

Demonstration of the clinical utility of the “Functional Status Assessment of Seniors in the Emergency Department (FSAS-ED)” with independent seniors consulting Emergency Department (ED) for minor injuries.

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Background

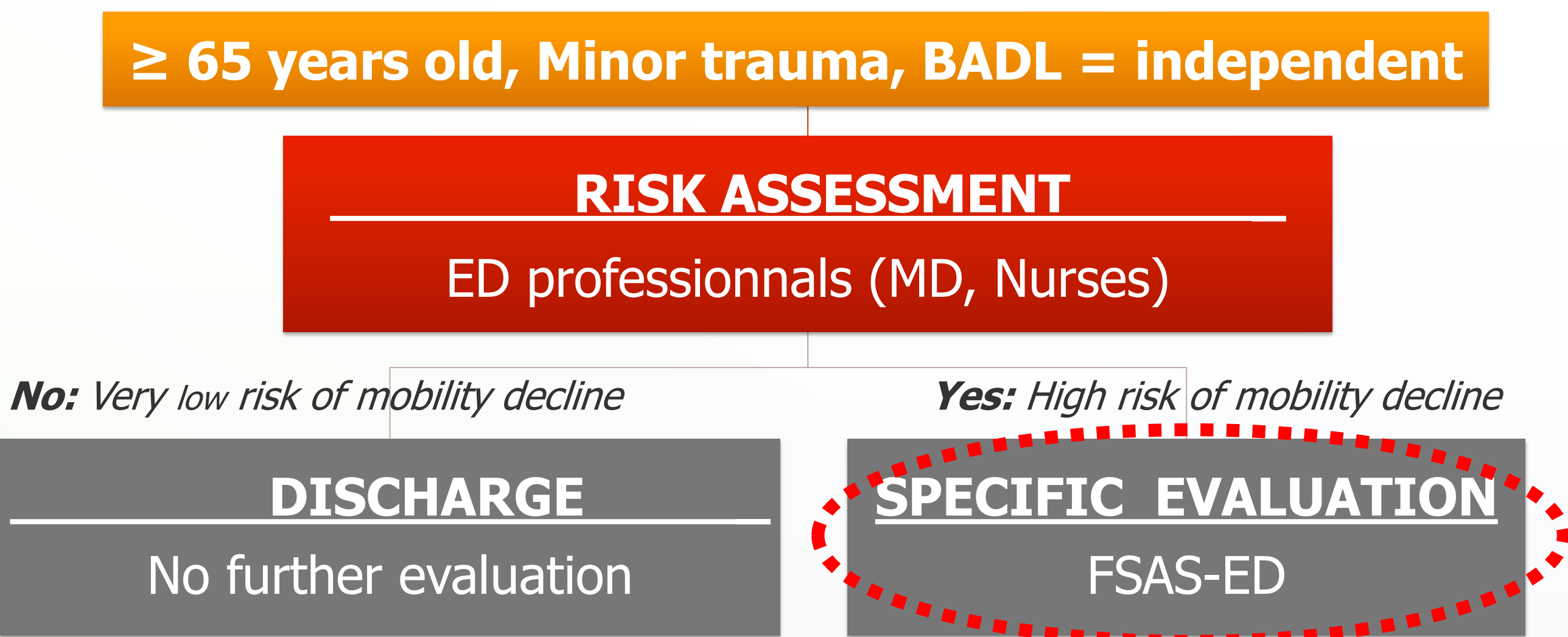
- Emergency Department (ED) visit is a "sentinel event" which reveals fragility and functional decline of older people¹⁻².
- However, once the medical examination is completed, the majority of seniors returned home without an assessment of their functional status³⁻⁵.
- The Functional Status Assessment of Seniors in the Emergency Department (FSAS-ED) was developed for this purpose⁶⁻⁷.
- The Canadian Emergency Team Initiative (CETI) showed a cumulative incidence of 15% of persistent functional decline six months after minor injuries in previously independent seniors⁸⁻⁹.

Objective

- To assess the clinical utility of the "Functional Status Assessment of Seniors in Emergency Department (FSAS-ED)" for these older people.

