators

Assessment of cognitive functioning

Clinically significant:

Delirium:

- Delirium is a preventable clinical syndrome[1]
- Benefit from rapid diagnosis and treatment[2]

Existing cognitive impairment:

- Benefit from early recognition[3]
- Referrals to interdisciplinary teams to slow disease progression and support prolonged independence[3]

[1] Inouye 2000.
[2] Sanders 2002.
[3] Fillet et al. 2006, Geldmacher et al. 1996.

2/5 Quality Indicators

Assessment of cognitive status:

- If CI is not recognised clinical decisions may be based on incorrect or incomplete data
- Compliance discharge instructions
- Achieving optimal care[1] and reducing risk of negative outcomes and adverse events.

[1] Fillit et al. 2006

2/5 Quality Indicators

Older ED patients:

- Cognitive impairment prevalence: 26%-40%1
- Delirium prevalence: ≈ 10%2

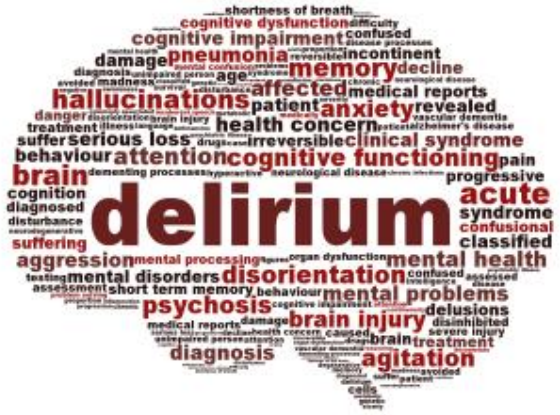
http://www.medicarehomehealth.com/education-center/resources-for-seniors/aarp-8-treatable-conditions-mimic-dementia/

[1] Wilber et al. 2008 & 2005, Hustey et al. 2003 & 2002, Naughton et al. 1995,Gerson et al. 1994
[2] Schnitker 2015 et al., Han et al. 2009, Hare et al. 2008, Hastings et al. 2007, Hustey et al. 2002, McCusker et al.1999

2/5 Quality indicators

2) Process Quality Indicator: Delirium screening

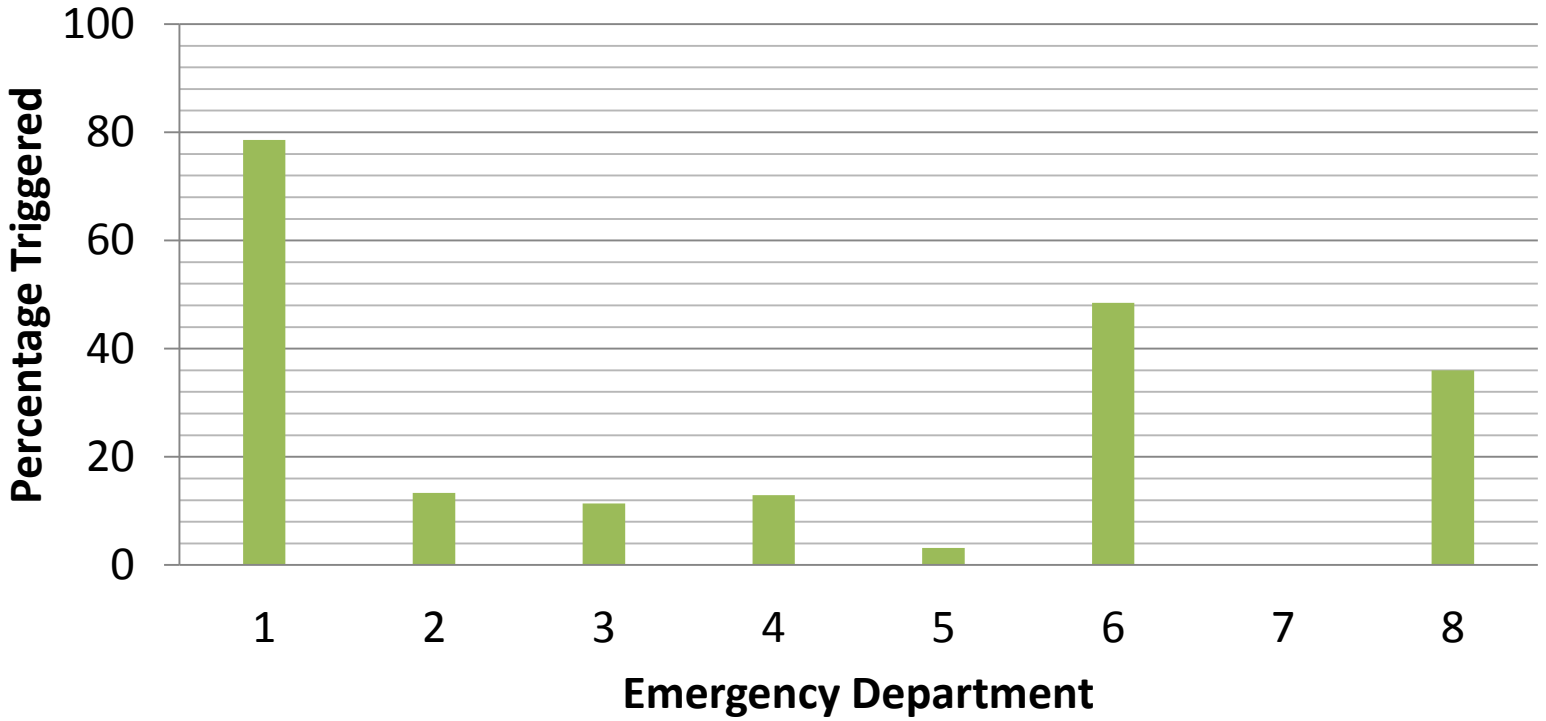
Proportion of older people who received a screen for delirium in ED



