Geriatric Team Collaboration Improves A&E Patients' Outcome

Ratnasari Y.[1], Ranjeev K.[1], Patel S.1, Seah S.T.A.[2], Ang Y.H.[2], Ng H.L.[2], Liu C.M.[2], Schmidt L.T.[3], Saw G.L.A.[4], Noribah A.R.[1], Lee T.K.[1]
[1]Acute & Emergency Care Centre, [2]Geriatric Medicine, [3]Ageing-In-Place Community Care Team (AIP-CCT), [4]Nursing Administration
Yishun Health

Introduction

Geriatric patients present a unique health care challenge in the emergency department and often they are discharged with unrecognized or unresolved problem.

Their visits characterized by comorbidity, cognitive and functional impairment, and complex social issues. In addition, older adults present with subtle, atypical symptoms making a diagnosis and discharge more challenging.

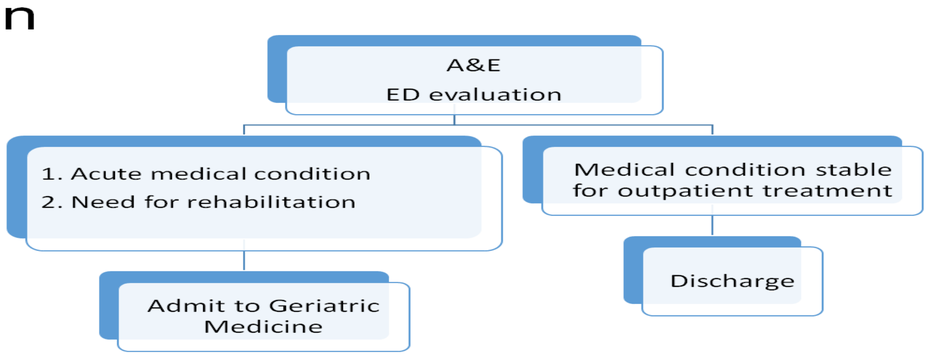
The aims of the collaboration are:

1. Ensuring early detection of geriatric syndromes and safe discharges for elderly patients, aged 78 years and above from A&E.
2. Right-siting elderly patients.

Methodology

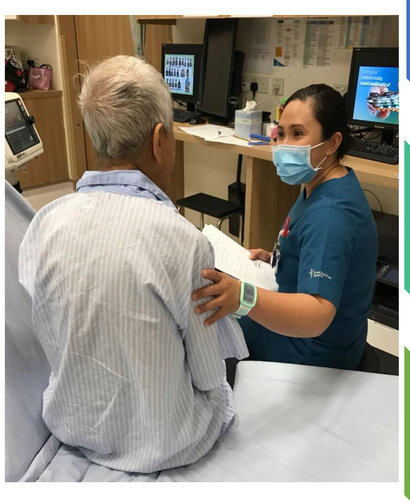
As is, geriatric patients when discharged, are not being screened for early syndromes or underlying conditions for early interventions since there is no geriatric screening tools available in A&E.

As-In



To-Be

1. Design the A&E Geriatric Assessment form with standardized geriatric assessment tools used throughout the wards and specialist outpatient clinics (SOCs).
2. Establish the work process and link up the services with the various departments.
3. Establish the workflow for A&E Geriatric Nurses to perform opportunistic screening for early pick-up and detection of geriatric issues at A&E.



Disposition
- Geriatric patients if plan for discharge will be screened for Geriatric Assessment.

