



Older Persons Evaluation, Review and Assessment (OPERA)

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Executive Summary

Acute illness has a greater adverse effect on older people than younger people as it impacts on all the major organs of the body including the brain. Older people also have higher rates of chronic diseases and underlying co-morbidities. As a result older people have higher utilisations of health services, particularly emergency departments. This increased volume of presentations combined with complexity of care means that older people usually wait longer to receive care and have higher levels of access block. This often leads to poor patient and carer experience when utilising the health services, causing unnecessary stress and disorientation. This is particularly likely if an older person spends an excessive time in the Emergency Department.

A multidisciplinary, comprehensive approach to geriatric assessment has evolved over the last 20 years as a way to improve the health care of elderly patients with complex conditions. An extensive body of literature confirms that geriatric assessment should ideally begin in the emergency department with high risk patients being referred to geriatric programs (McCusker et.al., 2001). Comprehensive evaluation and assessment in specialist units can dramatically improve the survival and functional status of older people (Cordato et.al., 2005, Cohen et.al., 2002).

The Older Person's Evaluation Review and Assessment (OPERA) program at Westmead Hospital places the older person at the centre of the care pathway to achieve better processes of care and improved outcomes. The key component of this model of care is the specialist evaluation, review and assessment of the older person at the beginning of the hospital care pathway. The skills of senior clinicians with expertise in the care of the older person are aligned to the needs of the unwell older person with minimum delay. In the Emergency Department context, these skills provide an added focus on the identification of underlying chronic diseases and/or the ageing process in addition to the acute presenting condition.

A multidisciplinary team capable of providing a comprehensive geriatric assessment supports these senior clinicians within a dedicated short stay unit for older people designed to achieve better processes of care and improved patient outcomes. OPERA provides options for older people, their families and carers to immediately access responsive and appropriate care that is designed to restore and maintain the older person's function and independence in the community. A key outcome of OPERA is to enable each individual to attain their goals in terms of remaining as independent and healthy as possible and participate in community and family life.

The Need for Change

Henry's Story

Henry's Story Prior to OPERA

Henry is an 85 year old retired priest who lives in a church residence. Henry is able to get around using a walker, a walking stick and his scooter. Henry has started to lose his functionality mainly because he has started to fall frequently. The staff at the residence are very concerned because after each fall Henry loses confidence in his ability to care for himself and to move around his residence.

Henry's story shows that without OPERA, it can be difficult for older people to regain their functionality and independence after a hospital admission.

This is a real story, only the names have been changed.

Over the past 12 months Henry has had five admissions into hospital following a fall. After the fall he had in July, Henry had to spend two days in the Emergency Department before he was assessed and transferred to a ward. Henry knows that the hospital staff are working really hard to make him comfortable but it is hard to be comfortable in the Emergency Department with so much going on all the time.

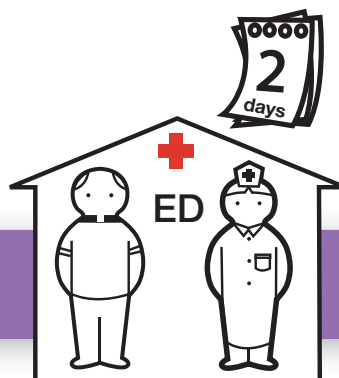
After each presentation to the Emergency Department, Henry has been transferred to a Medical Ward. After about 10 days Henry is usually able to regain his balance and functional abilities and is ready to return home again.

Once he returns home Henry gets very worried about falling again so he tries to be very careful when he is out and about. After the last fall, Henry decided not to walk outside again and to keep his walking to very short distances - just to the bathroom and down to the lounge room of the residence. It means he can't get to the library, which is at the other side of the residence but Henry really isn't confident that he will be able to get to the library and back without falling.

Henry's Journey



Henry is 85 and lives in a church residence. Henry's functionality has declined due to a number of falls he has had recently.