https://ccnb.com.au/can-protect-ageing-parent-delirium/

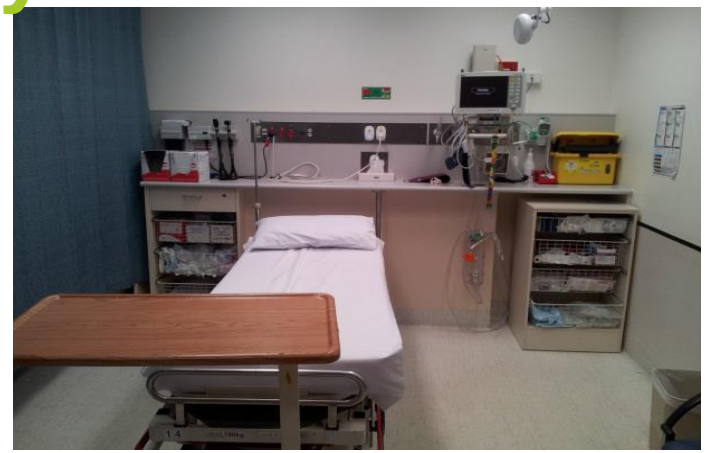
2/5 Quality Indicators

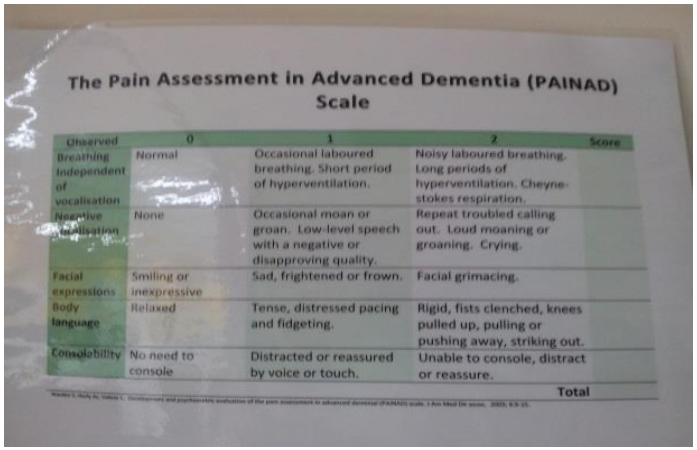
- *Proportion of older people who received a screen for delirium in ED*



2/5 Quality Indicators

Structural Quality Indicators:





Picture 1: Assessment of the ED environment searching for elderly friendly structural elements

Structural Quality Indicators

Domain	Quality Indicator: The ED has a policy outlining……	Triggered
Cognitive Impairment	*The **management of older people with cognitive impairment** during the ED episode of care*	25% (2/8)
Carer friendly environment	*Issues relevant to **carers of older people with cognitive impairment, encompassing the need to include the (family)** carer in the ED episode of care*	12.5% (1/8)
Assessment and management of behavioural disturbances	*The **assessment and management of behavioural symptoms**, with specific reference to older people with cognitive impairment*	37.5% (3/8)
Delirium prevention	***Delirium prevention strategies**, including the assessment of delirium risk factors*	43% (3/7)
Pain assessment and management	***Pain assessment and management** for older people with cognitive impairment*	43% (3/7)

2/5 Quality Indicators

Academic Emergency Medicine
Official Journal of the Society for Academic Emergency Medicine

ORIGINAL CONTRIBUTION

Process Quality Indicators Targeting Cognitive Impairment to Support Quality of Care for Older People with Cognitive Impairment in Emergency Departments

