



## GEDA (Level 3) Sample Application

This document has been prepared to help EDs interested in Geriatric ED accreditation to use as a guide to achieving level 3 accreditation. Each section provides submission examples from sites who are currently accredited. Thank you for your interest in Geriatric ED Accreditation.

### Level 3 Application Questions:

#### {Applicant Information}

Suggest completion by:  
June 1st.

Name, Position, Phone, Phone Type, Email, ED Site Name, Address

#### {Program Information}

1. According to local or state classifications, what is your hospital considered?
  - a. Urban non-teaching
  - b. Urban teaching
  - c. Rural
  - d. Unsure
  
2. What is your ED's bed size?
  - a. 0-5
  - b. 6-10
  - c. 11-15
  - d. 30-50
  - e. 50+
  
3. Most recent annual ED census?
  
4. What percentage of patient presentations are  $\geq 65$ ?

Please briefly tell us why you are interested in GEDA accreditation.

- a. Administrative mandate
- b. Improved point of care
- c. ED Director / Staff initiative
- d. Other

{ **Staffing /Education** }      Suggest completion by:  
July 1st.

Please tell us about the members of your geriatric team.

A physician champion / medical director is required for all levels of Geriatric ED. This physician champion/ medical director must demonstrate focused training in geriatric emergency medicine that provides added expertise in the emergency care of older adults and added ability to teach other physicians and advanced practice providers how to improve this care.

This training requirement must be demonstrated through coursework:

- 1) focused on geriatric specific syndromes and concepts (e.g., atypical presentation of disease, changes with age, transitions of care) relevant to emergency medicine,
- 2) focused on clinical issues nearly exclusive to geriatric ED patients (e.g., end of life care, dementia, delirium, systems of care for older adults), or
- 3) discussing issues common to all ED patients but focused on the unique factors found in older adults (e.g., trauma in older adults, cardiac arrest care for the geriatric patient).

Training in common emergency medicine conditions (e.g., stroke) that happen to affect older adults does not qualify for this requirement. Qualifying training courses may be in person, web-based (e.g., [Geri-EM.com](http://Geri-EM.com)) or equivalent provided through or led by an authoritative resource. *Reading a book or credit for a topic search in UpToDate (or similar) does not qualify for this training requirement unless CME is earned for this activity.*

- For physician champion / medical directors applying to lead Level 3 Geriatric EDs, 4 hours of education are required for the initial certification and for each renewal.

These educational requirements may be demonstrated through appropriate geriatric-focused CME with completion certificates (please be ready to share these certificates and which of the above mentioned geriatric content this includes.) Alternatively, applicants may submit other coursework that they believe should fulfill this requirement for review by the GEDA Board of Governors. The Board of Governors are under no obligation to accept this other coursework.

Physician Name

Physician Role/Title

Please upload a job description that identifies geriatric responsibilities

Please upload evidence of focused geriatric education completion (e.g. certificates of completion, CME credits, etc.) if possible, or, if not possible, describe geriatric courses taken including when taken, content and duration

List at least one registered nurse and provide the source(s) of focused education for geriatric EM (e.g. Nurses Improving Care for Health System Elders, Geriatric Emergency Nursing Education, in person courses focused on below topics) in topics such as:

- Atypical presentations of disease
- Trauma including falls
- Cognitive and behavioral disorders
- Emergency intervention modifications
- Medication management/polypharmacy
- Transitions of care
- Effect of comorbid conditions/polymorbidity
- End-of-life care

Nurse Name

Nurse Role/Title

Please upload a job description that identifies geriatric responsibilities

Please upload evidence of focused geriatric education completion (e.g. certificates of completion, CME credits, etc.) if possible, or, if not possible, describe geriatric courses taken including when taken, content and duration.

List of SOP/Guidelines you will work towards:  
suggest completion by July 1st.

**{Policies and Procedures}**

Initiative guidelines/SOP complete and schedule consultation with team:  
suggest completion by August 1st.

Please provide evidence of at least one geriatric emergency care initiative (e.g. urinary catheter utilization, elder mistreatment, cognitive impairment or other policies/ protocols listed as options for level 2 & 1 – insert page number or where to find policy/protocol)

Type of Initiative

Describe or Upload relevant documentation describing the initiative

Briefly describe how it is modified/implemented for older adults in the geriatric ED (by whom, in what scenarios) and how adherence to the protocol is monitored. Please include description of proportion of eligible older adults impacted by this protocol, if possible.

Highlight the areas within your document are most important for the reviewers, including page numbers.

**{Physical Environment}**

Suggest completion by:  
October 1st.

Does your ED provide access to mobility aids (canes, walkers) for use in the ED during all hours?

Yes/NO

Briefly describe the off-hours protocol to obtain these devices

Please upload policy/protocol document(s) and photos

Does your ED provide easy access to food and drink during all hours?

Yes/No

Briefly describe the off-hours protocol

Please upload policy/protocol documents, photos, and descriptions of the equipment/ food available and how obtained (example, free access in 24/7 kitchen preferred over vending machines.)

