FIONA STANLEY hospital

Dr Shabana Ahamed

Consultant Geriatrician
Clinical Lead Geriatrician , Falls Pathway & GOLD-ED
Chair, Geriatric Medicine Advanced Training Committee WA
DHOS Fiona Stanley Hospital

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Department of **Health**

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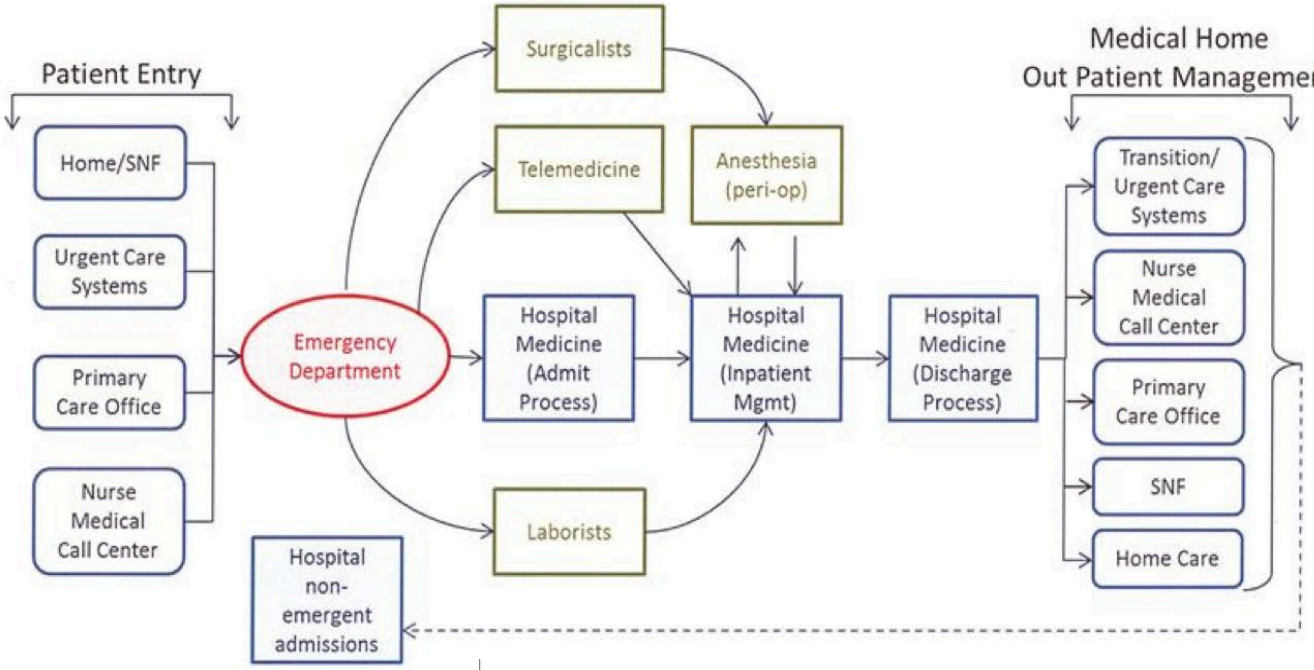
I acknowledge and pay my respects to the traditional owners of the lands upon which we meet



GERIATRIC EMERGENCY DEPARTMENT GUIDELINES

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

AGS THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals. Leading change. Improving care for older adults.

ENA EMERGENCY NURSES ASSOCIATION
SAFE PRACTICE, SAFE CARE

SAEM Society for Academic Emergency Medicine

Geriatric Emergency Department Guidelines: Annals of Emergency Medicine, Vol 63, Issue 5, e7-e25

FSH ED

FIONA STANLEY hospital

One of the busiest emergency departments in Australia – treats ~110,000 patients/year

~330 /day

80% adults

80 adults per day > 65 years

Emergency department short stay unit (ESSU) admits approx. 30 pts per day and is the busiest admitting unit in the hospital

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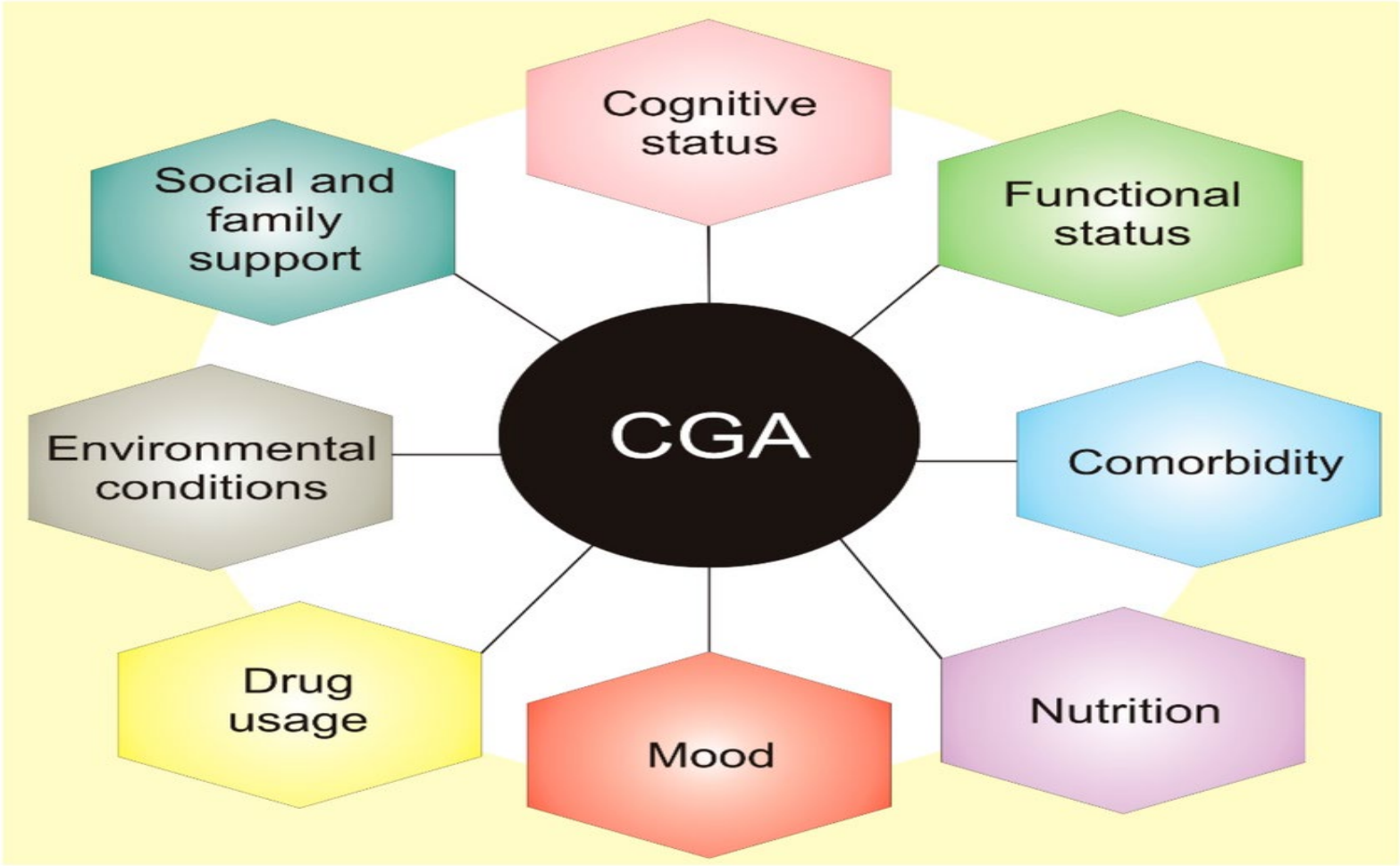
- Increasing frail older people attending the ED
- Frail older people have the highest 'conversion rate'
- Frail older people admitted to hospital
  - High risk of adverse events , increased mortality *
  - Long length of stay (LOS)
  - High readmission rates
  - High rates of residential care facilities (RCF) use