Method

- A prospective case-control pilot study is conducted within the CETI cohort research program.



- Participants were evaluated at the ED.
- All subjects were assessed according to the CETI program (socio-demographic measures, medical assessment in the ED, medication status, frailty, cognitive status, walking speed, fear of falling, running in ADL and AVD, social participation, use of health services in the ED and post-DU, social support, etc).
- In addition, the cases only were assessed by an occupational therapist trained for using the FSAS-ED.
- Analyses compared various characteristics, treatment plan and recommendations made by emergency physicians or those based on the FSAS-ED.

- 21 cases and 48 controls have been recruited.
- Both groups are similar in many characteristics, including level of autonomy and mobility.

Variables	Cases (N=21)	Controls (N=48)	P value ^b
Age	N (%)	N (%)	
65 -74	6 (29)	16 (33)	
5 -84	10 (48)	21 (44)	0.9
>85	5 (24)	11 (23)	
Gender			
Male	10 (48)	23 (48)	1.0
Female	11 (52)	25 (52)	
Comorbidities ^a			
0 – 1	3 (14)	7 (16)	
0 – 4	15 (71)	29 (64)	0.9
5 – 19	3 (14)	9 (20)	
Live alone without help ^a	9 (43)	13 (28)	0.2
Social support index >63/100 ^a	12 (75)	37 (82)	0.5
Number of GP consultations in the last 3 months ≥ 3 ^a	1 (6)	3 (7)	0.9
ED visits in the last 3 month ^a	1 (7)	4 (9)	0.8

