The GERI - ED TEAM and Falls: A Model of Interdisciplinary and Integrated Care for the Frail Elderly in the Emergency Department

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ON BEHALF OF,
THE ROYAL VICTORIA HOSPITAL GERIATRIC E.D.
WORKGROUP

FOR,
5TH ANNUAL GERIATRIC EMERGENCY MANAGEMENT (GEM) CONFERENCE 2009
THURSDAY, SEPTEMBER 17
1:15 P.M. – 2:15 P.M.
Disclosures

- None
- I cannot be bought, but can be rented
Educational Objectives

- To review the literature of Interdisciplinary Teams working in the E.D.
- To review the literature of Rehabilitation in the E.D.
- To present a model of interdisciplinary and integrated care for frail elderly in the E.D.
- To present a practice audit describing the interdisciplinary management and outcome of seniors presenting with a fall to the E.D.
Current Literature of Interdisciplinarity in the E.D.
• JOHNSON (2009) – Of the 4.8 million people presenting to ED’s in Australian Hospitals in 2005-2006, 59% were triaged as semi-urgent or non urgent

• WOOD (1986) – surveyed 218 patients to a British ED and found that 3 broad categories persisted of reasons for ED visits
  ○ ED accessibility
  ○ GP availability
  ○ Perceived appropriateness of the condition for ED referral
CARLILL (2002) – MDT assessment provides info to help inform decisions about whether or not patients with non-urgent medical conditions can be safely discharged home or need hospital admissions

DAVISON (2005) – MDT are effective in the prevention & management of falls within an older ED population

BERNSTEIN (2006) – MDT are particularly useful for “frequent” or “inappropriate” users

WEBSTER (2004) – MDT helpful in assessing and managing people with mental illness in the ED
CUSICK (2008) – Proposed that MDT:
- Prevent inappropriate and/or unnecessary admissions
- Reduce the number of repeat presentations
- Play a role in safe discharge to the community via counseling
- Helping pts and families understand their condition, proposed treatment plan, and discharge plan
- Facilitation links to community services
- Able to provide additional services like:
  - Home assessments
  - Prescriptions for mobility aids, assistive devices, daily living equipment
  - Functional evaluation
  - Cognitive evaluation
  - Psycho-social evaluation
  - Bereavement or crisis counseling
  - Placement
Current Literature of Rehabilitation in the E.D.
Evolution of Rehabilitation

- Traditionally

  Acute care ward → In-patient rehab or Transitional care → Home with CLSC → Out-patient rehab

- Now

  E.D. → I.C.U. → Acute care ward → In-patient rehab or Transitional care → Home with CLSC → Out-patient rehab
Description de la pratique des ergothérapeutes du Québec en salle d’urgence


Nathalie Veillette • Louise Demers • Élisabeth Dutil

Abstract

Introduction. Occupational therapists intervene in emergency departments, but the nature and scope of this practice is unknown. Objective. To describe the professional practice of Quebec’s occupational therapists in emergency departments. Methods. Questionnaires covering the general context of practice, nature of interventions, assessment tools, models of practice and the satisfaction of working in emergency departments were sent by mail to the members of l’Ordre des ergothérapeutes du Québec. Results. Occupational therapists have been working in emergency departments in several socio-administrative regions of Quebec and their work experience ranges from 1 to 11 years. They spend over 90% percent of their time with older adults and are members of interdisciplinary teams. They assess diverse areas of functioning and 75% of them use in-house assessment tools. The challenges encountered affect two thirds of the respondents who describe their satisfaction level toward the practice as being neutral or unsatisfied. Implications for practice. The respondents have confirmed the emergence of occupational therapy in emergency departments and the need to develop better tools in order to address the problems met in their practice.
Mainly observational, case or retrospective

- HOWARD (1995) reported that the OT based in A&E played a large part in the **decision to admit or discharge**.
- GEORGE (1994) described an OT in A&E in which the OT assessed whether or not the patients who presented there were **safe to return to the community**.
- HANN (1997) discussed the provision of an OT service in A&E which was aimed at **preventing unnecessary hospital admissions** and improving patient care for those discharged directly from the A&E. The OT was able to assess the patients home environment and identified equipment and continuing rehab needs. The OT identified risk factors to aid referral and screened via telephone all patients aged 75 years and over who were discharged from the A&E. The **study estimated that 562 bed days were saved in a one year period** but little detail was given on how this figure was determined.
CLOSE (1999) showed that an interdisciplinary approach to the assessment of the elderly people who had fallen and attended A&E could significantly decrease the risk of further falls and limit functional impairment.

