EDITORIALS

Emergency room geriatric assessment—urgent, important or both?

Most Western health services are seeking to reduce reliance on secondary care services where appropriate, whilst expanding primary care services [1, 2]. Much of the focus has been on the care of older people, predominantly those deemed to be frail, as this population tend to have greater health needs than younger populations. Methods to achieve this ‘transfer of care’ include an increased focus on managing long-term conditions, development of community-based comprehensive geriatric services and a focus on older patients with functional decline presenting as emergencies.

With such services, it is crucial that appropriate patients are referred to the appropriate service at the appropriate time. There is a perception that emergency physicians might not be best placed to make accurate rapid assessments of frail older people with complex comorbidities and polypharmacy, especially those who present non-specifically and have additional social needs [3]. As detailed in the article by Ngian et al. [4], various models of medical care have evolved to provide urgent comprehensive geriatric assessment (CGA), including mobile geriatric teams and nurse led teams. Several trials that have focussed on frail older people being discharged from the acute setting have included use of a screening tool to identify suitable patients and then delivering CGA to them with an outreach service from secondary care into primary care [5–7]; a variety of screening tools are in use internationally [8]. In North America and the Netherlands, the most frail care home residents are cared for by a dedicated nursing home physician working with a broad multidisciplinary team—this allows the emergency department (ED) to provide emergency care as needed, secure in the knowledge that ongoing geriatric management is in hand.

In evaluating a mature and well-established service, with geriatricians embedded in the ED, Ngian et al. have addressed part of an important question—whether a geriatrician is required in the emergency room to ensure that the correct trajectory is set in place for the patients presenting as an emergency, or whether this can be safely managed by emergency physicians? The most impressive finding was that on 94% of occasions, the ED decision to discharge a patient was in agreement with that of the specialist team. Where there was disagreement, it was most often a more junior ED staff who had taken the decision to discharge. The additional problems identified were the bread and butter of geriatric medicine—missed diagnoses, functional and cognitive decline. This is important, as the crude outcome (admit versus discharge) does not really address the quality issue; it is reasonable to infer that by making a more comprehensive assessment and identifying additional diagnoses or problems, that the quality of care should be better. Whilst a relatively small number of patients, the impact of having the patient in the wrong setting can be disproportionate, not only with poor outcomes for the individual but also others cared for in the discharge setting, as staff attention is diverted.

So in a relatively small proportion of cases, the presence of the Aged Care Service Emergency Teams (ASET) changes the destination of a given individual, as well as identifying additional issues in a much larger number of patients. A key question not addressed by this paper is whether or not such a service is clinically or cost-effective. It is possible, for example, that the admitted patients are at an increased risk of hospital-acquired illness, which in turn gave rise to the increased length of stay? Or even that the increased length of stay was relating to a delay in restarting services that had been suspended because the individual had been admitted? What would have happened if these patients had been managed in the community? Given appropriate support and expertise in the community setting, this may be a preferable option, though from a UK perspective at least, the optimum format of community geriatric services remains unresolved [9–11].

What is really needed is a whole systems comparison of different models of care, though as different systems will have different capacities, there will always be inherent selection bias. What works well in one setting may not work well in others. It is clear that the management of the frail older person with complex disease does need to be highlighted early in an acute episode, and that the initial assessment is key to that, setting the trajectory for the remaining spell. Essential components will include excellent, accurate and rapid communication [12], a specialist geriatric medical assessment, multidisciplinary care and a positive attitude towards older people [13–16]. Proactive primary care is an important component, with primary care physicians focusing on chronic disease management, including interventions such as advance care planning and liaison with nurse specialists (Kaiser Permanente) [17, 18]. As long as these evidence-based ingredients are in the mix, who delivers the care is of less importance.

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The geriatric day hospital: past, present and future

The day hospital concept was initially developed for psychiatric services and was modified in the 1950s in the UK as a key service for the emerging speciality for geriatric medicine [1]. At a time when hospital geriatric medicine was embryonic, and community services sparse, the geriatric day hospital (GDH) fulfilled an obvious need. It became a hugely successful service model for older people and was referred to by Arie as ‘one of psychiatry’s gifts to medicine’ [2]. The GDH became a display case for the big new idea of multidisciplinary team working, and departmental open days were held to promote day hospitals and their work. They were championed by health care planners who produced national GDH targets in relation to a key objective of ‘saving hospital beds’ [3]. There was inspirational language: (the GDH) ‘as a window through which the staff of the whole geriatric department can see the fruits of their labours as their elderly patients are resettled and maintained in the community’ [4].

In 1991/92, a national survey provided an estimate of over 400 day hospitals in the UK [5]. However, just over a decade later the major UK policy report on community health services contained not a single reference to the GDH [6]. What caused this apparent collapse in the identity of a core service for older people?

First, the GDH was always more contentious than generally acknowledged by its protagonists. There was a long-standing, smouldering debate around the extent to which...