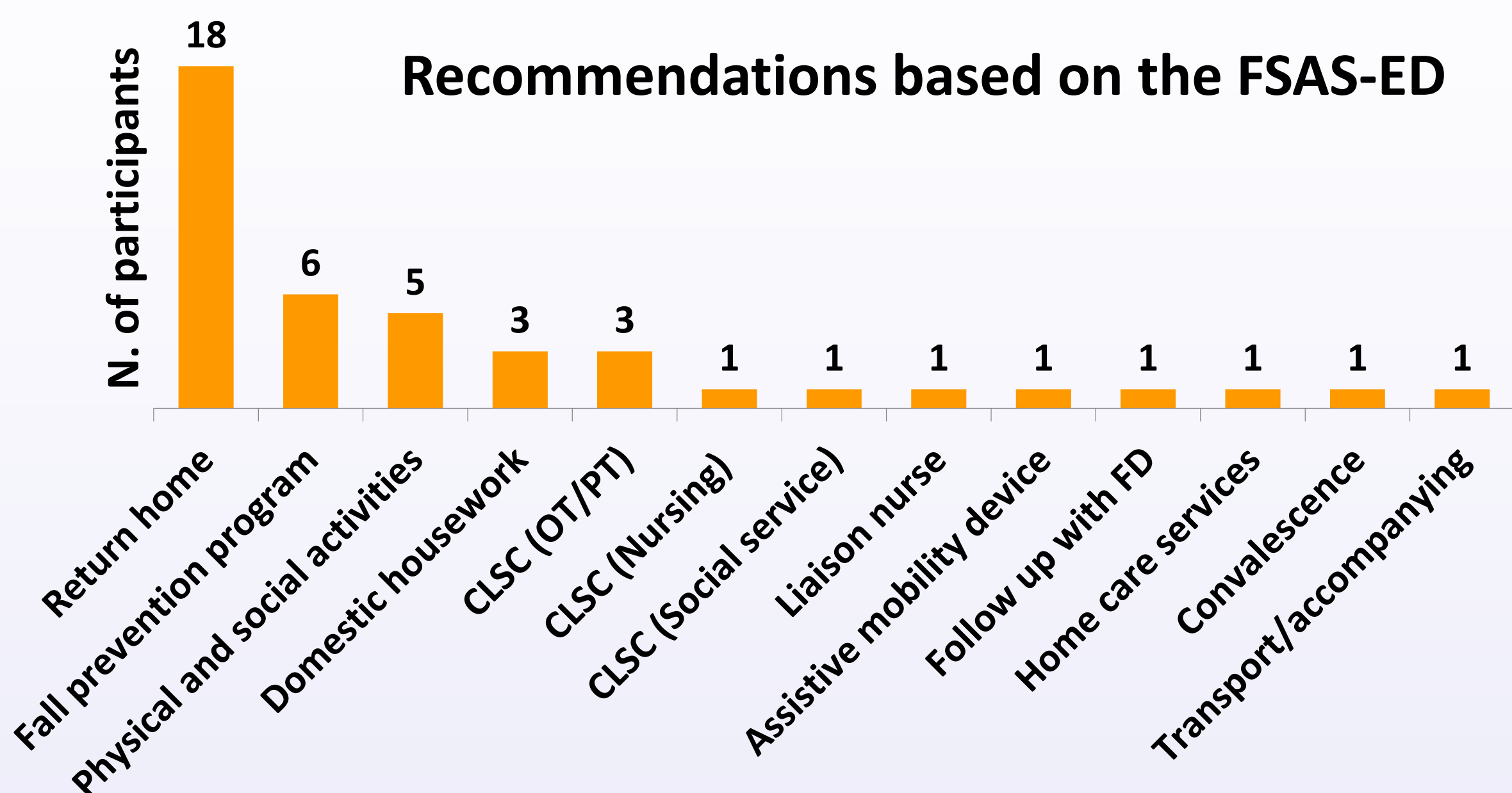
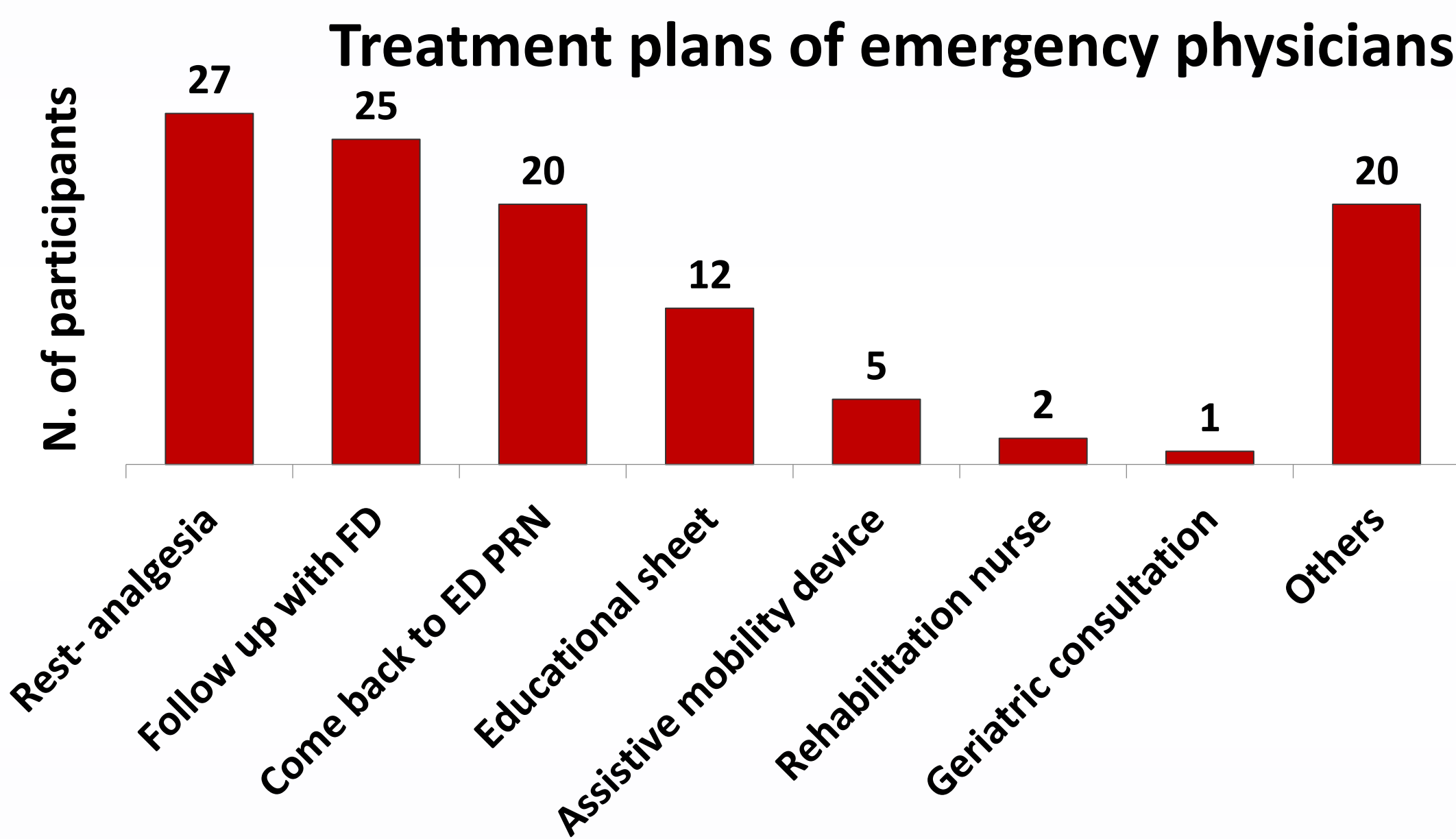
a. Because of missing data, the number of patients does not always add to the total b. Test de Fischer