SMITH (2004) showed that with OT services in A&E 306 saved admissions occurred, monthly average of 8.5.

CARLILL (2002) main reason for referral were mobility concerns, assessment of function in basic daily living tasks, concerns about coping at home, and request for home assessment.

CUSICK (2009) – Australian OT’s performing functional evaluations to determine the need for admission vs. discharge in older adults triaged as semi-urgent or non-urgent.
An occupational therapy consultation provided to older adults presenting to accident and emergency improves ADL functioning and reduces falls and hospital stays

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The Townsville Hospital Occupational Therapy Department

Date: August 2005
Next Review: August 2007

CLINICAL SCENARIO: Elderly people presenting to hospital emergency departments (ED) or accident and emergency (A and E) with symptoms after a fall are often not admitted to hospital. However, their ability to independently perform activities of daily living (ADL) can be significantly affected. While occupational therapy (OT) services are often available, a referral is not always made to assess home environment, supports and ability to perform ADLs. Does OT consultation improve functional outcomes for these people?

FOCUSED CLINICAL QUESTION: Among elderly people presenting to emergency and acute medical assessment units, does an OT referral/consultation result in greater ADL independence and safety post discharge when compared to those who do not receive OT?

CLINICAL BOTTOM LINE: Older adults (65 to 75 years +) presenting to A and E with a primary diagnosis of a fall, limb, back or rib trauma, and with no cognitive impairment or dementia, who receive an OT consultation have greater independence in ADL, reduced falls and less days in hospital up to a year following discharge.
Consensus-based policy recommendations for geriatric emergency care

Belinda Parke
Fraser Health Authority, Surrey, Canada, and
Jane McCusker
Clinical Epidemiology and Community Studies, St Mary’s Hospital, Montreal, Canada

Abstract

Purpose – The purpose of this paper is to establish policy recommendations to address service and care delivery challenges facing hospital emergency departments (EDs) responding to the needs of increasing numbers of older adults.

Design/methodology/approach – The consensus development process used an international expert interdisciplinary panel, convened at an international conference. Following a round table discussion and think-tank session, a nominal group method with constant comparative analysis and coding techniques was used to identify policy recommendations. Two rounds of electronic input followed the face-to-face meeting to reach consensus on priority ranking of the policy recommendations. Findings underwent an external review by four independent experts.

Findings – A total of seven categories of policy recommendations were developed: education, integration and coordination of care, resources, ED physical environment, evidence-based practice, research and evaluation, and advocacy.

Research limitations/implications – The consensus development process did not include a systematic literature review on the topic. However, participants included experts in their disciplines.

Practical implications – The recommendations may assist administrators, policy makers, clinicians, and researchers on future directions for improving emergency care and service delivery for older adults.

Originality/value – The paper describes the process and results of a consensus development activity for ED care and services of older adults.

Keywords Geriatrics, Emergency services, Service delivery, Health services, Elder care

Paper type Literature review
Geriatric Emergency Department Team

Consists of:

- Geriatric Medicine
- Geriatric Liaison Nurse
- Occupational Therapist
- Physical therapist
- Social Worker

High Risk Seniors Targeted via:

- Referral from the ED Staff & other specialties to any team member
- Contact by home care
- Screening

Geriatric Emergency Department Team
Background
Royal Victoria Hospital

- 1 of 6 hospitals within the McGill University Health Centre
- 440 bed tertiary care centre
- RVH ED holds 56 patients within the resuscitation rooms, acute care, minor care, psych ED, hallway, sub-acute areas
- 7 patient short stay unit
- 34 400 ED visits
- 26% (8917 visits) are 65+
- 15% (5005 visits) are 75+
- Non-trauma, dialysis, centralized cardiovascular (CHF)
Model of Care & Case Study
Chief Complaint: 78 y.o. male in ED with History of fall with increasing frequency in past 8 weeks, on coumadin

GLN Screens:
Past Medical History: Atrial fibrillation, Hypertension (new medication), Coronary Artery Disease, Diabetic Mellitus type 2, Cerebral Vascular Accident, mild vascular dementia (good insight), decreased vision, polypharmacy
Social History: Lives alone, socially isolated, elevator accessible apartment, autonomous residence

Active problems identified...