* Richardson 2006

Is it possible to embed Comprehensive Geriatric Assessment (CGA) within EDs?



A controlled evaluation of comprehensive geriatric assessment in the emergency department: the 'Emergency Frailty Unit'

Simon Paul Conroy[1], Kharwar Ansari[2], Mark Williams[2], Emily Laithwaite[3], Ben Teasdale[2], Jeremey Dawson[4], Suzanne Mason[4], Jay Banerjee[2]

- More discharged directly from ED
- Reduction in 90-day readmission rate
- Fewer admissions- conversion rate
- Length of stay increased

3 Randomized Clinical Trials (RCTs) * showed improvements in the functional status of patients

Targeting a high-risk group appears to be more effective**

**Caplan et al 2004, McCusker et al 2001, Runciman et al 1996*
***Hastings et al, 2005*

ED- Short Stay Unit (ESSU)

- Reduced hospital stay
- Improved quality of care
- Decreased pressure on hospital beds

Khan et al, 1997

- Reduce the number of admissions
- Optimize the care provided in other ambulatory and domiciliary geriatric settings

Pareja et al, 2009

Audit conducted in 2016*

- <50% older adults were discharged home from ED
- >50% admitted to acute medical unit (AMU) with a length of stay >5 days.
- Only 32% of patients reviewed by allied health (AH) in ED
- Few referred to outpatient services

Clear need to address how older people are cared for in an urgent episode.

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Geriatrician at the Front Door

Standardised Pathway

FIONA STANLEY HOSPITAL

FALLS PATHWAY

WARD _____

DOCTOR _____

SURNAME	UMRN	
GIVEN NAMES	DOB	GENDER
ADDRESS		POSTCODE
	TELEPHONE	

Falls are a major cause of death, injury, functional decline, hospital admission, psychological trauma and institutionalisation in older people. This pathway aims to support older people who present to ED by providing timely assessment of falls risk.

INCLUSION CRITERIA

- Aged 65 years or older
- Fall with 48 hours of presentation
- Has unintentionally come to land on ground or lower surface, **includes medical causes of a fall such as syncope, but not events such as being pushed over**

EXCLUSION CRITERIA

- ATS 1&2
- Suspected #NOF
- Suspected stroke or seizure causing fall
- Conscious state post fall is different to baseline
- Cervical spine precautions in place

STEP 1: If nil exclusion criteria **Triage to Falls stream**

STEP 2: Liaise with ESSU nursing lead (27636) on bed availability of 51 and 53 or high visible beds (Max 2 Falls patients in the **assessment phase** at one time). If nil beds in ESSU send to available bed space in main department and COMMENCE FALLS PATHWAY with paperwork. If isolation required – Bed 50.

STEP 3 (Medical/Nursing): EBM slip under emergency consultant of the day, diagnosis fall

STEP 4: Total ADD score within ATS time frame and completed by ESSU Lead

ATS – Australian Triage Scale
NOK – Neck of Femur
EBM – Enterprise bed management (system)
ADD – Adult deterioration detection

2024 WESTERN AUSTRALIAN FALLS REPORT

31% increase in the number of falls hospitalisations among people aged 65+ from 2018 to 2022

Older adults continue to experience the highest rate of falls

fatalities, hospitalisations and ED attendances

- Falls account for 28% of injuries to hospitals
- 22% of Fiona Stanley Hospital daily presentations ≥65 years (triage 3,4,5)
- Falls in older age are often treated with low priority
- ↑ hospitalisation and ↑length of stay with lack of systematic approach, ↑ representation rate
- Minimal referrals to outpatient clinics to reduce risk factors

KEY FINDINGS

Every 17 hours someone died due to a falls injury in 2021

Every 16 minutes someone was admitted to hospital due to a falls injury in 2022

Every 12 minutes someone attended the emergency department due to a falls injury in 2022

Injury Matters: 2024 WA Falls Report

Stay On Your Feet WA

NO FALLS NOVEMBER

Welcome to No Falls November, a campaign dedicated to promoting the many aspects of falls prevention and safety to patients, carers and health professionals.

