
XIII congresso nazionale
simeu
GENOVA 30 MAG - 1 GIU 2024
I.MEU
I.MEU
SOCIETÀ ITALIANA MEDICINA D'EMERGENZA-URGENZA
SIMEU

SABATO 1' GIUGNO 2024

9,00 – 10,30 **SALA GRECALE** **ETICA E CLINICA**

Moderatore: Beniamino Susi – Massimo A. Geraci

○ Il Boarding	*Massimo A. Geraci*
○ La desistenza negli anziani	*Mario Guarino*
○ Cura VS assistenza	*Davide Tizzani*

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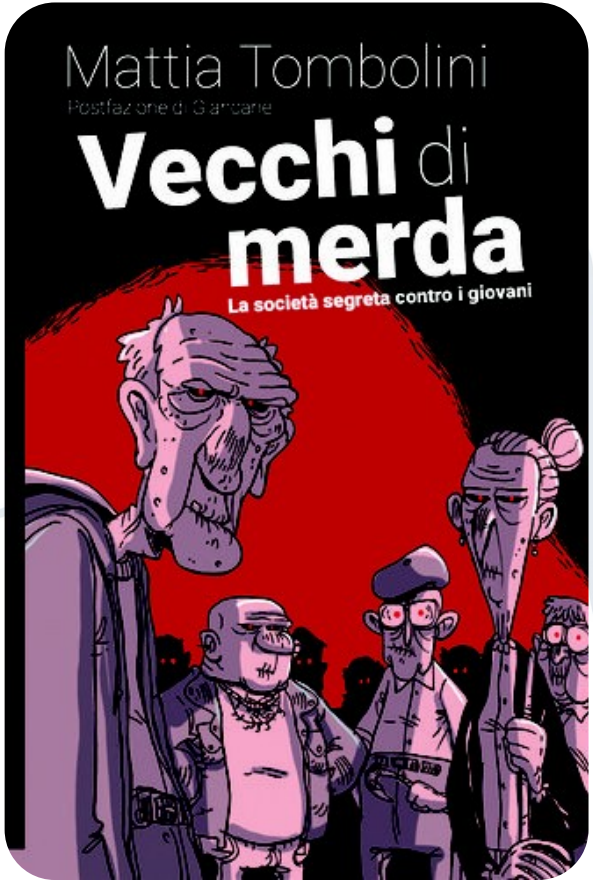
... dalla «resistenza» alla «desistenza»

… da Assuntulella a Babbo



Crostino
Casatiello
Tortano senza ‘nzogna
Scuorteco
‘Nfrancesato

Centro Traumatologico Zonale - Pronto Soccorso - C.T.O.

Responsabile Dr.: GUARINO MARIO

Verbale di accettazione e delle Prestazioni Sanitarie

Servizio di Pronto Soccorso **Ingresso N° 20240016446**

Cognome e Nome	[redacted] ANTONINO	**Sesso** M	età 94 anni
Data e luogo di nascita			
Residenza	NAPOLI		
Telefono	081/546241		NNN29S08F158S

Problema principale: Dolore addominale

Modalità Accesso: Autonomo (arrivato con mezzi propri)

Causa dichiarata all'accettazione: EPIGASTRALGIA

Inviato da: Decisione propria (di un genitore se minorenne)

Data Triage		Data Visita		Data Uscita	
10/05/2024	11:32	10/05/2024	12:34	10/06/2024	17:28

Urgenza triage: GIALLO **Urgenza dimissione:** GIALLO

Anamnesi:

Dott. : URSI MARIA PAOLA
10/05/2024 13:22

In PS per riferita epigastralgia da due giorni
in anamnesi: scompenso cardiaco ,FA , demenza senile
TD Pantorc , Provigil, Cerebrain ,Triatec 5 mg. Torvast 20 mg Lasix 25 mgX2. Luvion 50 mg. Debridat 1 cp x3/die, Eliquis 2.5 mgX2.
NEGA FARMACOALLERGIE
non assume eliquis da una settimana a detta del figlio

Esame Obiettivo:

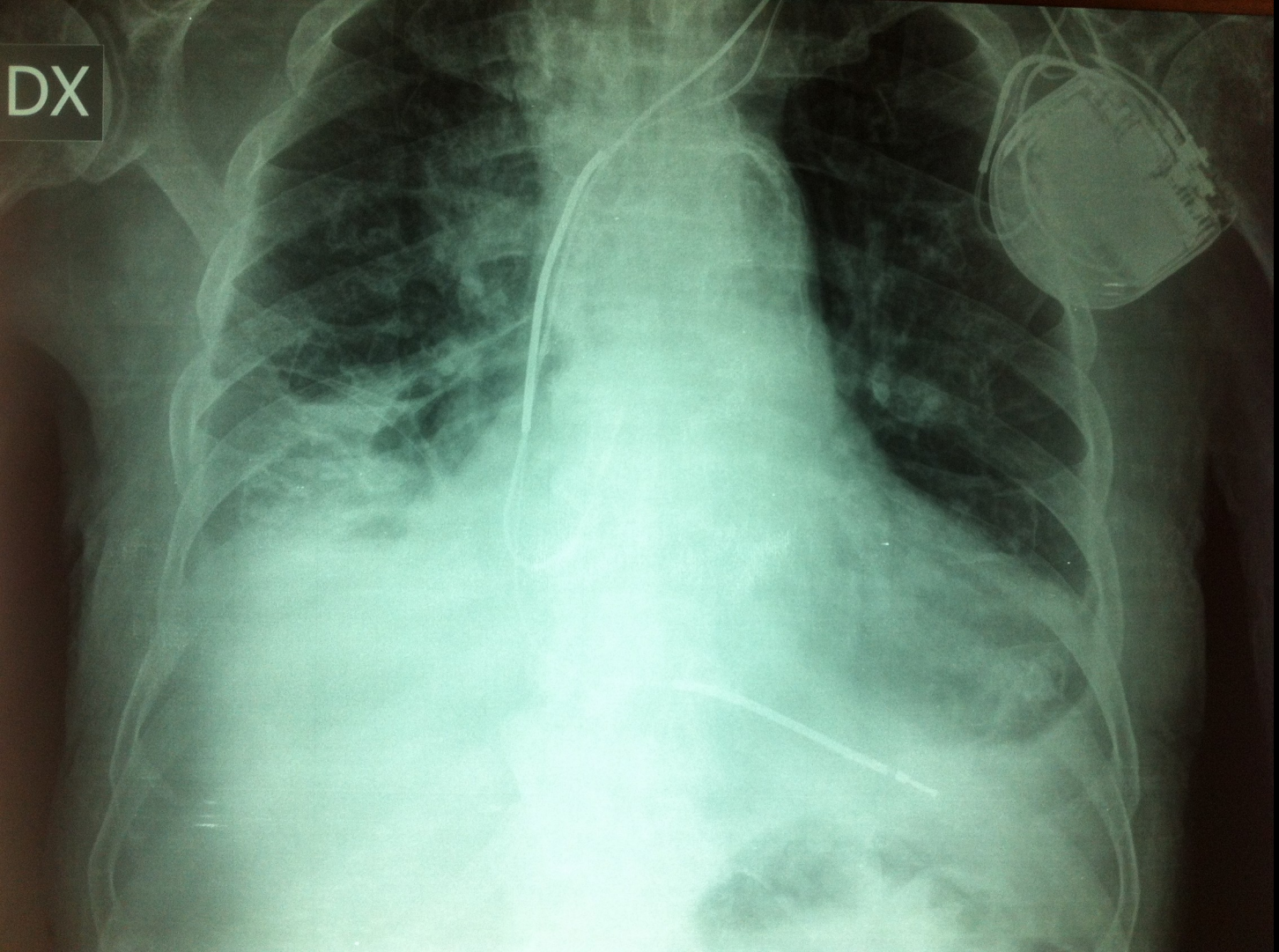
Dott. : URSI MARIA PAOLA
10/05/2024 14:15

Dott. : COSTANZO ANITA
10/05/2024 17:02

Dott. : URSI MARIA PAOLA
10/05/2024 13:24

vigile
EOC:Attività cardiaca aritmica
EOT:MV abolito in sede medio basale bilaterale
EOA: addome trattabile non dolente alla palpazione sup e profonda peristalsi presente no edemi
EOC FAST .VCI nella norma per decorso e calibro , normo collassante , assenza di versamento ascitico , e/o pericardico : Non evidenza alterazioni strutturali allo stato attuale a carico di fegato e milza;Reni in sede di normali dimensioni con spessore parenchimale conservato in assenza di urostasi ; quadro polmonare A - profile , sliding sign presente su tutto l'ambito esplorato .Aorta addominale per quanto esplorabile nella norma per decorso e calibro in assenza di dilatazioni patologiche per i segmenti esplorati . VERSAMENTO PLEURICO MODERATO BILATERALE





Instrumentation Laboratory

CAMPIONE PAZIENTE

P.O. S. Paolo
U.O. PRONTO SOCCORSO

Stato: VALIDATO
09/08/2014 15:56:03
Tipo campione:
Altro
Campione No.: 16
Paziente:
Sesso: S
Strumento:
Modello: GEM 3000
S/N: 22681
Nome: PO ''S. PAOLO

