MyED Touchpoints – Older adults

Summary:

More people are living longer with complex health problems and multiple chronic conditions. Older adults with complex care needs present frequently to all three study EDs and hospitals lack sufficient complex service capacity for timely transition from the ED to hospital or back home. ED Design principles promote a rapid assessment, timely treatment, facilitated by adequate observations. This is achieved via a design that promotes:

1. Rapid Access into and from treatment spaces
2. Unimpeded flow and access within the ED
3. High visibility of patients
4. Haemodynamic monitoring (very noisy with continuous alarms)
5. Optimal lighting for assessment
6. Rapid turn-over of patients

ED are designed to treat patients with acute illnesses on the premise that patients will only spend 4-6 hours within the ED. The ED environment is not designed for the needs of older adults, particularly those who are dependent with high frailty scores (Rockwood scale[1,2]). Lengthy wait times amidst the noise, 24-hour light, busyness, and lack of capacity to support comprehensive basic care needs contribute to complications specific to this cohort such as delirium, falls, pressure areas and functional decline. In our study sample, we found that perceived wrong-doing or harm distressed staff and carers, while many patients stoically accepted the limited care but expressed a preference to avoid ED in the future. Triangulating all data, there is a need for age-friendly care – a low stimulus environment equipped with age-specific equipment, e.g. hi-lo beds, capacity for comfort and basic nursing care, consideration of cognitive and physical decline, provision for carer rest. Specifically:

- early identification of older patients with complex conditions and frailty who need more direct admission and transition into geriatric care. These patients need to be managed via alternate Model of Care that should bypass the ED.

Step 1.1 – Non-participant observations

NPOs were conducted at Mount Druitt (MD), Blacktown and Westmead Emergency Departments. Overcapacity and long patient wait times were evident at all EDs. At MD, older adults needing admission for care other than the palliative care or simple surgical services provided at MD, required transfer to Blacktown (mostly) or Westmead. Timely transfer was dependent on the availability of transport services, and beds at the receiving ED, increasing delay to definitive care for the patient and increasing crowding at MD ED. At Blacktown and Westmead EDs, older patients, arriving by ambulance or private car, occupied acute beds among the general population, but alternative Models of Care (MoC) were available at Westmead, including a specialised geriatric service (HOPE - since closed) and a short stay unit.

Step 1.2 – Interviews with providers

We conducted 45 interviews – 43 with 44 ED staff, and 2 interviews with geriatricians. Interviews were coded to the Work Domain Analysis framework. Staff recognised that the ED is not an environment that suits the needs of older adults. As well as a high stimulus environment, ED staff did not have the capacity to provide the comprehensive basic care needed. Staff were distressed that the level of care afforded older adults was inadequate for their needs, perceiving wrong and harm through prolonged ED stays:

"I can't even tell you of the amount of falls that are coming through and bad falls that are coming through or the amount of pressure injuries that are being reported which have really started in the ED just because we're not able to provide that care for a multitude of reasons."

Staff recognised the need, but current lack of, complex care services to transition older adults into early from ED or alternate paths to bypass the ED:

"Not everybody needs to come through the ED. This ED is very much a complex processing area for complex patients. But the only way you can get there is maybe a 24-hour journey through here...and that's where a lot of our issues are. This is the only way to get a patient into hospital. Our problems are not GP patients, our problems are probably not inappropriate uses of ambulances. Our problems are we can't process patients into the complex services that we need. A sick geriatric patient is a very sick patient and then you need your nursing ratios, but not the waiting room of 33 patients."

At Westmead ED, there was recognition of the need for an interdepartmental response to facilitate early transition from an ED care to a geriatric care model. To support rapid transition, the ED had 24-hour daily access to a geriatric registrar and 18-hour daily access to an intern or junior doctor from the geriatric team.

Step 1.3 – Interviews with Users

We conducted 12 interviews with 8 patients and 4 carers. Themes arising from analysis of the data were:

1. Difficulty fulfilling basic patient needs - for food and drink, sleep, personal hygiene, and mobilisation
2. Variability of care – some reported high-level care while others reported lack of attention and lack of empathetic care, with little ability to accommodate age-specific needs eg hearing loss, dementia.
3. Unsuitability of ED environment – the environment was loud, high-stimulus, lacked privacy, was uncomfortable, and patients felt unsafe among more mobile and sometimes scary patients

The main priority identified by older adults related to provision of basic needs for care and safety.

'If they could give you something, I'd probably ask for something to drink which I was terribly thirsty and at – just something to eat and it seems hours before I got anything but that'd be the only thing but that's only me but anyhow.'

Carers advocated for the provision of basic care and were a key support for patients with cognitive decline, sensory loss or dementia. Given the importance of their carer role, and the exhaustion that many informal carers experience, accommodating carer need for rest was also important.

Touchpoints:

System-wide transformation is required to manage increasing care demand particularly for dependent older adults with high frailty scores (Rockwood scale). Triangulating all data, the main issues identified in ED were:

- Need for older-age-friendly care – a low stimulus environment equipped with age-specific equipment and trained staff eg hi-lo beds, good management of challenging behaviour, capacity to provide comfort and basic nursing care, consideration of cognitive and physical decline, carer rest,
- Specifically, early identification of older patients with complex conditions and frailty who need more direct admission and transition into geriatric care. These patients need to be managed via alternate Model of Care that should bypass the ED.

References:

1. Rockwood K, Andrew M, Mitnitski A. A Comparison of Two Approaches to Measuring Frailty in Elderly People. *The Journals of Gerontology: Series A*. 2007;62(7):738-743. doi:10.1093/gerona/62.7.738

2. Falk Erhag H, Guðnadóttir G, Alfredsson J, et al. The association between the clinical frailty scale and adverse health outcomes in older adults in acute clinical settings–a systematic review of the literature. *Clinical Interventions in Aging*. 2023:249-261.