Government of Western Australia
North Metropolitan Health Service
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Curtin University

From triage to departure: *Older adults' ED journey.*

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Background:

Rising Emergency Department (ED) demand strains resources to assess and manage frail older adults.[1] International practices stipulate that frailty should be identified at triage (alongside triage scores) and comprehensive geriatric assessment (CGA) commenced within one hour of presentation.[2] However this can be challenging in the ED setting.

Allied health professionals support comprehensive care, disposition planning and patient safety in the ED but often intervene late.[3] To date there have been no investigations into referral processes to ED allied health professionals and whether there are opportunities for earlier referral practices to streamline older adults ED journey.

Research aim:

The aim of this study was to explore factors that contribute to allied health referrals and codesign a new early allied health frailty pathway with ED stakeholders for future trial and evaluation.

Method:

This explanatory sequential mixed-methods study used patient journey mapping from ED triage to departure followed by stakeholder focus groups. Inclusion criteria were

- Adults ≥65 years.
- Clinical Frailty Scale (CFS) 4-6.
- Australasian Triage Score (ATS) 3-5.
- Presenting with falls, generalised illness, muscular injury, or back pain.

Primary outcomes included time to doctor and allied health assessments and ED length of stay (LOS). ED stakeholders were presented the outcomes of the patient journey mapping (Figure 1) and explored an early allied health frailty pathway.

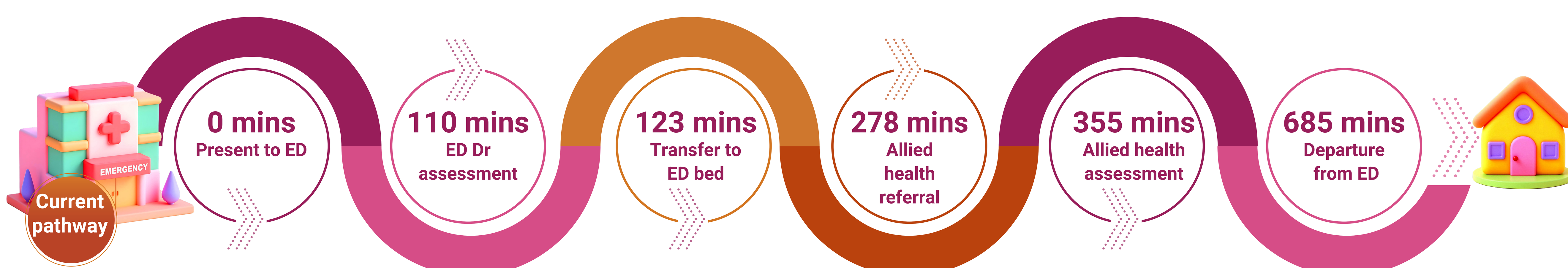

Figure 1. Current ED Allied health referral pathway with mean times from patient journey mapping.

Results:

In 20 patients, the majority were:

- Male (n=12, 60%).
- Living home alone (n=12, 60%).
- English the primary language (n=17, 85%).

The mean ED waits from triage were

Allied health were referred 15 patients (75%) and assessed 47% (n=7) as appropriate for discharge.

Ten patients (50%) missed usual medication prior to ED arrival and 30% (n=6) were prescribed medications after mean wait 341 minutes (SD 134 minutes).

Fifteen patients (75%) received food or fluid in ED (mean wait 263 minutes; SD 163 minutes).

Qualitative analysis revealed opportunities for early allied health included shorter LOS, earlier discharge plans, streamlined medical decisions and increased nurse confidence.

Barriers included competing doctor and allied health assessment, limited space for assessment, and assessments prior to medical investigations.