Misurati (37.0C)

pH		7.57	
pCO2		44	mmHg
pO2		78	mmHg
Na+		138	mmol/L
K+		3.7	mmol/L
Ca++		1.05	mmol/L
Glu		344	mg/dL
Lat		3.2	mmol/L
?Hct	<	15	%

Parametri derivati

Ca++(7.4)	1.13	mmol/L
HCO3-	40.3	mmol/L
HCO3std	37.7	mmol/L
TCO2	41.7	mmol/L
BEecf	18.3	mmol/L
BE(B)	16.4	mmol/L
SO2c	97	%
?THbc	-----	

?=Rivedere

Centro Traumatologico Zonale - Pronto Soccorso - C.T.O.
Responsabile Dr.: GUARINO MARIO

Verbale di accettazione e delle Prestazioni Sanitarie

Servizio di Pronto Soccorso **Ingresso N° 20240010883**

Cognome e Nome ASSUNTA **Sesso** F **età** 102 anni
Data e luogo di nascita 921 NAPOLI
Residenza
Telefono

Problema principale: Trauma
Data e ora del trauma: 28/03/2024 19:30
Luogo evento: Casa **Circostanze del trauma:** Incidente domestico

Modalità Accesso: Altra Ambulanza

Causa dichiarata all'accettazione: presenta SLO femore SX post caduta con trauma cranico non commotivo, nega altri traumi

Inviato da: Decisione propria (di un genitore se minorenne)

Data Triage		Data Visita		Data Uscita	
29/03/2024	12:34	29/03/2024	14:35	29/03/2024	17:26

Urgenza triage: GIALLO **Urgenza dimissione:** GIALLO

Anamnesi:

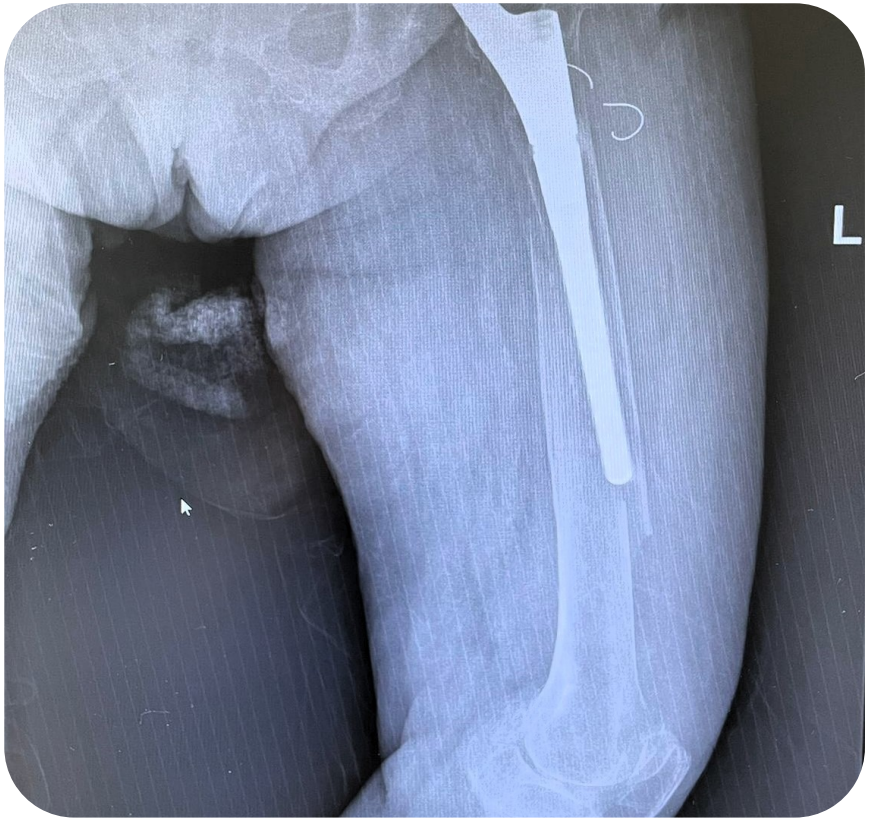
Dott. : CRISTIANO GIOVANNA 29/03/2024 14:36
Giunge in PS per caduta accidentale in casa
Intervento di protesi all anca sx circa 7 aa fa
riferiscce cabaratta bilaterale
nega patologie degne di nota
nega farmacoallergie

Esame Obiettivo:

Dott. : CRISTIANO GIOVANNA 29/03/2024 15:10
Pz vigile ed orientata
Cute asciutta, mucose normoperfuse
PA: 110/60 mmHg; Fc: Gc: 70 bpm, Spo*:97% in aa a, apiretica
Torace: lieve dolorabilità in corrispondenza dell'emitoarce di sx, MV fisiologico su tutto l'ambito polmonare
Cuore: toni puri pause libere
Addome: trattabile, non dolente, peristasli valida
Lieve succulenza ad entrambi gli arti inferiori

Esami:
VISITA DI PRONTO SOCCORSO 29/03/2024 14:35

Accertamenti:	2-Saturazione (O2/FIO2)	3-Freq. Respiratoria	4-Freq. Cardiaca (bpm)	5-Pressione arteriosa	6-GCS	7-Temperatura (°C)
29/03/2024 12:34	97 / 21	16	68	62 / 110	16	36.2



What is ageism?

Ageism consists of all stereotypes, prejudice and discrimination based on a person's age.

It affects people of all ages, both young and old, but it is most common with **older people.**



Banks

The **closure of branches** and **the rapid digitization** associated with the pandemic have discriminated against older people. For example, face-to-face services have been reduced.

Algorithms

The algorithms underpinning artificial intelligence **suffer from biases detrimental to older people**. For example, they do not include sufficient observations on this age group.

Media and advertising

Older people **are under-represented** and any actual depictions can be **fairly stereotypical**.

Data

Some public statistics **exclude older peoples**, leading to problems in public decision-making due to the lack of accurate information.



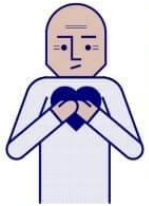
Digital design

The design of digital services often **overlooks older people** because it is assumed either that they are not interested or able to learn, get to grips with and gain an in-depth understanding of the digital world.

Job market

Long-term unemployment of the over **45** is a form of ageism.

Likewise, the high unemployment rate for young people in Spain is linked, in part, to age discrimination.



Health services

The treatment given to older people admitted to hospital may be discriminatory: **certain treatments are not given to older people**.

Clinical trials

Many clinical trials are conducted with young people or young adults. **Initial trials of COVID-19 vaccines excluded those aged over 65**. Also, children were given access to the vaccine much later.

References

Ayalon, L., & Tesch-Römer, C. (2018). Contemporary Perspectives on Ageism. Springer Nature. (Open access). DOI: https://doi.org/10.1007/978-3-319-73820-8.

World Health Organization (2021): Global Report on Ageism. Available in 5 languages at https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/combatting-ageism/global-report-on-ageism (consulted: 16 January 2022).

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uoc.edu

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CNSC

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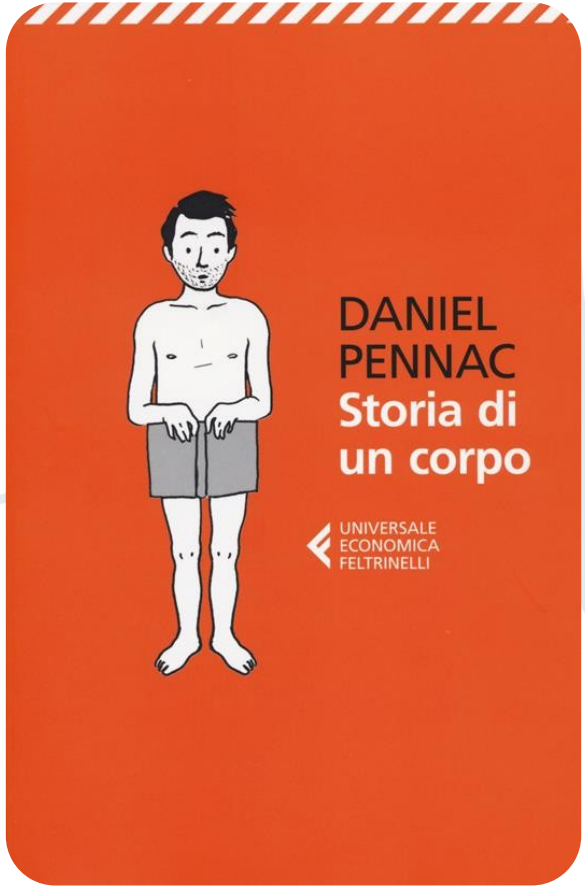