Linda M. Schnitker, MS, Melinda Martin-Khan, PhD, Ellen Burkett, MBBS, Elizabeth R. A. Beattie, PhD, Richard N. Jones, ScD, and Len C. Gray, PhD, The Research Collaboration for Quality Care of Older Persons: Emergency Care Panel*

Academic Emergency Medicine
Official Journal of the Society for Academic Emergency Medicine

ORIGINAL CONTRIBUTION

Structural Quality Indicators to Support Quality of Care for Older People With Cognitive Impairment in Emergency Departments

Linda M. Schnitker, MS, Melinda Martin-Khan, PhD, Ellen Burkett, MBBS, Caroline A. Brand, PhD, Elizabeth R. A. Beattie, PhD, Richard N. Jones, ScD, and Len C. Gray, PhD, The Research Collaboration for Quality Care of Older Persons: Emergency Care Panel*

https://onlinelibrary-wiley-com.ezp01.library.qut.edu.au/doi/epdf/10.1111/acem.12617
https://onlinelibrary-wiley-com.ezp01.library.qut.edu.au/doi/abs/10.1111/acem.12616

3. Other Care Challenges

2/5 Quality Indicators

Rationale

- Increasing older ED population with cognitive impairment[1]
  - Complex care needs
  - ED can be stressful and frightening[2]
  - Responsive behaviour[3]
  - Burden of care
  - Carer stress
  - Safety / Ethical issues
  - Increased risk delirium[4]
  - Increased risk delayed pain assessment and treatment[5]

[1] Ferri et al. 2005
[2] Cheston and Bender 1999
[3] Erel 2013
[4] Han et al. 2009, Weber et al. 2004, Elie et al. 1998, Inouye et al. 1993
[5] Hwang 2006, Meldon et al. 2003, McCusker et al. 1999

4. Best Practices

4/5 Best Practices

Evidence

- Limited!
  - Review by Schnitker et al. (2013)
  - Review by Clevenger et al. (2012)

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What is the Evidence to Guide Best Practice for the Management of Older People With Cognitive Impairment Presenting to Emergency Departments?
A Systematic Review

Linda Schnitker, MN-NP, RN
Melinda Martin-Khan, PhD
Elizabeth Beattie, PhD
Len Gray, MBBS, PhD

J Am Geriatr Soc. 2012 Sep;60(9):1742-8. doi: 10.1111/j.1532-5415.2012.04108.x.

Clinical care of persons with dementia in the emergency department: a review of the literature and agenda for research.

Clevenger CK, Chu TA, Yang Z, Hepburn KW.

Department of Veterans Affairs, Birmingham/Atlanta Geriatric Research, Education and Clinical Center, Atlanta, Georgia; Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta, Georgia.

Abstract

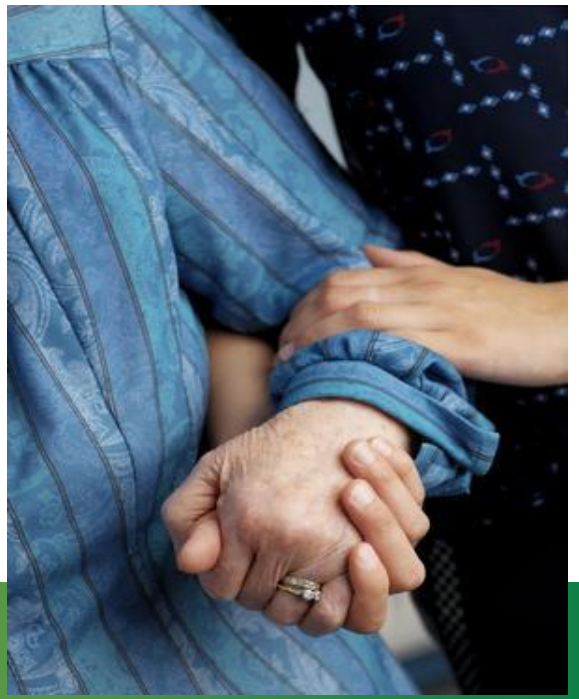
The segment of older adults who present to the emergency department (ED) with cognitive impairment ranges from 21% to 40%. Difficulties inherent in the chaotic ED setting combined with dementia may result in a number of unwanted clinical outcomes, but strategies to minimize these outcomes are lacking. A review of the literature was conducted to examine the practices undertaken in the care of persons with dementia (PWD) specific to the ED setting. PubMed and Cumulative Index to Nursing and Allied Health Literature were searched for published articles specific to the care of PWD provided in the ED. All English-language articles were reviewed; editorials and reflective journals were excluded. Seven articles ultimately met inclusion criteria; all provided Level 7 evidence: narrative review or opinions from authorities. The articles recommended clinical practices that can be categorized into five themes: assessment of cognitive impairment, dementia communication strategies, avoidance of adverse events, alterations to the physical environment, and education of ED staff. Many recommendations are extrapolated from residential care settings. Review results indicate that there is minimal guidance for the care of PWD specific to the ED setting. There are no empirical studies of the care (assessment, interventions) of PWD in the ED. The existing (Level 7) recommendations lack a research base to support their effectiveness or adoption as evidence-based practice. There is a significant opportunity for research to identify and test ways to meet the needs of PWD in the ED to ensure a safe visit, accurate diagnosis, and prudent transfer to the most appropriate level of care.