FALLS RISK

Below is the calendar for the 2024 FSFHG No Falls November program, outlining each weekly theme. Resources and promotional materials will be shared every Monday and made available on the Falls hub page for sharing and displaying.

NO FALLS NOVEMBER

4-10 NOVEMBER

PJ Paralysis and postural hypotension
The importance of getting up and doing it safely!

FSH concourse: 5th November
FH B5: 6th November

11-17 NOVEMBER

TEACH BACK

Teach back and patient education
How patient education is one of the best falls prevention strategies.

FSH concourse: 13th November
FH B5: 12th November

18-24 NOVEMBER

Standby means stand with!
Strategies for preventing falls in hospital.

FSH concourse: 21st November
FH B5: 20th November

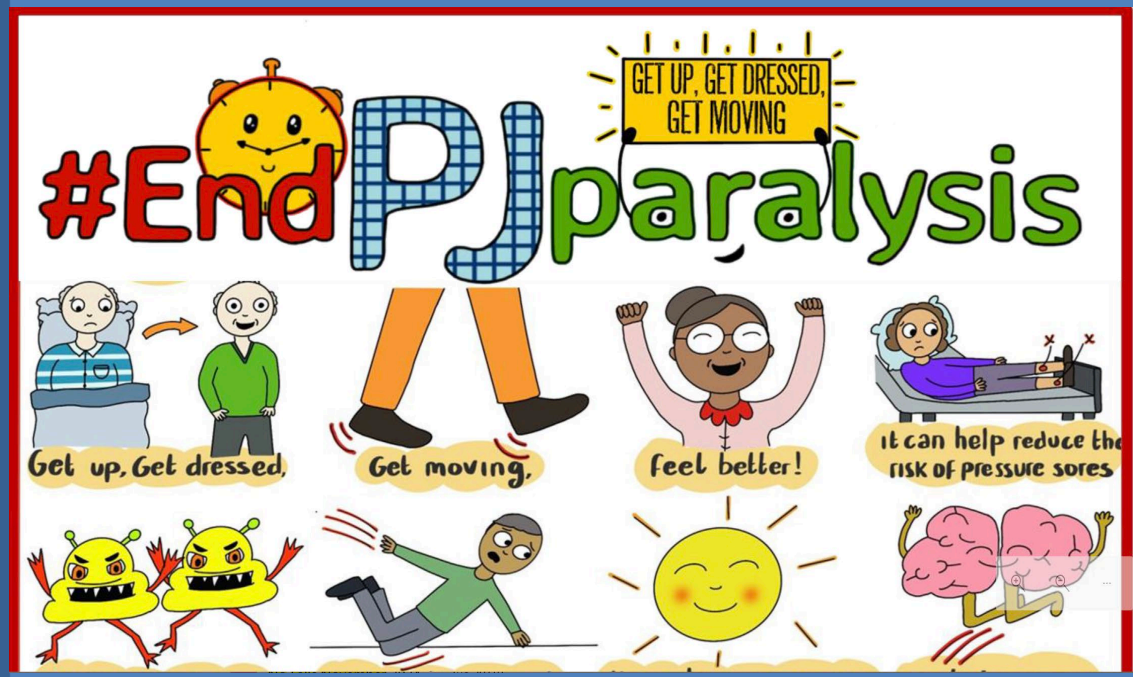
25-29 NOVEMBER

Neurological conditions and falls
How the brain impacts falls.

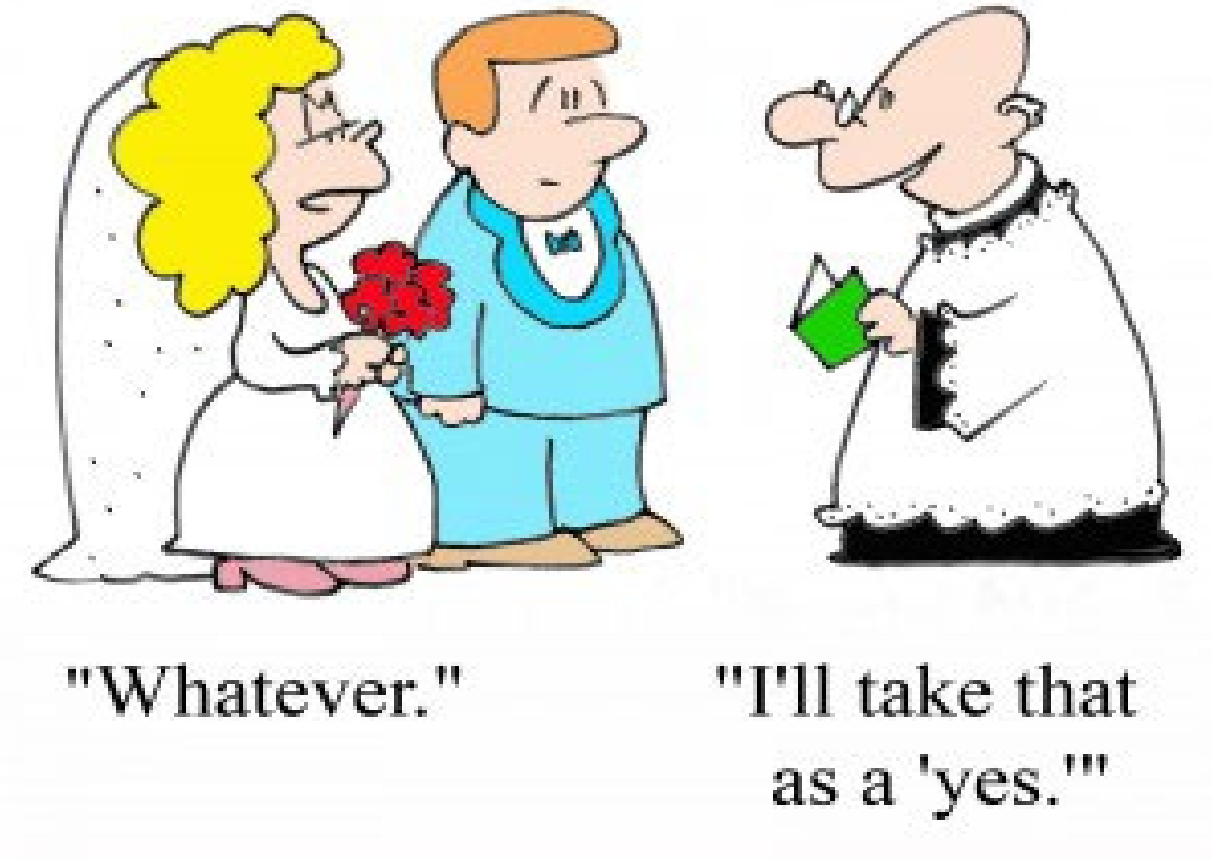
FSH concourse: 26th November
FH B5: 27th November

