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GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

San Diego County
Senior Emergency Care Initiative

GEDC Bootcamp

JULY 23, 2020
1:00–3:00 PM (PDT)

For all your Bootcamp resources, visit:

https://gedcollaborative.com/san-diego-westhealth-resources/

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COURSE OVERVIEW

AGENDA

1:00 – 1:15	Welcome and Introductions
1:15 PM – 1:30	Background on Geriatric EDs and Accreditation
1:30 – 1:55	Case Studies and Discussions in Small Group Break-Out Rooms
1:55 – 2:15	Case Study Debrief
2:15 – 2:45	Geri ED Implementation Toolkits, Quality Improvement, and Accreditation: Delirium, Mobility/Falls Assessment, and Dementia
2:45 – 2:55	Question and Answer Session Moderated by GEDC Faculty
2:55 – 3:00	Wrap-up and Next Steps

WHO SHOULD ATTEND?

Each ED should identify a team to participate in the course. All are welcome and there are no requirements, but we recommend at minimum an MD champion, a nurse champion, one other interdisciplinary team member, and an administrator/manager/data or IT lead.

GOALS OF THE GEDC BOOTCAMP

- Prepare all participating sites for Level 3 Geriatric ED Accreditation by December 2020
- Support a team at each site focused on excellent care of older ED patients
- Enhance models of care for older people in San Diego County EDs especially relating to the management of delirium, dementia, and falls/mobility.
- Foster a sense of community among San Diego County EDs around care of older patients

OBJECTIVES

At the end of the day, participants should be able to:

1. Describe the many possible components of a geriatric ED based on the GED Guidelines
2. List the components of a successful application for ACEP Geriatric ED accreditation
3. Demonstrate familiarity with the GED Toolkits around delirium, dementia, and mobility
4. Present a brief description of a specific project to implement in their own ED. CASE

GEDC BOOTCAMP
CASE STUDY

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Mrs. Cado

GOALS

1. To increase familiarity with the Geri ED Toolkits;
2. To discuss some opportunities for Quality Improvement in you ED;
3. To determine where that QI project fits into Geri ED Accreditation.

WORKSHEET

1. How would this patient be managed in your ED?

2. What components of the Geri ED Guidelines or the Geri ED Toolkits would be helpful in the management of this patient?

YOUR ASSIGNMENT

Your group's spokesperson will describe:

- **One barrier to quality care for such a patient and**
- **One component of the Geri ED Toolkits that could help your department.**

CASE

Mrs. Cado is a 78-year-old woman who lives independently in a two-storey house. Her daughter and son drop in to see her most weekends. She normally uses a cane because of knee and hip arthritis.

Past Medical History: Coronary artery disease with a CABG in 1999; she says she only gets chest pain sometimes now; followed by a cardiologist at the other hospital in town; Osteoarthritis; Hypertension; Increased lipids; Type 2 Diabetes.

Medications: in her bag she has:
Metoprolol 25 mg bd; Nitro spray; Ramipril 5 mg od; Candesartan 32 mg. od; acetaminophen 1000 mg tid; Atorvastatin 10 mg od; Aspirin 150mg od.; Gliclazide, 160 mg daily; Metformin 500mg bd. (If you call the pharmacy, you learn that the candesartan has not been prescribed for the past two months and that she filled a prescription for donepezil 10 mg last month by a doctor who is neither her family doctor nor her cardiologist.)

History of Present Illness: She arrives by ambulance on Thursday at 2 pm because she had a fall (off a step ladder while replacing a light bulb). She managed to get up and call EMS herself though it's not clear how much time elapsed before the call.

Examination: She is in a lot of pain, mostly from her right wrist. Her BP is 122/78; HR 84; Sat 100% She is triaged to the ambulatory area because she is complaining only of wrist pain.

The Emerg doc sees her: bloodwork (basic FBC and chemistry are "normal"); a CT of her head shows no bleed; an ECG shows nil acute; Right wrist X-ray shows a minimally displaced distal radius fracture which requires no reduction, only a volar splint. Follow up appointment is booked for the Orthopedic Clinic.

She seems ready for discharge at this point.

Log in to http://geri-em.com/functional-assessment/mrs-cado/ for **a video about Mrs. Cado!**

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CASE STUDY

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Mr. Waranski

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CASE

Mr. Waranski is an 82-year-old man. He is in your ED with his wife, after he fell on the stairs in his home. He has had a complete and thorough medical work up which suggests no serious medical cause of the fall and no other injuries. His left knee is tender and swollen, but he is able to mobilize fairly well, once his pain is controlled, using the ED's walker. He is discharged home with care instructions; and with a prescription for paracetamol and codeine in combination; and advice to purchase a walker to help with mobility and to see his primary care provider in 4-5 days.