PMID: 22985144 [PubMed - in process]

4/5 Best Practices

Nursing issues: specific needs

- Longer waiting time and periods of immobility:
  - Position Change
  - Pressure Injury Prevention
  - Nutrition
  - Toileting
  - Orientation



4/5 Best Practices

Pain Assessment IN Advanced Dementia PAINAD

	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling, or inexpressive	Sad. Frightened. Frown	Facial grimacing	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
				TOTAL

ıt)

[1] Herr et al. 2006
[2] Hurley et al. 1992
[3] Snow et al. 2004
[4] Kovach et al. 1999
[5] Warden et al. 2003
[6] Abbey et al. 2004

4/5 Best Practices

Delirium Symptoms according to DSM-V[1]

A. Disturbance in attention and awareness

B. The disturbance develops over a short period of time, represents an acute change from baseline attention and awareness, and tends to fluctuate in severity during the course of a day.

C. An additional disturbance in cognition

D. The disturbances in Criteria A and C are not better explained by a pre-existing, established or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal such as coma.

E. There is evidence from the history, physical examination or laboratory findings that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal, or exposure to a toxin, or is due to multiple etiologies.

[1]American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA: American Psychiatric Association; 2013.

4/5 Best Practices

DELIRIUM

I. HYPERACTIVE: hallucinations, repetitive behaviours, aggression, delusions (30%)

II. HYPOACTIVE: lethargic, quiet, withdrawn (25%)

III. MIXED (45%)

http://www.gettyimages.com.au/detail/video/patient-and-visitor-sleeping-in-hospital-room-stock-video-footage/96803967

4/5 Best Practices

Cognitive Screening Tools Tested in ED:

Screening Tool:	Diagnostic Performance:
▪ Orientation Memory Concentration Test[1]	95% sensitive, 65% specific
▪ Six Item Screener (SIS)[2]	63-94% sensitive, 77-86% specific
▪ Mini-Cog[3]	75% sensitive, 85% specific
▪ Cognitive Performance Scale (CPS)[4]	82-85% sensitive, 85.1-87.6% specific
▪ Brief Alzheimer's Screen (BAS)[1]	95% sensitive, 52% specific
▪ Ottawa 3DY5	93.8-95% sensitive, 51-72.8% specific
▪ AD8[1]	63-83% sensitive, 63-79% specific

[1] Carpenter et al. 2011
[2] Carpenter 2011, Wilber et al. 2008 & 2005
[3] Wilber et al. 2005
[4] Boyd et al. 2008
[5] Wilding et al. 2015, Carpenter et al. 2001

4/5 Best Practices

Delirium screening tools tested in ED:

Delirium tool:	Diagnostic Performance:
▪ Delirium Triage Screen[1]	98% sensitive, 55% specific
▪ (Brief) Confusion Assessment Method[1]	78-86% sensitive, 95.8-100% specific
▪ CAM-ICU[2] ▪ mCAM-ED[3]	68-72% sensitive, 98.6% specific
▪ Richmond Agitation Sedation Scale (RASS)[4]	82-85% sensitive, 85.1-87.6% specific

[1] Han et al. 2013, Monette et al. 2011
[2] Han et al. 2014
[3] Grossmann et al. 2014
[4] Han et al. 2015

4/5 Best Practices

The diagnosis of delirium by CAM requires the presence of BOTH features ***A*** and ***B***		
C A M **Confusion Assessment Method**	**A.** **Acute onset** and **Fluctuating course**	Is there evidence of an acute change in mental status from patient baseline? Does the abnormal behavior: ➢ come and go? ➢ fluctuate during the day? ➢ increase/decrease in severity?
	B. **Inattention**	Does the patient: ➢ have difficulty focusing attention? ➢ become easily distracted? ➢ have difficulty keeping track of what is said?
	AND the presence of EITHER feature *C or D*	
	C. **Disorganized thinking**	Is the patient's thinking ➢ disorganized ➢ incoherent For example does the patient have ➢ rambling speech/irrelevant conversation? ➢ unpredictable switching of subjects? ➢ unclear or illogical flow of ideas?
	D. **Altered level of consciousness**	Overall, what is the patient's level of consciousness: ➢ alert (normal) ➢ vigilant (hyper-alert) ➢ lethargic (drowsy but easily roused) ➢ stuporous (difficult to rouse) ➢ comatose (unrousable)

Inouye et al. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. Ann Intern Med. 1990;113(12):941-948.