# CURRICULUM VITAE

\* Please note we recognize that many of the GED medical directors will not have the number of academic accomplishments listed below.

**Name:** Seasoned Doctor, MD, FACEP, AGSF

## **Education:**

1990 B.S., College of Hope  
1994 M.D or D.O., Geriatric Friendly Medical School

## **Post-Graduate Training**

1994-1999 Emergency Medicine/Internal Medicine Resident, General Hospital of America  
1998-1999 Chief Resident Department of Emergency Medicine & Department of Internal Medicine  
General Hospital of America

## **Professional Certification:**

2001 Diplomate, American Board of Internal Medicine  
2002 Diplomate, American Board of Emergency Medicine

## **Academic Appointments**

1999-present Attending Physician, Hospital for Older Adults, Division of Emergency Medicine  
Assistant Professor of Emergency Medicine, Geriatric Friendly Medical School

## **Other Appointments**

2004-present Faculty, Geriatric EM Teaching Course (Geriatric City University)  
2010-2012 American College of Emergency Physicians Clinical Policies Geriatric Falls  
Subcommittee  
2015-2016 Co-Chair, *Academic Emergency Medicine* Consensus Conference Building the  
Geriatric-Friendly Emergency Department

## **Awards and Honors**

1987 Mungall Chemistry Scholarship  
1998 Emergency Medicine Foundation Resident Research Grant  
1999 General Hospital of America Emergency Medicine Outstanding Clinician Award  
1999 General Hospital of America Excellence in Ambulatory Medicine Award  
2003 American College of Emergency Physicians, Pennsylvania Chapter  
Best Resident Research Presentation, 2<sup>nd</sup> Place  
2004 General Hospital of America Golden Stethoscope Award (Outstanding Teacher)  
2006 Washington University Center for Aging Biese Award (Clinical Care)  
2009 EMRA Award for Excellence in Teaching (National Award)

## Professional Organizations:

American College of Emergency Physicians, Fellow

Geriatric Section (2012-2014)

Geriatric Section Alternate Councilor (2016-2018)

American Geriatrics Society, Fellow (2004-present)

American College of Physicians-American Society of Internal Medicine, Member (2002-present)

Society for Academic Emergency Medicine, Member

Geriatric Task Force (2005-2009)

Graduate Medical Education Committee (2007-2010)

Academy of Geriatric Emergency Medicine (2016-2017)

## Peer Review:

Guest Editor, *Clinics in Geriatric Medicine* (February 2018)

Reviewer, *Annals of Emergency Medicine*

Reviewer, *Journal of Patient Safety*

## Publications:

1. **Doctor S**, Promoting tobacco cessation - an example for emergency medicine providers. *Military Medicine* 1997; 162: 415-18.
2. Sandhu T, **Doctor S**; Clinical Decision Making: Unlocking the Secret Mechanics. *Ann Emerg Med* 2003; 46: 505-514.
3. **Doctor S**; Does This Patient Have Dementia? *Ann Emerg Med* 2010; 54: 54-56.
4. Smith J, **Doctor S**; Does This Pediatric Patient Have a UTI? *Ann Emerg Med* 2012; 56: 80-84.
5. **Doctor S**, Thorny T; No-Risk Pulmonary Embolism Patients and the PERC Score, *J Emerg Med* 2012; 39: 517-522.
6. **Doctor S**, German MD, Safety D; Fall Risk Factors in Older Adult Emergency Department Patients, *Acad Emerg Med* 2015; 22: 111-119.

## Books

Gross G, Shady P, **Doctor S**. Geriatric Emergencies: A Review, Wiley-Blackwell 2016 ISBN: 778-1-119-85334-4

## Book Chapters

1. **Doctor S**: Toxicology. Ohio D, Still D (eds): *Emergency Medicine in a Page* New York NY, Astute Science, 2013; 261-284.
2. Study E, **Doctor S**: Fever and Immune Function in the Elderly. George G, Jones ED (eds): *Geriatric Emergency Medicine*. New York, Bunker Hill, 2014; 155-169.

#### **Non-Peer Reviewed Editorials:**

1. Handle M, **Doctor S**; Best Reperfusion Strategies for ST-segment Elevation Myocardial Infarction in Non-percutaneous Intervention Hospitals, *Emergency Physicians Monthly* March 2007
2. **Doctor S**; Community Acquired Pneumonia and the Four Hour Window – Whose Standard Are You Practicing? *Emergency Physicians Monthly* May 2007
3. **Doctor S**; Could Medicare’s New “Preventable Complications” Policy Bring Your Emergency Department to Its Knees? – *Emergency Physicians Monthly* November 2008
4. **Doctor S**, Rosenberg M; Enhancing New Standards for Old Patients, *ACEP Now* March 2014 (<http://www.acepnow.com/article/new-guidelines-enhance-care-standards-elderly-patients-ed/>).

