THE ELDERLY IN THE EMERGENCY ROOM, WHAT A REALITY…
O IDOSO NO SERVIÇO DE URGÊNCIA, QUE REALIDADE…
LOS ANCIANOS EN LA SALA DE EMERGENCIAS. ESA REALIDAD…

Cristina Maria Grilo¹, Eliana Carina Martins², Marilia Rosario Ferreira³, Rita Carina Solas⁴, Silvia Manuela Alminhas⁵, Tatiana Marisa Piteira⁶

ABSTRACT

Objective: characterizing the urgency service in relation to the number of older people admitted, identifying the most frequent pathologies and social support needs. Method: a retrospective study, conducted between 2008 and 2012. The population under study was of users with age ≥ 65 years old. The data collection was performed using the ALERT system. All ethical procedures, informed consent, confidentiality and anonymity have been complied with, in accordance with the Declaration of Helsinki. Results: between 2008 and 2012, about 36% of the populations admitted to the urgency service were of elderly. Their clinic situation and the lack of responsiveness of the institution conducted, between 2009 and 2012, on average, about 400 hospital admissions in the service. The diminutive social response to this age group was reflected in the number of requests for social support. Conclusion: this study raises questions about the responsiveness of the health system and social protection facing the needs of the elderly. Descriptors: Aging; Urgency Service; Screening of Manchester; Elderly.

RESUMO

Objetivo: caracterizar o serviço de urgência relativamente ao número de idosos admitidos, identificar as patologias mais frequentes e necessidades de apoio social. Método: estudo retrospectivo, realizado entre 2008 e 2012. A população em estudo foram os utentes com idade ≥ a 65 anos. A recolha de dados foi efetuada recorrendo ao sistema ALERT. Todos os procedimentos éticos, consentimento informado, confidencialidade e anonimato foram cumpridos, de acordo com a Declaração de Helsinki. Resultados: entre 2008 e 2012 cerca de 36% da população admitida no serviço de urgência eram idosos. A sua situação clínica e a falta de capacidade de resposta da instituição conduziram, entre 2009 e 2012, em média, a cerca de 400 internamentos no serviço. A diminuta resposta social para esta faixa etária refletiu-se no número de pedidos de apoio social. Conclusão: este estudo levanta questões sobre a capacidade de resposta do sistema de saúde e de protecção social face às necessidades dos idosos. Descriptores: Envelhecimento; Serviço de Urgência; Triagem de Manchester; Idoso.

RESUMEN

Objetivo: caracterizar el servicio de urgencia en relación al número de personas mayores admitidas, identificar las patologías más frecuentes y necesidades de apoyo social. Método: estudio retrospectivo, realizado entre 2008 y 2012. La población estudiada fueron los usuarios con edad ≥ a 65 años. La recolección de datos se realizó mediante el sistema de ALERT. Todos los procedimientos éticos, consentimiento informado, confidencialidad y anonimato fueron cumplidos, con arreglo a la declaración de Helsinki. Resultados: entre 2008 y 2012 aproximadamente el 36% de la población ingresada en la sala de urgencias fueron ancianos. Su situación clínica y la falta de capacidad de respuesta de la institución condujeron, entre 2009 y 2012, en promedio, el alrededor de 400 hospitalizaciones en el servicio. La diminuta respuesta social a este grupo de edad se reflejó en el número de solicitudes de apoyo social. Conclusión: este estudio levanta preguntas sobre la capacidad de respuesta del sistema de salud y de protección social frente a las necesidades de los ancianos. Descriptores: Envejecimiento; Servicio de Urgencia; Triagem de Manchester; Anciano.

¹Nurse, Master of Socio-Organizational Intervention in Health, Hospital do Espírito Santo de Évora, The Urgency Service. Évora, Portugal. Email: cristinagrilo@gmail.com; ²Nurse Master of Medical-Surgical Nursing, Hospital do Espírito Santo de Évora, Urgency Service. Évora, Portugal. Email: elianacarina@it.pt; ³Nurse, Hospital do Espírito Santo de Évora, the Urgency Service. Évora, Portugal. Email: mmferreira@gmail.com; ⁴Nurse Specialist in Rehabilitation Nursing, Hospital do Espírito Santo de Évora, the Urgency Service. Évora, Portugal. Email: rita3cris@gmail.com; ⁵Nurse Specialist in Medical-Surgical Nursing, Master Teacher of the Elderly Health and Welfare, Invited at the School of Nursing São João de Deus, University of Évora. Évora, Portugal. Email: silvialalminhas@gmail.com; ⁶Nurse Postgraduate in Hospital Urgency and Emergency, Hospital do Espírito Santo de Évora, the Urgency Service. Évora, Portugal. Email: tatiana_piteira@msn.com
The aging process is considered a process / biological cycle, with interdependent social and psychological consequences, which occur in various structural and functional changes in body. But aging does not necessarily have to be pathological, should be seen as a natural stage of development. In this sense, the relationship with the elderly is essential to knowing and understanding their expectations in order to give meaning to their life, valuing it, dignifying and respecting it; thus, allowing the exercise of citizenship in an inclusive society.

