Table 2. ED Model of Care

- ☐ A guideline to define criteria for access to Geriatric Emergency Department Care from ED triage
- ☐ Standardized delirium screening protocol (examples: DTS; CAM; 4AT, other) with appropriate follow-up
- ☐ Standardized dementia screening protocol (Ottawa 3DY; Mini Cog; SIS; Short Blessed Test; other) with appropriate follow-up
- ☐ Protocol for standardized assessment of function and functional decline (ISAR; AUA; interRAI Screener; other) with appropriate follow-up
- ☐ Protocol for standardized fall assessment protocol (including mobility assessment, eg, TUG or other) with appropriate follow-up
- ☐ Protocol for identification of elder abuse with appropriate follow-up
- ☐ Protocol for medication reconciliation in conjunction with a pharmacist
- ☐ Protocol to minimize the use of potentially inappropriate medications (Beers' list, or other hospital-specific strategy, access to an ED-based pharmacist)
- ☐ Protocol for pain control in elder patients
- ☐ Protocol for accessing palliative care consultation in the ED
- ☐ Protocol for Geriatric Psychiatry consultation in the ED
- ☐ Development and implementation of at least three order sets for common geriatric ED presentations developed with particular attention to geriatric-appropriate medications and dosing and management plans (eg, delirium, hip fracture, sepsis, stroke, ACS)
- ☐ Protocol to standardize and minimize urinary catheter use
- ☐ Protocol to minimize NPO designation and to promote access to appropriate food & drink
- ☐ Protocol to promote mobility
- ☐ Protocol to guide the use of volunteer engagement
- ☐ A standardized discharge protocol for patients discharged home that addresses age-specific communication needs (large font, lay person's language, clear follow-up plan, evidence of patient communication)

- ☐ Protocol for PCP notification
- ☐ Protocol to address transitions of care to residential care
- ☐ Protocol to minimize use of physical restraints including use of trained companions/sitters
- ☐ Standardized access to geriatric specific follow-up clinics: comprehensive geriatric assessment clinic, falls clinic, memory clinic, or other
- ☐ A protocol for post-discharge follow up (phone, telemedicine, other)
- ☐ Access to transportation services for return to residence
- ☐ A pathway program providing easy access to short- or long-term rehabilitation services, including inpatient
- ☐ Access to an outreach program providing home assessment of function and safety
- ☐ Access to and an active relationship with community paramedicine follow up services
- ☐ An outreach program to residential care homes to enhance quality of care of ED transfers