4/5 Best Practices

Other Delirium Tools:

- **Delirium severity tools:**
  - DRS, Delirium index, delirium assessment scale and delirium severity scale
- **Delirium risk tools:**
  - Delirium Risk Assessment Tool (DRAT)1

https://www.aci.health.nsw.gov.au/chops/chops-key-principles/delirium-risk-identification-and-preventive-measures/delirium-risk-assessment

[1] NSW Agency for Clinical Innovation, Cognitive Assessment of the Older Person. 2012, NSW Health, District NSLH.

4/5 Best Practices

Delirium risk factors:

- Systemic illnesses (http://www.icudelirium.org/terminology.html)
- Medications
- Presence of other risk factors

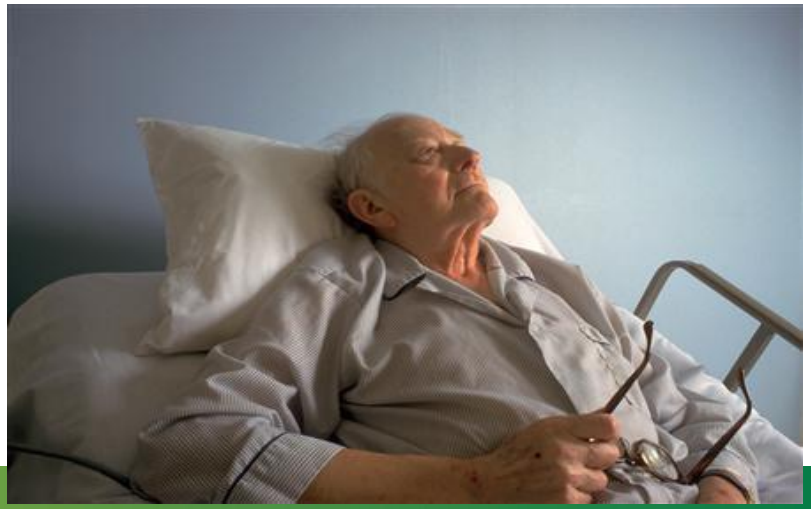
http://healthh.com/erysipelas/

http://www.huffingtonpost.com/david-belk/health-care-costs_b_4066552.html

4/5 Best Practices

Delirium risk factors:

- Older age
- Cognitive Impairment
- Visual and hearing impairment
- Functional dependence
- Dehydration
- Impaired nutritional status
- Pain
- Sleep deprivation
- Surgery



http://www.reuters.com/article/us-cancer-patients-poor-sleep-linked-mor-idUSTRE53T6M820090430

4/5 Best Practices

5P's Delirium Screen[1]

- **Pee: UTI, dehydration, urine retention**
- Poo: constipation
- Pus: infection
- Pain: unidentified, unmanaged
- Pills: Interactions, adverse events, new medication

4/5 Best Practices

NURSE MANAGEMENT OF DELIRIUM:	
1) Cognitive assessment, use reality orientation and cognitive activities[1]	6) Ensure using pt. has hearing aids and/or glasses[3]
2) Employ noise reduction strategies and prevent day and night reversal.	7) Maintain mobility, get patient moving[3]
3) Basic observations	8) Avoid physical restraints[4] and catheterisation[5]
4) Pain assessment and management[2]	9) Provide access to and offer food and fluid regularly[3]
5) Involve and inform family, education	10) Managing behaviour

[1] Kellie et al. 2013, Naughton et al. 2005, Milisen et al. 2001
[2] Milisen et al. 2001
[3] Inouye et al. 1999
[4] Price et al. 2005
[5] Tropea et al. 2008, Hanhoff et al. 2006, Inouye 2006, Archibald 2002

