



KEY POINT SUMMARY

OBJECTIVES

The objective of this study was to evaluate the impact of an embedded CGA service in the ED of a large teaching hospital in England.

DESIGN IMPLICATIONS

This study did not expand on the environmental aspects of an EFU. However, the study results indicate that incorporating a separate space for 85+ patients within an ED or the hospital will enhance a more complete decision-making ability pertaining to discharge or admission of these patients.

A controlled evaluation of comprehensive geriatric assessment in the emergency department: The 'emergency frailty unit'

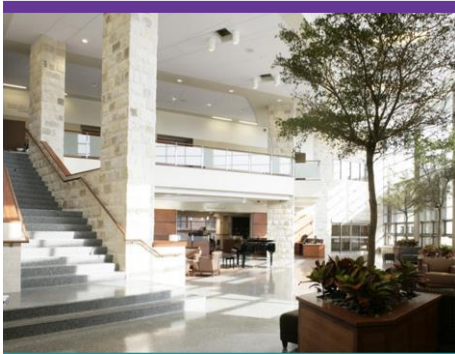
Conroy, S.P., Ansari, K., Williams, M., Laithwaite, E., Teasdale, B., Dawson, J.,..., Banerjee, J. 2014 | *Age and Ageing*. Volume 43, Pages 109-114

Key Concepts/Context

Referring to data from emergency departments (EDs) in England, the authors infer that as the number of elderly grow, so does their number attending emergency departments. The data also shows that almost 62% of seniors (80 years and over) visiting EDs in England are transferred to hospitals for further treatment. Literature indicates that such transfers result in increased use of resources, higher risk of adverse events, longer stays, and higher rates of readmission and use of long-term facilities. According to the authors, several studies provide evidence that 'hospitals at home' are proving to be more beneficial in terms of decreased rates of mortality and functional decline. In this context, the authors point to the significance of assessing seniors at the time of ED entry as to the possibility of managing their care at home, and suggest incorporating comprehensive geriatric assessment (CGA) in developing a long-term treatment plans and follow-up. In this paper the authors report on the evaluation of a CGA program incorporated in a British ED, thus, creating the 'Emergency Frailty Unit' (EFU). The study found that incorporating CGA into an ED leads to reduced hospital admissions and readmissions.

Methods

The methodology used for this research was a pre-post cohort study that took place over a period of two years from 2010 to 2012. The settings for this study included the Emergency Decision Unit (EDU) of an ED and an EFU in the same hospital. The EDU, located about 20 meters from the ED, is a 16-bed ward whose purpose was to hold people awaiting diagnostic results to support a discharge or inpatient admission decision. An old acute care unit in the hospital was made available for use as an EFU. It had eight-twelve beds at its disposal to observe frail elderly patients presenting at the ED pending a discharge or admit decision. Data pertaining to



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hospital admission from EFU (considered the primary outcome) were analyzed after 12 months of the unit's being developed. The secondary outcomes assessed included readmissions at seven, 30, and 90 days, length of stay (LOS), and total bed-days. The data were categorized into three periods – control period (referring to the pre-cohort study), transition period (when the EFU was being developed), and the intervention period (after the EFU was established). Data were analyzed statistically (descriptive and chi-square tests).

Findings

The study yielded the following findings:

- There was an increase in the number of 85+ patients presenting at the ED over the three periods – 6.3% in the control period, 7.6% in the transition period, and 8.2% in the intervention period.
- There was an 18% increase in the number of 85+ seniors presenting at the ED in 2012 compared with 2010.
- There was a significant decrease in the number of 85+ patients admitted -- from 69.6% to 61.2% -- from 2010 to 2012 ($P < 0.0001$).
- There was decrease in mean monthly rates of readmission at seven, 30, and 90 days for 85+ patients.
- There was an increase in mean LOS from 8.9 days in 2010 to 11.1 days in 2012 for 85+ patients.
- There was a slight increase in mean total bed-days from 27 days in 2010 to 29 days in 2012 for 85+ patients.

Limitations

The authors identified the following limitations in this study:

- The control and intervention periods used data from different time periods.
- There was no 'process data' to supplement the patient data.
- Individual patient data pertaining to quality of life and functional ability were not obtained.

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