For more information please contact:
Falls Clinical Nurse Consultant
FSFHG.fallsCNC@health.wa.gov.au

FALLS PREVENTION IS EVERYONE'S RESPONSIBILITY.



Marriage or Mayhem?



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FIONA STANLEY hospital

South Metropolitan Health Service **Excellence** *Awards* **2019**

Excellence in Innovation

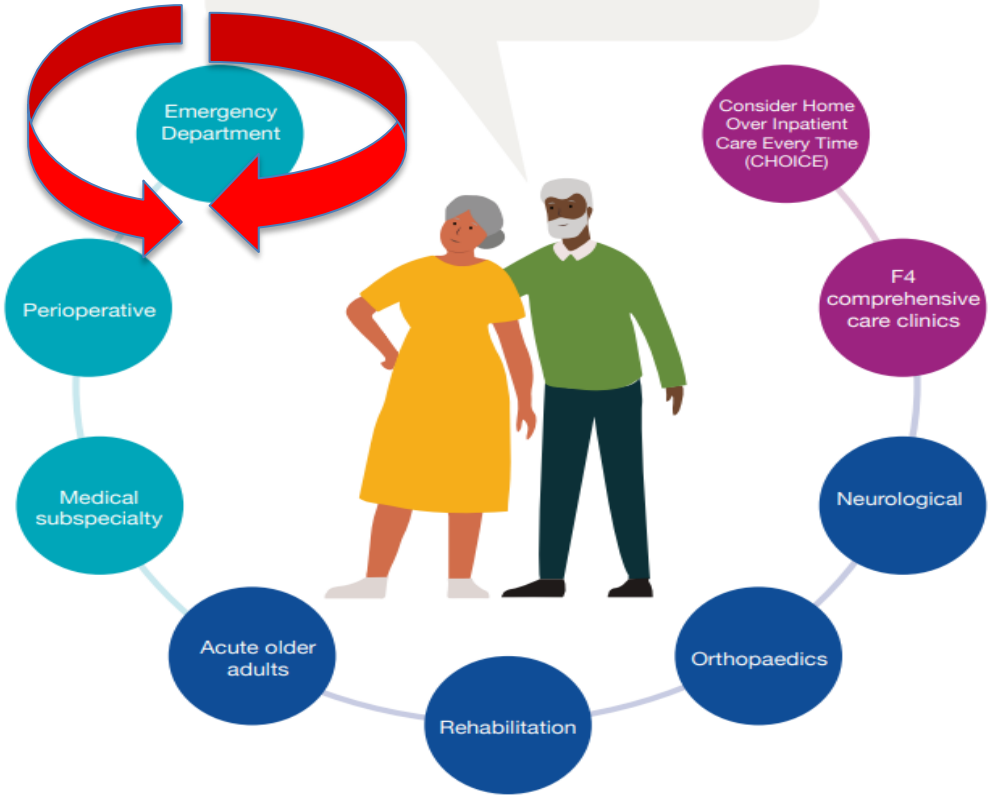
FINALISTS

Falls in Emergency Department and Aged Care Evaluation

Fiona Stanley Hospital

FSFHG Older Adult Services

FSH in-reach services



FSFHG outpatient community services

FH inpatient wards

FSHM202406190001

2024

A targeted pathway to identify and manage older adult patients that would include the following key features:

- **Service delivery** is based on current evidence and best practice, using a **standardized approach**
- **Direct access** to specialist acute aged care assessment in the ED, and direct access to geriatric ward
- **Multidisciplinary** review in ED
- **Increase discharges** from ED
- **Improved linkages for** discharge

GOLD-ED

Geriatricians for OLDer adults in the Emergency Department

Government of Western Australia
Department of Health

FIONA STANLEY hospital

Government of Western Australia
South Metropolitan Health Service
Fiona Stanley Fremantle Hospitals Group

FSH Older Adult Emergency Department In-Reach Service

Geriatricians for Older Adults in the Emergency Department (GOLD ED Team)

Inclusion criteria

- Physiologically stable (ADD's <4 / Suitable for transfer to Fremantle Hospital)
- Patients >65yrs (ATSI >50yrs)
- Falls and postural instability
- 'Falls Pathway' (Following 'trauma' component completed by ED)
- Clinical Frailty Score >4
- Geriatric Syndromes eg. Falls, Cognitive Dysfunction, Delirium, UTI, Parkinson's, Incontinence etc.
- Complex Older Adults
- Multimorbidity
- Inadequate social support
- Patients identified as suitable by the Older Adult In-Reach or ED Team
- Stable fractures with weight bearing/mobility status documented
- Parkinson's disease and Parkinson's Syndrome
- Heart failure in which the patient is haemodynamically stable
- Functional decline
- Infections (excluding septic shock) cellulitis, pneumonia, UTI etc.