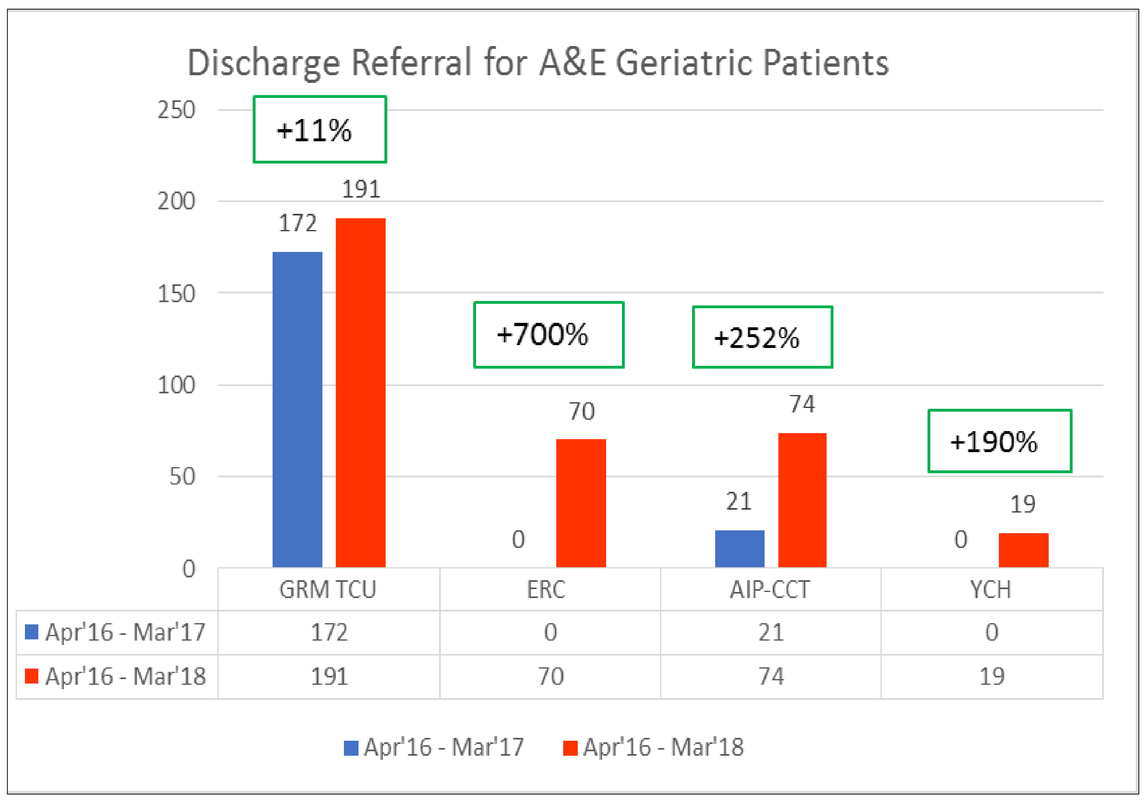
Screening and Assessment
- Geriatric patients will be screened. If 2 issues or more, Geriatric assessment will be performed.

Findings & recommendation
- Geriatric Nurse will assess on CAMs score, Social Assessment, Mobility & Functional Postural BP, Fall assessment, Urinary Continence assessment, Abbreviated Mental Score, Mood status assessment, Vision & Hearing.
- Disposition plan will be based on the patient's Clinical Frailty Scale (CFS)

Results

This collaboration started since April 2017 and the A&E Geriatric Nurses have screened a total of ***980 geriatric patients*** for issues like fall, fever, giddiness, breathlessness, constipation, etc.

626 geriatric patients were assessed fit for discharge and referred based on their Clinical Frailty score (CFS) to either the Geriatric SOC, Geriatric Early Review Clinic (ERC), Ageing-in-Place Community Care Team (AIP-CCT), Yishun Community Hospital (YCH), other SOCs or Polyclinic for review and follow up.



Project impact

1. Opportunistic findings of early geriatric issues for SOC referrals e.g. Eye, Urology and etc
2. The geriatric SOC received an increase of 11% referrals from A&E.
3. 588 average bed stay were saved with 70 patients (8.4 bed days) discharged with Geriatric ERC (3-5days) referrals.
4. 160 average bed stay saved with 19 patients admission to Yishun Community Hospital.

Conclusion

The project has helped detect early geriatric syndromes for our elderly patients and right-site them to the appropriate health care provider for follow-up. With this, hospitalization is prevented for some, which reduced their risk of nosocomial infection, deconditioning and delirium.

For sustainability, the team has periodical meetings to review the data and processes; and it acts as a platform to update each team of new services and/or implementation.