by mistake. Her only concern now was to go home. I assured her we could help her with this request. Once we found she was tolerating her oral fluids, obtained a urine spec, and started her on antibiotics for a UTI, we were able to arrange her discharge, with a referral to Home Health to ensure she had appropriate support to manage well.

Caring for seniors with dementia is not often this simple, but the reward is in finding which techniques help us to make contact with the person, and communicate that we are doing our best to help.

About the author

Cathy Sendecki has worked in Burnaby Hospital ED since 1987. As Educator, in 2005 she worked with the Clinical Nurse Specialist for Acute Care of Older Adults to improve the care of seniors in our ED. What started as a three-month project by an ED nurse who did not see great areas for improvement, became a full-time position that continues to be fascinating and challenging. She appreciates the opportunity to assess patients with a geriatric and emergency "lens" to assist the emergency team to provide the best care to those seniors with complex presentations.

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Identifying emergency-sensitive conditions for the calculation of an in-hospital standardized mortality ratio specific to emergency care

By Simon Berthelot, MD, CFPC(EM), FRCPC, Eddy S. Lang, MD, CFPC(EM), CSPQ, Hude Quan, MD, PhD, Henry T. Stelfox, MD, FRCPC, PhD, On behalf of the Panel on Emergency-Sensitive Conditions (PESC)

Introduction

The *Canadian Institute for Health Information* (CIHI) provides annual *Hospital Standardized Mortality Ratios* (HSMR) for each Canadian hospital. As a first step to developing an ED HSMR variant, we identified diagnosis groups (DGs) where high-quality emergency department (ED) care would be expected to reduce in-hospital mortality (emergency-sensitive conditions).

Methods

We used a two-step approach to identify emergency-sensitive conditions:

1. Using a modification of the RAND/UCLA Appropriateness Methodology, a multidisciplinary national panel of emergency care providers and managers (n=14) serially rated DGs included in the CIHI HSMR (n=72) according to the extent that ED management potentially decreases mortality.
2. The DGs selected by the panel were sent to members (n=2,507) of the *Canadian Association of Emergency Physicians* and the *National Emergency Nurses Affiliation* for evaluation. Using an electronic survey, they were asked to agree or disagree (binary response) with the panel classification.

Results

The expert panel rated 37 DGs (e.g., sepsis) over three rounds of review as having mortality potentially reduced by ED care. In addition, panelists identified 40 DGs (e.g., stroke) where timely ED care was critical, 43 DGs (e.g., atrial fibrillation) where ED care could reduce morbidity and 47 DGs (e.g., bacterial meningitis) not included in the Canadian HSMR, as diagnoses whose mortality could be decreased by ED care. Of the 37 DGs selected by the panel, 32 were rated by more than 80% of survey respondents (n=719) to be emergency-sensitive conditions for mortality. The level of agreement was above 68% for the five remaining DGs.

Conclusion

We identified 37 DGs representing emergency-sensitive conditions that will enable the calculation of an in-hospital standardized mortality ratio that is more relevant to emergency care.

Department(s) and institution(s) to which the work should be attributed

Department of Community Health Sciences, University of Calgary, Division of Emergency Medicine, University of Calgary, Institute of Public Health, University of Calgary.