

Quality care for older people with urgent and emergency care needs in UK emergency departments

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Over the next 20 years, the number of people aged 85 years and over in the UK is set to increase by two-thirds, compared with a 10% growth in the overall population. Hospital episode statistics indicate that patients over 70 years of age accounted for 15.5% of attendances to emergency departments (EDs) in 2010–2011.¹ The same hospital episode statistics data also show that patients aged 60 years or over account for 23% of attendances to the EDs and, compared with the 21–59 age group, are more likely to arrive by ambulance, have more investigations done and despite similar booking in and assessment times, spend a longer time in the ED. The admission rates for the over 60s is also higher compared with the 21–59 years age group and they currently account for 43% of all admissions to hospitals in England and Wales. A health service ombudsman's report² drew attention to the poor quality of care provided to older people in healthcare settings. There is a pressing need to change how we care for older people with urgent care needs, to improve quality (including outcomes, safety and experience) and efficiency, and this needs to happen urgently.

The multidisciplinary document 'Quality care for older people with urgent and emergency care needs' (the Silver Book),³ published on 20 June 2012, is a best practice guideline that describes the urgent care needs of older people and the competencies required to meet these needs

within the context of the National Health Service in the UK, although the majority are universally applicable. The project was jointly led by representatives of the College of Emergency Medicine and the British Geriatrics Society and sponsored by another 11 signatory organisations that provided the membership and peer reviewed the document at several stages. Several other non-signatory organisations also provided crucial feedback on the draft document. The three national clinical directors for urgent and emergency care, older people and dementia were the expert advisors. The guidance was developed to advice and influence the promotion, provision, commissioning, delivery and regulation of care for older people with urgent and emergency care needs. The main document was the subject of a recent editorial.⁴ The following section contains a summary of guidance relevant for EDs.

The majority of urgent care is delivered outside the hospital and in primary care.⁵ Despite this, an increasing number of older people are attending EDs and accessing urgent care services. This is multifactorial,⁶ and factors in primary care that may impact on the use of urgent care services include timely response and ready access to a general practitioner or other qualified clinician. The 'Silver Book' sets a standard of 30 min for an initial primary care response to an urgent request for help from an older person or their carer. The ambulance service also has a key role to play and can be an important contributor in doing things differently, including providing targeted management for specific conditions and in the pre-hospital setting. The new NHS 111 service will become increasingly important in supporting patients to access the service at the correct point to receive the best care first time. All of these services will also have vital information not available to the ED (eg, the home environment) and it is essential that this is handed over correctly and reliably.

With its highly selected population attendance, an ED is associated with a high risk of admission for older people. This may be partly related to the nature of the service and the environment in which it is provided. The contributing factors may include lack of competence in managing older people, poor availability of information, poor services outside the ED and a lack of integrated care, exacerbated by the lack of 7 day working and out of hours support services. A recent systematic review of negative health outcomes in older people attending EDs identified adverse events, including under triage of illness severity, lack of recognition of geriatric syndromes, sub-optimal drug therapy and adverse communication related events.⁷ Most of these are identifiable and many are preventable with the appropriate competencies and resources. EDs need to be supported to deliver the right care for these patients, as no one component of the health and social care system can manage this challenge in isolation; implementation of improved care for older people requires a whole system approach.

Multidisciplinary assessments will need to be undertaken by various teams and should be prioritised according to the needs of the individual. Therefore, an older person who has severe sepsis and is being actively resuscitated in the ED may not need assessment for falls, mobility, sensory loss or depression in the first hour. However, it would be important to monitor vital signs and at the earliest opportunity obtain information on activities of daily living, dementia, continence, safeguarding issues and any existing plans with regards to end of life care. This information would be crucially important to establish a balanced early intervention package that is tailored to this individual and their wishes, respects their dignity and attempts to deliver holistic care.

In more stable individuals, the presence of one or more frailty syndromes, such as falls, incontinence, cognitive impairment (delirium, dementia or both) and immobility, should trigger a more detailed comprehensive geriatric assessment, to start within 2 h if their condition deems it possible.⁸ EDs should be configured in such a way that they can screen for common frailty syndromes in all older people, and then initiate (but not necessarily deliver entirely) more detailed assessments in selected individuals. The ED would therefore need access to emergency pathways and multidisciplinary teams for older people who do not

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require admission but need ongoing treatment (eg, in a clinical decisions unit).

Several studies have examined the role of a team identifying older people in the ED and delivering coordinated care in the community setting on discharge, and a meta-analysis of these studies provides some evidence of improved outcomes.⁹ Hospital at home schemes that include multidisciplinary care and medical input can be effective¹⁰ and could support ED based teams such as those described above.

Presentation with intentional self-harm should be considered as for failed suicide and these older people are at increased risk of further harm.¹¹ Mental health services should be commissioned such that they can contribute to specialist mental health assessments in older people within 30 min if appropriate. It is essential that safeguarding issues are considered. Mechanisms to detect poor care at institutions is also important, as suggested in the recent 'Winterbourne View' report.¹²

Older people coming into contact with any healthcare provider or services following a fall, with or without a fragility fracture, should be assessed for immediately reversible causes. This needs to be carried out in the ED and the patient subsequently referred for a falls and bone health assessment using locally agreed pathways. There are missed opportunities in the management of falls and bone health in the ED.¹³

Older people attending hospitals are frequently unnecessarily deprived of food and drink pending assessment. This should be based on an assessment of the person's needs rather than an arbitrary 'policy' of no eating or drinking. Food and drink, therefore, should be readily available, and help with nutrition should be provided when necessary.

Urinary tract infections are frequently diagnosed in older people based on urinary dipstick testing. This may be incorrect and contrary to evidence based medicine. Urinary catheterisation is frequently unnecessary in frail older people and should not be carried out simply to treat incontinence.

Older people with cognitive impairment or sensory deprivation may become distressed by interventions. These are important considerations given that the traditional ED population is being rapidly replaced by an increasing number of older people who need a modified approach to their care. Training and development of staff in extended skills to improve the understanding and delivery of care for older people within a bio-psychosocial model is important to realise these outcomes. The 'Silver Book' has a dedicated section on training and development, including for medical and nursing staff.

The ED environment may not be suited for frail older people and we believe that the assessment area for older people should be located in a quieter, preferably separate, area of the department where observation is possible but noise, interruptions and over stimulation is minimised. Interventions need to be kept to a minimum and tailored to match outcomes. Clinical equipment should be kept to an absolute minimum, while ensuring that required is easily available, and where possible create an ambience consistent with the age of the individual. If the department has a clinical decisions unit or short stay unit, it is helpful to replicate exactly the décor from the ED to one of the cubicles in the clinical decisions unit so transfer does not add to confusion.

It seems that older people are the most important emerging group in healthcare for several economic, social and political reasons. There are significant implications for influencing outcomes within acute care as well as contributing to population health and cost effective care by developing front door 'frail friendly' models of care that address the axis and the continuum. This is an exciting and crucial opportunity for emergency medicine to take a leading role in this journey.

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