



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. Below is a copy of the current Level 3 application. Thank you for your interest in Geriatric ED Accreditation

Level 3 Application Questions:

{Applicant Information}

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 ≥ 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}

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) 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.

{Policies and Procedures}

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}

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.)

-END OF APPLICATION-

EXAMPLES:

Subject	Responsibilities of the Geriatric Physician Champion (ED MD)
Department/Location	Geriatric Emergency Department Program
Owner	ED Medical Director

Purpose

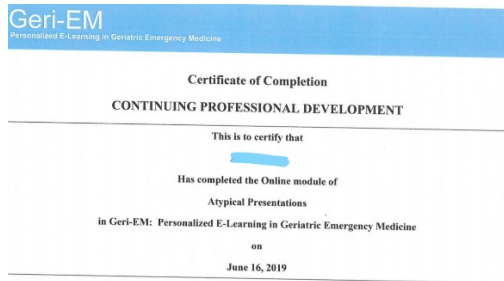
A. To ensure integrated and sustained older adult care into daily operations in the Emergency Department with utilization of a multidisciplinary team.

Statement

A. Geriatric Physician Champion ED MD:

1. Obtains specialized geriatric focused education related to Emergency Medicine
2. Oversees geriatric operations including geriatric ED staff workflow including multidisciplinary team members
3. Coordinates plan and implementation of geriatric education for Emergency Department Professional Staff. Work in conjunction with Geriatric RN Champion, ED RN Patient Care Manager and ED Medical Director to assure compliance.
4. Quality improvement team leader for adherence and annual review and update to policies related to Geriatric Emergency Medicine Care
5. Assists in coordinating and leading scheduled interdisciplinary site meetings
6. Develops and oversees outcome measures with documentation and monthly presentation of identified indicators and outcomes
7. Quality assurance of equipment needs present in Emergency Department for geriatric population
8. Participates multidisciplinary Quality Initiatives and quality assurance team leader for geriatric patient case reviews / complaints
9. Liaison between hospital leadership and geriatric ED

CME Proof:



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:

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

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

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

1998 Emergency Medicine Foundation Resident Research Grant

1999 General Hospital of America Emergency Medicine Outstanding Clinician Award

2004 Best Resident Research Presentation, 2nd Place

2006 Washington University Center for Aging 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)

Publications:

1. **Doctor S**; Does This Patient Have Dementia? *Ann Emerg Med* 2010; 54: 54-56.
2. **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. **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/>).

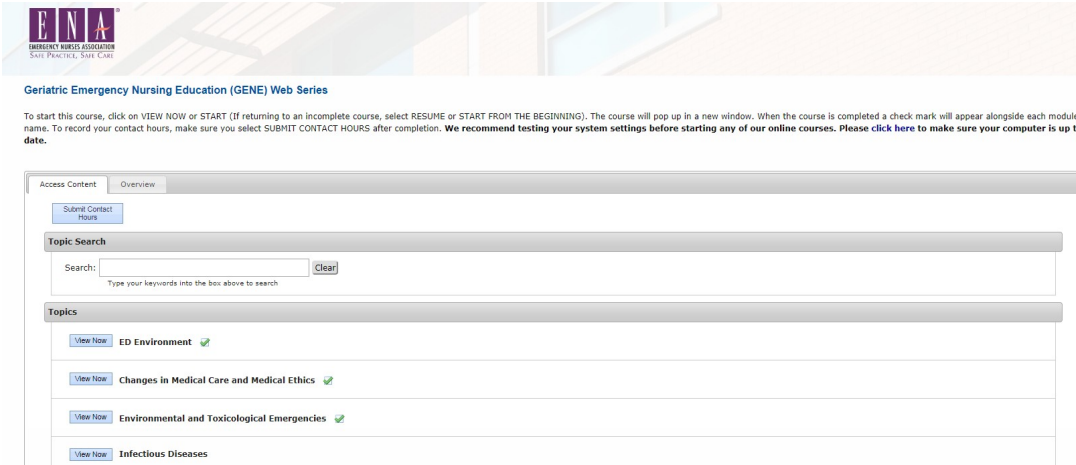
Scientific Presentations:

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

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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Topics

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- [View Now](#) Changes in Medical Care and Medical Ethics ✓
- [View Now](#) Environmental and Toxicological Emergencies ✓
- [View Now](#) Infectious Diseases

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 XX 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 XX 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. XX and XX will encourage every XX 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.

