CONGRÉS SOCIETAT CATALANA

XXV GERIATRIA GERONTOLOGIA

7-8 NOVEMBRE 2019 AUDITORI DE L'ACADÈMIA

Serveis d'Urgències centrats en els pacients d'edat avançada

Valoració geriàtrica sense geriatra

Valoració geriàtrica "sense equip de geriatria"

Mireia Puig Campmany

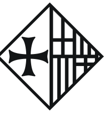
Servei d'Urgències

Hospital de la Santa Creu i Sant Pau

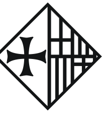
HOSPITAL DE LA SANTA CREU I SANT PAU

FUNDACIÓ DE GESTIÓ SANITÀRIA

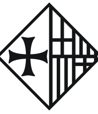
UNIVERSITAT AUTÒNOMA DE BARCELONA



Retrat d'Olga en un silló. Pablo Picasso, 1917.

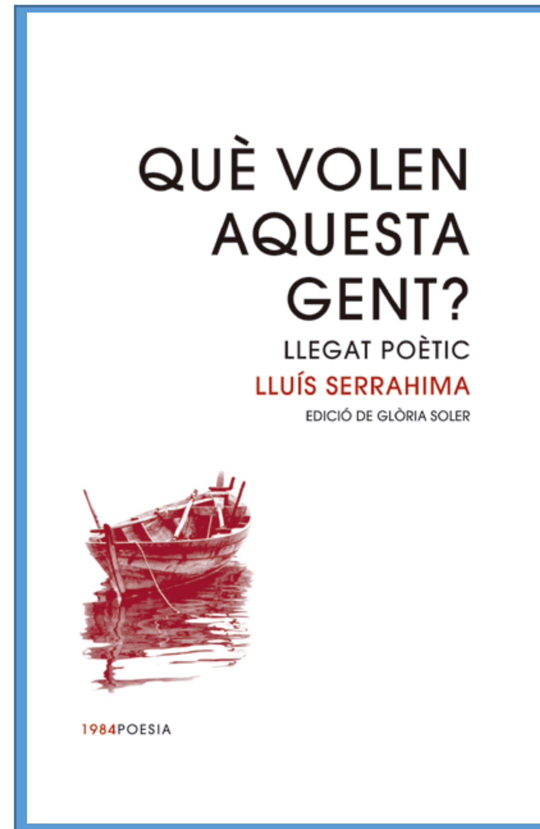


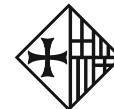
Gran nu en un silló roig. Pablo Picasso, 1929.



1.- **Cal** una atenció específica als ancians (a Urgències)?

2.- **Qui** i **com** ho farà?





HikingArtist.com

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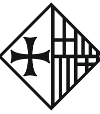

GERIATRICS/REVIEW ARTICLE

Older Patients in the Emergency Department: A Review

Nikolaos Samaras, MD, Thierry Chevalley, MD, Dimitrios Samaras, MD, Gabriel Gold, MD

From the Department of Community Medicine and Primary Care (N. Samaras), the Division of Bone Diseases (Chevalley, D. Samaras) and Department of Rehabilitation and Geriatrics (Chevalley, D. Samaras, Gold), Geneva University Hospitals, Geneva, Switzerland.

Older patients account for up to a quarter of all emergency department (ED) visits. Atypical clinical presentation of illness, a high prevalence of cognitive disorders, and the presence of multiple comorbidities complicate their evaluation and management. Increased frailty, delayed diagnosis, and greater illness severity contribute to a higher risk of adverse outcomes. This article will review the most common conditions encountered in older patients, including delirium, dementia, falls, and polypharmacy, and suggest simple and efficient strategies for their evaluation and management. It will discuss age-related changes in the signs and symptoms of acute coronary events, abdominal pain, and infection, examine the yield of different diagnostic approaches in this population, and list the underlying medical problems present in half of all "social" admission cases. Complete geriatric assessments are time consuming and beyond the scope of most EDs. We propose a strategy based on the targeting of high-risk patients and provide examples of simple and efficient tools that are appropriate for ED use. [Ann Emerg Med. 2010;56:261-269.]

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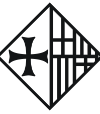
doi:10.1016/j.annemergmed.2010.04.015



Tea in a paper cup

Fear of being forgotten

Unable to sleep because of the noise in the Emergency Department

A pillow (if you're lucky)

Thin blanket for warmth

Unable to wash

Afraid of rolling off narrow trolley

No change of clothes

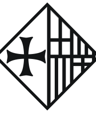
Uncertainty over what will happen next...