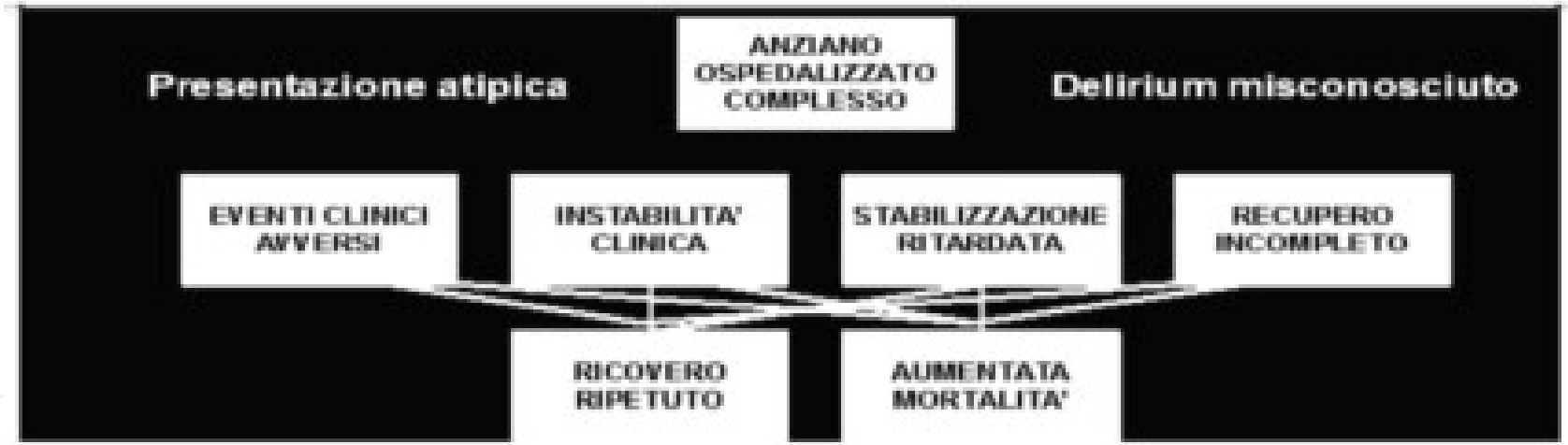
86 anni, 11 mesi, 4 giorni *Martedì 14 settembre 2010*

Più mi avvicino al termine, più ci sono cose da annotare, e meno ne ho la forza. Il mio corpo cambia di ora in ora. La sua disgregazione si accelera man mano che le funzioni rallentano. Accelerazione e rallentamento... Mi sento come una moneta che finisce di ruotare su se stessa.

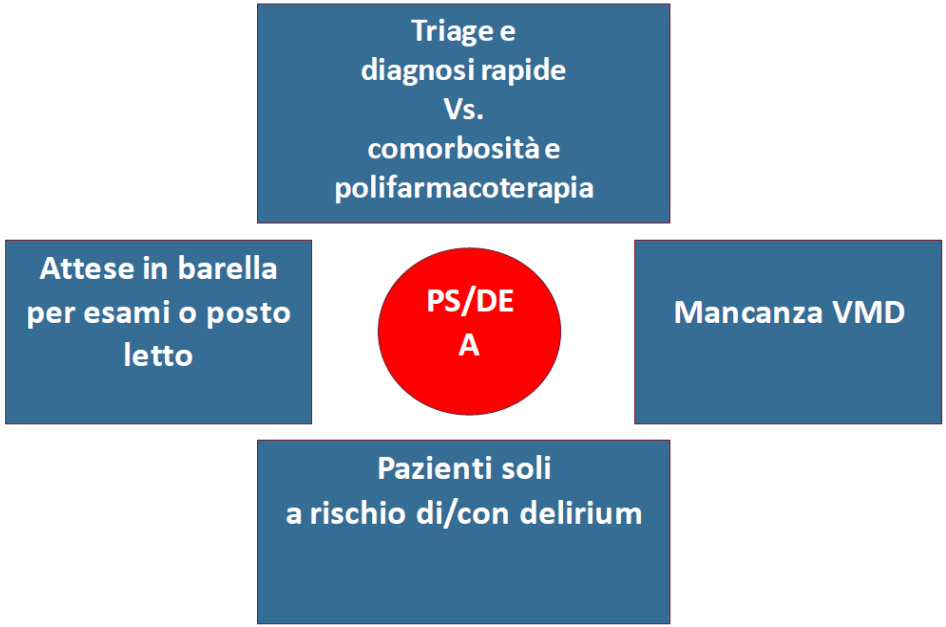


Raccomandazioni per la valorizzazione del caregiver in Pronto Soccorso:

- *Riconoscimento formale da parte dei professionisti sanitari della figura del caregiver, quale componente integrante, non professionale, del benessere e della rete di assistenza domiciliare alla persona (30, 31, 36)*
- *Adozione di un approccio di partecipazione proattiva del caregiver, già dall'ingresso del paziente in Pronto Soccorso, nei processi decisionali d'assistenza e cura (30), attraverso informazioni continue e tempestive, specie per i pazienti con limitazioni cognitive (36)*
- *Coinvolgimento nella valutazione, definizione e realizzazione del Piano Assistenziale Individuale (PAI) multidisciplinare, individuando il contributo di cura e delle attività di cui il caregiver può farsi carico in maniera appropriata e senza rischi per l'assistito e per se stesso, previo consenso della persona assistita (30)*
- *Fornire informazioni puntuali ed esaurienti sulle problematiche dell'assistito (36), sui bisogni assistenziali e sulle cure necessarie nonché sulle diverse opportunità e risorse esistenti nel territorio che possano essere di sostegno all'assistenza e alla cura (30)*
- *Durante il processo di dimissione, provvedere all'educazione sanitaria e counseling per il self-management (33) permettendo al caregiver di svolgere l'attività di sostegno del paziente*
- *Fornire istruzioni chiare e scritte in riferimento alle informazioni verbali, dando tempo al caregiver ed al paziente di comprenderle (33)*
- *Educare il caregiver all'adozione di azioni al fine di sostenerlo nella ricerca e mantenimento del benessere e dell'equilibrio personale e familiare (31)*


ANZIANO OSPEDALIZZATO COMPLESSO
Presentazione atipica
Delirium misconosciuto
EVENTI CLINICI AVVERSI
INSTABILITA' CLINICA
STABILIZZAZIONE RITARDATA
RECUPERO INCOMPLETO
RICOVERO RIPETUTO
AUMENTATA MORTALITA'

Problematiche degli anziani in DEA/PS



Liew et al. BMC Geriatrics (2024) 24:137
https://doi.org/10.1186/s12877-024-04724-9

BMC Geriatrics

RESEARCH Open Access

A novel scale for triage assessment of frailty in the emergency department (ED-FraS): a prospective videotaped study

Chiat Qiao Liew[1†], Yun Chang Chen[4†], Chih-Wei Sung[2,3], Chia-Hsin Ko[1], Nai-Wen Ku[5], Chien-Hua Huang[1,2], Ming-Tai Cheng[2,4*] and Chu-Lin Tsai[1,2*]

Conclusions

In conclusion, we developed and validated a novel ED-Fras tool that is simple and easy to administer as a screening tool for identifying frail older adults in the ED. Its straightforward design and proven validity and reliability make it a promising frailty assessment tool in the ED. The ED-FraS can also complement and enhance current triage systems. Further research is needed to test its real-time use at ED triage.

Table 1 The Emergency Department Frailty Scale (ED-FraS)

	Level	Description
Level 1 	1 Healthy	Individuals exhibiting positive well-being and agility, with no apparent constraints on their range of motion
Level 2 	2 Chronic Conditions	Individuals with well-managed chronic conditions (e.g., diabetes mellitus or hypertension) may exhibit slightly reduced mobility, yet no significant limitations in their range of motion are observed
Level 3 	3 Mildly Frail	Individuals with noticeably sluggish or limited body movement may require assistive devices but not the help of others. They are able to walk independently, occasionally needing a hand-held walker for support. Their cognitive function and reaction times may be observed as delayed at times
Level 4 	4 Moderately Frail	Individuals requiring assistance for mobility and unable to walk independently. They are characterized by delayed cognitive function and reaction times, which may be inefficient and time-consuming, yet they remain capable of communication. This category typically includes those who need a wheelchair for transfers (e.g., entering the emergency department), and/or require a dedicated caregiver for mobility assistance
Level 5 	5 Severely Frail	Individuals who are completely dependent on others for mobility (e.g., bedridden) or unable to communicate due to cognitive impairment

When evaluating a patient with varying degrees of impairment across different dimensions (e.g., mobility and cognition dimensions), the assessment should be based on the most severe aspect of the patient's condition

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L'anziano in PS

-Necessità e attitudine a concentrarsi su un solo sintomo
-Somministrazione di farmaci in acuto per rapida risoluzione sintomatologica
-Rapida acquisizione di informazioni
-Lunghi tempi d'attesa, attività frenetica
-Rapida comunicazione di prescrizioni terapeutiche

→ Presentazione atipica di malattie comune

→ Comorbosità

→ Polifarmacoterapia con conseguente rischio di interazioni farmacologiche e di reazioni avverse

→ Inadeguato supporto sociale e talora assenza di un care-giver → dati anamnestici approssimativi

→ Modifica dello stato funzionale

Presenza di declino cognitivo, talora misconosciuto, e possibile presenza di delirium in PS

Received: 7 March 2023 | Accepted: 29 March 2023
DOI: 10.1111/jgs.18372

SPECIAL ARTICLES

Journal of the American Geriatrics Society

American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults

By the 2023 American Geriatrics Society Beers Criteria® Update Expert Panel

Deprescribing

Successful deprescribing of medications on the AGS Beers Criteria® involves much more than a clinician simply telling an older person to stop taking a medication. Communication gaps and misunderstandings, patient reluctance and fear of stopping, coordination among multiple clinicians, dosage tapering, withdrawal symptoms, and conveying stop orders to pharmacies are just some of the challenges that can arise. The panel encourages clinicians to be aware of and develop skills to address these challenges. Useful resources include:

- https://deprescribing.org/resources/—deprescribing resources, especially evidence-based guidelines and easy-to-use algorithms about when and how to stop common types of medications
- https://www.deprescribingnetwork.ca/professionals—resources for healthcare professionals, including deprescribing-oriented patient handouts about medications that are commonly inappropriate for older adults

Systemic solutions are essential as well, for example increasing the adoption of the CancelRx Script Standard to communicate to pharmacies when a drug is stopped and should no longer be refilled.