Over the past 12 months Henry has had five admissions into hospital following a fall. After the fall he had in July, Henry had to spend two days in the Emergency Department before he was assessed and transferred to a ward.



Henry is transferred to a Medical Ward where he is given a medical assessment.

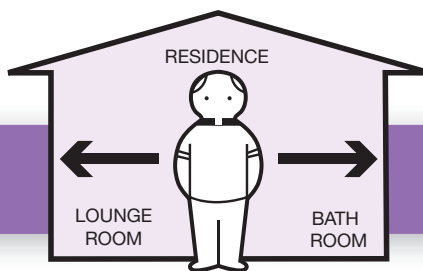
Despite his best efforts to be careful, within six weeks of his last discharge Henry presented to the hospital emergency department after falling at his residence.

What is wrong with this story?

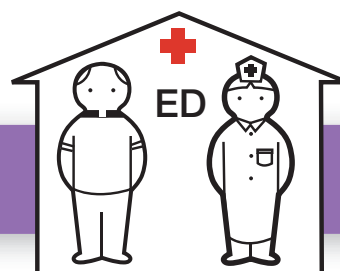
- Henry is falling frequently and having numerous hospital admissions.
- Although he recovers, after each fall Henry loses confidence and his ability to carry out ADL.
- A lack of comprehensive, specialist assessment means that he does not get the support needed to regain his functionality and mobility.



After about 10 days Henry is usually able to regain his balance and functional abilities and is ready to return home again.



Once he returns home Henry gets very worried about falling again. After the last fall Henry decided not to walk outside again and to keep his walking to very short distances - just to the bathroom and down to the lounge room of the residence.



Despite his best efforts to be careful within six weeks of his last discharge Henry presented to the hospital Emergency Department after falling at his residence.

Background to the Model



Older Emergency Department patients often have multiple interacting medical and social problems making their care particularly complex.

Their presentation at the Emergency Department often signals the beginning of loss of function and independence. They are usually more acutely and seriously ill and require longer and more complicated evaluations than younger patients (Mion et.al. 2001). Older people frequently have undetected problems including delirium, functional dependence, difficulties with self-care and depression (McCusker et.al., 2001). If discharged directly from the emergency department, older patients have poorer short term outcomes with higher readmission and mortality rates than other age groups. If admitted to hospital, many older people experience unnecessarily extended lengths of stay. As a result they lose precious remaining function.

Efficiently and effectively managing these acutely ill, complex, medical patients within the Emergency Department context is challenging. This is because emergency departments are generally structured to provide sophisticated treatment of single problems and they are often unable to accommodate the complexity of caring for older patients. This in turn means that older patients experience much longer waits and higher rates of access block.

A substantial body of evidence indicates that if an older person can be given comprehensive geriatric assessment when they present to the Emergency Department their long term outcomes are substantially improved (McCusker, 2001, Mion, 2001, Creditor, 1993). Interventions such as these can be successful at modifying risk factors for older people, improve functioning and increase their quality of life. Early, formal, geriatric assessment can identify and alleviate Emergency Department risk factors for older people and subsequent lengthy stays (Creditor, 1993). The literature confirms that programs with appropriate targeting that begin in the Emergency Department, lead to a reduction in length of stay, mortality, morbidity, nursing home placements, inappropriate medication use and improve quality of life and functional status of older people. A multi-centre, randomised trial carried out in the USA (Cohen et.al., 2002) found that inpatient geriatric evaluation and management has a significant positive effect on health related quality of life at discharge. This positive effect was especially noticeable on physical functioning and general health, bodily pain and basic activities of daily living (Cordato et.al., 2005).

The OPERA model of care is a new way of providing care to older people presenting at the Westmead Hospital Emergency Department. OPERA targets the older population who are responsible for 31% of measured access block at Westmead Hospital resulting in poor patient and carer journeys through the Emergency Department. At Westmead Hospital, OPERA provides rapid senior clinician review in the emergency department, transfer to a specialist ward, where staff have specific skills in caring for older people and multidisciplinary assessment and use of screening tools to help identify the elderly, chronic, complex patient

for rapid assessment units and short stay wards. Interventions such as these can modify risk factors for older people, improve functioning and increase quality of life. Providing this multidisciplinary care and assessment allows an extra focus on chronic illness prevention and management including the coordination of care.