The National Institute of Statistics set in 2011, seniors like all men or women who are 65 or older, while the percentage of elderly has increased over the years, surpassing the proportion of young people. The average annual rate of growth of the elderly population in Portugal is higher than the general population. The studies relate to the phenomenon of double aging characterized by an increase in the elderly population and reduction of young population, representing the age group of persons aged 65 or older, 19% of the total population, further indicating that the region of Alentejo is a the region most aged.

Aging can be considered, under the individual perspectives (increase in average life expectancy at birth) and demographic (increasing to the detriment of young people and / or the percentage of the active population of elderly in the total population). On closer examination, denotes that from this reality several issues emerge. If on one hand there are demographic implications. Moreover, there are also visible marked social issues, which relate to the fact that society is prepared or not to deal in terms of support needs, personal care and health.

However the issues of aging, this is sometimes accompanied by situations of physical weakness, sickness, crippling situation, and some decrease in quality of life, which leads to a change in the status of the elderly and the relationship that it has with others due to the crisis of identity, autonomy crisis, the crisis of belonging, retirement and work, family and emotional relationships and various losses that relate to loss of independence, autonomy and health.

Given this reality emerges a new paradigm, “the elderly in the urgency service” as the traditional model of primary care services focused on screening, treatment and fast forwarding does not disclose all the needs of seniors who have a complex presentation and require a comprehensive approach. The studies reveal that the number of admissions to emergency departments has increased steadily in recent decades with a greater increase of the elderly. It is estimated that this group represents 15-25% of all admissions. The elderly are characterized by an increased likelihood of atypical, comorbid diseases and polymedication.

When addressing this theme we aim to characterize the urgency service of a central hospital for the number of older people admitted, the most frequent pathologies, and the specific difficulties of this age group that presents complex social and medical problems, which implies greater permanence and resource utilization. It is because the professionals working directly or indirectly with the elderly in social contexts, political or health, the implementation of ongoing strategies as a means to ensure the maintenance of the roles and, consequently, their well-being and quality of life. Successful aging will only be achieved through a deliberate and concerted effort on the part of professionals.

**OBJECTIVE**

- Characterizing the urgency service in relation to the number of older people admitted, identifying the most frequent pathologies and social support needs of this age group.

**METHOD**

Under the 1st journeys of urgency nursing, a retrospective study was conducted, regarding the number of admissions in the urgency service, from 2008 to 2012. The data collection focused on individuals aged 65 or older. It was subsequently made an analysis in relation to flowcharts with greater relevance, the length of stay in the urgency service for admission or as a social case. The query was made by ALERT®, based on the Screening System of Priorities of Manchester.

All ethical procedures, authorization request to the ethics committee and direction, informed consent, confidentiality and anonymity were met, according to the Ethics Medical Handbook, in line with the Declaration of Helsinki (http://www.wma.net).

**RESULTS AND DISCUSSION**

Regarding the research results obtained, it allows us concluding that the total population admitted reached the maximum with 56895 in 2011. Regarding the population aged 65 or
In service where the investigation took place, the admission of the patient is taken according to the System of Screening Priorities of Manchester. This system allows the identification of clinical priority and time setting up the recommended target medical observation in each case, whether in situations of normal functioning of the urgency service or in disaster situations.

When is done the Manchester Screening is assigned to the patient a colorful bracelet, depending on the gravity of the situation: red (emergency situation), orange (very urgent situation), yellow (urgent situation), green (somewhat urgent situation) and blue (situation not urgent).

In Table 2 it can be seen that over the period, to people admitted aged over 65 years old, the priority given in greater numbers was urgent (yellow) with 12,309 patients in 2008; soon followed by not urgent (green) with 6,887 patients in 2011, however the number of very urgent (orange) in 2011 and 2012, came rising.