Key points

- The intention of the AGS Beers Criteria® is to: (1) reduce older adults' exposure to potentially inappropriate medications (PIMs) by improving medication selection; (2) educate clinicians and patients; and (3) serve as a tool for evaluating the quality of care, cost, and patterns of drug use in older adults.
- The target audience for the 2023 AGS Beers Criteria® is practicing clinicians and others who utilize the criteria including healthcare consumers, researchers, pharmacy benefits managers, regulators, and policymakers.
- The criteria are intended to be applied to adults 65 years old and older in all ambulatory, acute, and institutionalized settings of care, except hospice and end-of-life care settings.

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Eventi avversi durante la degenza ospedaliera

•Delirium incidente in aggiunta a delirium prevalente non diagnosticato (25-60%) con peggioramento degli outcomes a breve e lungo termine

•Declino funzionale (34-50%) con peggioramento degli outcomes a breve e lungo termine

•Reazioni avverse alla farmacoterapia (54%) con peggioramento degli outcomes a breve e lungo termine

•Infezioni nosocomiali (17%) con peggioramento degli outcomes a breve e lungo termine

•Cadute (15%) con peggioramento degli outcomes a breve e lungo termine

•Comparsa lesioni da pressione (< 15%) con peggioramento degli outcomes a breve e lungo termine

Si evidenzia come la degenza ospedaliera possa essere foriera di rilevanti effetti negativi sull'anziano.

Il possibile peggioramento degli outcomes a breve e lungo termine implica Valutazioni sia sul piano etico che clinico che socio-economico (maggior carico assistenziale nel post-ricovero) e induce ad alcune riflessioni negative sulla facilità con la quale tali pazienti accedono alle strutture per Acuti.

Intern Emerg Med (2018) 13:113–121
https://doi.org/10.1007/s11739-017-1705-x

CE - ORIGINAL

Italian intersociety consensus on prevention, diagnosis, and treatment of delirium in hospitalized older persons

Giuseppe Bellelli[1] · Alessandro Morandi[1] · Marco Trabucchi[1] · Guido Caironi[2] · Daniele Coen[2] · Carlo Fraticelli[2] · Ciro Paolillo[2] · Carolina Prevaldi[2] · Angela Riccardi[2] · Gianfranco Cervellin[2] · Corrado Carabellese[3] · Salvatore Putignano[3] · Stefania Maggi[4] · Antonio Cherubini[4] · Paola Gnerre[5] · Andrea Fontanella[5] · Nicola Latronico[6] · Concezione Tommasino[6] · Antonio Corcione[6] · Giovanni Ricevuti[7] · Nicola Ferrara[7] · Francesco De Filippi[8] · Alberto Ferrari[8] · Mario Guarino[9] · Maria Pia Ruggieri[9] · Pietro Amedeo Modesti[10,14] · Carlo Locatelli[11] · Patrizia Hrelia[11] · Marco Otto Toscano[12] · Emi Bondi[12] · Antonio Tarasconi[13] · Luca Ansaloni[13] · Francesco Perticone[10]

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Keywords Clinical management · Consensus · Delirium · Cognitive decline

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Strumenti: VMD

- VMD all'ingresso per avere una
- stratificazione prognostica per determinare la
- creazione di un percorso diagnostico-terapeutico appropriato nella scelta delle indagini, dei trattamenti, adeguate alla "traiettoria" clinica del paziente nel rispetto di tempistiche rapide e contestuale
- pianificazione della dimissione

Gruppo di Lavoro

Società Scientifiche e altre Istituzioni

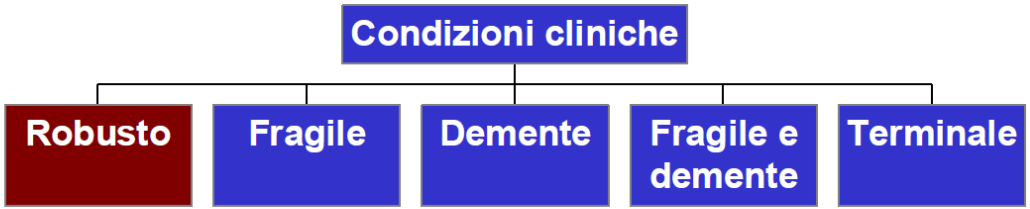
Società Italiana di Medicina Generale e Cure Primarie (SIMG) **(promotore)**
Società Italiana di Geriatria Ospedale e Territorio (SIGOT) **(promotore)**
Istituto Superiore di Sanità **(garante metodologico)**
AIOM - Associazione Italiana Oncologia Medica
AIP - Associazione Italiana di Psicogeriatria
Cittadinanzattiva
FAISF - Federazione Italiana delle Associazioni Scientifiche di Fisioterapia
FLI - Federazione Logopedisti Italiani
FNOPI - Federazione Nazionale Degli Ordini Delle Professioni Infermieristiche
SICG - Società Italiana Chirurgia Geriatrica
SICGe - Società Italiana di Cardiologia Geriatrica
SICP - Società Italiana di Cure Palliative
SIMI - Società Italiana di Medicina Interna,
SIGG- Società Italiana di Gerontologia e Geriatria
SIMEU - Società Italiana Medicina Emergenza e Urgenza
SIMFER - Società Italiana di Medicina fisica e riabilitativa,
SIMIT- Società Italiana di Malattie Infettive e tropicali
SIN - Società Italiana Nefrologia,
SIN - Società Italiana Neurologia
SIMdem - Associazione Autonoma Aderente alla SIN per le Demenze
SIOT - Società Italiana di Ortopedia Traumatologia,
SPI - Società Italiana di Psicologia
SITI - Società Italiana di Igiene, Medicina Preventiva e Sanità Pubblica
SITO - Società Tecnico-Scientifica Italiana di Terapia Occupazionale
SIU - Società Italiana di Urologia
SoiSS - Società Italiana di Servizio Sociale

Linea Guida

La valutazione multidimensionale della persona anziana

#	Raccomandazione	FORZA DELLA RACCOMANDAZIONE
R5a.1	Si raccomanda di usare la valutazione multidimensionale al fine di ridurre il tasso di ricovero in strutture residenziali nei pazienti anziani che afferiscono a reparti di area medica.	**POSITIVA FORTE**
R5a.2	Si raccomanda di non usare la valutazione multidimensionale al solo scopo di ridurre il tasso di mortalità o di re-ospedalizzazione nei pazienti anziani che afferiscono a reparti di area medica.	**NEGATIVA FORTE**

Tipizzazione e stratificazione dei pazienti geriatrici



Gillick 2001

La stratificazione (categorizzazione) dei pazienti secondo il loro stato di funzionale e di salute permette la definizione di outcomes ragionevoli diversi e la definizione di un ranking di priorita.

Lo stato di salute premorboso

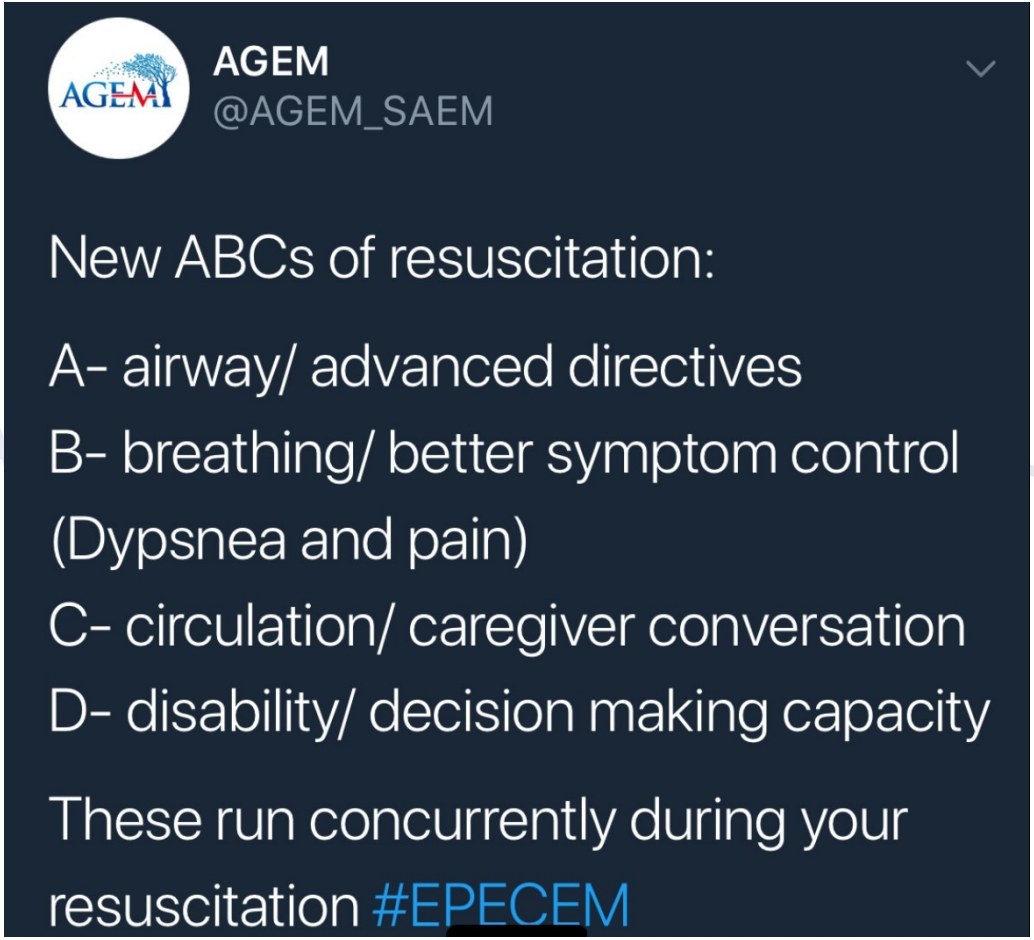
Lo stato di salute (il background clinico)