Geriatric Liaison Nurse:
Eval. identifies:
- Falls & Unsteady in ED (PT)
- Visual Deficits
- Calls Pt’s Pharmacist for med list (GERI)
- Question adequate social support (SW)

Occupational Therapist:
- MMSE 25/30
- Need for adaptive equip. for bed and bathroom transfers
- Home Safety Eval.
- Assistance for IADL’s

Social Worker:
- Exploration of relocation to semi-autonomous residence urgently vs. non-urgently
- Mandate
- Explore family support

Physical Therapist:
- Apraxic gait
- Orthostatic hypotension
- Moderate fall risk
- Difficulty with transfers
- Detects slight confusion

Geriatrician:
- Med. Review reveals polypharmacy and adverse drug interaction leading to OH
- CT head reveals old lacunar infarct

Emergency Department Physician:
- Low Hemoglobin Rx.
- INR monitor

Patient to go to Sub-acute part of ED for medical mgt., optimizing patient, and awaiting transfer to rehab.

Discharge Patient Home +/- Services
Admit Patient to most appropriate floor

Transfer Patient to Rehabilitation Center for:
- Physio: gait/transfer training, walking aid, education on fall risk factors and mgt.
- Nurse: diabetic mgt., health monitoring, blood pressures, cognitive screening, med. compliance with dosette box
- OT: ADL/IADL training, education on home safety adaptive equipment like bathroom adaptations, bedrail, activity in sitting, cognitive follow-up and retraining
- SS: Process of relocation, meals on wheels
- Notify family physician
- Geriatric Day Hosp. & CLSC application to optimize mobility, endurance, cognitive status and overall safety at home
## Model of Care

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Direct verbal communication</td>
<td>• Complete team on weekdays only</td>
</tr>
<tr>
<td>• Rapid transfer and sharing of key information</td>
<td>• No screening tool</td>
</tr>
<tr>
<td>• Increased time efficiency</td>
<td>• Pressure to discharge</td>
</tr>
<tr>
<td>• Optimal use of geriatric team members</td>
<td>• Fluctuation in workload</td>
</tr>
<tr>
<td>• Improvement of quality of care</td>
<td></td>
</tr>
<tr>
<td>• Distribution of burden of care of older adults in the ED between members</td>
<td></td>
</tr>
</tbody>
</table>
## Availability of Geri-ED Team Members

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Availability - FTE (full time equivalent)</th>
<th>Hours spent daily (mean (range))</th>
<th>New patients seen daily (mean (range))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Liaison Nurse</td>
<td>1</td>
<td>7.25</td>
<td>2.93 (1-8)</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0.34</td>
<td>1.5 (0.5-7)</td>
<td>0.67 (0-8)</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>0.50</td>
<td>2.8 (0.5-7)</td>
<td>1.6 (0-8)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>0.75</td>
<td>2 (0.5-7)</td>
<td>0.85 (0-4)</td>
</tr>
<tr>
<td>Geriatric Medicine Specialist</td>
<td>0.50</td>
<td>3 (0.5-8)</td>
<td>1.2 (0-8)</td>
</tr>
</tbody>
</table>
### Assessment by the Geri-ED Team Members

