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# Increasing the profile of the care of the older person in the ED: A contemporary nursing challenge

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## KEYWORDS

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**Abstract** The numbers of frail older persons using emergency departments are already considerable and will continue to increase over time. There are a number of issues related to the assessment and care of older patients that are significantly different to other patient groups. The traditional emergency department (ED) model focusing on rapid triage, treatment and throughput does not meet the needs of many older patients, who have complex presentations, and require comprehensive assessment and referral. In response to this, there are already a number of appropriate and innovative approaches to the care of the older patient demonstrated in the literature. Nurses have a crucial role in contributing to these approaches and in raising the profile of quality care of the older person. Some specific areas that ED nurses can focus on include a more comprehensive approach to assessment and discharge planning, improved communication with the patient and their personal carers, attention to basic nursing care, and making the physical environment safer and less stress-

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ful for the older patient. While developing collaborations with their aged care nursing colleagues is important, emergency nurses need to view care of the older person as a central part of their own core business.

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## Background

While there is great diversity in the health and independence levels of older persons, the use of the term “older person” in this paper focuses on those persons who are more likely to be in the older-age category i.e., over 75 years, who are physically frail and/or with multiple comorbidities.

There are a number of issues about care of the older person in the emergency department (ED) that have been well documented. Firstly, most societies are ageing, with the most dramatic proportional increase in the over-80 group. This will lead to an increasing use of the ED by older persons living in the community or in supported residential care (Hogstel, 1998; Howe, 1998; Grief, 2003; Moons et al., 2003; Emergency Nurses Association, 2003; Hastings and Heflin, 2005; Robinson and Mercer, 2007; Hwang and Morrison, 2007).

Secondly, there are a number of issues specific to the needs and care of older patients in the ED (Hayes, 2000; Aminzadeh and Dalziel, 2002; Adams and Gerson, 2003; Moons et al., 2003; Siebens, 2005; Robinson and Mercer, 2007). Their presentation is often complex, with a number of chronic comorbidities as well as psycho-social issues such as decreasing independence and involvement of various support services. Assessment of an older person’s condition may be difficult as signs and symptoms may not follow the normal patterns, instead being vague and non-specific. Complaints and symptoms may be over or under-reported. Effective management often cannot be achieved with a quick assessment and diagnosis, but requires a more comprehensive work-up, thoughtful discharge planning, and referral to health and community support services. Frequent presenting issues or problems that ED staff need to be competent in managing include cognitive impairment (Hayes, 2000), delirium (Thurston, 1997; Kakuma et al., 2003), falls (Letvak and College, 2000), polypharmacy (Hayes, 2000), elder abuse (Fulmer et al., 2000) and trauma (Criddle, 2006).

The third issue that is clear from the literature is that the typical ED is not ideally suited to the care of the older patient (Howe, 1998; Grief, 2003; Fernandes, 2005; Robinson and Mercer, 2007; Hwang and Morrison, 2007). In fact, their attendance at

the ED is associated with a high risk of adverse outcomes, such as functional decline, reduced health related quality of life, institutional placement and death (Mion et al., 2001; Hastings and Heflin, 2005). This is largely because of the complexity of many patients’ conditions and difficulties in easy diagnosis and appropriate case management (Adams and Gerson, 2003). Problems are exacerbated for the older patients by prolonged waiting times and restricted mobility, physical discomfort from ED trolleys, a noisy and rushed environment with minimal privacy – all of which can contribute to increased disorientation and confusion (Robinson and Mercer, 2007; Hwang and Morrison, 2007).

While the references used in this review are from the international literature, the authors’ views are influenced by their work as senior nurses in emergency departments, or as researchers, in the public health sector in Australia. Social policy in the care of the older person includes a strong emphasis on community-based support and an accessible public health system funded through a universal health insurance program. While the relevance of the issues discussed in this paper may vary across countries because of different health-care systems, the authors believe most of the issues will be relevant across the board.

## Mismatched models of care and some alternatives

Problems encountered by older patients in the ED should not be seen simplistically as due to poor quality of care by staff. It is more useful to see the problems as resulting from models of care and health systems that do not reflect the needs of a changing population demographic. (Mion et al., 2001; Aminzadeh and Dalziel, 2002; Adams and Gerson, 2003; Hwang and Morrison, 2007).