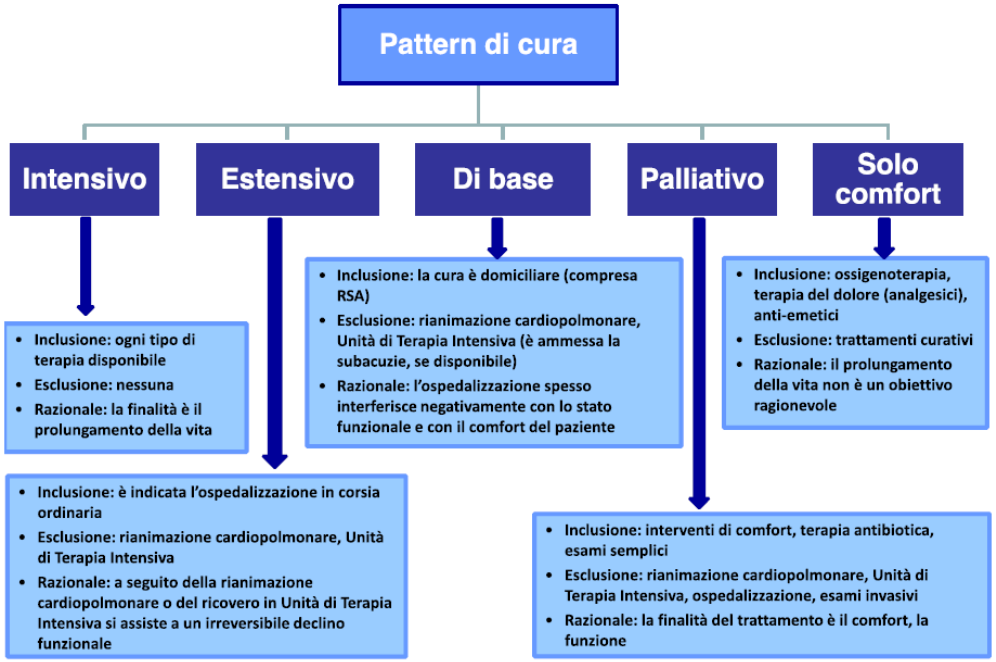
Il paziente robusto
- Non disabile (BADL=0/6)
- Senza demenza (MMSE≥18)

Il paziente fragile
- Con disabilità (BADL=1+/6)

Il paziente con demenza
- ▼cognitività (MMSE<18)

Il paziente fragile&con demenza
- Con disabilità (BADL=1+/6)
- ▼cognitività (MMSE<18)


AGEM
@AGEM_SAEM
New ABCs of resuscitation:
A- airway/ advanced directives
B- breathing/ better symptom control (Dypsnea and pain)
C- circulation/ caregiver conversation
D- disability/ decision making capacity
These run concurrently during your resuscitation #EPECEM


Pattern di cura
Intensivo
Estensivo
Di base
Palliativo
Solo comfort
Inclusione: ogni tipo di terapia disponibile
Esclusione: nessuna
Razionale: la finalità è il prolungamento della vita
Inclusione: è indicata l'ospedalizzazione in corsia ordinaria
Esclusione: rianimazione cardiopolmonare, Unità di Terapia Intensiva
Razionale: a seguito della rianimazione cardiopolmonare o del ricovero in Unità di Terapia Intensiva si assiste a un irreversibile declino funzionale
Inclusione: la cura è domiciliare (compresa RSA)
Esclusione: rianimazione cardiopolmonare, Unità di Terapia Intensiva (è ammessa la subacuzie, se disponibile)
Razionale: l'ospedalizzazione spesso interferisce negativamente con lo stato funzionale e con il comfort del paziente
Inclusione: interventi di comfort, terapia antibiotica, esami semplici
Esclusione: rianimazione cardiopolmonare, Unità di Terapia Intensiva, ospedalizzazione, esami invasivi
Razionale: la finalità del trattamento è il comfort, la funzione
Inclusione: ossigenoterapia, terapia del dolore (analgesici), anti-emetici
Esclusione: trattamenti curativi
Razionale: il prolungamento della vita non è un obiettivo ragionevole

Article

Twenty Years of Patient Satisfaction Research Applied to the Emergency Department: A Qualitative Review

American Journal of Medical Quality
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Shari Jule Welch, MD[1]

The Big 5 Correlates With Satisfaction

A growing body of research has demonstrated themes associated with high ED patient satisfaction including empathy/attitude (bedside manner), acceptable wait times (specifically perceived times vs actual wait times), technical competence (both technical skills and available technology), pain management, and information dispensation.[26-30]

Empathy/Attitude

It is becoming increasingly apparent that the "art of caring" for patients correlates with satisfaction. An uncaring attitude is cited in 7% to 13% of ED complaints.[31-33] "Caring physicians and nurses" are variables that show up repeatedly in satisfaction data and at times even override waiting times as predictors of patient satisfaction. Put simply, even speed cannot compensate for rudeness, disrespect, or an uncaring attitude. This empathy/attitude correlate with patient satisfaction is consistent with the patient-centeredness aim promoted by the IOM.

E.M.P.A.T.H.Y.: A Tool to Enhance Nonverbal Communication Between Clinicians and Their Patients

Helen Riess, MD, and Gordon Kraft-Todd

Academic Medicine, Vol. 89, No. 8 / August 2014

E: Eye contact

M: Muscles of facial expression

P: Posture

A: Affect and emotional state

T: Tone of voice

H: Hearing “the whole” patient

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Acceptable Wait Times

Patients presenting to the ED frequently overestimate the urgency of their need for health care. They typically do not understand the triage system and interpret patient flow in the department as somehow being unfair. These factors predispose the patient to perceive their wait time as too long. Bursch et al[29] have shown that perceived waiting time (as opposed to actual wait time) is the most important variable contributing to patient satisfaction, and this finding has been replicated by others.[51] Similarly, higher patient satisfaction has been shown to correlate with waits that are shorter than expected.[52] The authors suggest that a focus on appropriate expectations regarding wait times should have a positive effect on patient satisfaction as well. This goal of acceptable waiting times is in alignment with 3 of the IOM's quality aims: timeliness of care, safe-care, and efficient care. Acceptable wait times and empathy are consistently the most important correlates with patient satisfaction in the ED.

By quickly moving patients to a care area and having the physician evaluate them in a timely fashion (less than 30 minutes is the accepted service quality goal), patients perceive that wait times are acceptable.[53] When the time interval (from arrival to physician evaluation) lengthens,

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Technical Competence

Perceived technical skill correlates well with positive perceptions of staff; 2 studies found perceived good technical skills to be the best predictor of global satisfaction[62,63]—even more correlative than bedside manner. This may be

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Pain Management

Pain is one of the major symptoms that cause patients to seek medical care on an emergent basis, and the complexities of pain management in the ED are only beginning to be unraveled.[68-70] Though there is a general correlation between pain relief and satisfaction, cultural factors, the intensity of the original pain experience, and differing pain scales all work to confound an understanding of this area of medical research. Though this area is worthy of a literature review in and of itself, a few themes relating to pain management and satisfaction in the ED are emerging and worth noting.