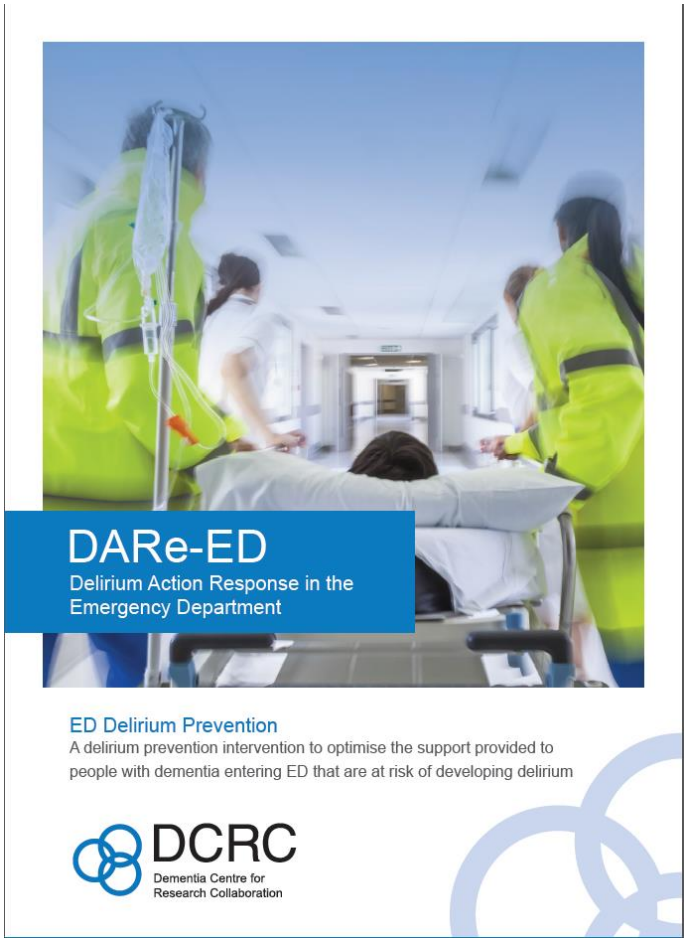
4/5 Best Practices

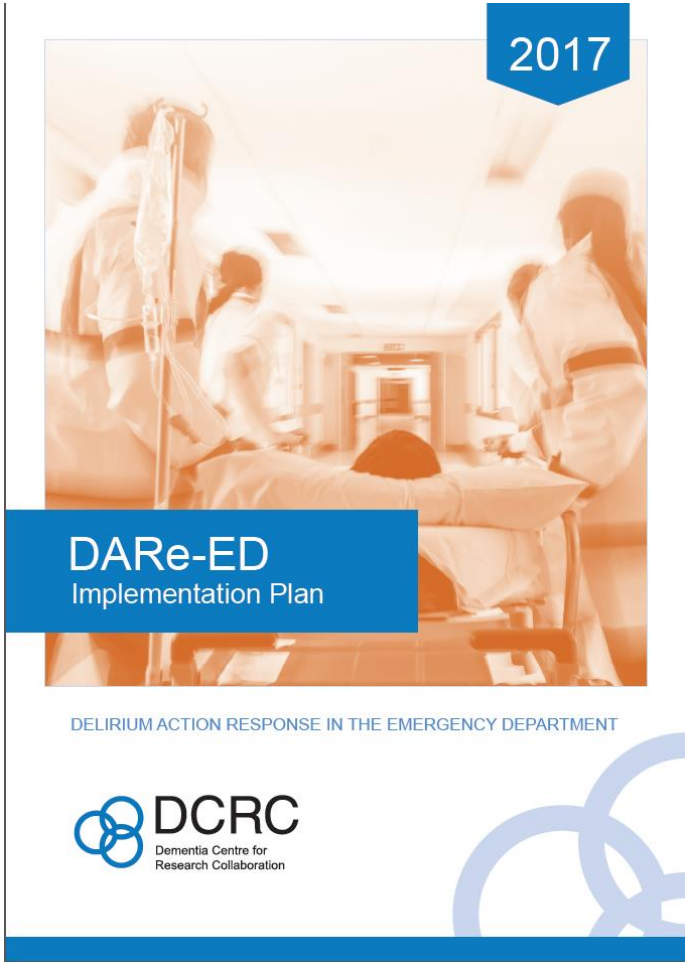
DARe-ED Intervention

Building delirium care for people with dementia into the emergency department (ED): Systematic development of the Delirium Action Response in ED (DARe-ED) intervention

To develop a valid multi-component delirium prevention intervention, *the Delirium Action in ED* (DARe-ED) intervention, for older people with dementia presenting to Emergency Departments (ED).

4/5 Best Practices





4/5 Best Practices

Screening tool to identify patients 'AT RISK'[1]

- The Identification of Seniors at Risk (ISAR) tool[2]
- BRIGHT[3]
- Triage Risk Screening Tool (TRST)[4]

Risk Factors:

- Cognitive impairment
- Functional issues
- Polypharmacy
- Vision problems
- Decreased independence
- ED use / Hospitalisation

[1] Dendukuri et al. 2004, Warburton et al. 2004, Meldon et al. 2003, McCusker et al. 2003, Mion et al. 2001, McCusker et al. 2001
[2] McCusker et al. 2003
[3] Boyed et al. 2008
[4] Meldon et al. 2003