*“It is worth noting that the current model of ED care was designed for the acutely ill and injured patient, not a medically complicated, slow-moving, functionally impaired geriatric patient. In fact, ED processes are usually inadequate and inhospitable for the older person. The rapid triage and care process is often unable to elicit a full understanding of the person to enable optimal*

*care. The full breadth of medical conditions, a long list of medicines, communication challenges, and sometimes slowly evolving problems rather than clear and acute events all impair effective understanding of the patient's current need.”* (Adams and Gerson, 2003, p. 272)

Following a systematic review of the literature, Aminzadeh and Dalziel (2002) suggest there is a general consensus that the current disease-oriented and episodic models of emergency care do not adequately respond to the complex care needs of older patients. They stress the need for care models for acute and chronic health concerns that involve continuity, comprehensiveness and integration of services.

### Care models more suited to older patients

As the problems of older patients in the ED have been recognised for some time, there have also been a number of programs that have sought to overcome these problems. Taylor et al., (2004) describe new ED programs or services that have particular relevance to the care of older patients. Many of these have involved a shift away from hospital admission to community care and support:

- Care coordination team: allied health and/or nursing staff who identify patients at risk and facilitate ongoing community support (Corbett et al., 2005; Basic and Conforti, 2005).
- Short stay observation unit: for patients who require observation for 24–48 h, often located adjacent to EDs.
- Hospital in the home: short-term healthcare for acute conditions that can be managed in the home or residential care facility rather than hospital.
- Nurse initiated management: management of low acuity patients meeting well defined criteria.
- Fast track programs: management of low acuity patients in streamlined fashion using clear protocols (Davies-Gray, 2005).
- Day treatment units: associated with the ED, for less-acutely ill ambulant patients.

Other models identified in the literature include: a two-stage screening and assessment program (Mion et al., 2001; McCusker et al., 2001); an ED-based nurse discharge coordinator for older patients (Guttman et al., 2004); small units attached to an ED that focus on the needs of older patients – with a comfortable environment, multi-disciplinary assessment, medical care review, pharmacological review and early discharge plan-

ning (Palmer et al., 1998); general practitioner units located alongside EDs to see less urgent cases; and secondary prevention programs such as home visits by primary care physicians, personal medication reviews and education by pharmacists, and targeted outpatient geriatric clinics (Aminzadeh and Dalziel, 2002).

Hastings and Heflin (2005) conducted a systematic review of interventions to improve outcomes for older patients discharged from the ED. They found that a number of programs had been documented but few had been systematically evaluated. Results from a small number of randomised controlled trials suggested that positive outcomes were associated with focusing on high risk patients, using a specially trained nurse to perform geriatric assessment and a component of home-based care.

### Nurses' roles in improving the care of the older patient

#### Contribute to alternative models of care

Nurses play a central role in both clinical and administrative aspects of the healthcare system. They are well attuned to the needs of patients as well as the day-to-day operational issues involved in patient care. Nurses have initiated and provide the focus for a number of the alternative models described above. They need to use their clinical and administrative experience and influence to acknowledge problems with care of the older person in the ED, and to help identify and implement alternative approaches that aim to overcome these problems. They can also undertake nursing and interdisciplinary research and quality improvement projects aimed at improving the care of older patients in the ED.

#### Lobby for increased emphasis on aged care

The Emergency Nurses Association (2003) has published a position statement that recognises the need to make EDs more receptive to the needs of older patients. They stress the need for education on the physiological, psychological, sociological and economic aspects of ageing. They also stress the need for greater collaboration within the healthcare team around assessment and care planning for older patients.

A number of authors (Hayes, 2000; Adams and Gerson, 2003; Hwang and Morrison, 2007) have pointed out that the healthcare system has provided specialised ED approaches to groups such as

paediatric, trauma and mental health patients. These have involved extra protocols, staffing models and physical adaptation of the ED environment. These authors suggest that the increasing use of the ED by older patients, combined with their special needs, is a strong argument that similar efforts should be directed to the care of older patients.