XX 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.

XX 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

6TH

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, this
could rise to

\$1.1 TRILLION

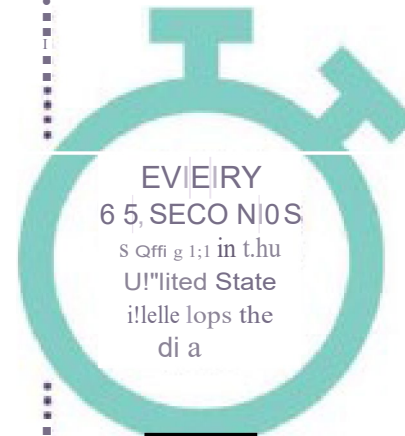


5.7 MILLION

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

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

Specific

Measureable

Achievable

Realistic

Timing

- 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

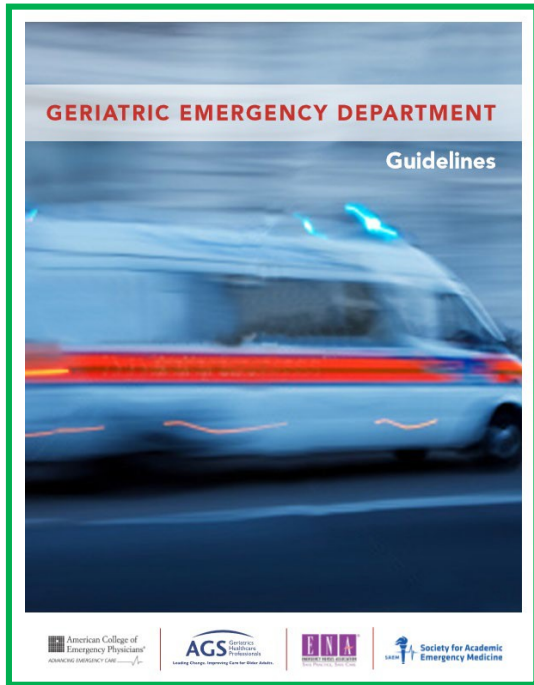
Early Delirium Identification and Interventions to Reduce Length of Stay

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.^{142, 148} 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.^{143, 150}

The ED is challenged with providing a comprehensive, thoughtful evaluation of patients presenting with delirium.^{151, 153-154} One issue is that dementia and mild cognitive impairment are common in geriatric ED patients and often undetected.^{152, 153, 154} 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.¹⁵⁵ 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.¹⁵⁶

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.

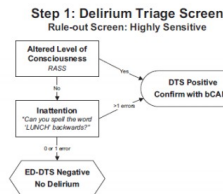
Policy: It is the policy of the Geriatric ED to comprehensively evaluate geriatric adults presenting with delirium, encephalopathy, or an altered mental status. Coordination of care, with special attention to directing interventions towards improving reversible causes and limiting factors that extend 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.¹⁵⁶

Procedure:

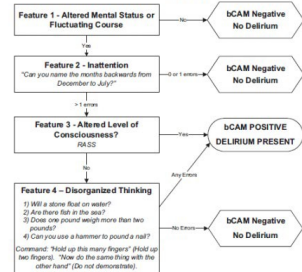
Validated screening tools will be used to identify patients presenting with dementia and delirium. The assessment for delirium will use a two-step process. Step 1 (Figure 4) is the highly sensitive delirium triage screen. Step 2 is the highly specific Brief Confusion Assessment Method.¹⁵⁷ A variety of 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.^{153, 158}

Figure 4. Delirium Screening Instruments



Step 2: Brief Confusion Assessment Method

Confirmation: Highly Specific



XX 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 XX Hospital policy on physical restraints, which is in compliance with the Joint Commission and XX state Department of Health. The goal of XX 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.

XX 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. ¹ 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.² 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 XX 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. *InfectionControl 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.

