

# Critical decisions

in emergency medicine

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## Age Restrictions

Emergency department visits and hospital admissions are on the rise in patients older than 65, who comprise the fastest growing segment of the US population. Preparation is the key to providing age-appropriate care, avoiding iatrogenic harm, decreasing the risk of morbidity and mortality, and averting unnecessary hospitalizations. Simple modifications to emergency department design, triage and discharge protocols, medication reconciliation, and targeted educational initiatives can pay big dividends for geriatric patients.

## In Too Deep

While pediatric drowning is more prevalent in regions populated by large numbers of swimming pools, lakes, rivers, and beaches, younger children are also at risk in poorly controlled situations that involve bathtubs and even buckets of liquid. An estimated 85% of drownings are preventable with adequate supervision and public safety initiatives. Because early resuscitation is vital to a good outcome, emergency clinicians must be prepared to recognize and manage drowning and submersion-related injuries without hesitation.



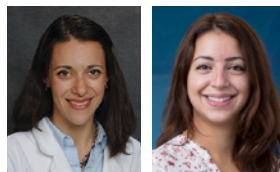




# Age Restrictions

## The Geriatric Emergency Department

### LESSON 17



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#### OBJECTIVES

On completion of this lesson, you should be able to:

1. Describe the unique challenges that geriatric patients face in the emergency department.
2. Recognize the shortcomings of current triage systems for geriatric patients.
3. Implement simple emergency department improvements to enhance the care of elderly patients.
4. Summarize strategies and resources to develop personal and department knowledge of geriatric emergency care.
5. Use evidence-based strategies to safely discharge geriatric patients from the emergency department.

#### FROM THE EM MODEL

- 20.0 Other Core Competencies of the Practice of Emergency Medicine
- 20.4 Systems-Based Practice

#### CRITICAL DECISIONS

- How should elderly patients be triaged?
- What early interventions should be considered when managing geriatric patients?
- What are the specialized needs of geriatric patients, and how should they be addressed?
- What is the best way to prevent returns to the emergency department or rehospitalization?
- How can emergency providers increase their knowledge of age-specific problems in geriatric patients?

**Emergency department visits and hospital admissions are on the rise for geriatric patients, who comprise the fastest growing segment of the US population.<sup>1,2</sup>** Preparation is the key to providing age-appropriate care, avoiding iatrogenic harm, decreasing the risk of morbidity and mortality, and averting unnecessary hospitalizations. Simple modifications to emergency department design, triage and discharge protocols, medication reconciliation, and targeted educational initiatives for emergency clinicians can pay big dividends for older patients.

## CASE PRESENTATIONS

### ■ CASE ONE

A 79-year-old man presents with weakness and a cough. He is diagnosed with pneumonia, started on antibiotics, and admitted to the hospital. Because a room is not immediately available, he waits on a stretcher in the emergency department's hallway for 6 hours. By the time an inpatient bed becomes available, he is confused, agitated, and tachycardic. The hospitalist no longer feels comfortable managing him with a floor level of care, so he requests a step-down unit or intensive care unit (ICU) admission.

### ■ CASE TWO

While out driving his classic Corvette, an 85-year-old man is T-boned at an intersection. The driver of the other car is taken to a level 1 trauma center by helicopter, and the elderly man is transported to the local emergency department. He has chest and hip pain but no loss of consciousness or head injury. On arrival, his vital signs are blood pressure 110/70, heart rate 98, respiratory rate 20, and oxygen saturation 98% on room air. He is afebrile but appears uncomfortable. He complains of localized tenderness on palpation to the right lower chest wall; his examination is otherwise normal. The emergency physician

evaluates him and orders x-rays. When the patient requests pain medication, the nurse relays that the doctor did not order anything because of the patient's age.

### ■ CASE THREE

A 67-year-old woman presents with vomiting for the past 2 hours. She is well appearing, her vital signs are stable, and she has a benign abdominal examination. Her laboratory values are normal. During her visit, she does not vomit and is able to tolerate saltine crackers. She is discharged home with written instructions and return precautions. The patient lives by herself and promises that she will read the instructions as soon as she finds her glasses at home.

