URGENCIAS GERIÁTRICAS EN UN HOSPITAL DE AGUDOS

¿CÓMO REALIZAR UN MEJOR ABORDAJE BIOÉTICO EN LA ATENCIÓN DEL PACIENTE MAYOR?

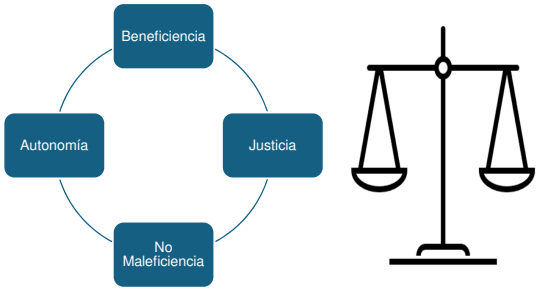
Jornada AEBI 2024: Cuestiones bioéticas alrededor del envejecimiento

Armando Pardo Gómez
Geriatra
Hospital Universitario Puerta de Hierro
Octubre 2024

Laguna
FUNDACIÓN VIANORTE-LAGUNA

aebi

Problema ético en medicina



- Vida
- Calidad de vida
- Salud
- Dinero/Recursos
- Tiempo
- Dignidad

Método deliberativo en la resolución de conflictos éticos

- Hechos
- Planteamiento del problema
- Determinación de los cursos de acción extremos
- Determinación de los cursos de acción intermedios
- Selección del curso óptimo

Hechos

Comment › JAMA Intern Med. 2023 Dec 1;183(12):1378-1385.
doi: 10.1001/jamainternmed.2023.5961.

Overnight Stay in the Emergency Department and Mortality in Older Patients

Melanie Roussel [1], Dorian Teissandier [2], Youri Yordanov [3 4], Frederic Balen [5], Marc Noizet [6], Karim Tazarourte [7], Ben Bloom [8], Pierre Catoire [2 4], Laurence Berard [9], Marine Cachanado [9], Tabassome Simon [4 9], Said Laribi [10], Yonathan Freund [2 4]; FHU IMPEC-IRU SFMU Collaborators; FHU IMPEC–IRU SFMU Collaborators

Conclusions and relevance: The findings of this prospective cohort study indicate that for older patients, waiting overnight in the ED for admission to a ward was associated with increased in-hospital mortality and morbidity, particularly in patients with limited autonomy. Older adults should be prioritized for admission to a ward.

Hechos

Observational Study › Am J Emerg Med. 2023 Apr:66:105-110. doi: 10.1016/j.ajem.2023.01.040. Epub 2023 Jan 26.

Association of delirium with increased short-term mortality among older emergency department patients: A cohort study

Mariah L Arneson [1], Lucas Oliveira J E Silva [2], Jessica A Stanich [3], Molly M Jeffery [4], Heidi L Lindroth [5], Alexander D Ginsburg [6], Susan M Bower [7], Aidan F Mullan [8], Fernanda Bellolio [9]

Results: A total of 967 ED visits were included for analysis among which delirium was detected in 107 (11.1%). The median age of the cohort was 83 years (IQR 79, 88), 526 (54.4%) were female, 285 (29.5%) had documented dementia, and 171 (17.7%) had a high acuity Emergency Severity Index triage level 1 or 2. During the hospitalization, 5/107 (4.7%) of those with delirium and 4/860 (0.5%) of those without delirium died. Within 7 days of ED departure, 6/107 (5.6%) of those with delirium and 6/860 (0.7%) of those without delirium died (unadjusted OR 8.46, 95% CI 2.68-26.71). Within 30 days, 18/107 (16.8%) of those with delirium and 37/860 (4.3%) of those without delirium died (unadjusted OR 4.50, 95% CI 2.46-8.23). ED delirium remained associated with higher 7-day (adjusted OR 5.23, 95% CI 1.44-19.05, p = 0.008) and 30-day mortality (adjusted OR 2.82, 95% CI 1.45-5.46, p = 0.002).