#### **Scientific Presentations:**

1. **Doctor S**, German MD, Safety D; Fall history and fall risk factors in ambulatory geriatric emergency department patients. Presented to the Society for Academic Emergency Medicine, Boston MA, May 30, 2012
2. **Doctor S**; Practice variability in the emergency department evaluation of older adults with acute abdominal pain using web-based vignettes. Presented to the American Geriatrics Society, Orlando FL, May 4, 2017

#### **Invited Presentations:**

1. Geriatric Emergency Medicine 2004: The Year in Review, American College of Emergency Physicians, State Branch. Fancy Lake Resort, America, August 10, 2005.
2. Lifelong Learning Series Review, 2005: American College of Emergency Physicians, State Branch. Fancy Lake Resort, America, August 12, 2005.
3. Developing the Perfect Journal Club, Pediatric EM Annual Fellows Conference, Miami FL, February 26, 2007.

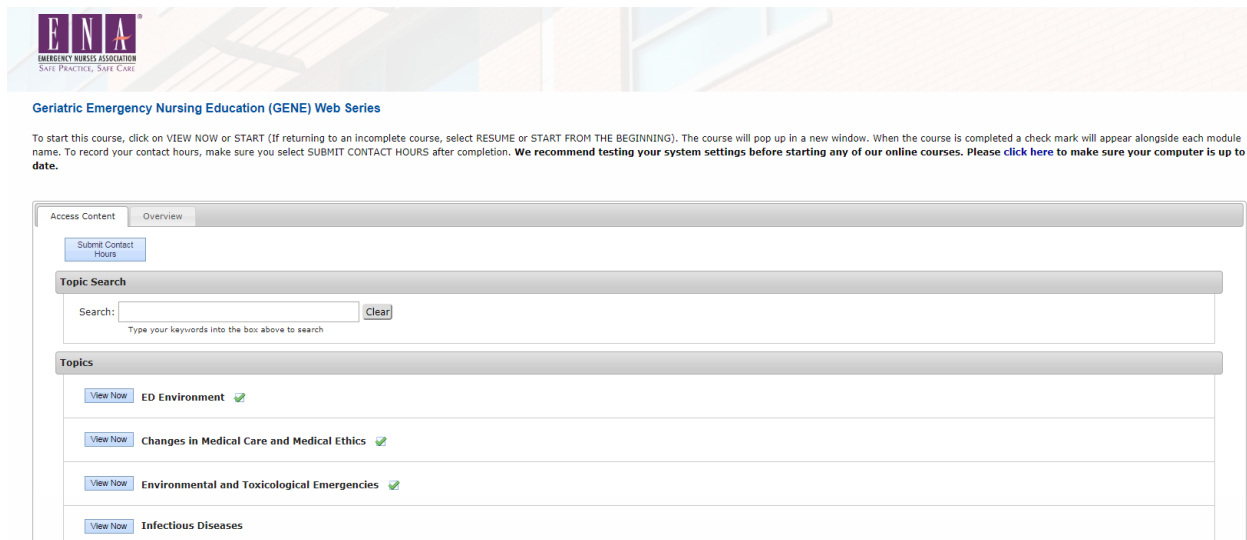
4. Knowledge Translation and Graduate Medical Education, Society for Academic Emergency Medicine Knowledge Translation Consensus Conference, Chicago IL, May 15, 2007.
5. Constructing Quality Indicators for the Care of Older Patients Visiting Emergency Departments: Proposed Quality Indicators for Prevention and Screening, American Geriatrics Society Annual Meeting, Washington DC, May 31, 2008.
6. Ten Simple Interventions to Improve the Care of the Emergency Department Elderly, ACEP Scientific Assembly, Chicago IL, October 29, 2008.
7. Defining Geriatric Competencies for Emergency Medicine Post-Graduate Education, Council of Emergency Medicine Residency Directors Conference, Las Vegas NV, March 6, 2009.
8. What is New in Emergency Medicine Diagnostic Testing in 2009? Best Evidence in Emergency Medicine Conference, New York AAEM, Beth Israel Medical Center, New York City, September 21, 2009.
9. Four Simple Measures to Improve the Care of the Older Adult in the Emergency Department, Michigan State University Rural Medicine Grand Rounds, Lansing MI, November 4, 2009.
10. Parachutes, Zealots, and Paradigm Shifts: Evidence Based Medicine in 2012, Washington University Surgical Intensive Care Unit Grand Rounds, St. Louis MO, February 22, 2012.
11. The Geriatric Tsunami and Emergency Medicine: Infrastructure, Education, and Evidence Based Resources, Stanford University Emergency Medicine Grand Rounds, Palo Alto CA, April 10, 2013.



## NAME Community Hospital

## Geriatric ED Nursing Champion – Education and Role

The HOSPITAL Geriatric ED Nurse Champion has completed education on geriatric emergency medicine through the Geriatric Emergency Nursing Education (GENE) modules from ENA as well as courses offered on <https://geri-em.com>. NAMEXXX, ED Nurse Champion has completed several modules, with education content on ED Environment, Changes in Medical Care, Environmental and Toxicological Emergencies, and is currently working on other modules, includes Infectious Disease.



