

Preparing the emergency departments for the “Silver Tsunami”

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INTRODUCTION

Over the next decades, the demographic trends will fundamentally change the makeup of the population served by Canadian emergency departments (EDs). By 2031, the proportion of adults aged over 65 will nearly double,¹ and this group could represent more than a quarter of the Canadian population by 2036.² Older adults already represent a high proportion of ED patients^{3,4} and have already been identified as disproportionate users of ED resources.⁵ Considering that access to primary care has been reported to be difficult for 25% of Canadians,⁶ it is therefore likely that the number of ED consultations will increase with their growing number. Undeniably, the “Silver Tsunami” will greatly impact the urgent care provided to Canadian seniors by ED professionals. It is therefore of utmost importance to evaluate, prepare, and engage in delivering high quality of care to this growing population.

Over the past decade, several health authorities have developed general guidelines to adapt acute older patients care. For example, in 2010, the *Ministère de la Santé et des Services Sociaux du Québec* launched the *approche adaptée à la personne âgée en milieu hospitalier*, which aimed to improve healthcare for patients ages 65 and over.⁷ In the same year, Toronto’s Mount Sinai Hospital launched its Acute Care for Elders Strategy,⁸ which also had the same objective. In 2014, American Geriatric ED guidelines⁹ were published and endorsed by the Canadian Association of Emergency Physicians, although these broad guidelines were mostly aimed at ED inpatient care and recommended no specific tools.¹⁰

Many published studies suggest that even though tools and models have been tested and are available for older

patient care, there is still an important gap for their adaptation, implementation, and actual use in EDs.^{11, 12} This issue of *CJEM* presents two articles exploring geriatric-friendly ED tools. Following the adaptation of the Canadian Triage and Acuity Scale, which now includes a senior-frailty modifier, Mowbray et al. aimed to investigate the relationship between triage acuity and frailty.¹³ The authors found no direct association between ED triage and older patients’ frailty status. This could be explained by the fact that frailty is a fairly new concept for the ED professionals and may be difficult to conceptualize in a time-pressure environment. Frail, older adults are at an increased risk for adverse outcomes during and after the ED visit.¹⁴ However, even though ED triage is a cornerstone of our Canadian acute care system, senior-friendly triage may not be the only window of opportunity to identify pre-frail or frail older adults at risk of complications in the ED or at discharge.

ED tailored geriatric assessment skills and clinical tools could help orient older patient care. In Afilalo et al., two specific tools were evaluated to predict potential functional decline or return to the ED after discharge: gait speed and grip strength.¹⁵ Their results showed that assessing patient walk in a structured *5-m gait speed test* can predict a post-ED discharge adverse event, such as functional decline. However, their grip strength results showed no association with functional decline. Other walk tests, such as the Timed Up and Go, have showed similar results regarding the association between walk speed and adverse event,¹⁶ leading to believe that mobility assessment should therefore be an important aspect of senior-friendly ED care, and that future research should focus on the continuity of care in frail elders at discharge.

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It is without any doubt that all health professionals caring for older patients either before, in, or after the ED will need to rapidly adapt their practice in order to provide high-quality care to meet the more complex needs of this growing population.

Keywords: Geriatric, triage, frailty, functional decline

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