GEDA Care Processes
July 2023

The implementation of geriatric-focused care processes constitutes the largest component of accreditation and has the greatest potential for direct improvement of patient care and outcomes. The care processes selected should be done so thoughtfully and with consideration of their impact on patient outcomes and experience in addition to their feasibility, sustainability, cost, and potential hospital-wide benefits.

As of July 1, 2023, three care processes are required and must be implemented by all sites pursuing new accreditation or renewing their accreditation, for all levels. These are care processes A.1 (minimization of urinary catheterization), A.2 (minimization of NPO status), and A.3 (minimization of physical restraint use). These three represent basic processes that all geriatric-friendly EDs should adhere to.

Sites will select an additional 1, 7, or 17 care processes to implement for accreditation at level 3, 2, and 1 respectively. Applicants for level 1 and 2 accreditations should also submit the required metrics and evidence of implementation and impact of the care processes as listed in the Care Process Description document on the GEDA website. This document also provides more details and references for the example screening tools suggested in the care processes.

The patient's eligibility for GED initiatives may vary based on intervention type and institution. For example, eligibility may be based on age, screening tool results, or prior ED history. While we will accept a range of definitions of patient eligibility, the applying institution should specify how they are defining eligibility for the purposes of measuring adherence (i.e., the denominator) for each criterion being evaluated.

Sites applying at Level 1 or Level 2 have the option of submitting one novel care process that is not included elsewhere. The care process should be specific to the care of older adults, should impact the

patient care or experience, and should include a strategy for assessing its implementation and/or impact. Applicants should explain the rationale for selecting this process and how it improves the care of older people in the emergency department.

#	Care process description
Baseline care processes required by *all* GEDA sites	
A.1	Protocol or care process to standardize and minimize urinary catheter use.
A.2	Protocol or care process to minimize NPO status and promote access to appropriate food and drink.
A.3	Protocol or policy to minimize use of physical restraints and promote use of trained companions or sitters instead.
Medication Safety and Orders	
B.1	Care process for medication reconciliation to be performed by pharmacist or pharmacy technician.
B.2	Guidelines to minimize potentially inappropriate medication use. This could be through an ED-based pharmacist or through a hospital-specific or other list of potentially inappropriate medications (PIMs) or dosing.
B.3	Guidelines for safe pain control including multi-modal options for mild, moderate, or severe pain.
B.4	Development and implementation of at least three order sets for common geriatric ED presentations developed with particular attention to geriatric-appropriate medications and dosing and management plans (e.g. delirium, hip fracture, sepsis, stroke, ACS).
ED Specialty Consultation Resources	
C.1	Care process for accessing palliative care consultation in the ED
C.2	Care process for accessing geriatric psychiatry consultation in the ED.
C.3	Care process to guide the use of volunteers in the care of older ED patients.
ED Screening	
D.1	Protocol for structured delirium screening with an established tool, with appropriate follow-up actions based on screening results. Example tools include the DTS followed by the bCAM, 4AT, or others.
D.2	Protocol for structured cognitive impairment screening with an established tool, with appropriate follow-up actions based on screening results. Example tools include the Ottawa 3DY, mini-cog, SIS, short blessed test, or others.
D.3	Protocol for structured assessment of function and functional decline with an established tool, with appropriate follow-up actions based on screening results. Example tools include the ISAR, interRAI AUA screener, or others.
D.4	Protocol for structured falls and mobility assessment using an established tool, with appropriate follow-up actions based on screening results. Example tools include the Timed Up and Go (TUGT), or other tools.

D.5	Protocol for structured screening or assessment for elder abuse using an established tool, with appropriate follow-up actions in response to screening results. Example tools include EM-SART, ED Senior AID, EASI or H-S/EAST, or others.
D.6	Protocol for structured depression screening using an established tool, with appropriate follow-up actions in response to screening results. Example tools include DIA-S4, PHQ9, GDS short form, or others.
D.7	Protocol for structured screening or assessment for social isolation with appropriate follow-up actions in response to screening results. Example tools include the Duke Social Support Index and the UCLA 3-Item Loneliness Scale.
D.8	Protocol for screening for alcohol or substance use with appropriate follow-up actions in response to screening results. Example tools include a 2-item quantity/frequency screener, SMAST-G, AUDIT-C, or others.
D.9	Protocol for screening of nutritional status or food insecurity with appropriate follow-up actions in response to screening results. Example tools include HFIAS, MNA.
Transitions of Care	
E.1	Care process for PCP notification of ED visit.
E.2	Care process to enable transitions of care from the ED to residential care. This could be for new placements to residential care, and/or a care transition plan on discharge to an existing placement.
E.3	Care process to address age-specific communication needs at discharge (e.g. large font, lay person language, clear follow-up plan, evidence of patient communication).
E.4	Care process to provide easy access to short- or long-term inpatient or outpatient rehabilitation services, and protocol or guidelines for how to access the pathway.
E.5	Care process for referrals to geriatric-specific follow-up clinics such as: comprehensive geriatric care clinic, falls clinic, memory clinic, or others.
E.6	Care process for accessing an outreach program that provides home assessments of function and safety such as a visiting nurse association (VNA) or physical therapy (PT) home safety evaluation.
E.7	Care process for coordinating with a community paramedicine group to perform a home visit after discharge.
E.8	An outreach program to residential care homes to enhance the quality of care of ED transfers. This should involve meetings with representatives at residential care homes to improve transfer to or from the ED.
E.9	Protocol for post-discharge follow-up with the patient or caregiver (e.g., phone call, telemedicine, or other follow-up). This could be to reassess their condition, assess needs, ensure follow-up or access to medications, to review discharge plans, or provide other services.
E.10	Patient access to transportation services for return to their residence.
Hospital Operations	

F.1	Care process to minimize ED boarding for geriatric patients or a sub-group of geriatric patients at particularly high risk for harm due with prolonged ED stay (e.g. with delirium).
F.2	Care process to optimize care of geriatric patients or sub-group of geriatric patients at particularly high risk for harm (e.g. those with delirium) who are boarding in ED for extended period after admission decision.
Novel Policy	
G.1	Create, implement, and describe a policy, protocol, or care process that does not fall into the above categories. It should be specific to the acute care of older patients. Include a strategy for assessing implementation and metrics to measure successful implementation. As with the above protocols, you will have the opportunity to describe it in the Care Process Executive Summary Template.