In 2010, 15% of the 130 million patients who visited a US emergency department were over 65 years of age.<sup>1</sup> Extra care must be taken when managing this special population, which suffers from high rates of cognitive impairment, functional impairment, depression, and polypharmacy.<sup>3</sup> Geriatric patients have more emergent problems, need more diagnostic tests, and are more likely to be admitted to the hospital or ICU than those in any other age group.<sup>4</sup> Every emergency department visit should be considered a high-risk event that puts the elderly at increased risk of medical errors and adverse drug interactions when compared to the general population.<sup>5</sup>

Although the number of older adults presenting to emergency departments has been increasing steadily, the number of those admitted to the hospital has increased more than those who were discharged, with an almost doubling of the use of ICU services.<sup>2</sup> These changes may indicate a more critically ill population but could also be due to the overutilization of services. Hospitalization itself can be dangerous for geriatric patients: They are susceptible to delirium, hospital-acquired infections, falls, iatrogenic

complications, and loss of functional status. With Medicare deducting reimbursements for iatrogenic complications, such as catheter and wound infections, the need to take better care of admitted elderly patients has a financial incentive.<sup>6</sup> Geriatric patients also require more services after discharge to prevent their immediate return to the hospital. Even if these services are provided, they are still at higher risk for bouncing back to the emergency department and requiring readmission than younger patients.<sup>7</sup>

Most patients over the age of 75 years are affected by functional problems and geriatric syndromes. Approximately 50% are dependent on others for personal activities of daily living, a number that increases to 75% after presentation to an emergency department. About 25% of elderly emergency department patients exhibit one form of cognitive impairment, and 50% cannot walk unsupervised.<sup>8</sup>

The unique challenges facing this population and the successes of prior initiatives focused on disease entities (eg, stroke) and patient populations (eg, pediatrics) have contributed to the birth of accredited geriatric emergency departments. These facilities are designed for older patients, including

quality improvement and enhancements of the physical environment — a safer layout — and geriatric-focused supplies. Geriatric emergency departments provide special education and interdisciplinary staffing, including specially trained providers and case managers. Standardized protocols are implemented to address common age-related issues, improve safety, decrease admissions, optimize discharges, and decrease moribund outcomes.<sup>6</sup>

Geriatric emergency departments focus on older patients as a whole, rather than on the acute chief complaint, as is the model with traditional emergency care (*Figure 1*). These facilities may also be better equipped to address comorbidities, such as depression, cognitive impairment, and medication interactions. In addition, they strive to optimize transitions to inpatient, home, community-based, rehabilitation, and long-term care settings. To learn more, visit the American College of Emergency Physicians (ACEP) website for the geriatric emergency department accreditation program at <https://www.acep.org/geda>.

Although studies have not yet proven whether geriatric-focused emergency departments can achieve all the goals set out above,<sup>9</sup> this new approach has

already been associated with a decreased rate of hospital admission.<sup>5</sup> Fellowships in geriatric emergency care and specially designated geriatric emergency departments are two approaches that enhance the delivery of age-appropriate care to older patients, but neither option is available to all providers. Regardless, emergency physicians should be cognizant of the differences in the care required for older patients.

## CRITICAL DECISION

### How should elderly patients be triaged?

The most common triage system in the United States is based on the Emergency Severity Index (ESI), which risk stratifies patients according to the severity of their presentation and how quickly they should be seen.<sup>10</sup> In a 2010 study that focused on older patients, the third iteration of the ESI algorithm (ESI-3) demonstrated validity, as it correlates with hospitalization, length of stay, resource utilization, and survival.<sup>11</sup>

This is important from a patient safety standpoint, as it ensures that sicker patients are seen first. However, when addressing individual outcomes in older patients, the ESI has many shortcomings. Its dependence on vital

signs makes it less sensitive, as vital signs can be deceptively normal for this population.<sup>12</sup> Specifically, a trigger for the “danger zone” in the ESI is a heart rate of 100 beats per minute (bpm), but tachycardia is not easily mounted by older patients. In addition, altered mental status or “disorientation” warrants a higher acuity triage level, yet delirium is frequently missed on evaluation of geriatric patients.<sup>13</sup>

Other vital signs that are not explicitly addressed in the ESI, but that are used for consideration of triage level by nursing staff, are blood pressure and fever, both of which have different normal ranges in older patients. Thus, older adults without grossly abnormal vital signs, those with dementia or other cognitive disorders, patients with nonfocal complaints and atypical presentations, and seniors with less apparent illness, in general, can be easily assigned to lower triage acuities.<sup>14</sup> Under-triage leads to increased wait times, with subsequently worse outcomes; a more negative patient experience; discomfort, nervousness, mistrust, and confusion; and feelings of abandonment and anxiety.<sup>15,16</sup>