Rubbery mattress

Loss of privacy

...But relief that at least you're not in a chair...

Anatomy of a Patient in a Trolley



GERIATRICS/ORIGINAL RESEARCH

Delirium in the Emergency Department: An Independent Predictor of Death Within 6 Months

Jin H. Han, MD, MSc, Ayumi Shintani, MPH, PhD, Svetlana Eden, MS, Alessandro Morandi, MD, Laurence M. Solberg, MD, John Schnelle, PhD, Robert S. Dittus, MD, MPH, Alan B. Storrow, MD, E. Wesley Ely, MD, MPH

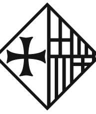
From the Department of Emergency Medicine (Han, Storrow), the Department of Biostatistics (Shintani, Eden), and the Department of Internal Medicine, Division of Allergy, Pulmonary, and Critical Care (Morandi, Ely) and Division of General Internal Medicine (Solberg, Schnelle, Dittus), Vanderbilt University Medical Center, Nashville, TN; and the Veterans Affairs Tennessee Valley Geriatric Research, Education and Clinical Center, VA Service, Department of Veterans Affairs Medical Center, Tennessee Valley Healthcare System, Nashville, TN (Solberg, Dittus, Ely).

Study objective: Delirium's adverse effect on long-term mortality in older hospitalized patients is well documented, whereas its effect in older emergency department (ED) patients remains unclear. Similarly, the consequences of delirium on nursing home patients treated in the ED are also unknown. As a result, we seek to determine whether delirium in the ED is independently associated with 6-month mortality in older patients and whether this relationship is modified by nursing home status.

Methods: Our prospective cohort study was conducted at a tertiary care, academic ED, using convenience sampling, and included English-speaking patients who were aged 65 years and older and were in the ED for less than 12 hours at enrollment. Patients were excluded if they refused consent, were previously enrolled, were unable to follow simple commands at baseline, were comatose, or had incomplete data. The Confusion Assessment Method for the Intensive Care Unit was used to determine delirium and was administered by trained research assistants. Cox proportional hazard regression was performed to determine whether delirium in the ED was independently associated with 6-month mortality after adjusting for age, comorbidity burden, severity of illness, dementia, functional dependence, and nursing home residence. To test whether the effect of delirium in the ED on 6-month mortality was modified by nursing home residence, an interaction term (delirium*nursing home) was incorporated into the multivariable model. Hazard ratios with their 95% confidence intervals were reported.

Results: Of the 628 patients enrolled, 108 (17.2%) were delirious in the ED and 58 (9.2%) were from the nursing home. For the entire cohort, the 6-month mortality rate was higher in the delirious group compared with the nondelirious group (37.0% versus 14.3%). Delirium was an independent predictor of increased 6-month

Annals of Emergency Medicine 2010; 56 (3): 244-252



GERIATRIC EMERGENCY MEDICINE

Length of Stay in the Emergency Department and Occurrence of Delirium in Older Medical Patients

Mario Bo, MD, PhD, Martina Bonetto, MD,† Giuliana Bottignole, MD,* Paola Porrino, MD,* Eleonora Coppo, MD,* Michela Tibaldi, MD,* Giacomo Ceci, MD,* Silvio Raspo, MD,† Giorgetta Cappa, MD,† and Giuseppe Bellelli, MD‡*

OBJECTIVES: To determine whether emergency department (ED) length of stay before ward admission is associated with incident delirium in older adults.

DESIGN: Prospective cohort study.

SETTING: Hospital.

PARTICIPANTS: Individuals aged 75 and older without delirium at ED entry, coma, aphasia, stroke, language barrier, psychiatric disorder, or alcohol abuse (N = 330).

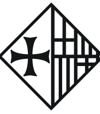
MEASUREMENTS: On ED admission, individuals underwent standardized evaluation of comorbidity (Cumulative Illness Rating Scale), cognitive impairment (Short Portable Mental Status Questionnaire), functional independence (activities of daily living, instrumental activities of daily living), pain (Numeric Rating Scale), and acute clinical conditions (Acute Physiology and Chronic Health Evaluation II). During the first 3 days after ward admission, the

older adults, after adjusting for age and cognitive impairment. **J Am Geriatr Soc 64:1114–1119, 2016.**