Background: He emigrated after WWII, and never completed high school. He has Mild Cognitive Impairment (not full dementia but significant memory problems that do not impair his ability to complete iADLs and ADLs). He and his wife speak Polish at home and she has never worked outside the home. He worked as a custodian in various office buildings. Mrs. Waranski has quite significant dementia; he is the primary caregiver for her, assisting with almost all of her ADLs. Their sons both live in a different province and visit at least once a year.

Clinical Course: Supported by Mrs. W., he is able to hobble out of the ED and take a taxi home. Once there, he is not able get back out to a pharmacy to fill his prescription. The next day his neighbor stops in to take in the prescription. Mr. W. is not able to get out of bed but not able to sleep because of the pain. Once taking the medication he becomes constipated which is okay because he can't get to the toilet anyhow. He is voiding in a basin which Mrs. W. carries to the bathroom. Mrs. W. tries to

make some food but can't manage to use the stove. Mr. W. calls their doctor, to request an urgent appointment, but the receptionist has trouble understanding him and he can't remember what happened in the ED. The receptionist doesn't appreciate the urgency so books him in for the next available spot in two weeks. On day five post-ED visit, the neighbour drops in again and calls an ambulance when he finds Mr. W. still in bed, looking unwell, confused, and complaining of abdominal pain and cramping.

He is taken back to your ED and is admitted to your hospital with multi-factorial delirium secondary to pain, fecal impaction, dehydration, and hypernatremia. He has a prolonged hospital stay because of the confusion and physical deconditioning. His wife is also admitted because of concerns about her safety to manage on her own. Their sons eventually arrive and start legal proceedings, claiming sub-standard care by the hospital.

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CASE STUDY

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Mrs. Perdito

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CASE

Mrs. Perdito is a 79-year-old woman who comes to your ED on Thursday evening for unclear reasons, seemingly related to voiding frequently but she has a long list of minor complaints too. Vital signs are normal. She hasn't been in your ED for several years. She lists a family doctor in your community.

She is triaged to the Ambulatory area where she waits happily for two hours to see the Emerg doc. The doc elicits no acute findings but notices 4+ WBCs in her urine. He prescribes trimethoprim, tells her to drink lots of water, and discharges her home.

She is found wandering on a highway three hours later by the police who were called by her desperate family. The family subsequently lodges a complaint with the hospital administration.

Log in to http://geri-em.com/cognitive-impairment/mrs-perdito/ for a video about Mrs. Perdito!

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CASE STUDY

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Miss Piedra

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CASE

Miss Piedra is a 74-year-old woman who is in your department for her third visit in three days.

On Day One she was complaining of flank pain and a CT showed a 3 mm (small) stone in her distal ureter. She was started on tamsulosin, acetaminophen, low-dose hydromorphone, dimenhydrinate (an anti-cholinergic anti-emetic).

On Day Two she was back because of "pain" although the plain X-ray suggested the stone had passed. She was sent home with reassurance.

On Day Three a neighbor has called the ambulance because Miss Piedra knocked on her door, crying and distressed.

The Emerg physician finds no acute findings on physical exam or lab/imaging and makes a referral to Internal Medicine for "failure to cope".

The third-year medical student on the Medicine services conducts a thorough med student exam and notices an MMSE of 18 consistent with moderate dementia. When the student calls the pharmacy, she learns the prescription was filled and she discovers all the empty bottles in the bottom of Miss Piedra's purse.

GEDC BOOTCAMP
CASE STUDY

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Mrs. Schwach

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CASE

Mrs. Schwach is an 80-year-old old retiree who calls the ambulance on Tuesday morning because she's "not feeling right" on waking at 0800. She looks well and is in no distress so is triaged CTAS 4 and placed in a bed.

She can't remember what medications she takes, did not bring her list, and EMS did not bring the bottles. She has had not previous visits at your hospital. She thinks she may have had some chest pain and so is placed on a monitor. She can't void on the bed pan and so she has a catheter inserted. Her daughter from Ontario reaches her on her cell and subsequently calls the nurse to say that "Mom seems a little off." This information is not recorded or passed on.

It's a busy day in the department so she waits 3 hours before being seen by the doctor. She mentions that she may have had some abdominal pain yesterday, so an ultrasound is ordered for 1500 and she is kept NPO for that test. It is reported at 1700 as "unremarkable with no acute findings." Her bloodwork, including two Troponins, is all back and is normal.

She is prepared for discharge at 1800 with diagnosis and plan of "No Acute Medical Problem; Follow up with family doctor." She is very weak and light-headed on standing, and can't find her house keys or any money for a taxi home. The physician is ready to go home and it's change of shift for the nurses.