**ENA**  
EMERGENCY NURSING ASSOCIATION  
SAFE PRACTICE, SAFE CARE

Geriatric Emergency Nursing Education (GENE) Web Series

To start this course, click on VIEW NOW or START (If returning to an incomplete course, select RESUME or START FROM THE BEGINNING). The course will pop up in a new window. When the course is completed a check mark will appear alongside each module name. To record your contact hours, make sure you select SUBMIT CONTACT HOURS after completion. We recommend testing your system settings before starting any of our online courses. Please [click here](#) to make sure your computer is up to date.

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As outlined in the Geriatric Care in the Emergency Department HOSPITAL guideline, the role of the Nurse Champion is as follows:

Job Summary/Responsibilities – The geriatric ED nurse champion works closely with the geriatric EM physician champion and ED nursing leadership to collaborate on and implement initiatives related to the care of geriatric emergency department patients. Responsibilities include:

1. Build a culture of specific geriatric-centric care within the HOSPITAL ED.
2. Serve as the liaison between nursing leadership and the geriatric ED.
3. Coordinate with the nurse educator and geriatric nursing champion to provide regular geriatric focused training and education to nursing staff.
4. Work with the HOSPITAL ED team to continue to build, formalize, and implement current workflows and initiatives for geriatric care within the ED.
5. Participate and engage in the quality improvement process as it relates to geriatric ED care.
6. Support and coordinate with nursing leadership on the maintenance of supplies and environment for geriatric ED patients (mobility aids, access to food and drink, etc.).

Qualifications

1. Current NAME State Nursing License
2. Registered Nurse at the NHCH ED
3. Evidence of nursing-focused geriatric EM education

## **Example of how Geriatric ED physicians and nurse leads can work together to advance GED QI initiative**

The XXX Fall Prevention team meets monthly to review this quality improvement data and discuss opportunities. If there are any gaps in performance, the team aligns on actions to address the gaps and monitors the effectiveness of the actions.

To maintain nurse and physician engagement, monthly “success stories” will be shared via email with XXX staff and a randomly selected enroller will win a coffee card. Nurses and physicians will be encouraged to provide feedback about the feasibility and value of the falls program. Patient feedback will be solicited by the ACO.

In addition, Dr. XXX and XXX will encourage every XXX nurse and physician provider to complete the “Trauma and Falls” module of <http://geri-em.com> in the first 12-months after accreditation. Over the subsequent two years, nurse and physician providers will be asked to complete an additional two modules from this website and submit their CME certificates.

**XXXXX Hospital Emergency Department**  
**Geriatric Emergency Department Protocol/Guideline**  
**on Falls in Older Adults**

**Background:** Over half of fallen older patients present to the emergency department for care without disclosing the fact that they sustained a fall. However falls are a sentinel of potential functional decline and define an older adult at high risk for morbidity and mortality. We recognize that it is important to identify older adults with falls. To provide optimal care for our older population we screen all older adults for the existence of fall. We have also developed specific ED falls assessments, interventions, and referrals.

This protocol/guideline goes beyond to the XXXXX Hospital policy on preventing new falls in the hospital setting for older adults. Rather we intend to promote optimal patient safety and preserve function in fallen older patients to limit future falls, morbidity and mortality. This Geriatric Emergency Department Protocol/Guideline is intended to supplement any existing hospital policy, thereby providing additional guidance for fallen older adults in the ED setting.

How is this policy disseminated to EM nurses and physicians?

If EMR reminder, consider including screenshots of the falls protocol reminder.

**Procedure:**

- All older adults will be screened for occurrence of fall related to the current emergency department visit.
- Patients who screen positively for fall will be evaluated in the ED for both medical cause of the fall and injury resulting from the fall.
- Connection with either inpatient or outpatient care specifically addressing safety in the prevention of future falls and maintenance of function will be made as appropriate.

**Fall assessment:**

- Screening for falls  
Patients will be asked if *this ED visit* is the result of a fall  
Positive falls screening will be evident to emergency providers in real time as follows: A or B.
- Protection from falls in the hospital setting  
Protection from fall in the ED/hospital setting will occur as follows: A or B  
Examples: Use bed alarm, or non-restraint roll belt  
Ensure frequent toileting  
Bedrails will be up unless required down for patient care

**Clinical interventions:**

- Assess for medical acute medical conditions or deterioration of chronic medical issues that could have resulted in this fall.
- Assess for existing geriatric syndromes.
- Assess for any trauma as the result of the fall.
- Assess for associated hemorrhage in any fall patient taking anticoagulant medication.
- If possible, a gait assessment will be performed in ambulatory patients as follows: A or B  
Example: a TUG test will be performed and recorded during the ED visit.
- Abnormal gait assessment is defined as X and will be addressed by Y.
- Discharged patients, who are ambulatory, will be referred to physical therapy or PCP for attention to home safety, mobility, balance, strength and fall prevention.
- Admitted patients who are ambulatory, will have a request for physical therapy assessment as appropriate.