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Role</th>
<th>Tools/Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapist</td>
<td>Establish patients functional baseline, social network, and environmental barriers. Assessment of activities of daily living (ADL’s), Instrumental ADL’s, cognition, swallowing, transfers, home safety concerns. Make appropriate recommendations and discharge planning.</td>
<td>MMSE, MOCA, Barthel, OARS, Dysphagia Outcome and Severity Scale</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>Establish baseline, social context, and fall history. Assessment of transfers, mobility, balance, falls risk, orthostatic hypotension. Screen physical status, make appropriate recommendations, and discharge planning.</td>
<td>BERG Balance Scale, Timed Up and Go (TUG), Gait speed, 2 minute walk test</td>
</tr>
<tr>
<td>Geriatric Liaison Nurse</td>
<td>Assessment of overall ability to manage safely at home, given formal and informal support network, cognition, physical status, medication regime, mobility, home environment, caregiver stress/fatigue. Makes recommendations and referrals for patient management: hospital admission/rehab admission/discharge home +/- home care services</td>
<td>MMSE, Barthel, InterEtablissement Transfer form, DSIE</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Assessment of baseline, home situation, risk factors, support network, family dynamics, and coping strategies. Needs assessment including relocation, financial issues, emotional needs, and recommendations for follow-up. Liaison with community partners, family, and friends.</td>
<td>PIE Supportive counseling, problem solving strategies, crisis intervention</td>
</tr>
<tr>
<td>Geriatrician</td>
<td>Assess medical-status of patient and readiness for discharge vs. need for admission. Recommend further testing/management. Share info amongst both the geriatrics and emergency teams.</td>
<td>Blood work, X-Rays, CT scan, Rx review</td>
</tr>
</tbody>
</table>
Falls in Seniors Presenting to the Emergency Department

DOES MANAGEMENT BY AN INTERDISCIPLINARY GERIATRIC TEAM HAVE AN IMPACT ON PATIENT’S CARE AND OUTCOME?
Objective

- To describe the interdisciplinary management and outcome of seniors presenting with a fall to the Emergency Department of a large university affiliated hospital in North America. This was achieved by a practice audit of the interdisciplinary care executed by the Geri-ED team.
All visitors ≥ 65 years of age appearing on weekday census

Dx: Fall within the last 2 weeks 100% (93 seniors)

Case finding by GLN Direct referral to GERI ED team members

Brief patient stratification in the daily GERI ED rounds

Seen by most appropriate member of the GERI ED team

GLN Geriatrics PT SW OT

Outcome: Discharge plan at the index visit

Home or Rehabilitation Centre Admit to the Hospital

Outcome: Return ED visit within 30 days of index visit
Results – Mgt of Seniors with Falls in ED

- All visitors ≥65 years of age appearing on weekday census
- Dx: Fall within the last 2 weeks 100% (93 seniors)
- Case finding by GLN: 47%
- Direct referral to GERI ED team members: 53%
- Brief patient stratification in the daily GERI ED rounds
- Seen by most appropriate member of the GERI ED team:
  - GLN: 84%
  - Geriatrics: 53%
  - PT: 33%
  - SW: 10%
  - OT: 4.3%
- Outcome: Discharge plan at the index visit:
  - Home or Rehabilitation Centre: 53%
  - Admit to the Hospital: 47%
- Outcome: Return ED visit within 30 days of index visit
## Results – Basic Characteristics