These challenges have led many experts to propose geriatric-specific modifications to the ESI, specifically

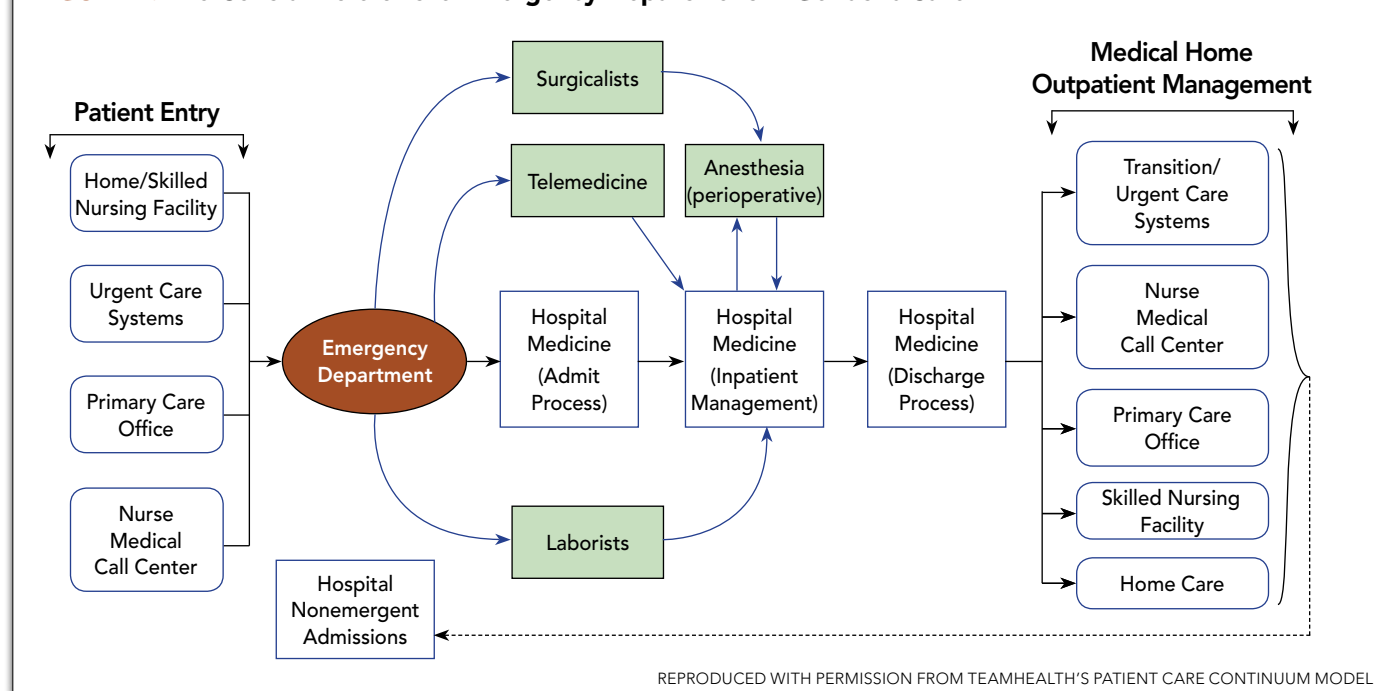
increasing the sensitivity of vital signs (*Table 1*) and the level of consciousness, which follows the logic of pediatric-specific parameters. Research is still required to validate this approach. Another important intervention is to encourage the involvement of a family member or care provider in the process,<sup>6</sup> especially for patients who are cognitively impaired.

Even when geriatric patients are accurately triaged, they are less likely to be seen within the appropriate time frame for their assigned urgency.<sup>17</sup> It is unclear why the elderly wait longer for care, even though they are more likely to be sicker and to require admission and critical care.