Hechos

HEALTH IN AGING FOUNDATION
THE OFFICIAL FOUNDATION OF THE AMERICAN GERIATRICS SOCIETY

Geriatric 5Ms	Focus Areas
Mind	■ Maintaining mental activity ■ Helping manage dementia (a decline in memory and other mental abilities that make daily living difficult) ■ Helping treat and prevent delirium (an abrupt, rapid change in mental function that goes well beyond the typical forgetfulness of aging) ■ Working to evaluate and treat depression (a mood disorder that can interfere with all aspects of your daily life)
Mobility	■ Maintaining the ability to walk and/or maintain balance ■ Preventing falls and other types of common injuries
Medications	■ Reducing polypharmacy (the medical term for taking several medications) ■ De-prescribing (the opportunity to stop unnecessary medications) ■ Prescribing treatments exactly for an older person's needs ■ Helping build awareness of harmful medication effects
Multi-Complexity	■ Helping older adults manage a variety of health conditions ■ Assessing living conditions when they are impacted by age, health conditions, and social concerns
Matters Most	■ Coordinating advance care planning ■ Helping manage goals of care ■ Making sure that a person's individual, personally meaningful health outcomes, goals, and care preferences are reflected in treatment plans

*© Frank Molnar & Allen Huang, University of Ottawa; Mary Tinetti, Yale University

Hechos

Randomized Controlled Trial › PLoS One. 2024 Jul 31;19(7):e0304397. doi: 10.1371/journal.pone.0304397. eCollection 2024.

Training and provision of mobilit autonomy and mobility of older p geriatric emergency department: randomized controlled trial

Fernanda Sato Polesel [1], Sâmia Denadai [1], Márlon Juliano Rom Christian Valle Morinaga [4], Mario Chueire de Andrade-Junior [1], Wellington Pereira Yamaguti [1], Pedro Kallas Curiati [4], Renato Fr

Abstract

Older adults have higher rates of emergency department (ED) admissions when compared to their younger counterparts. Mobility is the ability to move around, but also encompasses the environment and the ability to adapt to it. Walking aids can be used to improve mobility and prevent falls. According to international guidelines, they must be available in Geriatric EDs. This study aims to evaluate the efficacy of a program of training and provision of walking aids (WA), associated or not with telemonitoring, on fear of falling, mobility, quality of life and risk of falls up to 3 and 6 months in older adults cared for in an ED. A randomized controlled trial will be carried out in the ED. Participants will be randomized and allocated into three groups, as follows: A) walking aid group will be trained for the use of a walking aid and receive guidance on safe gait; B) walking aid and telemonitoring group will receive training for the use of a walking aid, guidance on safe gait, and telemonitoring (every two weeks for first three months); C) Control group will receive only guidance on safe gait. Patients will undergo a baseline evaluation encompassing sociodemographic and clinical data, mobility in life spaces, gait speed, muscle strength, functionality, quality of life, fear of falling, history of falls, cognition and mood before the intervention. Gait time and fear of falling will be assessed again after the intervention in ED. Finally, mobility in life spaces, functionality, quality of life, fear of falling, history of falls, cognition, and mood will be assessed 3 and 6 months after discharge from the geriatric ED through a telephone interview. Provision of walking aids in the geriatric ED is currently recommended. This study will be the first randomized controlled trial that will evaluate the impact of training and provision of these devices in the ED. Trial registration number: NCT05950269.

Hechos

Observational Study › J Am Geriatr Soc. 2024 Aug:72 Suppl 3:S60-S67. doi: 10.1111/jgs.18947. Epub 2024 May 8.

Initiative to deprescribe high-risk drugs for older adults presenting to the emergency department after falls

Katherine Selman [1], Ellen Roberts [2 3], Joshua Niznik [2 3 4], Greta Anton [5], Casey Kelley [2 3], Kalynn Northam [6], Brittni B Teresi [5], Martin F Casey [5], Jan Busby-Whitehead [2 3], Kathleen Davenport [5]

Background: Over 35 million falls occur in older adults annually and are associated with increased emergency department (ED) revisits and 1-year mortality. Despite associations between medications and falls, the prevalence of fall risk-increasing drugs remains high. Our objective was to implement an ED-based medication reconciliation for patients presenting after falls and determine whether an intervention targeting high-risk medications was related to decreased future falls.