Clinical frailty scale

Exclusion criteria

- Physiologically unstable (ADD's >3)
- Primary surgical / subspecialty input required
- Multispecialty input needed at FSH
- Rib fracture requiring intercostal block
- Fractures: lower limb fractures, unstable pelvic fractures, spinal precautions, fractures requiring reduction, spinal fractures requiring a brace
- Bariatric patients (>230kg or shoulder width >60cm or pelvic width >55cm)
- Patients requiring Telemetry

Patients with behavioural disturbances
Require: Discussion with ED Geriatrician to ensure suitability for GOLD team review

Patient arrives at ED and initial assessment completed by ED team.

↓

Patient identified as suitable for assessment by the Older Adult In-Reach Team and meets the inclusion criteria.

↓

Patient referred to the Older Adult ED In-Reach Team for assessment. Referral captured on EDIS following phone call referral and acceptance.
Note: Primary Governance will remain with the ED clinician whilst patient in the ED.

↓

Patient to be referred back to the FSH ED team if the Older Adult ED In-Reach team assess the patient as non suitable for the service.
a) Initial discussion between GOLD ED team and ED Senior identifies patient not suitable for service. ED to arrange alternative disposition.
b) Following GOLD ED team review, patient identified as not suitable for the service: for GOLD ED team to arrange alternative care

↓

Patient assessed by Older Adult ED In-Reach Team includes:

- Comprehensive Geriatric Assessment (CGA)
- Diagnostic tests
- Management plan
- Initial assessment documented in BOSSNET (*including 6 hour plan for admissions)
- GOLD team to ensure regular updates to ED Medical POD lead and EBM listing (out of HUDDLE times)
- Handover to ED Medical Lead/POD Lead following completion of assessment (Agree patient disposition eg. home, community follow up or admission to FH or FSH)
- Older Adult ED In-Reach Team organise patient disposition or support services if continuing care of the patient
- Complete discharge documentation/summary.

↓

- Patient transport organised by ED Administration as per usual process. Patient ideally to be transferred before 7:30pm. Cancel transport if not arrived by 8pm.
- ED to on refer to AMU if <10 bed cards for AMU. If >10, consider ESSU overnight and book transport for 7am (does not need medical review prior unless clinical condition has changed).
- Patients requiring admission overnight to be admitted to SAMU/AECC (not 5A/5B)

GOLD Team (Tel: 27634)

- Geriatrician
- Registrar
- RMO
- CNC (TBA)
- Pharmacist (TBA)
- ED Allied Health Support

Operational hours

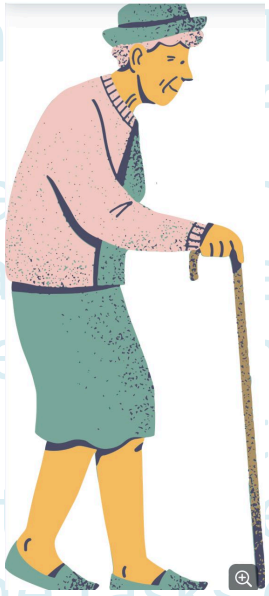
7 days per week
(9am - 5pm)
Out of hours: on call Geriatrician can be contacted via switchboard

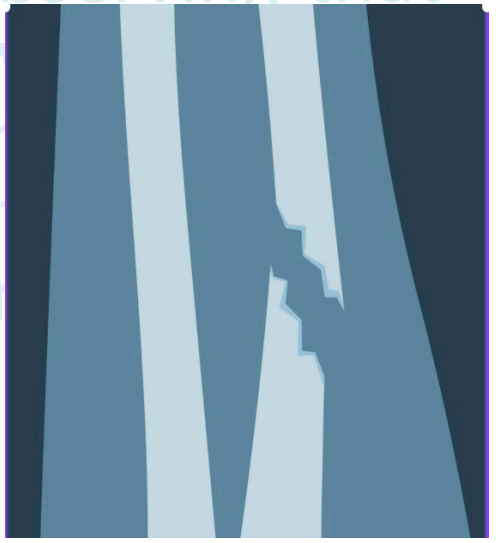
Patient referral

- ED Medical Lead, POD Leader, A/NUM, Allied Health
- Location area: GOLD Team office area (ESSU)
- Main ED assessment area 'Huddle' 11am and 3pm

FSHM20240619001

Scenario





85-year-old comes into the hospital with a broken The emergency physicians help reset fracture, give the patient medica the pain, and—observing that the pa eems rwise w for the t's discharge. Wh didn't for, however, is the pa es alone and has with the tasks of daily living.

