Beyond an admission - Support for an ageing population

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With outmigration and a lower birth rate, Newfoundland and Labrador (NL) has the most rapidly ageing population in Canada. Compound this with a further loss of access to healthcare in NL, and the result is that rural emergency departments (EDs) and hospitals have a significant increase in older adults using the system. More specifically, older patients who present without a clear diagnosis, primarily requiring long-term care placement, ultimately require extended ED and hospital stays. Classified as 'community emergencies' or loosely as 'social admissions', they often occupy crucial acute care beds even when long-term care beds are available. These patients have extended stays and waits to complete multidisciplinary assessments, with the perceived goal of delaying and/or preventing long-term acute hospital admissions.

It is always a challenge when assessing a decompensating geriatric patient. Interpreting their presentation, however, is not. Family members crowd a clinic room barely meant for two, or a dishevelled house call belies years of elaborate broaches and colourful handknit scarfs. Slightly more obvious in a rural ED, a tea-infused nighty, a handwritten-with-a-tremor pill list and a dated suitcase all serve as less than subtle signs. Well-intended family members usually attempt to guide them in search of something better, a safer way for their loved ones to live.

Often, over the sound made when transferring medication from an overflowing ziploc medication bag, a concerned family member hastily describes the inability of their elderly relative to manage independently at home. The patient often sits quietly, with restricted participation. However, when prompted, they are commonly witty and bright, stating 'I don't know why they brought me here'. Under their cracking patina, they fear losing everything they hold dear in their rural homes and fear placement in a distant centre or community void of connection.

I've learned to initially lighten the mood, with open conversation about their lives long ago. A worn smile generally emerges from the neutral palate of hospital bed sheets and confidential curtains. Resettled communities, fishing the Labrador, 'just a housewife' or 'jack of all trades' are present geriatric themes. Adjacent family members then also smile and boast of their relative's grit and survival as they warm to their associated ancestry. These satisfying stories, however, only delay the

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ultimate functional assessment review that is certain to unravel the patient.

Octogenarian physical examinations are always abnormal, but they are an ideal opportunity to educate medical learners. In reviewing their assessment, my mind wanders to the high probability of another weather-beaten rural Newfoundland house boarded up and community icon lost. Questioning the medical learner for a post-examination diagnosis is silently philosophical. I know we can find something wrong to justify an acute inpatient hospital admission. However, will it truly benefit the patient?

Without correlating the mandatory history and examination, it is not hard to determine what the families are desperate to have. They believe it is the best, the only option. A nurse in the family, a retired teacher in the community, recommended it and they often appeal for immediate hospital admission.

Casually countering, I quickly agree that their loved one needs more. Still, is an extended acute inpatient bed the answer? Absent will be their familiar nightstand clock and bathroom grab bar. Their unfamiliar breakfast and tea will reinforce their uncomfortable and risky stay. It is here that I also fear the unnecessary intrusive Foley catheter or the unconsidered consequences of one tiny benzodiazepam. Mostly though, I dread a protracted stay, complete with a new loss of independence, decline in cognition and physical function, all in crowded isolation.

Is the alternative, that of a lengthy ED 'assessment', a better option? Lost is access to an acute care emergency bed for critical patients, supports for waiting family members and sadly, confidentiality and humanity. Guaranteed though is the constant flow of infectious patients, loud annoying monitors and one terribly uncomfortable, inappropriate stretcher. Moreover, as I am often aware, and ashamedly silent, having their loved one potentially boarded in the ED for days.

The evidence against hospital admissions for certain 'well' older adults is hard to preach. Family members sit immersed in our well-lit sterile world that likely contrasts with their loved one's home environment. I imagine cluttered closets, worn floors with ragged mats and mixed unwashed cutlery. My spiel of increased risk of hip fractures, confusion and infection follows with the family's request for admission as they see the hospital as the best solution.

We are told that 'well' older adults awaiting long-term placement will occupy acute inpatient beds significantly longer if admitted into hospital. Apparently, if they stay in the ED, it prioritises assessments that for unknown reasons are hindered by the walls of inpatient wards. Hence, for now, they, unfortunately, continue to have extended disrupted stays in a rural transitional bed or choose the risky return home to wait for the next 'opening' in a long-term care centre.

What is clearly necessary is to internally expedite and prioritise rural multidisciplinary teams to best address patients' societal needs. Required is the option of transferring older, non-coping, 'well' patients directly to available respite beds in long-term care centres, rather than extended stays in the ED or inpatient hospital beds. Finally, as our rural population continues to age, it is essential that we have the appropriate services and facilities to fully support their golden years, in their own homes and local community.

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