Triage for geriatric trauma patients is a robust area of interest. As injuries to elderly people increase in frequency, so do the associated rates of morbidity and mortality. These increases are not limited to major traumatic injuries; they also occur among people with seemingly minor injuries, such as those sustained in falls. One obvious reason for the two- to five-fold increase in mortality is the abundance of comorbidities in this population; under-triage becomes an additional complicating factor.<sup>18</sup>

An estimated one-third of older trauma patients are under-triaged,

**FIGURE 1. The Central Role of the Emergency Department in Geriatric Care**



REPRODUCED WITH PERMISSION FROM TEAMHEALTH'S PATIENT CARE CONTINUUM MODEL

**TABLE 1. Suggested Thresholds for Vital Signs in Older Patients**

Vital Sign	Current Abnormal Threshold	Proposed Abnormal Threshold
Heart rate	>100 bpm	>90 bpm
Blood pressure	<90 mm Hg	<110 mm Hg
Temperature	>38°C (100.4°F) (oral)	>37.4°C (99.3°F) (oral)

**TABLE 2. Risk-Stratification Tools for Geriatric Patients**

Identification of Seniors at Risk (ISAR)
Triage Risk Screening Tool (TRST)
Silver Code
Variables Indicative of Placement (VIP) risk
Mortality Risk Index
Rowland
Runciman
Score Hospitalier d'Evaluation du Risque de Perte d'Autonomie (SHERPA)

with the rate climbing to almost 60% for patients 90 years and older, which negatively affects both mortality rates and costs.<sup>18,19</sup> A unique initiative in Ohio, started in 2009, used an evidence-based triage protocol in the field for injured patients older than 70 years to determine destination, utilizing lower thresholds for transfer to a trauma center. This protocol improved the sensitivity of identifying injury severity and increased the proportion of individuals discharged home, but it failed to change the mortality rate.<sup>19,20</sup>

## CRITICAL DECISION

### What early interventions should be considered when managing geriatric patients?

In addition to applying the classic triage model to identify patients' ESI levels, emergency department visits are used as opportunities to screen patients for a variety of conditions, including depression, suicide, abuse, and substance abuse, and direct them toward appropriate resources. Clinicians should also assess for those at high risk for an adverse event after discharge, such as hospital readmission, another emergency department visit, institutionalization, functional decline, or death. An awareness of these events can help focus the use of time, personnel, and resources,

which are hot commodities in an era of decreased federal funding for health care.<sup>6</sup>

A recent meta-analysis<sup>21</sup> evaluated a variety of screening tools (*Table 2*) with regard to their ability to identify at-risk patients during triage and, thereby, improve care through targeted management. By definition, screening tools should be sensitive, have a good negative predictive value, and be simple and reproducible. Unfortunately, none of the screening tools evaluated yielded "compelling evidence" to justify recommendation of their use.<sup>21,22</sup> An earlier review article evaluated a targeted screening process, in which geriatric patients underwent a brief evaluation. Patients identified as high risk then underwent a comprehensive geriatric assessment. In this review, evidence supported the two-step process to identify at-risk patients in need of further intervention and to decrease emergency department readmissions.<sup>22</sup>

While the meta-analysis could not advocate a specific screening test, given the lack of statistical evidence, it did emphasize the need for a focused, evidence-based tool that can identify high-risk populations at the time of triage and positively influence management decisions. This recommendation is consistent with

the *Geriatric Emergency Department Guidelines* compiled by ACEP, the American Geriatrics Society (AGS), the Emergency Nurses Association (ENA), and the Society for Academic Emergency Medicine (SAEM), available online at <https://www.acep.org/geda/resources/pdfs/GEDA-Guidelines.pdf>.<sup>6,21</sup>

## CRITICAL DECISION

### What are the specialized needs of geriatric patients, and how should they be addressed?

#### Physical Environment

Building a geriatric emergency department with amenities specifically designed to accommodate elderly patients seems difficult for many providers working in small community hospitals or crowded academic centers. However, not all changes require a contractor or a large budget (*Table 3*). When seniors were asked what they would like to see in an emergency department, they reported that they wanted their independence, mobility, and safety prioritized.<sup>23</sup>

Ideally, hallways should be clear from clutter and easily accessible by someone using a walker or a wheelchair. Handrails should be installed, and signage with easy-to-read graphics should be clearly visible to direct patients to amenities such as the bathroom, the waiting room, and the exit to parking. Orientation in each patient's room, including an easy-to-read clock and a sign denoting the date and day of the week, would also help patients at high risk for delirium (*Figure 2*).<sup>23</sup>

**TABLE 3. Emergency Department Interventions to Improve Outcomes for Geriatric Patients<sup>6</sup>**

Physical Environment	Staffing	Patient Care Initiatives
Handrails	Pharmacist	Frailty assessment
Clutter-free hallways	Volunteers	Delirium detection
Large clocks	Social worker/case manager	Pain management
Signage indicating date	Physical therapist	Palliative care
Ambient light		
Lower-level beds		
Even walking surfaces		
Bedside interventions		
Avoidance of medical tape		
Thick, soft mattresses		