<table>
<thead>
<tr>
<th>Characteristics of Fallers</th>
<th>%  (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of fallers</td>
<td>100.0 (93)</td>
</tr>
<tr>
<td>Women</td>
<td>59.1 (55)</td>
</tr>
<tr>
<td>Age groups: 65-74</td>
<td>21.5 (20)</td>
</tr>
<tr>
<td>75-84</td>
<td>48.4 (45)</td>
</tr>
<tr>
<td>85 +</td>
<td>30.1 (28)</td>
</tr>
<tr>
<td>Language spoken: English</td>
<td>52.7 (49)</td>
</tr>
<tr>
<td>French</td>
<td>25.8 (24)</td>
</tr>
<tr>
<td>Italian</td>
<td>4.3 (4)</td>
</tr>
<tr>
<td>Greek</td>
<td>3.2 (3)</td>
</tr>
<tr>
<td>Others</td>
<td>14.0 (13)</td>
</tr>
<tr>
<td>Living arrangements: Home</td>
<td>78.5 (73)</td>
</tr>
<tr>
<td>Autonomous Residence</td>
<td>10.8 (10)</td>
</tr>
<tr>
<td>Semi-autonomous Residence</td>
<td>6.5 (6)</td>
</tr>
<tr>
<td>Living Alone</td>
<td>41.9 (39)</td>
</tr>
<tr>
<td>Home Care support</td>
<td>54.8 (51)</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>76.3 (71)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristics of Fallers</th>
<th>%  (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief complaints: FALLS</td>
<td>67.7 (63)</td>
</tr>
<tr>
<td>Injury</td>
<td>4.3 (4)</td>
</tr>
<tr>
<td>Others</td>
<td>28.0 (26)</td>
</tr>
<tr>
<td>Baseline Walking aid: None</td>
<td>41.9 (39)</td>
</tr>
<tr>
<td>Cane/Walker</td>
<td>15.1 (14)</td>
</tr>
<tr>
<td>Walker</td>
<td>37.6 (35)</td>
</tr>
<tr>
<td>Wheelchair</td>
<td>2.2 (2)</td>
</tr>
<tr>
<td>Fall</td>
<td>75.3 (70)</td>
</tr>
<tr>
<td>Trauma post Fall: None</td>
<td>37.6 (35)</td>
</tr>
<tr>
<td>Soft Tissue Injury</td>
<td>37.6 (35)</td>
</tr>
<tr>
<td>Fractures: Total</td>
<td>28.0 (26)</td>
</tr>
<tr>
<td>Upper limb</td>
<td>15.4 (4)</td>
</tr>
<tr>
<td>Lower limb</td>
<td>23.1 (4)</td>
</tr>
<tr>
<td>Pelvis /ribs</td>
<td>38.5 (10)</td>
</tr>
<tr>
<td>Spine</td>
<td>30.8 (8)</td>
</tr>
<tr>
<td>Head/Subdural</td>
<td>7.7 (2)</td>
</tr>
</tbody>
</table>
## Outcome According to Team Members Involved

<table>
<thead>
<tr>
<th>Disposition of Seniors at the Index ED Visit / Team Member Involved</th>
<th>DISCHARGE Home n</th>
<th>DISCHARGE Rehabilitation n</th>
<th>ADMISSION Hospital n</th>
<th>TOTAL Seen by Team Member % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Liaison Nurse*</td>
<td>43</td>
<td>3</td>
<td>32</td>
<td>84 (78)</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>1</td>
<td>-</td>
<td>3</td>
<td>4.3 (4)</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>9</td>
<td>3</td>
<td>19</td>
<td>33 (31)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>10 (9)</td>
</tr>
<tr>
<td>Geriatric Medicine Specialist</td>
<td>14</td>
<td>3</td>
<td>32</td>
<td>53 (49)</td>
</tr>
<tr>
<td>TOTAL as per Disposition</td>
<td>46</td>
<td>3</td>
<td>44</td>
<td>Total n = (93)</td>
</tr>
</tbody>
</table>
## Outcome According to Team Members Involved

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<th>TOTAL Seen by Team Member % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Liaison Nurse*</td>
<td>33</td>
<td>2</td>
<td>25</td>
<td>89.6% (60)</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>1</td>
<td>-</td>
<td>3</td>
<td>6% (4)</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>5</td>
<td>2</td>
<td>16</td>
<td>34.3% (23)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>4.5% (3)</td>
</tr>
<tr>
<td>Geriatric Medicine Specialist</td>
<td>8</td>
<td>2</td>
<td>21</td>
<td>46.3% (31)</td>
</tr>
<tr>
<td>TOTAL as per Disposition</td>
<td>52.2% (35)</td>
<td>3% (2)</td>
<td>44.8% (30)</td>
<td>Total n = (67) Falls/injury only</td>
</tr>
</tbody>
</table>
## Return ED Visits within 30 days & Disposition

<table>
<thead>
<tr>
<th>Return ED visit % (n) of all seniors (total n=93)</th>
<th>TOTAL Return ED Visit</th>
<th>Discharged Home At Return ED Visit</th>
<th>Admitted to Hospital At Return ED Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit related to fall/injury</td>
<td>4.3% (4)</td>
<td>4.3% (4)</td>
<td>(0)</td>
</tr>
<tr>
<td>Visit related to comorbidity</td>
<td>6.5% (6)</td>
<td>2.2% (2)</td>
<td>4.3% (4)</td>
</tr>
</tbody>
</table>
First description of the Process of Care by an Interdisciplinary Team, where seniors undergo a multifactorial fall risk assessment and receive targeted interventions during the initial ED visit