- The treatment plans of emergency physicians include rest/analgesia (45%), recommendation to see family doctor (35%) and return to ED PRN (30%).
- Pre-frail and frail patients seem to get more numerous and specific recommendations compared to treatment plans suggested by MDs.

Frailty status	FSAS-ED	Emergency physicians
Very fit (≤1)	Return at home (3) Community resources (2) Fall prevention program (1) CLSC (1)	Rest/analgesia (3) Others (3) Emergency department PRN (2) Follow up with family doctor (1) Assistive mobility device (1)
Well/ Well+comorbidity (2 - 3)	Return at home (10) Community resources (5) CLSC (4) Fall prevention program (3) Assistive mobility device (2) Follow up with family doctor (1) Home care services (1) Convalescence (1) Liaison nurse (1)	Educational sheet (1) Rest/analgesia (6) Emergency department PRN (6) Follow up with family doctor (5) Assistive mobility device (2) Educational sheet (2) Others (2) Rehabilitation nurse (1)
Apparently vulnerable/ Moderately frail (4 - 6)	Return at home (3) Fall prevention program (2) Assistive mobility device (1) Community resources (1)	Follow up with family doctor (2) Rest/analgesia (1) Emergency department PRN (1) Others (1)

Results

Variables	Cases (N=21)	Controls (N=48)	P value ^b
Number of outings /week ≥ 5 ^a	9 (60)	27 (63)	0.8
Occasional use of a walking aid ^a	1 (6)	7 (16)	0.3
IADL score =14/14 ^a	9 (53)	29 (60)	0.6
Falls in the last 3 month ^a	4 (25)	11 (24)	1.0
Mechanism ^a Falls own height	17 (81)	28 (64)	
Falls high height	2 (10)	7 (16)	0.6
Motor Vehicle Accident	1 (5)	3 (7)	
Other	1 (5)	6 (14)	
Pain level ≥ 70/100 ^a	3 (23)	6 (14)	0.3
Timed-Up-Go (seconds) ^a <10	6 (60)	2 (67)	
10 – 19	3 (30)	1 (33)	1.0
20 -29	1 (10)	0 (0)	
Short fall efficacy scale ≥9.8 ^a	9 (56)	23 (51)	0.7
Frailty status			
Very fit	4 (21)	5 (11)	
Well/Well+comorbid	12 (63)	29 (64)	0.5
Apparently vuln./Moderately frail	3 (16)	11 (24)	



Conclusions

- The nature and number of recommendations vary depending on the level of fragility.
- While emergency physicians target short-term interventions, those based on the FSAS-ED aim to maintain and improve mobility in the mid/long-term, which are key elements in limiting functional decline.

Acknowledgements

- Tammie Nadeau (research assistant), Brice Lionel Batumen (epidemiologist-statistician), Daniel Robin (computer engineer)

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