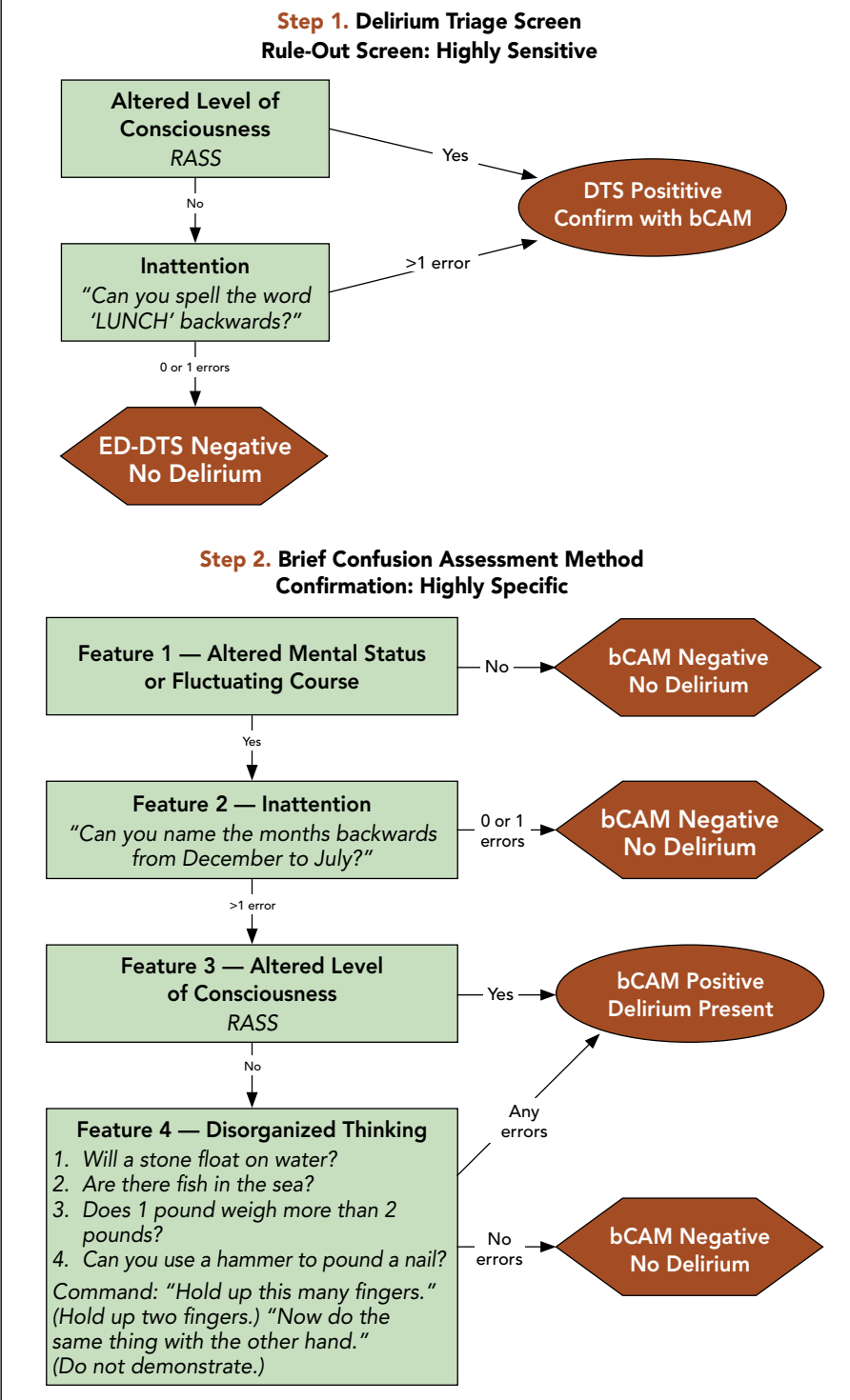
Improved lighting is a simple way to decrease the risk of adverse events, such as falls and delirium. Patients should be able to control the light in their rooms; older adults require three times as much light as younger adults for visual clarity. In addition, they should be able to turn off the lights in their rooms at night, which can lessen the disruption to their circadian rhythms and subsequently decrease the risk of delirium. Indirect light is preferred to spot lighting, which increases glare and makes it more difficult for elderly people to see.<sup>6</sup>