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EMA Emergency Medicine Australasia

Emergency Medicine Australasia (2020) doi: 10.1111/1742-6723.13562

ACUTE GERIATRICS

Emergency department pain management in older patients

Katren R TYLER,[1] Carolyn HULLICK,[2] Brittany A NEWTON,[3] Christopher B ADAMS[3] and Glenn ARENDTS[4,5]

[1]Department of Emergency Medicine, University of California, Davis, Davis, California, USA, [2]Emergency Department, Hunter New England Health, Newcastle, New South Wales, Australia, [3]Department of Pharmacy Services, UC Davis Health System, University of California, Davis, Davis, California, USA, [4]School of Medicine, The University of Western Australia, Perth, Western Australia, Australia, and [5]Emergency Department, Fiona Stanley Hospital, Perth, Western Australia, Australia

TABLE 2. *Pain Assessment in Advanced Dementia (PAINAD) tool*

	0	1	2	Score
Breathing independent of vocalisation	Normal	Occasional laboured breathing. Short period of hyperventilation	Noisy laboured breathing. Long period of hyperventilation. Cheyne-stokes respirations	
Negative vocalisation	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling or inexpressive	Sad. Frightened. Frown	Facial grimacing	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched, knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
				Total

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Discharge

In both the inpatient and ED environment, discharge medication reconciliation and education is associated with lower 30-day re-admission and return to ED rates, prevents adverse effects, promotes adherence and encourages appropriate use.[37] A dearth of evidence exists regarding outcomes associated with prescription discharge quantities. The prescription discharge quantity is largely cultural, depending on the practice environment and on availability of commercial quantities of medications. Limited numbers of tablets or a few days' supply makes sense until patients are able to follow up with their general practitioner. If older patients require discharge opioids, consider an opioid management plan with referral to hospital in the home programmes or other transitional care services if available. A bowel regime including laxatives should generally also be prescribed. Finally, remember older patients are vulnerable to opioid medication theft by friends, relatives and caregivers.

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Summary and conclusions

1. Compared to younger adults, acute pain in older ED patients is more frequently seen on a background of chronic pain, and more difficult to assess and manage.
2. Geriatric prescribing principles are important, but often difficult to operationalise in brief ED encounters, leading to inappropriate polypharmacy and over-prescribing. Use of non-drug and non-systemic drug therapies, and transitional arrangements to titrate systemic drugs, are under-utilised strategies.

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Information Dispensation

Some studies have shown that a lack of information (explanation) has a greater effect on patient satisfaction than perceived wait times and that staff overestimate the amount of information they give patients.[78] In some departments this has given rise to the possibility of a new staff position in the ED: the patient advocate. The patient advocate can be a licensed practical nurse, social worker, or volunteer. The patient advocate makes frequent contact with the patient and family members, keeping them informed of delays and progress, and may also be trained to assist with noninvasive comfort measures such as getting blankets, telephones, or ice chips. An additional benefit of having a patient advocate in the department is to free the professional staff for the more pressing technical tasks.

Unexplained and uncertain waits feel longer and have a negative effect on patients' perceptions of the wait.[79] Frequent updates regarding a patient's progress and delays correlate with patient satisfaction and satisfactory length of stay.[80,81] A study from the University of Barcelona revealed that patients older than age 65 are particularly reassured and appreciative of frequent updates and explanations about their clinical care.[82] Providing patients with

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Physician's Specific Correlates With Satisfaction

To be sure, not all physicians are likable, and the literature is replete with information about what patients like and dislike about their health care providers. On the other hand, it may be helpful to be informed and adapt a personal bedside manner to increase the likelihood of positive encounters with patients. A few physician attributes and behaviors deserve mention. Does the sex of the physician influence patient satisfaction? The simple answer is yes and no. Female physicians are positively associated with women's satisfaction in the ED.[43] This may be factored into physician assignments, especially where more invasive examinations and procedures will be required for female patients. With adolescent female patients in particular, or those women whose religious background makes interacting with male physicians prohibitive, the deliberate assignment of a female physician may make sense.

Emergency department crowding: An examination of older adults and vulnerability

Nursing Ethics
2024, Vol. 0(0) 1–12
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Meghan MacIsaac and Elizabeth Peter
University of Toronto

Care in emergency departments, particularly care in unconventional spaces, can add additional layers of challenge for many older adults that reflect implicit structural ageism. Defined by Chang et al. as the ways "in which societal institutions reinforce systematic bias against older persons"[42(p2)] structural ageism can be seen in the failure to accommodate the unique needs of older adult patients in the emergency department. As such, the emergency department as a place of care for older adults can contribute to pathogenic vulnerability because it further compounds vulnerability through its dysfunctional approach to meeting their care needs.[16]

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A feminist ethics approach

Feminist healthcare ethics is a wide-ranging and continuously progressing ethical approach with foundations originating in the ethics of care.[13] Feminist ethicists critique major tenets of mainstream bioethics, including the penchant for abstract thinking, individualistic autonomy, and the universal, depoliticized, and decontextualized view of ethics that often relies on fixed moral principles.[14] Instead, feminist ethics emphasizes a more fluid ethical decision-making that is grounded in everyday experiences, and considers the uniqueness of individuals, and their interdependent, relational nature.[15] Scrutiny of power dynamics and vulnerability is important from a feminist ethics view because the approach stresses the importance of identifying how oppression and inequities factor into healthcare arrangements ultimately to address social justice concerns.

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Conclusion

Of the prolonged and pervasive nature of care provided in hallways and other unconventional spaces, McNeilly et al.[66] write "the chronicity of gradually evolving disasters makes them insidious." (p282) They

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A feminist ethics and human geography framing could also be applied to consider the needs of other groups of people who may have increased risk for situational and pathogenic vulnerabilities when receiving care in a crowded emergency department environment. For example, patients presenting with mental health concerns or patients with disabilities may have care needs that are not met or are even worsened, by the place of care in the emergency department, such as those issues brought forward regarding a lack of comfort, privacy, and compromised communication. While some concerns raised may be common across people with similar vulnerabilities, the unique experiences of each group warrant further exploration in future research.

In conclusion, while crowding, access block, and boarding of admitted patients in the emergency department are complex logistical problems, they are also ethical problems. The insights provided through an ethical analysis of the emergency department places of care can give rise to solutions that can aid in moving beyond the current seemingly intractable situation to instead consider how to make care more equitable.

Ermers et al. BMC Geriatrics (2021) 21:58
https://doi.org/10.1186/s12877-020-02002-y

BMC Geriatrics

RESEARCH ARTICLE Open Access

Life-sustaining treatment preferences in older patients when referred to the emergency department for acute geriatric assessment: a descriptive study in a Dutch hospital

Daisy J. M. Ermers[1*†], Marit P. H. van Beuningen-van Wijk[2†], Evi Peters Rit[3], Sonja C. Stalpers-Konijnenburg[4], Diana G. Taekema[4], Frank H. Bosch[5,6], Yvonne Engels[1] and Patricia J. W. B. van Mierlo[4,7]

ıble 2 Known patients' preferences regarding life-sustaining treatments at referral to the ED for an acute geriatric assessment. The udy population is split by type of referrer. For patients for whom preferences were known, the frequencies of the individual eferences are presented

	Referred by elderly care physician, N = 69	*Referred by GP, N = 279*	*Total, N = 348*
Patients for whom at least one preference is known; N (%)	61 (88.4)	97 (34.8)	158 (45.4)
	Referred by elderly care physician, N = 61	*Referred by GP, N = 97*	*Total, N = 158*
Cardiopulmonary resuscitation (CPR) known; N (%)	61 (100)	97 (100)	158 (100)
When known, preference 'yes'; N	4	10	14
Invasive ventilation known; N (%)	27 (44.3)	32 (33.0)	59 (37.3)
When known, preference 'yes'; N	3	7	10
Admission to the intensive care unit (ICU) known; N (%)	17 (27.9)	19 (19.6)	36 (22.8)
When known, preference 'yes'; N	3	7	10
Admission to the coronary care unit (CCU) known; N (%)	6 (9.8)	8 (8.2)	14 (8.9)
When known, preference 'yes'; N	2	7	9
Dialysis known; N (%)	3 (4.9)	6 (6.2)	(5.7)
When known, preference 'yes'; N	2	6	8
Defibrillation known; N (%)	3 (4.9)	6 (6.2)	9 (5.7)
When known, preference 'yes'; N	2	6	8
Only comfort-focused care (no life-prolonging treatments) known; N (%)	2 (3.3)	4 (4.1)	6 (3.8)
When known, preference 'yes'; N	0	3	3
Other preferences, including blood transfusion and antibiotics known; N (%)	1 (1.6)	0 (0.0)-	1 (0.6)
When known, preference 'yes'; N	0	-	0

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Conclusions

To conclude, we found that patient preferences were known by the referring physician in less than half of the older patients referred to the ED for an acute geriatric assessment. When known, these preferences were mainly limited to CPR policy, and occasionally to invasive ventilation and ICU admission. This limited knowledge of preferences may lead to less personalized care with unnecessary futile interventions, unwanted life-prolonging treatments, but also to undertreatment based on ageism. Therefore, ACP needs more attention in daily practice in order to provide more appropriate, desired, and personalized care to older patients in a non-acute setting.

GPs and elderly care physicians are both in a position to initiate ACP conservations, as both have a long-term patient relationship and the ability to discuss this in a quiet place with sufficient time and without the need for direct decisions [45, 46]. Preferably, these conversations should not take place at the ED. There are also several non-acute moments at a geriatric department in which ACP could be initiated or continued. A recent ED visit or hospitalization can be a trigger and reference to initiate ACP conversations [47] as referring to this recent situation makes the discussion more tangible. Moreover, geriatricians are experts when it comes to frailty and co-morbidity. They possess knowledge that can support GPs and elderly care physicians in these ACP conversations. Therefore, geriatricians can also contribute to a consistent and clear transmural message; ACP should be a shared responsibility of professionals in primary and secondary care.