Adams and Gerson (2003) put forward three principles underlying best practice in the care of older patients in the ED. The first of these is to set up systems that recognise many older persons present to the ED on a number of occasions, and information about their ongoing care should be readily available to staff. This would save time for staff and patients as well as avoid each presentation being seen as a single isolated event. The second principle is to embrace a multidisciplinary approach that makes greater use of nursing and allied health staff involvement. The third principle is to create a more comfortable and safe environment for older patients.

An interesting question to consider is whose responsibility is it to increase the profile of aged care within the ED. Most healthcare systems have aged care specialist nurses and some of these may be working in special programs within an ED. Emergency nurses should make use of the expertise of their aged care colleagues and work together on collaborative programs wherever possible. However, it is not appropriate to think that all aged care issues and patients can be passed on to the aged care nurse. Care of the older person is a mainstream issue and must be the responsibility of the whole healthcare team. Emergency nurses will play an increasingly important role within that team approach.

## Focus on quality nursing care

**Empathy, understanding and basic nursing care** Kihlgren et al. (2005) examined the nature of good nursing care of ED patients over 75 years. They found that the key aspects of good care are: to be knowledgeable, to be understanding of the older patient's situation and to take responsibility for their care.

Older patients are likely to require basic nursing care, such as help with toileting, mobilising and changing positions. They may also need prompting or assistance with accessing food and water, as well as care to maintain body temperature and comfort Hayes (2000).

## Assessment

Within the ED environment, initial assessment must focus on any injury or illness that requires immedi-

ate treatment. Once immediate concerns have been accounted for, the next challenge with the older patient is to undertake a more comprehensive assessment. If this is not done, there is a good chance the person's underlying problems will not be identified and resolved, and they will end up back in the ED before too long (Bentley and Meyer, 2004).

Assessment of the person's cognitive status is vital, as a delirium may be the only sign of an acute physical illness. Recognising underlying dementia is also important in terms of determining how the person is likely to manage on discharge (Hayes, 2000; Hwang and Morrison, 2007). Other areas that need to be considered in making a proper diagnosis and in making meaningful discharge planning include the person's functional status, their existing support networks, current medications and compliance with these, and their falls risk (Hayes, 2000; Moons et al., 2003).

A number of authors have developed screening instruments that nursing staff can use to detect older patients who would particularly benefit from a more comprehensive assessment. This is a useful approach within a busy ED setting, as it will allow the most vulnerable to be appropriately targeted in a systematic way. Two of these screening instruments are the Triage Risk Screening Tool (Meldon et al., 2003) and the Identification of Seniors at Risk (McCusker et al., 2001).

## Communication

Effective communication is vital on a number of levels: with the patient, the family or other personal carer, other members of the local health service, and with other care providers outside the health service.

In terms of the older patient, consideration must be given to cognitive and sensory issues. Some older patients may be confused or have dementia and may not be able to answer questions or express their needs easily. Staff must be aware of this possibility and provide information in a simple and consistent manner, including explanations about procedures and reasons for waiting times (Moons et al., 2003). Staff also need to be aware of possible hearing deficits, made worse in a noisy ED environment. It may be possible to move older patients to a quieter area or at least make sure the person is able to hear clearly what is communicated to them.

Open communication with family or other personal carers is particularly important if the older patient is not able to provide a history or answer questions clearly. The family or personal carer often has a thorough knowledge of the person's

history, medications and how well they are – compared to their normal state. The carer will also be able to communicate with and provide support to the older patient, if they have been involved and given appropriate information. A comprehensive assessment should also include awareness of caregiver burden as this may impact on how well the older person is going to be able to cope at home (Moons et al., 2003).

Care of the older person in the ED may be compromised if there is inadequate communication between different parts of the health system. The patient may have been treated in a clinic or outpatient setting but notes about these treatments may not be easily available to the ED staff (Bentley and Meyer, 2004). Efforts should be made to develop streamlined information systems within the one health service so that all aspects of a patient's care are freely available to treating ED staff.