ED

- Main Diagnosis
- Life threatening
- Efficiently quickly move out of here

Geriatrics

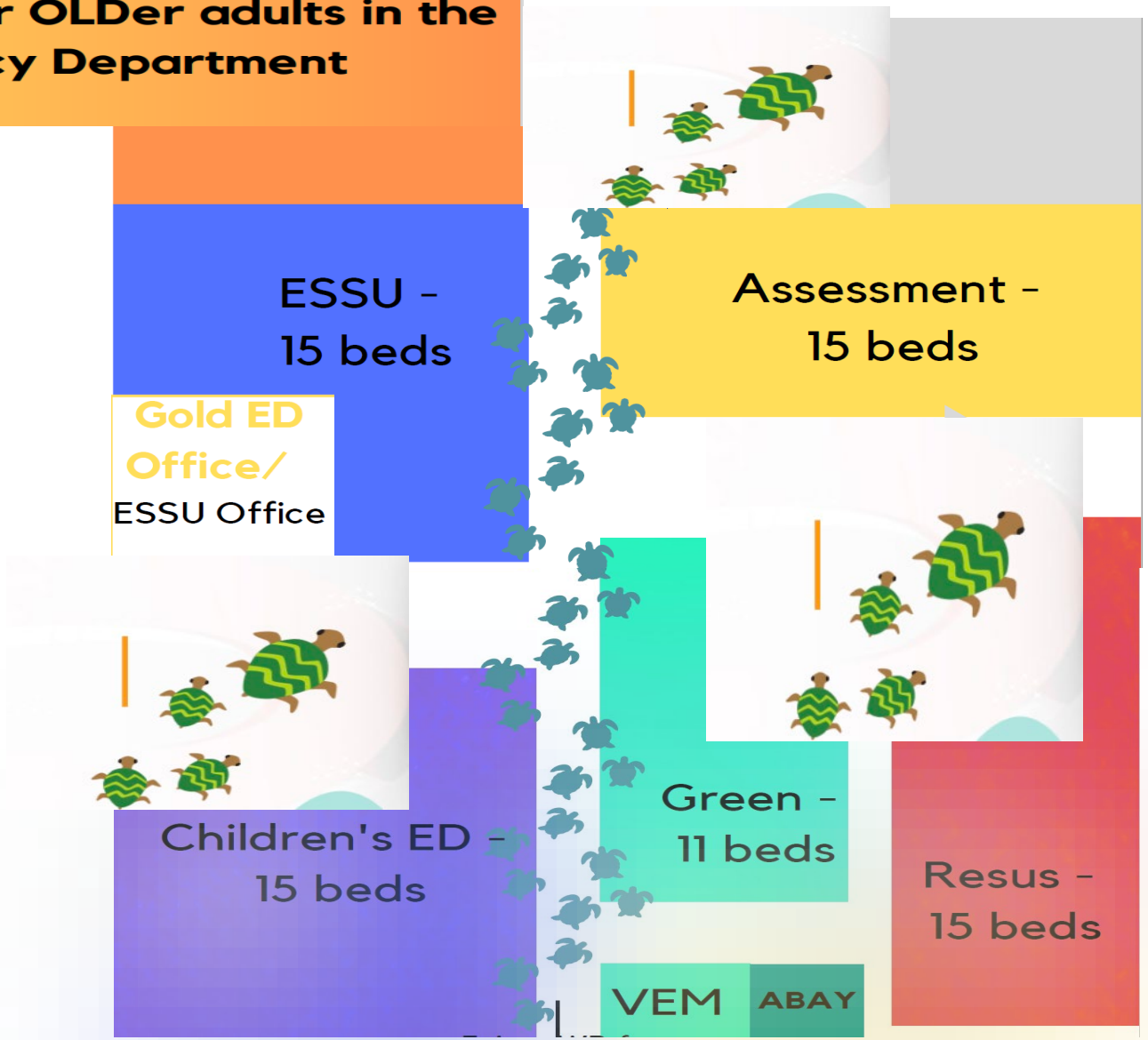
- Current level of function
- Co-morbidities
- Support systems
- What else is needed for the support systems

Same patient with the same problems

- Back pain – sciatica, acute/chronic
- Congestive Cardiac Failure CCF exacerbation
- Carer stress
- Lower respiratory tract infection LRTI – pneumonia/Chronic Obstructive Pulmonary Disease (COPD)/bronchitis
- Dementia/Behavioural and Psychological Symptoms of Dementia (BPSD)
- Constipation
- Fractures – pubic rami, distal radial, proximal humerus, vertebral
- Cellulitis
- Lower limb haematomas
- Urinary tract infections
- Vertigo
- Gastroenteritis
- Subdural haemorrhage
- Postural hypotension
- Seizures
- Poorly controlled Parkinson's disease/Parkinson's plus syndromes
- Titration of medications/polypharmacy
- Hypertensive urgency
- Gout/rheum/Osteoarthritis flares
- Hypoglycemia