Elderly patients are at significant risk for falls. While some interventions such as fall-risk bracelets do not improve outcomes, others can decrease complications and should be implemented. Bed rails should not be used. They do not reduce fall risk and actually increase the risk of injury if the patient does fall.<sup>6</sup> Beds should be kept at low levels to allow patients to stand more easily. Elevated thresholds in room doorways should be removed. Uneven walking surfaces, textured tiles, rugs, and carpets should be eliminated. Reducing the number of patient transfers during the emergency department stay also decreases the risk of falls.<sup>6</sup> Bedside radiological studies and portable laboratory equipment for bedside blood draws limit the number of transports and decrease the risk of disorientation by keeping the patients in one treatment space for the entirety of their stay.<sup>6</sup>

Geriatric patients are also at high risk for skin breakdown while in the hospital. Simple changes in practice can limit this complication. The use of medical tape and adhesive should be limited because it can injure frail skin.<sup>5</sup> Extra-thick, soft mattresses are usually available in the hospital and should be requested for geriatric patients who are expected to have an extended stay in the emergency department. Patients should be given the option to use a soft reclining chair, instead of a stretcher, if it does not interfere with treatment. Furniture should be easy to clean and soft to protect frail skin.

The emergence of delirium in the emergency department is common and may have an iatrogenic component.

**FIGURE 2. Delirium Screening Instruments**



Interventions that decrease the risk of delirium include frequently orienting patients to the time and place, using signs or sitters, avoiding unnecessary tethering in the form of monitor leads or urinary catheters, and turning the lights off in patients' rooms at night.<sup>6</sup> Patients should

be encouraged to use their glasses and hearing aids to help them remain oriented and engaged.

## Staffing

The role of emergency department pharmacists in managing the geriatric population is unclear. Polypharmacy

is prevalent in older patients, making them prone to medication errors, adverse events, and drug interactions. In addition, given the physiological changes and comorbidities typical among the elderly, some medications are inappropriate for older patients and have been identified in several initiatives, including Beers list and the Screening Tool of Older Persons' potentially inappropriate Prescriptions (STOPP) criteria.<sup>24,25</sup> It therefore seems reasonable that the presence of an emergency department pharmacist, who could address this population specifically, could improve outcomes. One study reported that an emergency department–based pharmacist or clinical pharmacy specialist identified at least one medication-related problem in almost half of those in an elderly patient cohort; however, the presence of a pharmacist was not associated with improved clinical outcomes in previous studies.<sup>26</sup>

Although many emergency departments have limited budgets and staff, they often have access to a plethora of hospital volunteers. Engaging this supplemental workforce in efforts to improve geriatric outcomes can pay off with improved patient experiences. On patient satisfaction surveys, many seniors report not receiving enough attention and reassurance during their visit. They describe the emergency department as busy and chaotic and feel that their basic needs (eg, hunger or use of the toilet) are addressed insufficiently. A robust volunteer service can fill many of these gaps and support a strained clinical staff.<sup>23</sup>

### Patient Care Initiatives

Several specific aspects of care should be addressed when managing any elderly patient in the emergency department. For example, delirium screening can be very effective in decreasing in-hospital morbidity and can detect patients at heightened risk of death, thereby prompting appropriate interventions. When health care professionals do not use a dedicated screening tool, they miss the diagnosis of delirium more than 50% of the time.<sup>27</sup>

The Mini-Mental State Examination (MMSE) is cumbersome and not

suitable for the emergency department. Alternatives include the Quick Confusion Scale, the Brief Confusion Assessment Method (bCAM), and the Modified Richmond Agitation and Sedation Scale (mRASS), specifically because each takes less than 1 minute to administer. The Quick Confusion Scale is a shorter version of the MMSE and is the test with the best performance-to-time ratio in the emergency department.<sup>22</sup> The bCAM is derived from the Confusion Assessment Method (CAM) used in ICUs for the detection of delirium.

Undertreatment of pain is also a common problem for geriatric patients. One study showed that older patients are 20% less likely than their younger counterparts to receive pain medication.<sup>28</sup> This difference probably stems from concerns about the use of opioids in the elderly population. It is important to consider alternatives to opioids for pain management, such as acetaminophen, topical anesthetic treatments like lidocaine patches, and nerve blocks. The use of low-dose opioids, with titration, is safe in older patients; however, increased bioavailability and medication interactions must be factored into dosing decisions. Uncontrolled pain, especially after an injury, increases the risk of delirium in susceptible patients and is frequently associated with functional decline, disability, and an increased risk of falls.