Conclusions: Our findings identified opportunities for medication optimization in over half of emergency visits for falls and demonstrated that medication counseling in the ED is feasible. However, evaluation of the effect on future falls was limited.

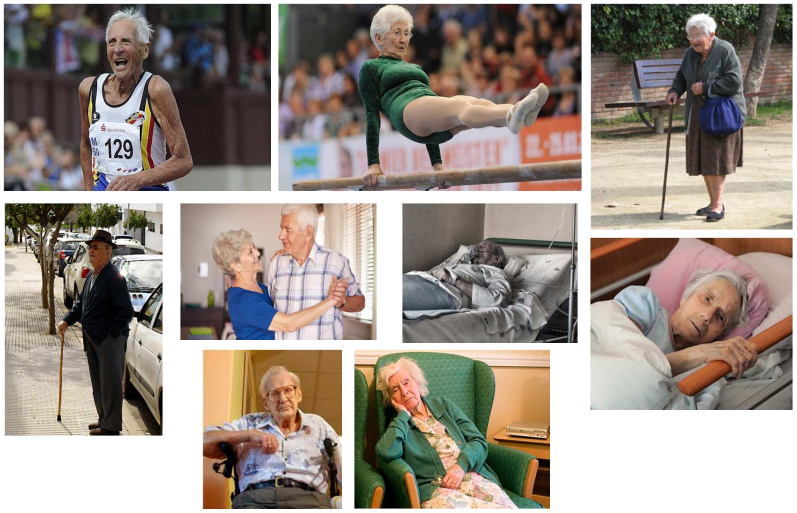
Problemas éticos en la atención urgente del paciente mayor

- ¿Es adecuado que los pacientes mayores esperen el ingreso en planta según su turno de llegada?
- ¿Es aceptable no identificar el delirium en pacientes mayores durante su atención hospitalaria?
- ¿Es beneficioso para los pacientes mayores el reposo en cama durante un evento agudo de salud?
- ¿Es apropiado el uso de recursos y tiempo para revisar la polifarmacia en pacientes mayores durante una atención urgente?

Problemas éticos en la atención urgente del paciente mayor

¿Es adecuado tratar a los pacientes mayores igual que a los adultos jóvenes durante su atención en un servicio de Urgencias hospitalarias?

¿Qué es un paciente mayor?



Multi-complejidad
Multidisciplinariedad

- Servicio de Farmacia
- Personal de enfermería de Urgencias
  - Triaje
  - Boxes
- Personal de enfermería de Geriatría
- TCAEs
- Trabajo social
- Médicos de Urgencias
- Geriatras
- Servicio de Admisión
- Servicios interconsultores

Perspectivas de futuro

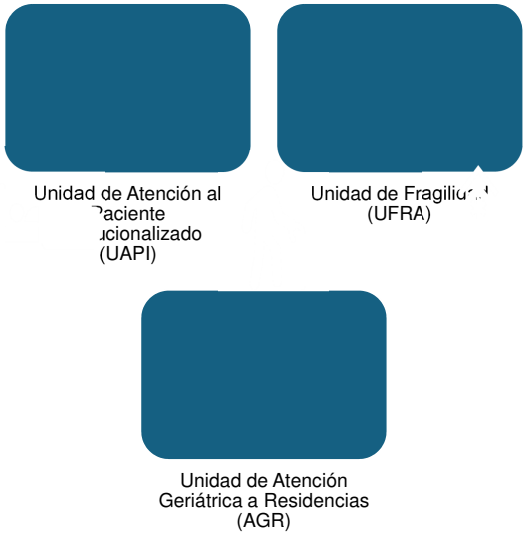
› BMJ Open. 2024 May 2;14(5):e083372. doi: 10.1136/bmjopen-2023-083372.