Key words: delirium; emergency department; older adults

Older adults are frequently sicker, require more examinations, and are hospitalized more often than younger individuals.[1] Moreover, elderly adults have a greater level of urgency, longer average length of stay, and greater risk of adverse events (delirium, functional decline, readmission to the emergency department (ED), death).[1–3]

According to the Diagnostic and Statistical Manual of

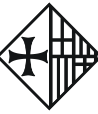


Objectiu

- Procurar una atenció
  - ✓ Integral de qualitat,
  - ✓ Enfocada a la fragilitat,
  - ✓ Aplicada de **manera universal (24h x 7d)**,
  - ✓ Estandarditzada **i des del primer contacte amb el Servei**,
  - ✓ En un espai adaptat
  - ✓ Connectada amb els diferents dispositius intra i extrahospitalaris
- La població diana
  - ✓ Són tots els pacients amb fragilitat (vellesa, demència, deterior cognitiu, dependència, cronicitat, malaltia oncològica, necessitats pal·liatives)

Mètode

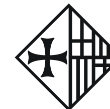
- Protocol·litzar el Procés Ancià Fràgil a urgències
  - ✓ igual que la IC, o el SCA, on els professionals d'urgències responen les 24 h del dia de manera integrada amb les especialitats



Pla de Treball 2011-2017

- ✓ Tres Eixos Estratègics

1. Adaptació del Servei d'Urgències en l'atenció a la Fragilitat
    - Implantació d'una Avaluació Integral
        - Disseny i Protocol·lització exhaustiva (amb U. Geriatria)
        - Integració de Treball Social i Farmàcia Hospitalària
        - Fer participar les especialitats hospitalàries (ja integrades)
        - Generar indicadors per a revisió i millora contínua
    - Creació d'un Pla de Cures específic
    - Aconseguir una presa de decisions adaptada
    - Programa de Formació
2. Creació d'una Àrea adaptada a la fragilitat <u>dins</u> del Servei d'Urgències
3. Promoure la integració del Servei d'Urgencies en la xarxa de proveïdors de salud del AIS Dreta en una atenció urgent compartida



POLICY STATEMENT

Geriatric Emergency Department Guidelines

0196-0644/$-see front matter
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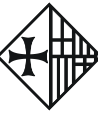
http://dx.doi.org/10.1016/j.annemergmed.2014.02.008

SEE RELATED ARTICLE, P. e1.

This document is the product of two years of consensus-based work that included representatives from the American College of Emergency Physicians, The American Geriatrics Society, Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Approved by the ACEP Board of Directors October 2013; by The American Geriatrics Society October 2013; by the Emergency Nurses Association January 2014; and by the Society for Academic Emergency Medicine October 2013



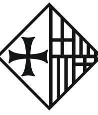
SAEM
Academic Emergency Medicine
Official Journal of the Society for Academic Emergency Medicine

SPECIAL CONTRIBUTION

Optimal Older Adult Emergency Care: Introducing Multidisciplinary Geriatric Emergency Department Guidelines From the American College of Emergency Physicians, American Geriatrics Society, Emergency Nurses Association, and Society for Academic Emergency Medicine

Christopher R. Carpenter, MD, MSc, Marilyn Bromley, RN, Jeffrey M. Caterino, MD, MPH, Audrey Chun, MD, Lowell W. Gerson, PhD, Jason Greenspan, MD, Ula Hwang, MD, David P. John, MD, William L. Lyons, MD, Timothy F. Platts-Mills, MD, MSc, Betty Mortensen, RN, Luna Ragsdale, MD, MPH, Mark Rosenberg, DO, MBA, and Scott Wilber, MD, MPH

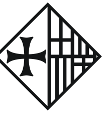
Academic Emergency Medicine 2014; 21 (7): 806-9



Atenció Urgent "Clàssica"

Població atesa → Avaluació Clínica → Presa de decisions → Sortida

Problema únic de salut
Diagnòstic
Tractament
Sortida precoç



Atenció Urgent Adaptada

Detecció de població a avaluar	Avaluació de les necessitats	Presa de decisions ajustada a necessitats	Transferència assistencial correcta	Entorn Posthospitalari Actuacions coordinades

Tria	Avaluació integral	Intensitat Dx i Terapèutica	Treball en xarxa
		Àrea nova	Nous circuits

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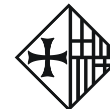


Rapid Improvement Guide to:

Identifying and managing frailty at the front door

Why is it important to identify frailty at the front door?

Hospitalisation can be the initial event that heralds an intensive period of health and social care use, especially for 'older people with frailty', a distinctive late-life health state in which apparently minor stressor events are associated with adverse health outcomes.

