Optimal acute care of the older adults: Are we ready to open the Pandora box?

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ABSTRACT

The emergency departments (ED) present as the gateway to healthcare services for an increasing number of older adults. Acute care of this vulnerable population in a busy ED presents its own unique challenge. They have higher mortality in the hospital and following discharge, a higher revisit rate to the ED, and are at a higher risk of functional decline following an ED visit. Extra caution and mindfulness are needed when caring for them as they differ from younger patients in several ways. This article tries to put forward feasible strategies with an integral and holistic view to meet their complex need in the ED.

Keywords: emergency department, older adults, optimal care

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INTRODUCTION

The Nepal government has declared people of age ≥ 60 years as elderly citizens. Over 2.5 million people living in Nepal are aged over 60 years as of 2019, which is expected to double by 2050. Almost a quarter of the total emergency department visits accounts for older adults.[1] With the increase in the life expectancy of the population worldwide, we can expect an increase in the proportion of older patients in the emergency departments requiring acute care in the future. Emergency Medicine is in a primitive stage in our country and are not "senior-friendly". There are some unique aspects of geriatric emergency care as it is a challenging and more vulnerable group,[1] therefore, it is important to develop and introduce cost-effective strategies to improve acute care of older patients in low resource settings like ours.

Challenges

Compared with their younger counterpart, older patients use emergency services at a higher rate (45.4 visits x100 person x year vs. 38), have a greater level of urgency (63% vs. 34% of emergent and urgent category), and are more likely to get admitted (30-50% vs 10-20%).[1,2] Moreover, they have longer stays in the emergency department, frequent ED revisits, and higher rates of adverse health outcomes after discharge (10% mortality and up to 45% functional decline at 3 months).[1,2]

Older patients in the ED are more likely to have complex presentations with confounding effects of co-morbid diseases. "Older adults break easily": They deteriorate rapidly and have higher mortality in comparison to their younger counterpart. "They don't play by rule": atypical presentation is common as age advances and the treating healthcare personnel should be hyper-vigilant not to miss the life-threatening conditions. "They are great masquerades": Apparently normal can be abnormal and vice versa for the older patients. Currently, there are limited clinical guidelines to optimize acute care of older adults. Poly-pharmacy and adverse drug reaction is common in this age group. Therefore, a particular focus on drug reconciliation and DE-prescribing should be considered in the older patients presenting to the ED.

Cognitive disorders like delirium and dementia possess an additional challenge to care for older patients in the busy and chaotic EDs. It is estimated that the prevalence of delirium is approximately 17% of all ED older adults.[3] Despite its well-established negative consequences (increased mortality and longer hospital stay), it is often overlooked in the ED and even after admission (76%–84% of cases missed). The prevalence of dementia increases with age and studies show that older adults with dementia are frequent ED visitors (34%) who have greater comorbidity, have higher admission rates, higher ED revisits, and have higher mortality following an ED visit.[4] It is important to recognize dementia in the ED setting before discharge as they are less likely to understand or follow discharge instructions.

The baseline functional capacity of the older patient is very important but often not considered in the ED. Frailty is an important geriatric syndrome that is highly prevalent with advancing age and is a strong predictor of adverse outcomes including falls, mortality, length of stay and hospitalization.[5] However, it is to note that biological and chronological age is not synonymous, therefore recognition of the frailty status of each older patient is important.

Global strategies

A simplified comprehensive framework of geriatric care "The geriatric 5M" was introduced in 2017 which urges to focus on five key target areas of geriatric care, the 5 M:[6] (Figure 1)

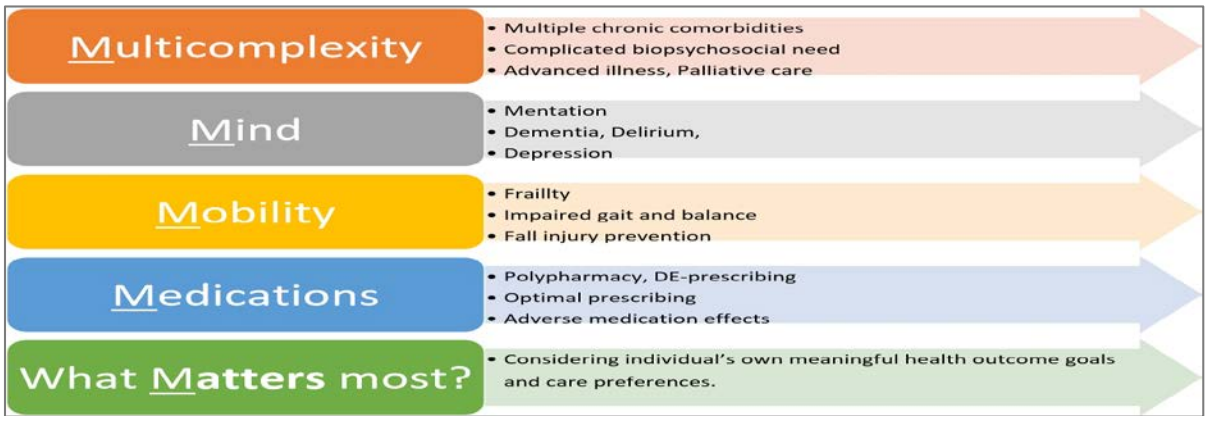

Figure 1. The Geriatric 5Ms

The American College of Emergency Physicians began accrediting Geriatric EDs into 3 tiers based on adherence to their guidelines since 2018. Four GED models of care: a Geriatric ED-specific unit, Geriatrics Practitioner models, Geriatric Champions, and Geriatric-Focused Observation Units are being practiced globally. Each of them has its own advantages and limitations and choosing a model of care depends on the hospital's existing resources and priorities.

Way forward

There is a shortage of geriatricians and geriatric nurse practitioners in Nepal, however, this need not be a hindrance to providing high-quality care to older ED patients. The General practitioners and the ED team have an even greater responsibility to provide the best care for vulnerable older patients requiring acute care. Each visit to the ED should be taken as an opportunity to identify and address the important issues of the older adults. Their curriculum should be revisited and the core competencies focused on geriatric care should be defined. Training modules incorporating the primary domains of geriatric care should be designed and disseminated. Geriatric-focused screening tools at the triage or before discharge from the ED should be implemented, which will determine the proportions of patients that require additional assessments or referral to the specialist. Development of geriatric-specific protocols are required for standard care. The integration of the other elements of multidisciplinary geriatric assessment-community workers, pharmacists, nutritionists and physical and occupational therapists can assist the ED physician in providing holistic, patient-centered care in accordance with geriatric principles. Higher quality acute geriatric care is possible for any ED by identifying one physician and one nurse to undergo additional geriatrics education and perform one quality improvement activity a year, which is highly attainable.

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