The experience of life, persistent complaints and no other assistance organizations are multiple and sometimes complex that for those who listen to them, it becomes difficult to select the correct flowchart Screening of Manchester, often decide the flowchart “Malaise adult” since it covers a larger number of unspecified complaints. As one can see in Table 2, the most selected flowchart is “unwell adult” every year, yet there are some situations that allow a more specific reference, such as “dyspnea”, the “chest pain” and “problems in the limbs”, the latter being associated with falls.

The identification of the most frequent pathologies can be performed by encoding the diagnosis output; however, this is rather loosely by the existence of very comprehensive codes.

As the flowchart “indisposition in adult” covers multiple complaints, it is not possible to say with certainty what the most frequent pathology is; however the data collected patents in Table 3 indicate a respiratory and circulatory disease such as medical disorders of larger incidence.

In the elderly, the physical, mental and social weakness leads to dependence and in turn to the worsening situation of illness requiring hospitalization; however, overcrowding of the inpatient services causes remain hospitalized in the urgency service while waiting for vacancy in the infirmary, which can translate the lack of preparation that many institutions have to deal with the elderly population with regard to social issues such as health care.

Between 2009 and 2011 the average hospital admissions of patients over 65 years of age amounted to 450, with a decrease of almost halved in the year 2012.

With regard to its distribution according to gender, from 2009 until the year 2011 the masculine gender prevailed with a maximum
of 240 individuals in 2011, however, in 2012, the female gender has overlapped with 148 women compared to 123 of male gender. Often the elderly are considered “a burden and a cost” for the family, plus for its social condition deficit, leads to a longer stay in the emergency service, implying the referral to social services.

Table 4 shows the number of applications to social services to support these elderly, with highest expression in the year 2010 with 497 requests. In 2008 it was not possible to determine due to lack of records.

<table>
<thead>
<tr>
<th>Years</th>
<th>No. of applications to social services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>446</td>
</tr>
<tr>
<td>2011</td>
<td>351</td>
</tr>
<tr>
<td>2010</td>
<td>497</td>
</tr>
<tr>
<td>2009</td>
<td>387</td>
</tr>
<tr>
<td>2008</td>
<td>-</td>
</tr>
</tbody>
</table>

With regard to table 5, we see that it was in the year 2012 that had the highest average age with 86.6 years old, with a maximum age of 100 years old.

<table>
<thead>
<tr>
<th>Years</th>
<th>Average age of elderly residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>86.6</td>
</tr>
<tr>
<td>2011</td>
<td>76.5</td>
</tr>
<tr>
<td>2010</td>
<td>81.83</td>
</tr>
<tr>
<td>2009</td>
<td>80.6</td>
</tr>
<tr>
<td>2008</td>
<td>No Register</td>
</tr>
</tbody>
</table>

The reasons involved in this process are sometimes dramatic: living alone in often degrading conditions; the cohabitation with relatives aged equal or older and disability in care for the elderly with the level of dependence acquired; family abandonment and lack of socio-economic conditions often associated with the current economic and financial situation and the inability of the family to dealing with the person in the terminal stage.

These situations have pride of place over the years, but the most prevalent are living alone and family abandonment, which determine the permanence of the elderly in the urgency service. There were only taken into account the social cases with more than 3 days of stay, with most staying 88 days with an average of 22.83 in 2012.

Despite the gains in life time, the proportion of years that can be expected to live without any kind of long-term disability decreases with age, along with the increased number of chronic diseases with increased risk of permanent disability.

Regarding the referral / resolution of cases these elderly in 2009 were directed mostly to continuing care units, coinciding with the opening year of the same. Throughout the period covered by the study we can also see that the resolution depends on their economic condition.

The present investigation contributed to a reflection on the action and multidisciplinary health services intervention in addressing the elderly person bearing in mind the maintenance of autonomy, independence, quality of life and recovery.

Regarding the objectives outlined, it could be able to state that the target of this research group was characterized and the variables were explored in the proposed study.

It will be pertinent to reflect on what has been achieved in these last decades, it was investigated and invested to improve and increase life expectancy. The so called quality in old age, yet we are faced with a paradox, is that these achievements have become a concern.

Aging is considered a public health problem, with predictable growth for decades to come, not only because the population is ageing, but also, and mainly, because the pair of ageing there is a system of health and social protection which is not prepared to cope with the problems and needs of the elderly and their families.

The way we age mirrors the strategies of development and quality of life of the community where we operate. Access to health care, social support and the recognition of the value of the elderly are developers of the principles of inclusion and exclusion of our society and of development models.

**REFERENCES**

1. Fernandes E. Qualidade de Vida e Maus-Tratos do Idoso na Comunidade. DigitUMa Repositório Científico Digital da Universidade da Madeira [Internet]. Funchal: Universidade