About 5-10% of all emergency department (ED) attendees and 30% of patients in Acute Medical Units are older people with frailty. Focusing on frailty is an exercise in risk stratification - identifying a cohort at especially high risk of adverse outcomes.

Once identified, the Acute Frailty Network (AFN) principles two and three apply: 'put in place a multi-disciplinary response that initiates Comprehensive Geriatric Assessment (CGA) within the first hour' and 'set up a rapid response system for frail older people in urgent care settings.'

There is concern in clinical teams that there will be too many patients to manage if we measure accurately. However unless the demand is identified (i.e. the number of older people with frailty and urgent care needs) and gaps exposed, we won't understand the true need. Do not be scared about the size of the problem. It exists already, and it is better to know about it and start plans to address it, than to deny it.

Which frailty tool should I use?

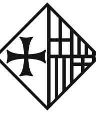
There is limited evidence for the discriminant ability of frailty scales in the urgent care context. Until more accurate tools become available, simple, clinically acceptable criteria can be used to identify a large proportion of older people who are frail (sensitivity). Some patients will be incorrectly scored as not frail (specificity), this can be sorted by sensible discussion between clinical teams. Examples include:

- Age 65+ AND presenting with one or more frailty syndromes (confusion, Parkinson's disease, presenting with fragility fractures and/or falls, care home residents) OR people aged 85+ unless their need is best met by a single organ team

  AND/OR

- Moderate or severe frailty (grade 6-9) using the Canadian Frailty Scale

Setembre 2016
https://improvement.nhs.uk/resources/rapid-improvement-guide-identifying-and-managing-frailty/



European Geriatric Medicine (2019) 10:559–565
https://doi.org/10.1007/s41999-019-00177-1

SPECIAL ARTICLE

The Acute Frailty Network: experiences from a whole-systems quality improvement collaborative for acutely ill older patients in the English NHS

James David van Oppen[1] · Deborah Thompson[2] · Matt Tite[2] · Simon Griffiths[2] · Finbarr C. Martin[2,3] · Simon Conroy[1,2]

Received: 1 December 2018 / Accepted: 22 February 2019 / Published online: 7 March 2019
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Key summary points

Aim To describe the approach and methods of the Acute Frailty Network.

Findings Local case studies are used to illustrate the early impact of the Network. Reflections on three years' experience of planning and implementing a whole-systems quality improvement collaborative are shared.

Message Initiatives through which hospitals improved services and outcomes for older people with frailty and urgent care needs are illustrated.

Abstract

Older people form a growing proportion and volume of those accessing urgent care, much of which is provided by non-specialists in geriatric medicine. Non-specific presentations, multiple comorbidities and functional decline make assessment and management of this cohort challenging. In this article we describe the approach and methods of the Acute Frailty Network (AFN), a national quality improvement collaborative designed to support acute hospitals in England to deliver evidence-based care for older people with frailty. We report on 3 years' experience of whole-systems quality improvement through the network. Using local case studies, we illustrate initiatives through which AFN hospitals improved services and outcomes for older people with frailty and urgent care needs. We describe returns on investment and sustainability of implementation, and reflect on future directions for the AFN.

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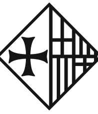

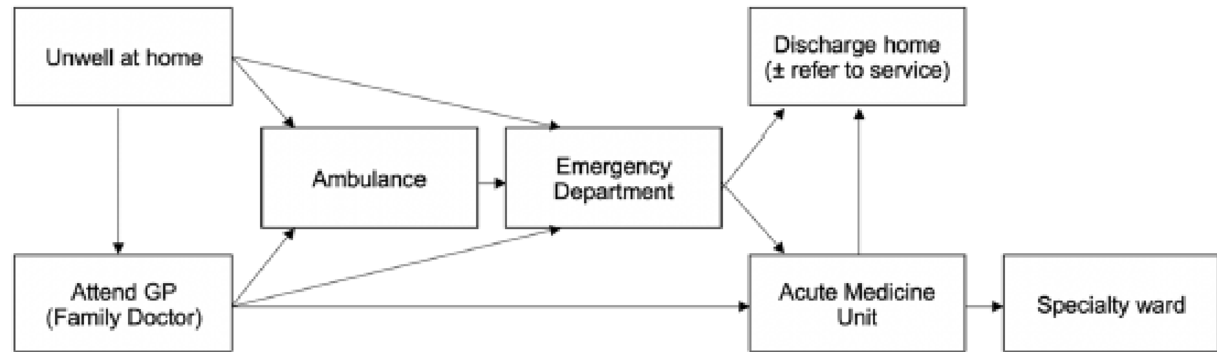

Fig. 1 The acute care chain: process to acute admission (example)