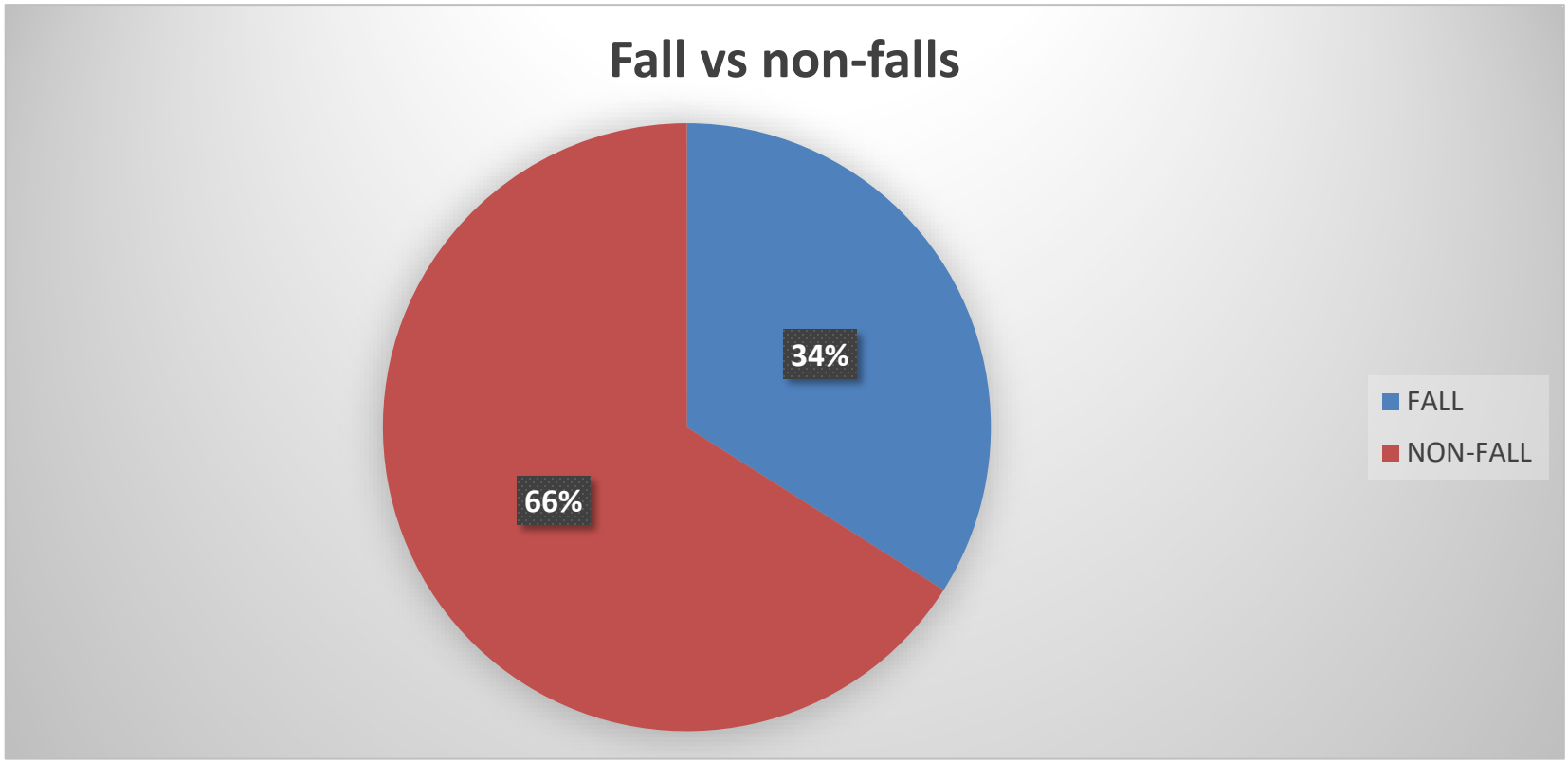
GOLD-ED

Geriatricians for OLDer adults in the Emergency Department

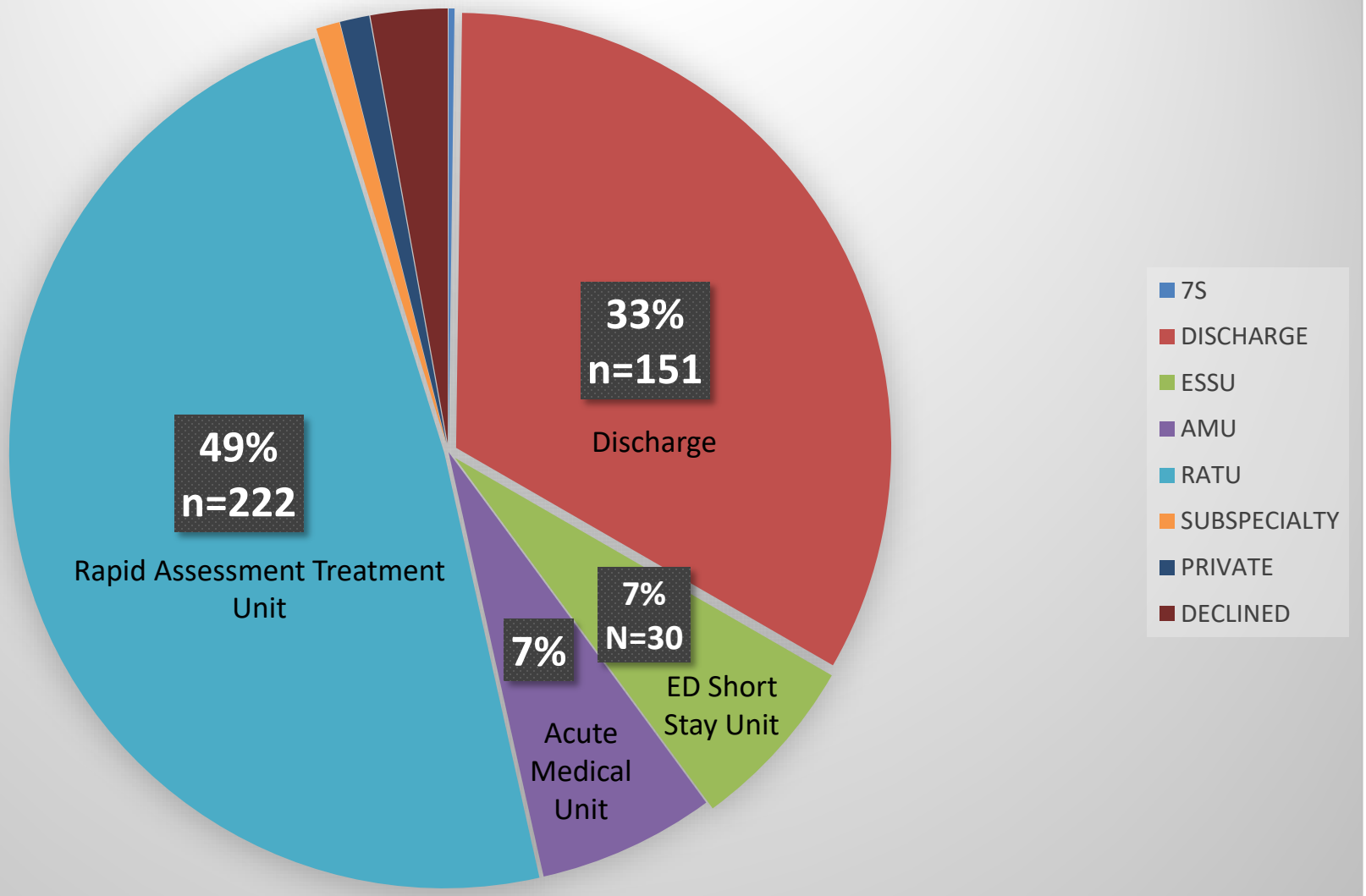


GOLD ED

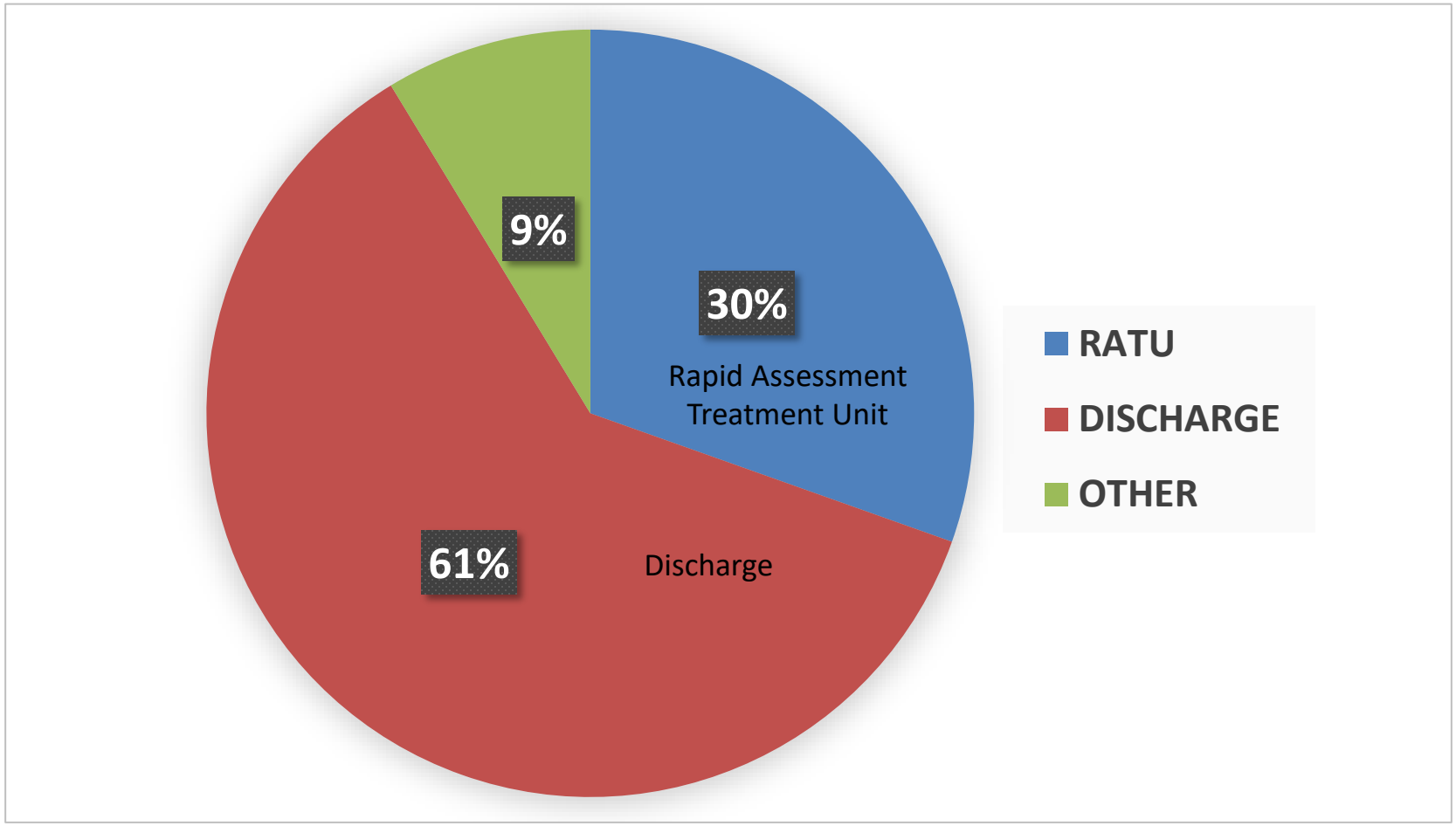
- 456 referrals in the first 3 months


Fall vs non-falls
34%
66%
FALL
NON-FALL

Outcomes of Referrals



ED Short Stay Unit



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Benefits of GOLD ED

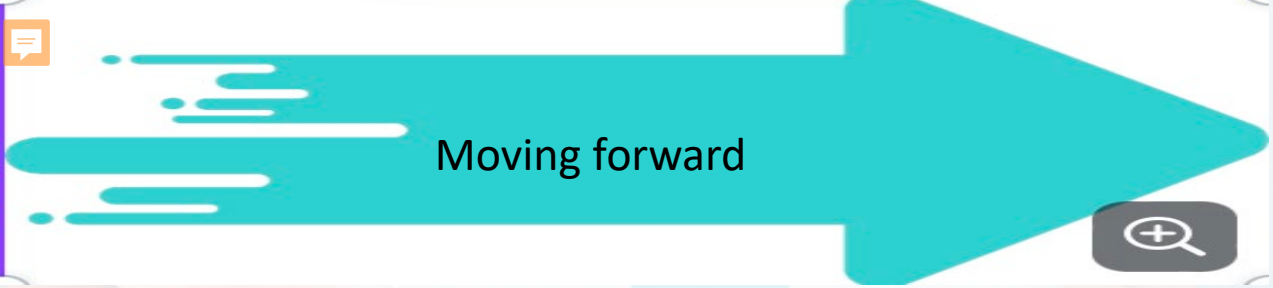
Fast tracking – rapid assessment and targeted care while in ED

Improved patient care – assessment of physical and cognitive functioning

Improved care **coordination** with medical and allied health professionals

Facilitation of care – diagnostic testing, chronic disease management

Reduce need for patient hospitalization – community supports on discharge



•Principles of existing model of care and recognizing the value of existing services and how to **maintain, expand, and integrate** these services broadly

•Understand the challenges associated with patient **inflow** (ED ramp) and the implications for care delivery

•Highlight the current **gaps** in training and current workforce in geriatrician presence at the front door

•Address the bottlenecks that lead to delayed access for our patients, particularly concerning **follow-up** services (community/clinic)

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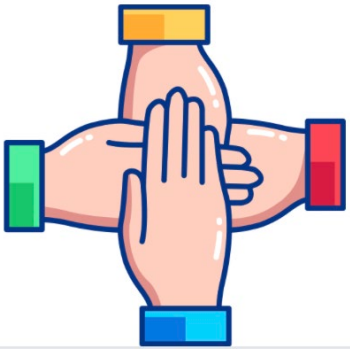

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- Head of Geriatrics Bhaskar Mandal
- Head of ED Colleen Taylor
- ED Pharmacist Shannon Mullen
- ED Gold Reg Robyn Gallagher
- GOLD ED Geriatricians :
- V Surendran, V Khokulan, S Ahamed, Suk L,
- Mugi K, Imran R C Wilson
- Project Manager Hazel Hudson
- Allied Health Team lead Gracie Reynolds

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