Consistency in Application of Clinical Practice Guidelines for Fallers

Studies have shown that there is poor consistency in application of clinical practice guidelines to fallers in the ED. (Kalula, 2006, Paniagua, 2006, Salter, 2006). In this project, best practice guidelines for prevention of recurrent falls in older people (AGS, BGS, AAOSP guideline care 2001) and evidence based guidelines for secondary prevention of falls in Emergency care setting (Gates 2008, Cochrane Gillespie 2003) are consistently applied at the most critical time, while entering and leaving ED, when team present. Optimally, such service should be provided 24-7 but feasibility is limited to weekdays because of insufficient resources.
Many fallers discharged safely home and/or to rehabilitation facilities

Comparison with published data is limited by the fact that very few studies examined the outcome of fallers specifically, as most included all medical problems. Onen (2001) reported of all patient ≥70yo discharged from ED, 13% returned to their residence, 55% transferred to a medical specialty ward, 4% to other facilities, 19% to the geriatric ward and 9% died in ED. Ferrera (1999) also demonstrated that of the 29% of elderly patients (≥65yo) sent home from ED, (29%) with injuries from a fall or MVA, most (88%) were safely discharged home.

Low rate of return ED visits related to the initial fall

We can only speculate that the low rate for return ED visits within 30 days with a new fall or fall related problem is related to this unique INTEGRATED approach and process of care given in the ED. Ferrera (1999) reported a return ED visit rate of 11% has been found for elderly patients seen and discharged from ED with injuries from falls or MVA. (Ferrera 1999). Return visit was as often related to co morbid conditions as to initial injury. In adults aged ≥ 75 years, rates of hospital admissions in the month following an ED visit ranged from 16.5% to 22.2%(Caplan 2002, Williams 1992).
Targeted Interdisciplinary Care for Fallers in the ED

- Integrated care is provided in the ED with key factors being active case finding of patients with presenting complaint of fall and comprehensive geriatric assessment with identification of fall risk factors. Critical information is rapidly communicated among members in order to optimize patient care and prioritize use of most appropriate professional depending on expected disposition from ED. With a high volume of referrals and turnover, the tasks are shared and assessments are completed by the healthcare provider with the relevant skills and expertise to intervene quickly and effectively. This immediate response to positively influence fall risk factors is expected to have a positive impact on prevention of recurrent falls. More involvement from the ED staff re identification of cases and rapid access to homecare services & rehabilitation beds would be beneficial.
### Discussion – Impact of Team on Mgt. & Outcome

**Strengths**

- Translational research where evidence based guidelines/models of care is in use
- Number of subject
- Prospective analysis
- Follow-up

**Limitations**

- Absence of control group
- No details on cause or recurrence of falls
- No measure of patient satisfaction
- No evaluation of cost-effectiveness
Future Projects

- To identify fall risk factors and describe multi-factorial management/interventions of seniors presenting with a fall or fall related ED visit and relate the number of recurrent falls and return ED visits to the degree of compliance to the recommendations and services rendered.
- Cost- effectiveness study of such approach would also be of interest.
Management of seniors presenting with falls by an interdisciplinary geriatric team in the ED of a large university affiliated hospital is feasible and seems to have a positive impact on care and outcome, allowing to safely discharge these most complex cases, while ensuring a low return ED visit rate. This programme could be enhanced by formalizing links to the community, development of falls clinics, increasing fall awareness/knowledge of ED staff and general public. Comparison with other models of care, cost-effectiveness study and correlation with clinical outcomes would all be of interest in future.
First Row (left to right)
Kashif Baig (OT)
Mary Sullivan (GLN)

Second Row (left to right)
Patricia Barassi (PT)
Nancy Plaisir (GLN)
Dr. Josee Verdon (Geri)
Greg Ramsay (SW)
Kimberly Brown (SW)

Absent
ED Staff & Nurses

Geriatric Emergency Department Team