Care of the acutely ill elderly in ER: Growth of the role of geriatric ER nurses

By Cathy Sendecki, RN, BSN, ENC(C)

The majority of emergency departments in Canada are facing the increasing problems of ER congestion and inability to transfer admitted patients in a timely manner to in-patient beds. Additionally, with the population aging, there are greater numbers of older adults needing to access emergency room services. Burnaby Hospital is no different than the rest of Canada.

We are a community hospital of 267 beds, with more than 51,000 ER visits annually. The population demographics reflect the need to be elderly-friendly:

- The total volume of older adults seen in our ER is the highest in Fraser Health
- Residents 70 years and older use approximately 70% of the total bed days at Burnaby Hospital (BH)
- In 2005, those 75 and older had an ER admit rate of approximately 37%, while the average admit rate for all ages was closer to 15%.

Just over two years ago, BH committed to improve the care of older adults treated in the ER, with a two-part plan: education for all ER nurses, and a nurse in ER dedicated to the care of our geriatric patients.

GENI Program: Education and networking

The Geriatric Emergency Network Initiative (GENI) program is led by Marcia Carr, CNS for Acute Geriatrics in Fraser Health who worked collaboratively with the B.C. Acute Care Geriatric Nurse Network (ACGNN) CNS Collaborative and interdisciplinary health professional colleagues. The focus is on unique aspects of elderly assessment and proactive care planning from the perspective of ER nurses that is presented by the GENI Faculty. The Faculty includes a geriatrician, clinical nurse specialists, pharmacists, community social workers, PT, OT, clinical ethicist, geriatric emergency nurse (GEN) and nurse educators. The curriculum was designed and developed specifically with ER nurses as the target audience. Great care was taken to reflect ER nursing practice including role, functions and workload. Given that geriatrics and geriatric psychiatry are clinical practice specialties requiring specialized knowledge, skills and abilities, and the recognition that ER is also a specialty area with its own specialized set of requirements, the goal of GENI has been to provide the applicable geriatric/geropsychiatric knowledge, skills and abilities that an ER nurse can implement into their day-to-day practice. For example, we need to assess falls as a symptom that requires investigation of root causes, treatment plan follow-up and risk reduction to prevent another fall, as well as assessing for injuries related to this episode.

A personal "epiphany"

As clinical nurse educator, I prepared a case study of an elderly patient who presented in the ER with abdominal pain. A short while earlier, the mother of a close friend had been to an ER. As my friend recounted the long wait, and the perception that her mother's experience was being ignored, I listened with a new focus. For example, this woman had stated, "I know I have a bladder infection, but I've never felt such pain." She felt the ER staff had disregarded her statements, concentrating on her shortness of breath and history of COPD. How could we work with her to start the necessary care, respecting her experience, even as we used our specialized knowledge to assess her?

The demonstration project: The journey starts

When we planned a four-month demonstration project of a geriatric emergency nurse (GEN), I volunteered to take that position. It was not a hotly contested role, and I was accepted at once! Other hospitals had developed this position, and had been able to reduce the number of admissions, as well as improve the quality of care. My orientation included a day with community care staff, including a home care nurse and a case manager, which gave me some insight about the challenges and supports available in the community. A further two days with nurses in this role at Vancouver General Hospital and Peace Arch Hospital, the first two B.C. ERs with GENs, helped me to feel more confident in starting this role.

What soon became apparent was that many of those 75+ year-olds coming to ER were acutely ill. They could not be successfully discharged from the ER with increased home support. The focus of the GEN rapidly evolved into identifying needs and starting a proactive care plan that would be used during the patient's admission, and alerting community care to anticipated needs upon discharge. For example, a woman whose presenting complaint is abdominal pain with a weight loss of 8 kg in the past six months, has fallen three times in the past two days, and is now disoriented to place and date. She is diagnosed with pneumonia. The

GEN is able to identify that the patient is highly likely experiencing a delirium, which requires careful and clear care planning. The GEN ascertains what services are currently in place and discusses with the spouse and other family members the patient's usual level of functioning. If this patient was generally alert and active two months ago, and has become increasingly less active, with less social interaction, the health care team providing care over the next several days can work toward restoring this patient to her previous level, rather than immediately considering the option of facility placement. A referral to the registered dietitian is needed. Providing the family with information about delirium can help them to deal with this sudden and profound change in her mental status. Assessment of concurrent chronic illness, recent changes in medications, and concerns of family members can add important information needed for optimal care. The GEN can bring to the attention of the health care team the need for a depression assessment once the patient is medically stable. The case manager, who has assessed this patient in the past year at home, may contribute a valuable perspective. A referral to the geriatrician proactively facilitates the assessment of concerns with her overall medical status including cognition. Although her admission diagnosis is pneumonia, there is considerably more complexity to this patient.

At the end of four months,

- The GEN had seen a total of 592 patients (23.5% of all > 75-year-olds); of those, 50% were admitted to hospital
- The focus was on those with complex care needs
- The average LOS of patients who had been assessed by the GEN and admitted through ER was 11.5 days, compared with 15.4 for those of the same age group admitted through ER, but not seen by the GEN.

The journey continues

Now, more than two years later, the role has grown. Working relationships have developed, and some benefits include:

- Increased communication between community care, the GEN, and acute care, and LTC facilities. For example, when a home care physio finds her client experiencing increasing pain and diminished activity post-hip surgery, and sends him to ER, she can call the GEN and explain her concerns. The GEN is aware of these when assessing this patient, and can advocate for appropriate investigations and treatment. Similarly, when a patient with repeated visits to ER is found, again, to have no acute condition, the GEN is able to speak with the case manager to discuss what home support interventions may be possible to help this patient feel secure at home. By the same token, the GEN may help to uncover an acute illness that was presenting atypically.
- More comprehensive information for the health care team providing ongoing care, including physician, therapy, nursing, nutrition, social work, and discharge planning services.
- Referrals to a community pharmacist to visit patients soon after discharge to assess their medication regimen, their understanding of their medications, and prepare a medication calendar for their use.
- Opportunities to communicate the ER experience to other areas of the health care system. Those whose background doesn't include the controlled chaos of ER may not appreciate the constant busy, bright environment that contributes to delirium in older adults. We need to work together to establish new options for care.
- This role is a resource for staff, particularly ER nurses. For example, an elderly patient was receiving inadequate control of her pain, and her nurse felt frustrated in providing comfort. After discussing options with the GEN, the primary nurse got an order for a stronger opioid, and a referral was made to the clinical pharmacist. When the GEN checked the following day, the patient reported she was finally comfortable.

Future directions may include referring patients to a seniors' health clinic that is being developed, or making referrals for falls assessment in the community. Another aspect is to analyze statistics of patients admitted to determine other factors that may need to be addressed earlier in the hospital stay to accomplish shorter admissions with optimum outcomes.

In looking back on the experience of having an ER nurse to do specialized assessments and plans for care of older adults, it is apparent that this is an extension of what emergency care has always been about: identifying unmet needs and working creatively to find solutions. We saw gaps in communication between different areas of health care, and have been instrumental in improving this, both in listening and giving information. We have been able to work more closely with others who specialize in geriatric care, with benefit to both groups and, most importantly, to our patients and their families.

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