**XXXXX Hospital's Fall Prevention Policy may also be included with application**

## Sample Presentation

Rational and description: delirium and dementia screening initiatives

Geriatric Delirium Identification and Interventions  
in the Emergency Room

### **PROJECT THEME:**

# **EARLY DELIRIUM IDENTIFICATION AND INTERVENTIONS TO REDUCE LENGTH OF STAY**

## Length of Stay in the Emergency Department and Occurrence of Delirium in Older Medical Patients

Bo, M., Bonetto, M., Bottignole, G., Porrino, P., Coppo, E., Tibaldi, M., Ceci, G., Raspo, S., Cappa, G., & Bellelli, G. (2016). Length of stay in the emergency department and occurrence of delirium in older medical patients. *Journal of American Geriatrics Society* 64(5). DOI 10.1111/jgs.14103

- Emergency medical services providers, emergency nurses, and emergency physicians frequently encounter delirious patients, but do not employ clear diagnostic strategies for identifying the condition and have varying levels of comfort in managing the condition. Clear steps should be taken to improve delirium care in the emergency department including the development of mechanisms to communicate patients' baseline mental status, the adoption of a systematized approach to recognizing delirium, and the institution of a standardized method to treat the condition when identified.

**Incidence of Delirium in the Canadian Emergency Department and its Consequences on Hospital Length of Stay: A prospective Observational Multicentre Cohort Study**

Edmond, M., Boucher, V., Carmichael, P., Voyer, P., Pelletier, M., Gouin, E., Daoust, R., Berthelot, S., Lamontagne, M., Morin, M., Lemire, S., Vu, T., Nadeau, A., Rheault, M., Juneau, L., Sage, N., & Lee, J. (2018). Incidence of delirium in the Canadian emergency department and its consequences on hospital length of stay: A prospective observational multicenter cohort study. *British Medical Journal*. doi:10.1136/bmjopen-2017-018190

- An incident delirium was observed in one of eight independent/semi-independent older adults after an 8-hour ED exposure. An episode of delirium increases hospital LOS by 4 days and therefore has important implications for patients and could contribute to ED overcrowding through a deleterious feedback loop.



## Delirium in the Emergency Department and its Extension into Hospitalization (Delineate) Study: Effect on 6-Month Function and Cognition

Han, J., Vasilevskis, E., Chandrasekhar, R., Liu, X., Schnelle, J., Dittus, R., & Ely, E. (2017). Delirium in the emergency department and its extension into hospitalization (delineate) study: Effect on 6-month function and cognition. *Journal of American Geriatrics Society* 65(6). DOI: 10.1111/jgs.14824

- Delirium in the ED is not a transient event and frequently persists into hospitalization. Longer ED delirium duration is associated with an incremental worsening of 6-month functional and cognitive outcomes.

## Predicting Outcome in Older Hospital Patients with Delirium: a Systematic Literature Review

Thomas A Jackson, T., Wilson, D., Richardson, S., & Lord, J. (2015). Predicting outcome in older hospital patients with delirium: A systematic literature review. *International Journal of Geriatric Psychiatry* 31. DOI: 10.1002/gps.4344

- Important predictors of poor outcomes in patients with delirium have been demonstrated. These could be used in clinical practice to focus direct management and guide discussions regarding prognosis. These results also demonstrate a number of key unknowns, where further research to explore delirium prognosis is recommended and is vital to improve understanding and management of this condition.

## Delirium Risk Prediction, Healthcare Use and Mortality of Elderly Adults in the Emergency Department

Kennedy, M., Enander, R., Tadiri, S., Wolfe, R., Shapiro, N., & Marcantonio, E. (2014). Delirium risk prediction, healthcare use and mortality of elderly adults in the emergency department. *Journal of American Geriatrics Society* 62(3). DOI: 10.1111/jgs.12692

- This risk prediction rule may help identify a group of individuals in the ED at high risk of developing delirium who should undergo screening, but it requires external validation. Identification of delirium in the ED may enable physicians to implement strategies to decrease delirium duration and avoid inappropriate discharge of individuals with acute delirium, improving outcomes.

## Emergency Medical Service, Nursing, and Physician Providers' Perspectives on Delirium Identification and Management

LaMantia, M., Messina, F., Jhanji, S., Nazir, A., Maina, M., McGuire, S., Hobgood, C., & Miller, D. (2017). Emergency medical service, nursing, and physician providers' perspectives on delirium identification and management. *Dementia* 16(3). DOI: 10.1177/1471301215591896

Emergency medical services providers, emergency nurses, and emergency physicians frequently encounter delirious patients, but do not employ clear diagnostic strategies for identifying the condition and have varying levels of comfort in managing the condition. Clear steps should be taken to improve delirium care in the emergency department including the development of mechanisms to communicate patients' baseline mental status, the adoption of a systematized approach to recognizing delirium, and the institution of a standardized method to treat the condition when identified.