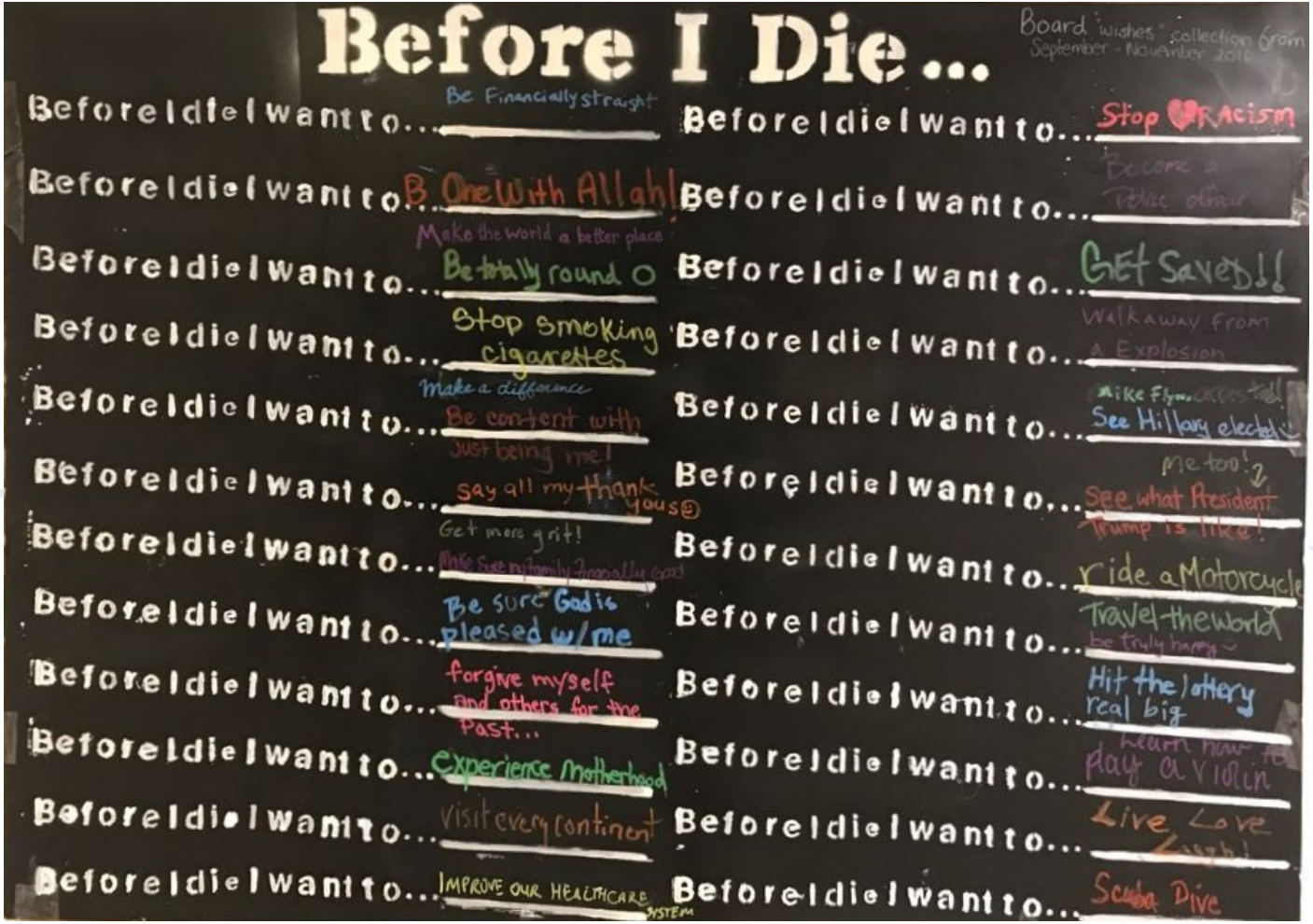
Emergency department care for older people with frailty

Author James van Oppen is National Institute for Health and Care Research (NIHR) doctoral research fellow and higher specialty trainee in emergency medicine, University of Leicester; Emma Wilkinson is freelance journalist; Helen Saul is editor in chief, NIHR Evidence.



What's next?

Many healthcare settings already use risk scores to identify people with frailty, but more work is needed to ensure that these patients receive the aspects of care they consider to be important. This study's results suggest that emergency department staff and policy makers may need to rethink how they measure quality of care. The results could help develop person-reported outcome measures for patients with frailty. Such measures are unlikely to replace waiting time targets and mortality rates, however, they could be used alongside these to assess whether hospitals are providing care in a way that really matters to the patient.



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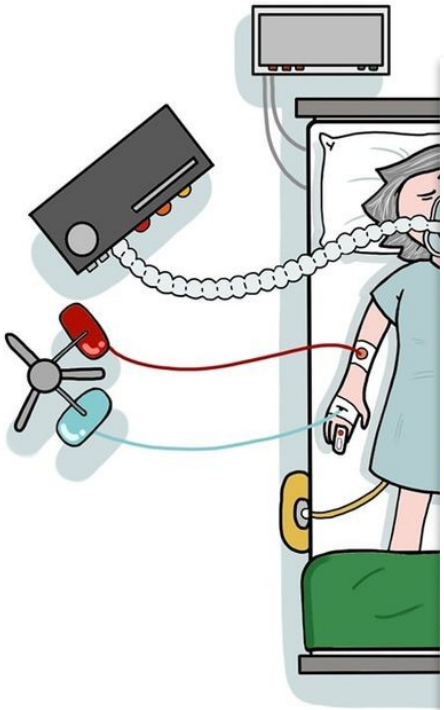

QUANDO LA MORTE È INELUTTABILE,
IL MODO DI MORIRE È FONDAMENTALE.

Dott.ssa Alice Rotelli



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Centro Traumatologico Zonale - Pronto Soccorso - C.T.O.

Responsabile Dr.: GUARINO MARIO

Verbale di accettazione e delle Prestazioni Sanitarie

Servizio di Pronto Soccorso **Ingresso N° 20240016446**

Cognome e Nome [redacted] ANTONINO **Sesso** M età 94 anni
Data e luogo di nascita
Residenza NAPOLI
Telefono 081/546241 NNN29S08F158S

Problema principale: Dolore addominale

Modalità Accesso: Autonomo (arrivato con mezzi propri)

Causa dichiarata all'accettazione: EPIGASTRALGIA

Inviato da: Decisione propria (di un genitore se minorenne)

Data Triage		Data Visita		Data Uscita	
10/05/2024	11:32	10/05/2024	12:34	10/06/2024	17:28

Urgenza triage: GIALLO Urgenza dimissione: GIALLO

Anamnesi:

Dott. : URSI MARIA PAOLA
10/05/2024 13:22

Esame Obiettivo:

Dott. : URSI MARIA PAOLA
10/05/2024 14:15
si effettua previa disinfezione della cute toracentesi evacuativa a dx infruttuosa si rimuove unico. si sutura con 1 punto e si effettua rx torace di controllo

Dott. : COSTANZO ANITA
10/05/2024 17:02
paziente agitato
- serenase
- midazolam 1 mg

Dott. : URSI MARIA PAOLA
10/05/2024 13:24



Centro Traumatologico Zonale - Pronto Soccorso - C.T.O.
Responsabile Dr.: GUARINO MARIO

Verbale di accettazione e delle Prestazioni Sanitarie

Servizio di Pronto Soccorso **Ingresso N° 20240010883**

Cognome e Nome ASSUNTA **Sesso** F **età** 102 anni
Data e luogo di nascita 921 NAPOLI
Residenza
Telefono

Problema principale: Trauma
Data e ora del trauma: 28/03/2024 19:30
Luogo evento: Casa **Circostanze del trauma:** Incidente domestico

Modalità Accesso: Altra Ambulanza

Causa dichiarata all'accettazione: presenta SLO femore SX post caduta con trauma cranico non commotivo, nega altri traumi

Inviato da: Decisione propria (di un genitore se minorenne)

Data Triage		Data Visita		Data Uscita	
29/03/2024	12:34	29/03/2024	14:35	29/03/2024	17:26

Urgenza triage: GIALLO **Urgenza dimissione:** GIALLO

Anamnesi:

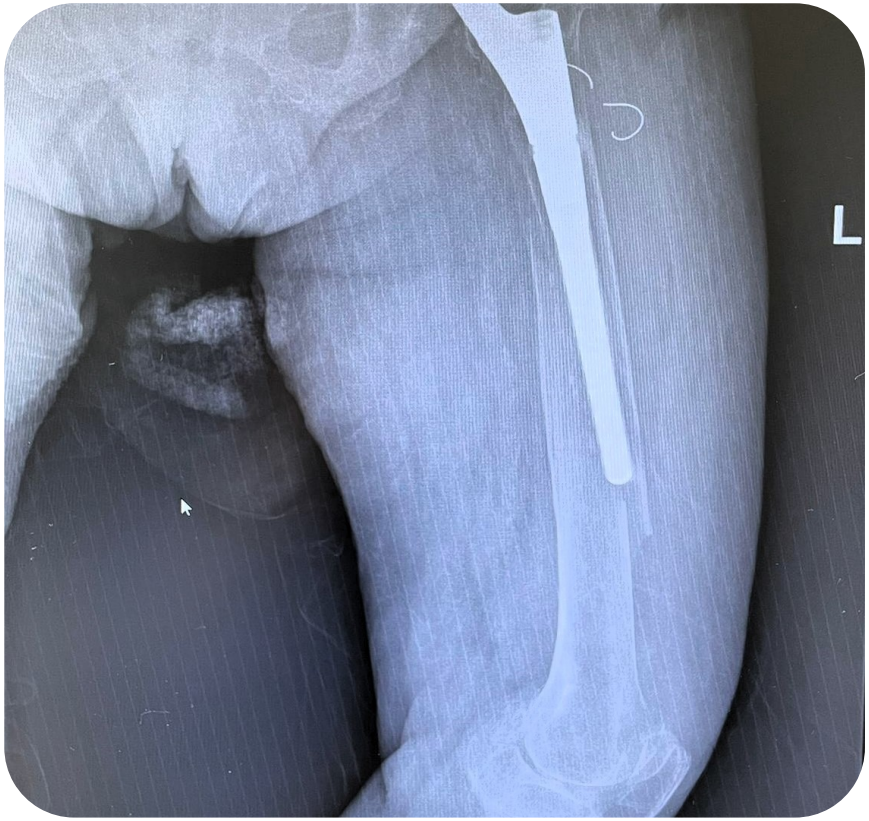
Dott. : CRISTIANO GIOVANNA 29/03/2024 14:36
Giunge in PS per caduta accidentale in casa
Intervento di protesi all anca sx circa 7 aa fa
riferiscce cabaratta bilaterale
nega patologie degne di nota
nega farmacoallergie

Esame Obiettivo:

Dott. : CRISTIANO GIOVANNA 29/03/2024 15:10
Pz vigile ed orientata
Cute asciutta, mucose normoperfuse
PA: 110/60 mmHg; Fc: Gc: 70 bpm, Spo*:97% in aa a, apiretica
Torace: lieve dolorabilità in corrispondenza dell'emitoarce di sx, MV fisiologico su tutto l'ambito polmonare
Cuore: toni puri pause libere
Addome: trattabile, non dolente, peristasli valida
Lieve succulenza ad entrambi gli arti inferiori

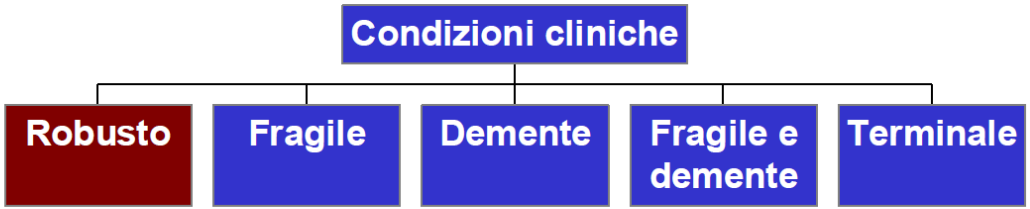
Esami:
VISITA DI PRONTO SOCCORSO 29/03/2024 14:35

Accertamenti:	2-Saturazione (O2/FIO2)	3-Freq. Respiratoria	4-Freq. Cardiaca (bpm)	5-Pressione arteriosa	6-GCS	7-Temperatura (°C)
29/03/2024 12:34	97 / 21	16	68	62 / 110	16	36.2





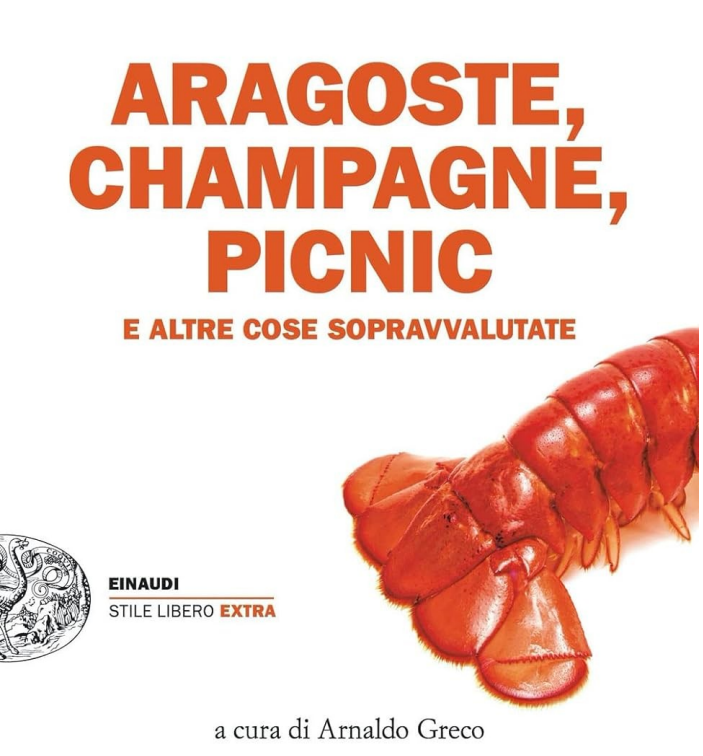
Tipizzazione e stratificazione dei pazienti geriatrici



Assuntulella Babbo

Gillick 2001

La stratificazione (categorizzazione) dei pazienti secondo il loro stato di funzionale e di salute permette la definizione di outcomes ragionevoli diversi e la definizione di un ranking di priorita.



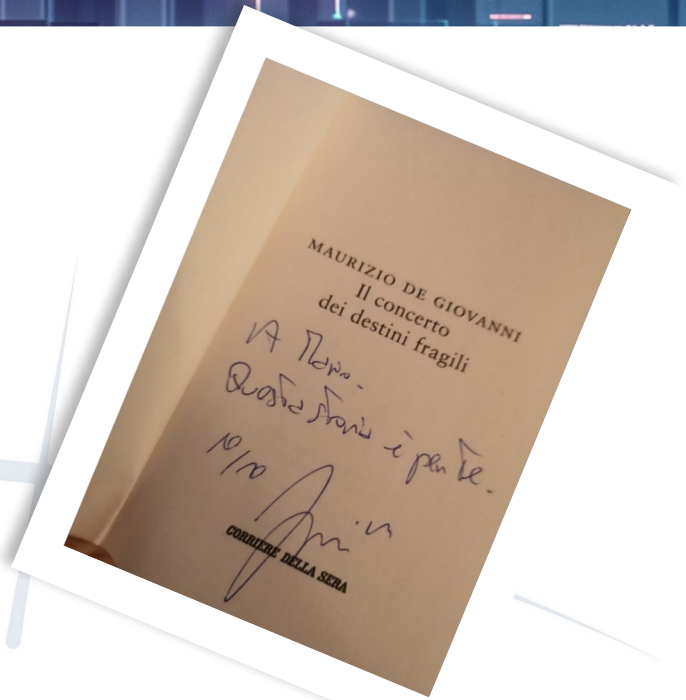
L'idea, di per sé folle, di possedere qualcosa o addirittura qualcuno ci accompagna, condannandoci a un lavoro di polizia costante e di sorveglianza maniacale. Viviamo esistenze fatte di casseforti, contraeree, allarmi e ponti levatoi. Giacché, invece di abitare accanto alle cose e alle persone, ne facciamo nostre proprietà, quindi punto di non ritorno, status acquisito: capite che esistenza piena di ansie siamo destinati a colmare coi nostri giorni. Chi possiede sarà derubato. Le conseguenze di questa inclinazione a sopravvalutare la perdita di cose o persone sono, come si sa, terrificanti. E si allungano per anni nei giorni della gente. Innumerevoli sono i casi di vite quotidiane ridisegnate dallo shock di una perdita, e non sembra poi avere una grande importanza la dimensione della perdita.
Come la morte di una persona cara può trasformarsi in un verdetto di condanna su un'intera vita, la perdita di una possibilità di lavoro, o di una onorificenza o di una gara, può allungarsi come un'ombra nera su tutte le vite circostanti, per anni.
E' straziante pensare quale luce e quanta vita si sarebbe potuto generare se solo si fosse stati capaci, in quel preciso momento, di lasciare andare le cose, invece che sopravvalutare tragicamente l'effetto del loro abbandono. SI dirà che elaborare una perdita, o un lutto, o un furto, non è una cosa semplice e che in generale non si sceglie come reagire allo strappo che ci porta via una vita, una fortuna, un amore: si soffre e basta. Ci si ribella. Ci si vendica. Ma non è poi così vero. **La capacità di lasciare andare le cose e le persone parte da lontano, è un modo di stare al mondo ed è cosa che si può educare in ogni nostro fare.** Non è vero che ci sia estranea, ci è solo, culturalmente, lontana. Ma ci appartiene e, se solo evitiamo di arrenderci senza condizioni alla paura, la possiamo ritrovare nelle mosse più spontanee del nostro animo. Analogamente, **non è affatto fuori dalla nostra portata la capacità di trovare saldezza e riparo non tanto nelle cose e persone in mezzo a cui viviamo (e che ci illudiamo di possedere) ma in una regione intima del nostro sentire che, come un'isola, come un ombelico, come una sorgente, pre-esiste all'arrivo di qualsiasi scheggia di mondo e sopravvive, intonsa, a**



"Tra la libertà e la sicurezza ho sempre scelto la libertà. Tra la libertà e la salvezza, la libertà. Sopra ogni cosa. Volete farmi venire un dubbio: la libertà o la bellezza?"







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