

Title

Patterns of attendance of care home residents to an emergency department

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In the UK, nearly 380,000 people live in care homes (nursing or residential) [1]. These numbers are expected to rise in the coming years and lead to increased demand on emergency care services. The frequently poor quality of care for older patients in hospital, particularly those with cognitive impairment, has led to an increased awareness of the problems facing this population. [2] Reviews of Emergency Department (ED) attendance suggest that Care Home Residents (CHR) represent about 1.3-2.5% of all ED attendances [3]. This study investigates what information was readily available to the receiving team.

A 2-week prospective data collection was carried out from first point of contact of CHR with an ED in London. After identification, the patient was triaged and standard care was provided for the patient. Data collected from completed ED notes included demographics, medical background, clinical presentation and outcome. Any patient admitted to hospital was followed up and the time until discharge was recorded.

Over the first 2 weeks of July 2011, 3015 patients attended the ED. Of these, 562 were aged 65 and older. Thirty-three patients (1.05% of all admissions) were identified as being from either a nursing or residential care home. Of these, 25 were women (76%), 23 were residential home residents and 10 were nursing home residents. Five (15%) had been seen by a general practitioner (GP) who referred them to the ED, 28 (85%) were sent directly to the ED without medical consultation and 18 (55%) presented within working hours (8:00 am-5:00 pm).

Twenty-eight CHR (85%) were not accompanied by either staff or family. Seven (21%) had a fall associated with the attendance. None had evidence of an advance directive decision documented in the notes or information that could provide guidance about treatment (e.g. preferred methods of communication, how distress might be expressed, usual behaviour). Once in the ED, the average length of stay was 3 h and 46 min.

Of the 33 attendances, 12 were discharged back to the care home from the ED and 21 were admitted to the care of the medical teams. Twenty-three (69%) of the 33 residents were still alive at 6 months follow up.

None of the attendees had any documentation on resuscitation status or baseline cognitive status. In the case of peri-arrest situations, a face-to-face handover from the patient's care worker would be ideal. The reality is that care homes can seldom release staff to accompany patients to ED or if they do, they would often send the most inexperienced staff member. To date the emphasis has been on reducing inappropriate admissions and referrals.

Contrary to common belief, this patient group accounted for a small percentage of all attendances to the ED. However, the underlying frailty of the patients, the length of stay in ED before decisions are made about discharge or admission and the high 6-month mortality rate suggest that older individuals from care homes represent a discrete group with special needs (which extend beyond the presence or absence of dementia).

Care home access to primary care services is variable and only five residents (15%) had a GP referral even though over half of admissions occurred during office hours. Little is known about how to improve liaison between care homes, ED and primary care. There is some evidence that enhanced payments to GP services can reduce rates of hospital admissions [4]. Liaison between Care homes, ambulance services, ED and GPs could further benefit from the development of shared guidelines and documentation. This could inform how cognitive impairment, a previous history of care, the wide range of presenting complaints and overall frailty are documented and shared. Robust integration of health and social care services and the voluntary sector may lead to better outcomes for the health and well-being of older individuals [5].

This prospective study showed there is need for more research that develops and tests interventions, which can work across the different care settings and reduce the avoidable distress experienced by residents admitted from care homes.

Conflicts of interest

There are no conflicts of interest

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