Geriatric Emergency Medicine Core Rotation for Geriatric EM Fellows and elective residents

Components:

1) A beginning-of-rotation meeting with Dr Melady to orient to the department and to address some of the principles of Care of the Elderly in the Emergency Department (structured around Sanders' Eleven Principles of Geriatric Emergency Medicine and the GEM Core Curriculum Competencies. See below). Ideally this will be scheduled in advance of the first Monday of the rotation. In preparation, write down three learning objectives for yourself: what do you want to get out of this rotation? Reviewing the Geri EM Competencies at the end of this document may help you. We will review this Learning Contract at our first interview.

2) 14 shifts per block distributed between days and evenings (0800-2400) including two weekend shifts. No midnight or late evening shifts are required.

3) As many shifts as possible will be buddied with Drs. Melady Tejpar, Ringer, or Dr. Jacques Lee; for the others, fellows/residents will be supervised by the other ED attending staff.

4) The Geri EM fellow/resident will **preferentially** see only patients over the age of 75 (=12.5% of the census, on average 20 per day). This should include patients in all areas of the department – Resuscitation, Major, and Ambulatory. The Geri EM fellow/resident will be available to see other younger patients depending on department needs. Since most of the older patients are in Major, this arrangement may often mean reviewing patients with multiple different staff members.

5) On day shifts the Geri EM fellow/resident will take responsibility for all older patients who have been **held overnight** for further assessment. This will mean participating in the OT/PT assessment, the Geriatric Psychiatry assessment, interacting with SW regarding Transitional Care transfers, completing all referral forms, and interacting with the Geriatric Emergency Management nurse to coordinate these assessments.

6) The Geri EM fellow/resident should schedule a meeting with the Geriatric Emergency Management nurse in the first days of the rotation (Contact MaryAnn.Hamelin@sinaihealth.ca with subject heading "Meeting with Geri EM Resident"). There should be close collaboration between the fellow/resident and the GEM nurse regarding the management of patients: participate closely in the GEM assessment.) There should be close collaboration with the ED SW and LHIN case manager and PT and OT to understand their roles and the various discharge options available.

7) The Geri EM fellow/resident should complete phone or in-hospital follow-up on at least one patient per shift on Day 2 and Day 5 post-ED visit.

8) **The Geri EM fellow/resident should complete a written reflection (1-2 pages in a Word document) to be submitted to Drs. Melady and Ringer on each Friday of the rotation. This is an opportunity to reflect on your growing experience in care of older ED patients. It can be**

informed by the follow-up of patients, by the Eleven Principles of GEM (see below), by the 5Ms, by the key readings, by system-level considerations – or by any other topic that seems important to you. You will receive feedback within 2-3 days.

9) Learning resources: During the first two weeks of the rotation, complete:
   a) www.geri-EM.com six modules covering the basic topics in ED management of the older patient
   b) Acute Geriatric series in Emergency Medicine Australasia: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Sections/Geriatric-Emergency-Medicine
   c) The six attached articles

   Other resources:
   a) https://geriatric-ed.com : an introduction to ED models of care that prioritize older patients;
   b) https://gempodcast.com : a podcast covering most Geri EM topics;
   c) Emergency Care of the Elder Person, Arthur B. Sanders, editor, Beverly Cracom Publications. (Especially first three chapters on ED Models of Care.) Used copies are available on Amazon or can be borrowed from Dr. Melady.
   d) Geriatric Emergencies: A Discussion-based Review, Amal Mattu, Shamai Grossman, Peter Rosen; Wiley-Blackwell, 2016; (Available in the ED Physicians' Office).
   e) Care for the Older Adult in the Emergency Department, An Issue of Clinics in Geriatric Medicine. 2018, Michael Malone, Kevin Biese (relevant chapters available from Dr. Melady)

10) Assessment for this rotation will be based on the following:

- the Daily Shift Feedback,
- the weekly Reflective Practice Exercise
- the completion of the www.geri-EM.com modules,
- the Learning Contract,
- the mid-rotation evaluation.

  Dr Melady will be responsible for an exit interview and final evaluation and In-Training Evaluation Report.

Society of Academic Emergency Medicine Core Competencies in Geriatric Emergency Medicine (1)

1) Hogan TM, Losman ED, Carpenter CR, Sauvigne K, Irmiter C, Emanuel L, et al. Development of geriatric competencies for emergency medicine residents using an expert consensus process. Acad Emerg Med 2010;17(3):316-324.

The emergency medicine resident at the completion of PGY3, in the context of a specific older adult patient scenario in an emergency setting, must be able to:

Atypical Presentations

1. Generate a differential diagnosis with an appropriate evaluation and management plan for elderly patients presenting to the ED that recognize the broad range and multi-factorial nature of potential etiologies of their symptoms (e.g. pain, general weakness, dizziness, falls, altered mental status).