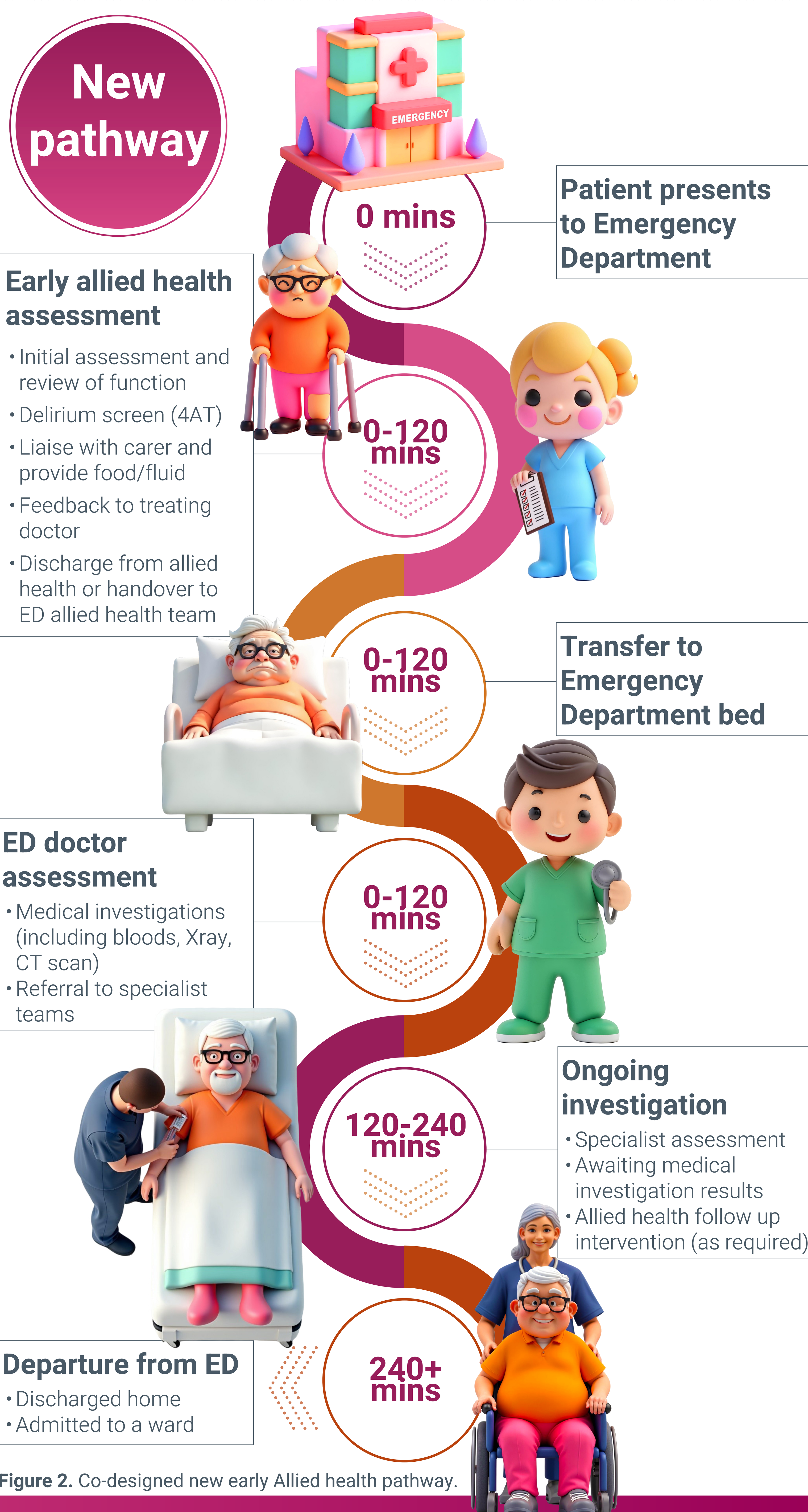

Figure 2. Co-designed new early Allied health pathway.

Overall, stakeholders were accepting of an early allied health frailty service assessing patients with the new pathway moving allied health to assess older patients within one hour of ED presentation. (Figure 2)

Conclusion:

Allied health assessment occurred at approximately six hours post presentation. Opportunities and barriers identified have supported the development of an earlier allied health frailty service. This new service could provide comprehensive assessment earlier, addressing and minimising adverse events and streamlining referral processes to reduce LOS.

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