Table 1 The core AFN principles (https://www.acutefrailtynetwork.org.uk)

1. Establish a mechanism for early identification of people with frailty
2. Put in place a multi-disciplinary response that initiates comprehensive geriatric assessment (CGA) within the first hour
3. Set up a rapid response system for frail older people in urgent care settings
4. Adopt clinical professional standards to reduce unnecessary variation
5. Develop a measurement mind-set
6. Strengthen links with services both inside and outside hospital
7. Put in place appropriate education and training for key staff
8. Identify clinical change champions
9. Patient and public involvement
10. Identify an executive sponsor and underpin with a robust project management structure

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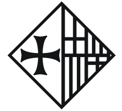

EDITORIAL

Creación del Currículum Europeo de Medicina de Urgencias y Emergencias Geriátrica: una colaboración entre la European Society for Emergency Medicine (EuSEM) y la European Union of Geriatric Medicine Society (EUGMS)

The European Curriculum of Geriatric Emergency Medicine: A collaboration between the European Society for Emergency Medicine (EuSEM) and the European Union of Geriatric Medicine Society (EUGMS)

Abdelouahab Bellou[1,2], Christian Nickel[1,3], Francisco Javier Martín-Sánchez[4,5], Olivier Ganansia[1,6], Jay Banerjee[1,7], Anna Björg Jónsdóttir[5,8], Els Devriendt[5,9], María Fernández[5,10], Simon Mooijaart[5,11], Fredrik Sjöstrand[5,12], Simon Conroy[5,13]
por la European Geriatric Emergency Medicine Task Force (EGTF)

XXV GERIATRIA I GERONTOLOGIA 7 - 8 NOVEMBRE 2019 BARCELONA

European Geriatric Medicine 7 (2016) 315–321

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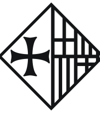
Research paper

The development of a European curriculum in Geriatric Emergency Medicine

S. Conroy[a,*], C.H. Nickel[b], A.B. Jónsdóttir[c], M. Fernandez[d], J. Banerjee[a], S. Mooijaart[e], F. Sjöstrand[f], E. Devriendt[g], O. Ganansia[h], F.J. Martín Sánchez[i], A. Bellou[j,k]



Pragmatic barriers to assessing post-emergency department vulnerability for poor outcomes in an ageing society

C.R. Carpenter[1]*, M. Émond[2]

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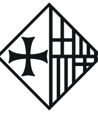
[2]Department of Family and Emergency Medicine, Université Laval, Québec, Canada,
*corresponding author: email: carpenterc@wustl.edu

Table 1. *Challenges for assessment of older adult vulnerability in ED settings*

Process	• Focus on screening or case-finding? • Who will assess at what time during episode of ED care? • What are personnel and monetary costs of routine assessment?
Quality	• Thresholds of instrument accuracy and reliability sufficient to justify widespread use? • Should instruments be designed to identify high-risk or low-risk patients? • Can multiple stakeholders appropriately acquire, interpret, and incorporate instrument's risk stratification? • Which patient-centric intended and unintended outcomes of instrument use should be evaluated? • Can a single instrument predict all adverse outcomes or is one instrument needed for trauma victims, another for medical patients, and another for psychiatric patients?
Definitions	• Standardised or comparable qualifiers for prevalent geriatric syndromes including dementia, delirium, and frailty across specialties and nations? • Equivalent, well-accepted qualifiers for key outcomes such as *preventable* ED returns?
Interventions	• Linkage of available actions to high-risk strata? • One-size fits all interventions or preventive actions guided by individual's unique vulnerabilities?

The Netherlands Journal of Medicine 2016; 74(8):327-329



EDITORIAL • COMMENTARY

Geriatric emergency medicine: Research priorities to respond to "The Silver Boom"

Don Melady, MD, MSc(Ed)

Quines són les característiques de qualitat en l'atenció als ancians en el SU?
Com es pot identificar la vulnerabilitat i la complexitat al SU?
Són útils els indicadors clàssics (LOS, IR)?
Quin són els indicadors i els objectius a mesurar?
Quines son les intervencions més útils?
Quin impacte real tenen aquestes intervencions?

