Geriatric Emergency Medicine (GEM) Rotation for fellows or elective residents

Goals:

- To develop ease and familiarity with common ED presentations of older people – especially delirium, falls, atypical presentations of disease, and critical care
- To adapt models of care that specifically prioritise older ED patients – with a particular focus on unnecessary admission avoidance and effective transitions of care;
- To enhance comfort in working with the interdisciplinary geriatric assessment team and accessing resources specific to older ED patients;
- To identify opportunities for Quality Improvement that benefit older patients

Objectives:

At the end of this rotation, the fellow will be able to:

1. Describe and implement an approach to common ED presentations of older people – especially a broad-based and efficient approach to delirium, falls etiology and consequences, identification of atypical presentations of disease, critical illness
2. Demonstrate and teach effective and compassionate communication skills especially with patients with cognitive, sensory, and social impairments
3. List five strategies to avoid unnecessary hospital admission for complex older patients
4. Demonstrate comfort and facility with enhanced communication skills especially around goals of care discussion and advance care planning
5. Describe the roles and unique skills and knowledge of the ED-based interdisciplinary assessment team – geriatric case management nurse, physiotherapist, occupational therapist, pharmacist, community care coordinator.
6. Give evidence of all of the geriatric-specific EM competencies established by SAEM (below)

Society of Academic Emergency Medicine Core Competencies in Geriatric Emergency Medicine

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.