The last aspect of communication impacting on care of the older patient is with care providers outside the immediate health system – especially with primary physicians in the community. Often changes in medications or appointments for further investigation are not followed up because these issues have not been communicated to the patient's primary physician. It is vital that ED staff provide clear and timely information about the person's ED visit to their primary physician and others providing direct care in the community setting.

### Discharge planning

One of the core aspects of care of the older patient, which is closely linked to assessment issues, is appropriate discharge planning. Unfortunately this is not part of the core business of most EDs – where the emphasis is on rapid assessment, treatment and turnover. If the patient has not had a comprehensive assessment that examined their cognitive, functional and social support status, and an appropriate support plan has not been put in place, there is a strong chance they will continue to re-present to the ED (Moons et al., 2003). It is a good investment of time for ED staff to develop links with community services that might be able to provide more appropriate support to many of these older patients, thereby increasing their health and reducing their need to use the ED (Mion et al., 2001).

### Physical environment

Hwang and Morrison (2007) suggest that new ED facilities should have natural light, handrails, sound proof curtains, stretchers with pressure relieving mattresses, reclining chairs, floors with aisle lighting, non-skid floors, improved signage, ambient

temperature, and communication devices (such as magnifying lenses, fluorescent tape on call bells and hearing devices). For existing facilities, nurses may use their influence to improve the physical environment for older patients by using reclining chairs, thick or pressure-relieving mattresses, providing a quieter position where possible, and ensuring the person has safe access to toilet facilities.

### Initiate nurse-led local innovations

Apart from contributing to new programs developed within the healthcare system, nurses can use their initiative to develop innovative programs in more of a "bottom-up approach". These can often be done without extra resources other than imagination and a willingness to develop a collaborative approach.

One author of this paper (KS) identified that many older patients presenting to the ED were taking a large amount of medication and this was often contributing to their illness and also to recurrent presentations. She took the initiative to develop a comprehensive medication history, including the possibilities of adverse drug reactions and non-compliance. For patients who are identified as having a problem, the nurse writes a discharge letter to the person's local medical officer highlighting these medication issues, as well as requesting the medical officer to make a referral for a Home Medication Review by an accredited community pharmacist (Appendix 1).

Another author of this paper (RT) became aware of problems related to transfer of older patients to and from her ED and local nursing homes and aged care hostels. These included a lack of understanding of nursing home and hostel levels of care by ED staff, poor communication on transfer from all parties, and patients not being well enough to transfer back to nursing home or hostel. In collaboration with other staff, RT developed solutions to these problems. These included regular meetings between staff from the hospital and the nursing homes and hostels, the development of new transfer forms and protocols, inclusion of nursing home and hostel staff in hospital case conferences about their residents, and organising a visit by the ED doctors to a nursing home and hostel.

### Conclusion

The numbers of older persons using the ED is already considerable and will continue to increase over time. The traditional ED model focusing on rapid tri-

age, treatment and throughput does not meet the needs of many older patients, who have complex presentations, and require comprehensive assessment and referral. In response to this, there are already a number of appropriate and innovative approaches to the care of older patients demonstrated in the literature. Nurses have a crucial role in contributing to these approaches and in raising the profile of quality care of the older person. While developing collaborations with their aged care nursing colleagues is one strategy they can use, emergency nurses need to view care of the older person as a central part of their own core business.

### Appendix 1: Discharge letter to medical officer requesting pharmacy review follow-up

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## REQUEST TO GP for Assessment for Referral for Home Medicines Review (HMR)

	Name	Contact Details
For	Dr	
From		
Contact Signature		

Patient's Preferred Pharmacy \_\_\_\_\_

Reason for request (please tick appropriate reason)

Taking 5 or more medications	Attending different doctors	
Taking more than 12 doses a day	Recently discharged from hospital	
Symptoms of a possible adverse drug reaction	Sub-therapeutic response to treatment	
Significant changes made to regimen in last 3 months	Suspected non compliance or inability to manage medication	
Difficulty in managing medication regimen	On medication with a narrow therapeutic index	

Other \_\_\_\_\_

Please consider whether the patient identified would benefit from HMR. On completion of the HMR consider sending a copy of the new management plan to the above referrer.

(Based on a form from the Pharmacy Guild of Australia NSW Branch)

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