Introducing the concept of palliative care early and correctly is essential in the care of all patients, but even more so in those with multiple comorbidities. It is important to recognize that palliative care and hospice care are not one and the same. Palliative care is an interdisciplinary approach focused on improving the quality of life for persons of any age who are living with serious illness and their families. Hospice care, on the other hand, provides palliative care to dying patients in their final months of life. Clarifying this distinction helps to enable patients and their families to accept a referral to palliative care, if appropriate, and to improve the quality of life for the patient, reduce hospital stays, and decrease the cost of care.<sup>29</sup>

### CRITICAL DECISION

#### What is the best way to prevent returns to the emergency department or rehospitalization?

Prior to discharge, consider that as many as 80% of elderly patients who are discharged from the emergency department have at least one unrecognized geriatric problem — delirium, dementia, depression, undernutrition, or an unmet social service need.<sup>30</sup> Emergency providers should take the time to look for insidious diagnoses, while determining a safe discharge plan.

### Pearls

- Reduce bounce-back visits by making follow-up phone calls to high-risk elderly patients.
- Geriatric patients typically want more information about advance care directives, elder services in the community, and the compilation of medication lists. Include this material in your standard discharge paperwork.
- Make small physical changes to the emergency department — hang a clock with large numerals, display a calendar with the day and date, ensure patients can control the light settings in their room — to help prevent complications such as delirium.
- Make educational resources on geriatric care readily available. Staff members want to know more about how to care for elderly patients.



A multidisciplinary approach is necessary for a safe discharge and can improve patient outcomes. An emergency department pharmacist should review the medication list; a geriatric life specialist should conduct screenings for depression, neglect, abuse, and other geriatric-specific topics; a social worker should create a safety plan; and a physical therapist should assess the patient's needs.<sup>5</sup> One barrier to the safe discharge of elderly patients from the emergency department is the limited availability of ancillary staff, such as social workers, who typically work during usual business hours. Expanding the resources that are already in place can improve the process.

Prior to discharge, a few other things should be assessed. One is the patient's mobility, which affects safety and fall risk at home.<sup>6</sup> Interestingly, older adults overestimate their ability to perform simple tasks — like getting out of bed, walking 10 feet, and then returning to bed — up to 20% of the time, even more so if they are cane or walker dependent. Therefore, a member of the emergency care team should observe the patient's mobility directly prior to discharge. The timed "Get Up and Go Test" is used in inpatient settings and in emergency departments as a predictor of return visits and hospitalizations.<sup>31</sup>

The importance of discharge protocols that enhance communication between the emergency department team and outpatient care providers has been supported by various specialty societies.<sup>6</sup> However, one study found that communication with community

physicians by emergency care providers was infrequent and that telephone follow-up after discharge was rare.<sup>32</sup> As expressed in the *Geriatric Emergency Department Guidelines*,<sup>6</sup> emergency department personnel should contact the patient's outpatient care provider to relay information about the complaints that precipitated the visit, the available test results, the treatment administered, the patient's response to treatment, any consultations obtained, the discharge diagnosis, any new prescriptions, and a concrete follow-up plan.

The discharge instructions handed to an elderly patient should be in a large font. As applicable, they can also be shared with family members in accordance with the parameters of the Health Insurance Portability and Accountability Act (HIPAA). Best practice is for the emergency physician to personally review the discharge instructions with the patient. Emergency department staff can improve the discharge experience by providing additional information about geriatric topics to patients and families. Popular topics in a geriatric patient survey included information about advance care directives, elder services in the community, and how to create a list of medications.<sup>23</sup> If written in general terms in an easy-to-read style, patients and families appreciate this relevant information.

The most appropriate disposition for a patient might not be the place they left to come to the emergency department. For example, a patient who lives at home might be better served by entering

hospice or an assisted living facility. Other placement considerations should include the need for rehabilitation or observation.<sup>5</sup>

If a patient is discharged home, follow-up phone calls can reduce the likelihood of bounce-backs and improve outcomes. In a 2014 study, nurses with training in geriatric emergency medicine made follow-up calls 1 to 3 days after discharge and again at 10 to 14 days after discharge.<sup>33</sup> The calls aimed to assess pain, answer medication questions, confirm the scheduling of outpatient follow-up appointments, and inquire about home health-care status. Rates of return visits to the emergency department within 3 days and hospital admissions were lower in the group that received the follow-up consultation than in the group that did not. Follow-up phone calls are an easy, inexpensive way to reduce admissions and bounce-backs to the emergency department.