CJEM 2018;20(3):327-328

European Geriatric Medicine
https://doi.org/10.1007/s41999-018-0151-2

17 edició Premis de recerca

SPECIAL ARTICLE

FUNDACIÓ MUTUAM CONVIURE 25è Aniversari

Development of a comprehensive, multidisciplinary program of care for frailty in an emergency department

Mireia Puig Campmany[1,2,3] · Josep Ris Romeu[1,3,4] · Marta Blázquez Andión[1,2,3] · Salvador Benito Vales[1,2,3]

Integrative Clinical Medicine

Commentary ISSN: 2515-0219

Identifying improvements in an emergency department elder friendly area based on patient experience “ED_EFA their voice project”

Mireia Puig[1,3,4], Miriam Mateo[1,3,4], Marta Blázquez[1,3,4] and Josep Ris[1,2,4]
[1]Emergency Department, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain
[2]Urgent Care Process, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain
[3]Universitat Autònoma de Barcelona, Medicine Department. Barcelona, Spain
[4]IIB Sant Pau Research Institute, Barcelona, Spain

quironsalud campus
espacio de conocimiento e innovación

Aprender, desaprender y reaprender para asistir ancianos en Urgencias. El secreto del cambio

“El secreto del cambio es enfocar toda tu energía no en luchar contra lo viejo sino en construir lo nuevo”. Sócrates

SOCIETAT CATALANA DE GERIATRIA I GERONTOLOGIA

LAUNIÓ

+FUTUR PREMIS 2019

MODEL D'ATENCIÓ Col·laboratiu EN XARXA, NOU PARADIGMA EN L'ATENCIÓ URGENT ADAPTADA A PACIENTS AMB ALTES NECESSITATS

(HIGH-NEED HIGH-COST PATIENTS - HNHC)

Flexibilització d'estructures, integració de serveis i models en xarxa

"As we characterize the HNHC, population and its needs, we should avoid stereotypes and oversimplification. For example, some observers mistakenly believe that most HNHC patients are near the end of life. In fact, the population is clinically diverse. Some have multiple chronic conditions that are stable with treatment and will persist for years. Others have extreme functional limitations. Some have mostly severe, persistent behavioral health challenges. Others have conditions that are greatly exacerbated by social factors such as lack of housing, food, and supportive personal relationships".

"Quan caracteritzem el pacient amb altes necessitats (PAN), a la població i les seves necessitats, hauríem d'evitar estereotips i simplificacions. Per exemple, alguns observadors creuen erròniament que la majoria dels PAN estan gairebé al final de la vida. De fet, la població és clínicament diversa. Alguns tenen múltiples malalties cròniques estables amb el tractament i sobreviuran durant anys. Altres tenen limitacions funcionals extremes. Alguns tenen malalties cròniques, trastorns de salut mental o de conducta. Altres tenen condicions molt agreujades per factors socials com la manca d'habitatge o d'alimentació i suport social suficient ".

Blumenthal D, Chernof B, Fulmer T et al. Caring for High-Need, High-Cost Patients. An Urgent Priority. NEJM 2016; 375(10): 909-911

Organitzacions implicades

- ✓ Hospital de la Santa Creu i Sant Pau:
  - Procés d'Atenció Urgent (PAU)
  - Servei d'Urgències (SU), Treball Social d'Urgències (TS), S. Farmàcia (SFH)
- ✓ Hospitals Atenció Intermèdia o Centres Socio Sanitaris
  - Hospital Mutuam Güell (HMG)
  - Nou Hospital Evangèlic (NHE)
  - Hospital Hestia Palau (HHP)
  - Hospital Dos de Maig (HDM)
  - Centre Integral de Salut Cotxeres (CIS)
  - Centre Socio Sanitari Isabel Roig (CSS-IR)
- ✓ Equips d'Atenció Residencial Grup Mutuam (EAR)
- ✓ Hospitalització a Domicili Dos de Maig (HADO-DM)
- ✓ PADES
- ✓ Dispositius d'Atenció Primària: Equips d'Atenció Primària (Sanllehy, La Salut, Lesseps, Vila de Gràcia, Joanic, Dreta Eixample, Monumental, Passeig de Sant Joan, Sardenya, Sagrada Família, Gaudí, Congrés, Encants, Camp de l'Arpa, Guinardó, La Sagrera), CUAPs, atenció continuada.

LAUNIÓ

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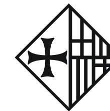

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AUDITORI DE L'ACADÈMIA

SUMEM SALUT AMB LES PERSONES GRANS

"LET'S COME TOGETHER"

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