## ALZHEIMER'S DISEASE IS THE

# 6<sup>TH</sup>

leading cause of death  
in the United States

## 16.1 MILLION AMERICANS

provide unpaid care for people with  
Alzheimer's or other dementias

These caregivers provided an estimated

## 18.4 BILLION HOURS

of care valued at over

## \$232 BILLION

Between 2000 and  
2015 deaths from heart  
disease have decreased

## 11%



while deaths from Alzheimer's  
disease have increased



## 123%



## 1 IN 3

seniors dies  
with Alzheimer's  
or another  
dementia

It kills more than  
breast cancer and  
prostate cancer

## COMBINED

## EARLY AND ACCURATE DIAGNOSIS COULD SAVE UP TO

# \$7.9 TRILLION

in medical and care costs

IN 2018, Alzheimer's and other  
dementias will cost the nation

## \$277 BILLION

BY 2050, these costs  
could rise as high as

## \$1.1 TRILLION




## 5.7 MILLION

Americans are living  
with Alzheimer's

BY 2050, this  
number is projected  
to rise to nearly

## 14 MILLION



EVERY  
65 SECONDS  
someone in the  
United States  
develops the  
disease

alzheimer's  association®

THE BRAINS BEHIND SAVING YOURS!

## Accuracy of Dementia Screening Instruments in Emergency Medicine: A Diagnostic Meta-Analysis

Carpenter CR, Banerjee J, Keyes D, Eagles D, Schnitker L, Barbic D, Fowler S, LaMantia MA (2019). Emergency medical service, nursing, and physician providers' perspectives on delirium identification and management. *Acad Emerg Med* 26(2): 226-245. DOI: 10.1111/acem.13573

At least 8 dementia screening instruments have been evaluated in ED settings.

Balancing brevity and accuracy, the Abbreviated Mental Test-4 most convincingly increase the likelihood of dementia, whereas the Ottawa 3DY most accurately reduces the likelihood.

# Abbreviated Mental Test-4

1. How old are you?
2. What is your birthday?
3. What is the name of this place?
4. What year is this?

Any single incorrect response = high-risk for dementia

# Ottawa 3DY

1. What day is today?
2. What is the date?
3. Spell world backwards
4. What year is this?

Any single incorrect response = high-risk for  
cognitive impairment



# Population

- Who or what is at the center of the issue specifically?
  - Geriatric patients, 65 years old and older, in the emergency room.

# Intervention

- What is the actionable change needed?
  - Early recognition and intervention of delirium in the emergency through use of the Brief Confusion Assessment Method (B CAM) and activation of the delirium order set by physicians.

# Comparison

- Is there an alternative intervention or what is the current standard of practice?
  - There is currently no practice in place for this screening in the emergency room.
  - This is a fairly new development, work within the last 3 years for inpatient setting.
  - 24 hour gap identified between patient arrival time in emergency room and time patient is admitted to floor where assessment is not complete.

# Outcome

- What outcome(s) would be beneficial as a result?
  - Early identification of delirium to reduce length of stay in ER and inpatient, improving patient safety and reducing prevalence of morbidity and mortality associated with delirium.
- How will the outcome(s) be measured?

SMART

**S**pecific

**M**easureable

**A**chievable

**R**ealistic

**T**iming

- Measure length of stay in emergency room
- Measure overall length of stay in hospital/inpatient



# Timing

- What is the timeframe you are looking at?
  - Initial assessment and interventions to be completed prior to the patient leaving the emergency room
    - Prior to inpatient/hospital admission
    - Prior to discharge

# PICO statement

P- Geriatric patients, 65 years old and older, in the emergency room

I- Early recognition and intervention of delirium in the emergency through use of the Brief Confusion Assessment Method (B CAM) and activation of the delirium order set by physicians

C- There is currently no practice in place for this screening in the emergency room

O- Identification of delirium early to reduce length of stay in ER and inpatient

T- Assessment and interventions complete before patient leaves emergency room

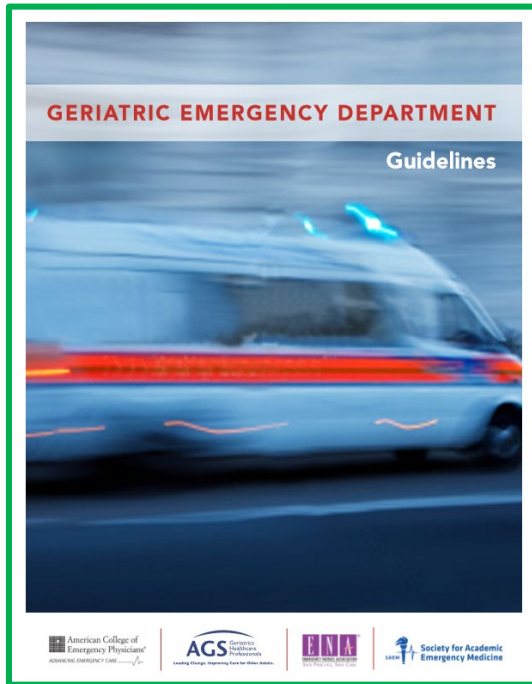
# Early Delirium Identification and Interventions to Reduce Length of Stay

How will the team project enhance the current delivery of care and body of research?