4/5 Best Practices

Geriatric interventions in ED

- Comprehensive geriatric assessment (CGA) **AND** Multidisciplinary care coordination teams[1]

- Reduce hospital admission[2]
- Reduce nursing home admission[3]
- Reduce ED readmission[4]
- Greater levels of physical[3] and mental functioning[5]
- Improved patient satisfaction[3]

[1] Hegney et al. 2006, Caplan et al. 2004, McCusker et al. 2003 & 2001, Moss et al. 2002, Mion et al. 2001, McCusker et al. 1999.
[2] Caplan et al. 2004, Mion et al. 2001.
[3] MCCusker et al. 2001.
[4] Hegney et al. 2006, Caplan et al. 2004.
[5] Caplan et al. 2004

4/5 Best Practices

Models of care:

- Hand to Home Response Team (H2HRT)
- Aged-care Services in Emergency Team (ASET)[1]

- Provide a comprehensive plan of care / discharge plan
- Refer patients to services
- Act as a resource for patients on aged care issues
- Act as a resource for ED staff

[1] Shanley et al. 2009

4/5 Best Practices

Focused Communication[1]:

- Involvement of family, carer, GP and agencies[2]
- Information provided must compensate for their disabilities[2]
- Effective communication[2]
- Identification of staff[3]

[1] Clevenger et al. 2012
[2] Cunningham and MCWilliam 2006, Baraff et al. 1992, Eliastam 1989.
[3] Goldsmith et al. 1997

4/5 Best Practices

Nursing care:

- Identify a key worker[1]
- Reduce relocations
- Choose the safest area[1]

[1] Archibald 2002

4/5 Best Practices

Nursing care:

- Provide access to and offer food and fluid regularly[1]
- Use fall[2] and pressure injury prevention guidelines
- Avoid physical restraints[3] and catheterisation[4]
- Pay attention to caregiver burden[5]

[1] Archibald 2002
[2] The National Ageing Research Institute 2007
[3] Price et al. 2005
[4] Tropea et al. 2008, Hanhoff et al. 2006, Inouye 2006, Archibald 2002
[5] Moons et al. 2002

4/5 Best Practices

Review medication list[1]

- Beers criteria[2]
- STOPP START tool kit[3]
- Prescribing with electronic decision support[4]

[1] Graf et al. 2010, Baraff et al. 1992, Eliastam 1989.
[2] Beers et al. 2003
[3] Gallagher et al. 2008
[4] Terrell et al 2009

Mr Clarkson, a 86 year old married male, presents to ED on a Friday evening

- Fall at home
- Mild cognitive impairment
- Vision and hearing impaired
- # Humerus (right)

Ambulance ramping

Source: http://www.theage.com.au/victoria/hospital-woes-hit-ambulance-services-hard-20130709-2pnbn.html accessed 11/11/2015

1. Geriatric streaming

2. Geriatric-friendly waiting areas

Environmental strategies that may reduce delirium risk on ED arrival

1. Avoid ED in high delirium risk

2. Reduce access block

3. Early screening for delirium and risk factors

4. Triage pain assessment and NIA

Environmental strategies that may reduce delirium risk on ED arrival

Walk-in triage

Walk-in triage


Go Here Fi
Hearing Loop

ED acute area: structural environment


PHILIPS


PHILIPS

You are in the PAH Emergency Department

Date:

Your nurse is:

Your doctor is:

You are currently awaiting:

4/5 Best Practices

4/5 Best Practices

4/5 Best Practices

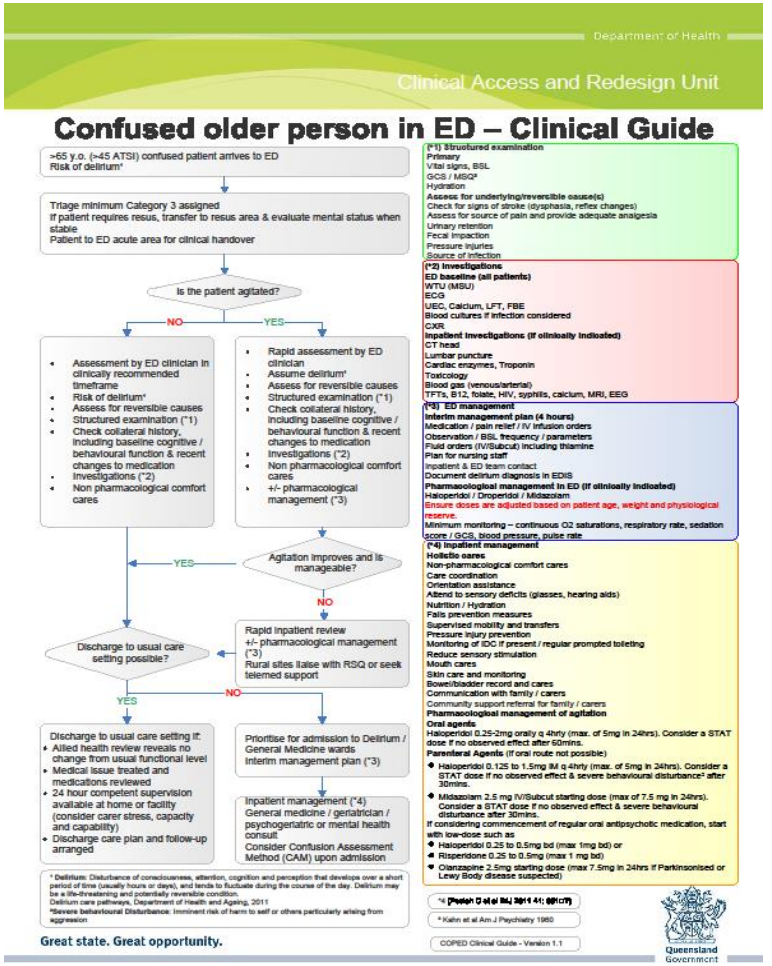
Education resources:

https://www.dementia.org.au/files/reports/ED-Dementia-Care-Training.pdf

4/5 Best Practices

Confused older person in ED – Clinical Guide:

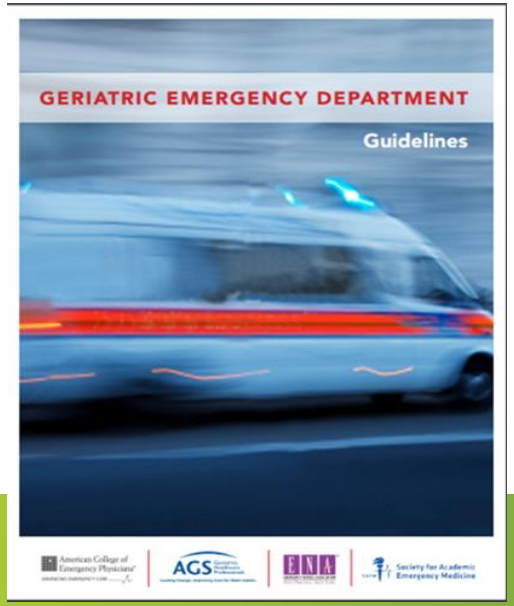
- https://www.health.qld.gov.au/__data/assets/pdf_file/0019/621550/coped-guide.pdf

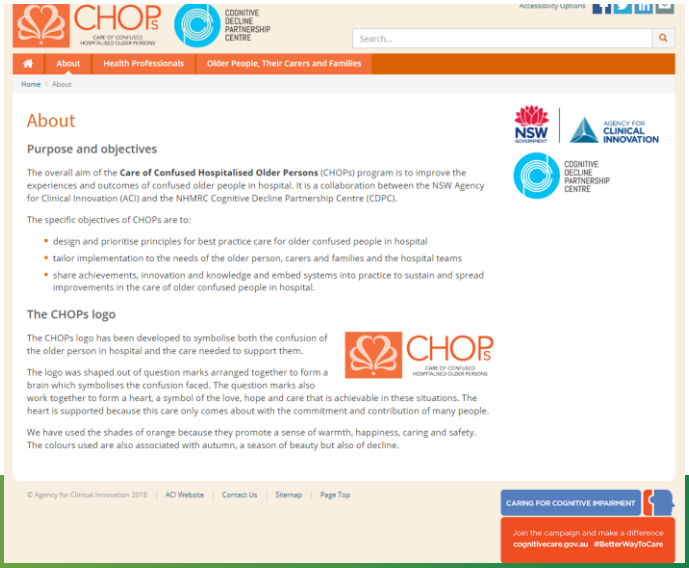


4/5 Best Practices

Further Reading

- https://www.acep.org/geriedguidelines
- https://www.aci.health.nsw.gov.au/chops/about





5. Conclusion

5/5 Conclusion

KEY POINTS:

- Cognitive impairment (CI) is common in the ED population (26% - 40%)[1]
- Cognitive impairment may go undetected[2]
- Recognition of cognitive impairment is critical
- ED patients with CI have an increased risk of negative outcomes and adverse events[3]
- Evidence based practice
- Increased role of aged care in emergency medicine

[1] Hustey et al. 2003 & 2000, Gerson et al. 2002, Naughton et al. 1995.
[2] Han et al. 2009, Kakuma et al. 2003, Hustey et al. 2003 & 2000, Elie et al. 2000, Lewis et al. 1995.
[3] Hastings et al. 2007, McCusker et al.1999

Thank You!

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