Hospital at home for elderly acute patients: a study protocol for a randomised controlled trial

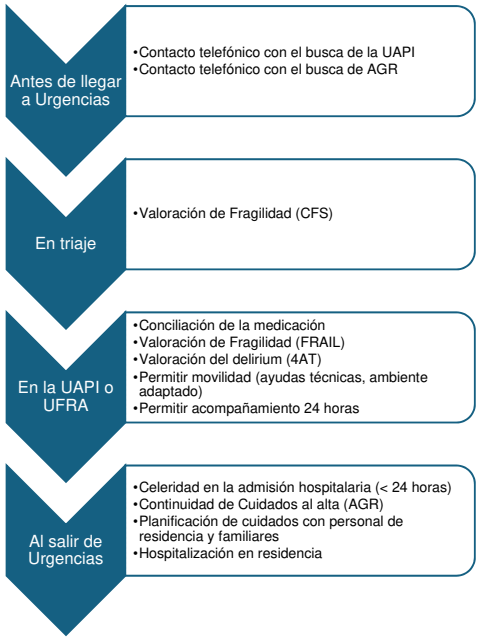
Anne Marie Ladehoff Thomsen [1 2], Nasrin Tayyari [3 4], Iben Duvald [5 6], Hans Kirkegaard [7], Børge Obel [8], Camilla Palmhøj Nielsen [3 2]

Introduction: The increasing elderly population has led to a growing demand for healthcare services. A hospital at home treatment model offers an alternative to standard hospital admission, with the potential to reduce readmission and healthcare consumption while improving patients' quality of life. However, there is little evidence regarding hospital at home treatment in a Danish setting. This article describes the protocol for a randomised controlled trial (RCT) comparing standard hospital admission to hospital at home treatment. The main aim of the intervention is to reduce 30-day acute readmission after discharge and improve the quality of life of elderly acute patients.

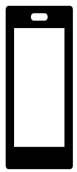
Adaptación de la estructura del servicio



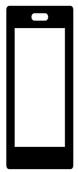
Integración de la atención al paciente mayor Servicio de Urgencias y Servicio de Geriatría HUPHM



Antes de llegar a Urgencias



UAPI
Hasta las 23:00 horas



AGR
24 horas/7 días

En triaje

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

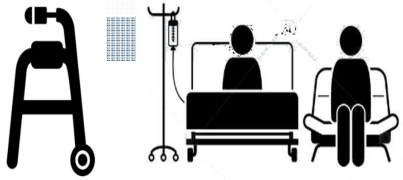
In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

DALHOUSIE UNIVERSITY
Inspiring Minds

UAPI y UFRA

Escala FRAIL (Fatigue – Resistance – Ambulation – Ilnessess – Loss of weight)		
En las últimas 4 semanas, ¿Se ha sentido usted más cansado?	SI	NO
¿Es incapaz de subir un piso de escaleras (10 escalones) sin ayudas?		
¿Es incapaz de caminar una manzana? (varios cientos de metros)		
Comorbilidades (5 o más): HTA DM EPOC Asma Angina ICC IAM Artritis Cáncer (excepto piel no melanoma) Ictus ERC		
ás del 5% de su peso en los últimos 12		
		3-5:



Al salir de la Urgencia

- Ingreso en planta de Geriatría
- AGR
- Hospitalización en residencias (HADG)

Conclusiones

- El paso por urgencias es un episodio de especial vulnerabilidad para el paciente mayor
- Hay que asegurar una transición de cuidados adecuada entre urgencias y otro niveles asistenciales

- Para ello hay que pasar de la ética de teorías, valores y principios a la ética de la realidad
- La ética clínica se considera una subespecialidad de la bioética, y se refiere a la toma de decisiones en el día a día de aquellos que atienden al paciente.

¿preguntas?

Muchas Gracias

armando.pardo@salud.madrid.org

Hospital Universitario
Puerta de Hierro Majadahonda