Early identification of delirium in geriatric patients over 65 years of age will reduce length of stay in the emergency department and the inpatient setting thus reducing the prevalence of morbidity and mortality. Baseline B CAM score for patients upon arrival for future assessment in inpatient setting.

# Geriatric ED Guidelines

## SECTION ON DELIRIUM AND DEMENTIA



### Delirium and Dementia in the Geriatric Emergency Department

**Background:** Delirium and agitation are among the most common problems in the geriatric adult, occurring in approximately 25% of hospitalized geriatric patients.<sup>142, 148</sup> Consequences of delirium include increased mortality, morbidity, extended hospital length-of-stay, increased need for restraints and/or added staffing (sitters), and increased potential for lasting functional decline and subsequent need for nursing home placement.<sup>149, 150</sup>

The ED is challenged with providing a comprehensive, thoughtful evaluation of patients presenting with delirium.<sup>151, 152, 153</sup> One issue is that dementia and mild cognitive impairment are common in geriatric ED patients and often undetected.<sup>152, 153, 154</sup> Routine cognitive screening and documentation provides a formal assessment of mental status at the index ED evaluation, but also provides a baseline for future ED visits. Several dementia screening instruments have been validated in ED settings.<sup>155</sup> When done well, this assessment can lead to directed interventions that can positively affect the duration of the patient's hospitalization. The features that distinguish dementia and delirium are presented in the Table. Often the cause of a delirium is multifactorial, including acute medical illness overlying baseline cognitive dysfunction, medication effects and interactions, and decompensating co-morbidities. An appropriate evaluation and management of each of these factors is critical to a positive outcome.<sup>155</sup>

Another challenge for the ED is the effective management of agitated geriatric patients. Medications and restraints (both chemical and physical) are critical interventions that, when used well, can improve patient health and safety, but when used inappropriately can actually increase the severity

or length of a delirium. Fundamentally, the treatment of the geriatric patient with this concern is very different from that of a younger patient with similar concerns.

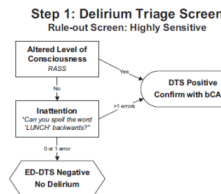
**Policy:** It is the policy of the Geriatric ED to comprehensively evaluate geriatric adults presenting with delirium, encephalopathy, or an altered mental status. Coordination of care, with special attention to directing interventions towards improving reversible causes and limiting factors that extend or cause delirium is the main goal.

It is the policy of the Geriatric ED to limit the use of chemical and physical restraints to only those situations in which they are absolutely necessary. Appropriate use of medications and alternative safety measures will be maximized to manage the agitated geriatric patient.<sup>156</sup>

#### Procedure:

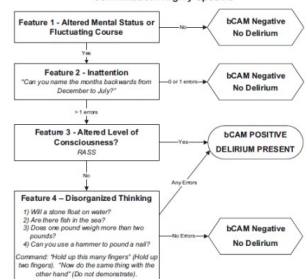
Validated screening tools will be used to identify patients presenting with dementia and delirium. The assessment for delirium will use a two-step process. Step 1 (Figure 4) is the highly sensitive delirium triage screen. Step 2 is the highly specific Brief Confusion Assessment Method.<sup>157</sup> A variety of ED-appropriate dementia and mild cognitive impairment screening instruments have been validated, but all are most useful to reduce the probability of non-delirium cognitive impairment (dementia or mild cognitive impairment) rather than to rule-in the diagnosis. An assessment for dementia should be conducted after delirium screening. One of the most accurate dementia screening instruments is reproduced below in Figure 5.<sup>158, 159</sup>

Figure 4. Delirium Screening Instruments



### Step 2: Brief Confusion Assessment Method

Confirmation: Highly Specific





**XXXXX Hospital Emergency Department**  
**Geriatric Emergency Department Protocol/Guideline**  
**on Minimizing Use of Physical Restraints**

**Background:** Older patients may be more prone to issues of delirium, altered mental status, depression and dementia. The ED is an unfamiliar environment and older patients may be very afraid. Providing reassurance and modifying the environment may help to reduce the need for restraints. If physical restraints are used for geriatric patients, they should only be used as a last resort, in the least-restrictive manner, and for the shortest possible time.

This protocol/guideline conforms to the XXXXX Hospital policy on physical restraints, which is in compliance with the Joint Commission and XX state Department of Health. The goal of XXXX Hospital is to preserve the rights, dignity and safety of our patients by utilizing nonphysical interventions wherever possible and to minimize the use of restraints when they become necessary to ensure the immediate physical safety of the patient or staff member. This Geriatric Emergency Department Protocol/Guideline is intended to supplement the hospital policy, providing additional guidance for older adults in the ED setting.