2. Demonstrate consideration of adverse reactions to medications, including drug-drug and drug-disease interactions as part of the differential diagnosis on presentation.

Trauma including Falls

3. In patients who have fallen, evaluate for precipitating causes of falls such as medications; alcohol use/abuse, gait or balance instability; medical illness and/or deterioration of medical condition.

4. Document gait on all ambulatory fallers; ensure appropriate disposition and follow up including attempt to reach primary care provider.

5. Institute appropriate monitoring early with the understanding that elders are at risk for occult shock.

6. Demonstrate ability to recognize patterns of trauma (physical/sexual, psychological, neglect/abandonment) that are consistent with elder abuse. Manage the abused patient in accordance with the rules of the province and institution.

Medication Management

7. Prescribe appropriate drugs and dosages considering the patient's acute and chronic diagnoses, other medications, functional status, and knowledge of age-related physiologic changes.

8. Search for interactions and document reasons for use when prescribing drugs which may present high risk either alone, or in drug-drug or drug-disease interactions (e.g. benzodiazepines, digoxin, insulin, NSAID's, opioids, and warfarin).

9. Explain all newly prescribed drugs to patients and caregivers at discharge assuring they understand how and why the drug should be taken, the possible side effects, and when it should be stopped.

Effect of Co-Morbid Conditions

10. Assess and document the presence of co-morbid conditions (e.g. pressure ulcers, cognitive status, falls in the past year, ability to walk and transfer, renal function, and social support) and include them in the differential diagnosis and plan of care.

11. Develop treatment plans that anticipate and monitor for dysfunction in multiple organ systems that can cause decline or complications in the patient's condition.

12. Communicate with patients with hearing/sight impairments, speech difficulties, aphasia and cognitive disorders using adaptive equipment and communication options (e.g. family/friend, caregiver).

Cognitive and Behavioural Disorders

13. Assess whether an older patient is able to give an accurate history, participate in determining the plan of care, and understands discharge instructions.

14. Assess and document current mental status and any change from baseline in every older adult; with special attention to determining if delirium has been superimposed on dementia.

15. Emergently evaluate and formulate an age-specific differential diagnosis for an older patient with new cognitive or behavioral impairment, and initiate a diagnostic work-up to determine the etiology, and initiate treatment.

16. Assess and correct (if appropriate) causative factors in agitated patients such as untreated pain, hypoxia, hypoglycemia and use of irritating tethers (monitor leads, blood pressure cuff, pulse ox, IV and Foley), environmental factors (light, temperature), disorientation.

Palliative Care

17. Rapidly establish and document patient goals of care for those who present with a serious or life threatening condition and institute an ED plan of care consistent with their plan of care.

18. Assess and provide ED management for pain and key non-pain symptoms based on the patient's goals of care.

19. Know how to access community-based palliative care and how to manage palliative-care patients while in the ED.

Emergency Intervention Modifications

20. Recommend therapy based on the actual benefit-to-risk ratio, including but not limited to acute myocardial infarction, stroke and sepsis, so that age alone should not exclude patients from any therapy.

21. Identify and implement measures that protect older patients from developing iatrogenic complications common to the Emergency Department including invasive bladder catheterization, spinal immobilization and central line placement.

Transitions of Care

22. Obtain history from long term care home of the acute events necessitating ED transfer including goals of visit, medical history, medications, allergies, cognitive and functional status, advance care plan and most responsible physician.

23. Provide long term care home with visit summary and plan of care, including follow-up when appropriate.

24. Assess and document suitability for discharge considering the ED diagnosis, including cognitive function, the ability in ambulatory patients to ambulate safely, availability of appropriate nutrition/social support and the availability of access to appropriate follow-up therapies with recognition of unique vulnerabilities in an older patient.

25. Select and document the rationale for the most appropriate available disposition (home, LTCH, hospital) with the least risk of complications commonly noted in inpatient hospitalizations.

SAEM Committee on Geriatric Emergency Medicine Education

Principles of Geriatric Emergency Medicine

1. The patient's presentation is frequently complex.

2. Common diseases present atypically in this age group.

3. The confounding effects of co-morbid diseases must be considered. (Polymorbidity)

4. Polypharmacy is common and may be a factor in presentation, diagnosis and management

5. Recognition of the possibility of cognitive impairment is important.

6. Some diagnostic tests may have different normal values.

7. The likelihood of decreased physiologic reserve must be anticipated.

8. Social support systems may not be adequate, and patients may need to rely on caregivers.

9. Knowledge of baseline functional status is essential for evaluating new complaints.

10. Health problems must be evaluated for associated psychosocial adjustment.

11. The emergency department encounter is an opportunity to assess important conditions in the patient's life.

Sanders AB, Witzke D, Jones JS, Richmond K, Kidd P. Principles of care and application of the geriatric emergency care model. In: Sanders AB (ed). Emergency Care of the Elder Person, St. Louis, MO: Beverly Cracom Publications, 1996, pp. 59-93