## CRITICAL DECISION

### How can emergency providers increase their knowledge of age-specific problems in geriatric patients?

In an ideal geriatric emergency department, physicians would be fellowship-trained geriatric emergency physicians with a support staff that includes geriatric life specialists and nurses with special training in elder care.<sup>5</sup> While these standards may not be possible for all emergency departments, physicians and nurses can pursue education in geriatric topics with minimal extra effort.

In surveys about geriatric care, providers often report moral angst about the quality of care and cite a lack of education as the main reason for their discomfort.<sup>23</sup> When surveyed about their comfort level in caring for geriatric patients in the emergency department, staff cited a need for education and training on geriatric-specific issues — the health problems associated with aging, communication with elders, elder abuse, and cultural sensitivity.<sup>23</sup> Clinicians also wanted to learn more about appropriately managing patients with dementia and about responding to



## Pitfalls

- Ignoring age-specific factors when triaging geriatric patients.
- Making elderly patients wait longer for care than is appropriate for their acuity level.
- Failing to recognize that 80% of elderly patients have one of the following undiagnosed conditions at the time of discharge: delirium, dementia, depression, undernutrition, or an unmet social service need.
- Neglecting to look for signs of elder abuse. Have a system in place to fully evaluate every elderly patient.



## CASE RESOLUTIONS

### ■ CASE ONE

The 79-year-old man with pneumonia responded well to antibiotics and started to improve. When his family arrived in the emergency department, their familiar faces, plus some rest, helped resolve his delirium. He was eventually admitted to an inpatient floor, but his stay in the emergency department had been prolonged significantly. Once he got to his hospital room, his nurse noticed a stage 1 decubitus ulcer on the left side of his sacrum. In his hospital bed, the patient was adequately turned, but the ulcer

progressed. He then developed a fever and superinfection, which significantly lengthened his hospital stay.

### ■ CASE TWO

The 85-year-old man's x-rays showed a sternal fracture, left hemothorax, and grade II pelvic fracture. He was under-triaged by the paramedics at the scene when they decided not to transport him to the trauma center for evaluation. In the emergency department, the patient was stabilized with a pelvic binder and a left-sided chest tube. Given the patient's age, the physician was afraid to prescribe opioids, so he was transferred without pain medication.

He suffered significant delays in care and pain control.

### ■ CASE THREE

When the elderly woman returned home, she was unable to find her glasses and she could not read her discharge instructions. When her vomiting resumed, she called an ambulance, which took her to the emergency department across town. A CT scan of her abdomen revealed diverticulitis complicated by an abscess. She was treated with intravenous antibiotics and a percutaneous drain and was discharged home from the hospital 5 days later.

confusion, aggression, and agitation.<sup>23</sup> Other topics of interest to emergency department staff include living wills and the community services available to elders.

The *Geriatric Emergency Department Guidelines* are presented as a consensus publication of ACEP, AGS, ENA, and SAEM. While not a mandate or requirement, they provide evidence-based material that is relevant to the acute care of geriatric patients. Topics include atypical presentations of disease, pain management and palliative care, the effect of comorbid conditions on current presentation, common complaints that prompt older patients to seek emergency care, and the logistics of making an emergency department more geriatric friendly. These high-yield topics can help practitioners target areas where geriatric patients have been shown to have delays in diagnosis or worse outcomes than their younger counterparts.

### Summary

Geriatric patients require careful consideration. They are at high risk for complications and have increased morbidity and mortality after they present to an emergency department. All providers can make small changes to their emergency departments and can

focus on continuing medical education in geriatric care to improve the experience and outcomes of the oldest and most vulnerable patients.

For those who wish to learn more about creating dedicated geriatric emergency departments, email the ACEP Geriatric Emergency Department Accreditation (GEDA) program at [geda@acep.org](mailto:geda@acep.org) or visit <https://www.acep.org/geda> to learn more about the accreditation levels, application process, GEDA guidelines, GEDA criteria, news, events, articles, podcasts, and more on the evolving trends in geriatric care and emergency medicine.

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## ADDITIONAL READING

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