**Procedure:**

- Restraints may not be used as part of a falls prevention program
- Restraints may not be used because of patient/family request
- Appropriate use of alternatives to physical restraints should be implemented prior to the use of physical restraints

**Alternatives for physical restraints:**

- Modifying the Environment
  - Call bell within reach
  - Maintain quiet, dark environment at night as possible
  - Promote mobilization during day time hours
  - If possible, have patient out of bed in recliner during the day
  - Use bed alarm if patient is a falls risk, or non-restraint roll belt
  - Ensure patient has access to hearing device and/or glasses as needed
  - Ensure patient has access to dentures as needed
- Psychological interventions
  - Engage patient in conversation (use volunteers if available)
  - Maintain non-threatening body language and tone of voice; keep your hands in sight when possible, avoiding gestures or rapid movements that may be misinterpreted as aggressive
  - Talk clearly, slowly repetitively
  - Use interpreters if difficulty with comprehension of the language
  - Provide explanations of procedures to decrease fear and anxiety
  - Promote family presence at bedside
  - Use relaxation techniques: back rub, massage, healing touch with patient permission

- Use music therapy via headphones or through TV channel
- Try distraction techniques such as use of activity belt or art project if appropriate
- Clinical interventions
  - Assess and treat pain
  - Minimize bothersome stimuli
  - Cover tubes, catheters with gown, or wrap IV in gauze
  - Remove catheters and drains as soon as possible
  - Ensure frequent toileting
  - Change position frequently
  - Ensure patient has regular mealtimes, assist with feeding if necessary, and check if patient hungry

### **Use of a trained companion/sitter**

In the event that a patient is at danger from self-harm they may need to be placed under supervision in the ED zone designated for patients requiring watch or under 1:1 supervision of a specially trained sitter. A trained sitter may also be required for those patients where other alternatives have been tried without success and patient is at danger from falling due to agitation or confusion.

**This policy is available on the XXXX Hospital Intranet and accessible via link from the “ED Policies,” “Policies for ED Physicians,” “Policies for ED Nurses,” and “Geriatric ED Information” pages.**

**XXXXX Hospital’s Physical Restraints Policy also included with application**

**XXXXXXX Medical Center**  
**Geriatric Emergency Department Guidelines**

**Subject: Guideline for Use of Urinary Catheters for Older Patients**

**Background:**

CAUTIs (Catheter associated urinary tract infections) are the most common hospital-associated infections and 70-80 percent of these infections are attributable to an indwelling urethral catheter. <sup>1</sup> Catheter use is also associated with negative outcomes other than infection, including mechanical trauma, immobility and sepsis. The length of time that a catheter is in place contributes to infection. so limiting catheter use and duration are important to preventing infection.<sup>2</sup> A urinary catheter should only be inserted when medically necessary due to the potential risk of infection.

**Purpose:** This guideline follows the recommendations of the CDC and the XXXXX Health System policy on Urinary Catheters (see attached)

**Indication:** Indication for placement of indwelling Urinary Catheter in the ED includes the following, and an active order for catheter placement from a physician/NP/PA is required:

- Urinary retention/obstruction
- Critically ill patient or trauma patient requiring close monitoring of output
- Stage III or stage IV pressure ulcer or wound with urinary incontinence
- Patient with hematuria requiring continuous bladder irrigation
- Neurogenic bladder
- Emergent surgical candidate
- Patient receiving palliative care if indicated
- Additional documentation by LIP/PA required for other indications

**Procedure:** follow procedure noted in AHS policy

**Alternatives to urinary catheter:** Consider use of external catheter (condom catheter for men, external female urinary collection system for women) for patients with limited mobility, unmanageable urinary frequency or incontinence with need for strict measurement of output.

**Dissemination:** This policy is emailed out monthly as part of the “Daily Dose” of best practices. It is also available for reference 24/7 within the hospital/ emergency department intranet.

**References:**

1. Weber DJ, et al: Incidence of catheter-associated and non-catheter-associated urinary

tract infections in a healthcare system. *Infection Control and Hospital Epidemiology*. 2011 August;32(8):822-823

2. Centers for Disease Control and Prevention (CDC) and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Guidelines for the prevention of catheter associated urinary tract infections. (2009).

<http://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf>

Mobility aids are stocked in the emergency department supply room and are available for all staff to access and provide to patients 24 hours a day. Mobility aids, such as canes and walkers, do not need a physical therapy consult or an order from the provider to be provided to a patient.





The Emergency department has a nutrition supply room that is stocked with sandwiches, chips, crackers, peanut butter, jello, Ensure beverages, water, juice, and soda and is available to all patients 24 hours a day. All staff have access to the nutrition room including physicians, nurses, patient care techs, and unit clerks and can provide food and beverages to patients at all times during the day and night. In addition, hot meals are provided to all patients based on dietary needs through the cafeteria for breakfast, lunch, and dinner. All food is provided free of charge. Vending machines are also easily accessible within the ED waiting room area.