There is growing recognition that geriatric medicine is hard work, non-procedural, low prestige and has escalating levels of inpatient loads in terms of numbers and complexity. Services, particularly developing services such as OPERA, properly resourced and supported with clearly defined and achievable goals can be effective solutions to health care system blocks. The OPERA program is designed to achieve better processes of care and improved patient outcomes. It aims to help each person to attain their goals in terms of remaining as independent and healthy as possible and continue their participation in community and family life.

OPERA

Henry's New Story

Henry is an 85 year old retired priest who lives in a church residence. Henry has a variety of aids to assist his mobility including a walker, a walking stick and a scooter. Henry is experiencing decreasing functional independence and mobility, mainly as the result of falling. These falls are occurring more frequently and he has had five hospital admissions in the last twelve months as a result of his falls.

Henry's story shows that with care under OPERA, older patients can receive rapid access to comprehensive, specialist assessment and care at home avoiding the need for lengthy hospital stays and loss of functionality and independence.

Not long after he presented to Emergency Department after his last fall he was surprised to have the Aged Services Emergency Team (ASET) visit him. The ASET nurse did a medical review with Henry and he was soon being transferred to the OPERA unit. Henry was pleased he did not have to spend very long in the Emergency Department.

Shortly after he arrived in the OPERA Unit, the geriatrician came to see him and carried out an assessment. Soon after that the occupational therapist, physiotherapist and the social worker each came to have a chat with him. Henry hadn't had so many visitors in a good while. These assessments help to ascertain that Henry needs a physiotherapy program and that he is medically stable enough to be treated at his residence. Henry is quickly allocated to one of the OPERA community beds.

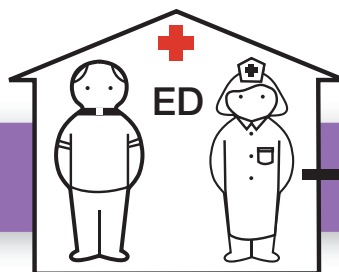
A patient coordinator is allocated to Henry and she ensures that all the appropriate referrals and his care plans are provided to the Sydney Home Nursing Service. This service provides the nursing care, assistance with personal care and domestic assistance. The OPERA occupational therapist, physiotherapist and social worker also visit Henry at home.

The carers meet with Carl who is Henry's carer and Person Responsible and note that Henry lives in a small one bedroom residence at the rear of a larger communal residence.

Henry's New Story



Henry is an 85 year old retired priest who lives in a church residence. Henry has a variety of aids to assist his mobility. Henry has had five hospital admissions over the last twelve months due to falls.



Not long after he presented to Emergency Department after his last fall he was surprised to have the Aged Services Emergency Team visit him. The ASET nurse did an assessment with Henry and he was then transferred to the OPERA unit.

OPERA Program



After he arrived in the OPERA Unit, the geriatrician, occupational therapist, physiotherapist and the social worker came to see Henry. These assessments ascertained that Henry will be medically stable enough to be treated at his residence. Henry is quickly allocated to one of the OPERA community beds.

During the meeting it becomes clear that Henry spends a lot of his time in the communal residence, in the dining room and communal recreation space. It is identified that many of Henry's functional difficulties appear to happen when he is transferring between his flat and the communal space. The 'at home' team suggest that Henry may benefit from having a room in the communal residence. It will also mean that one, and not two bathrooms can be modified to assist Henry with personal care.

The physiotherapist visits Henry at home three times a week and he is also given a home based exercise program. The occupational therapist assessed the bathroom and advised on the type and location of hand rails. The Social Worker completed an Aged Care Assessment Team (ACAT) assessment that determined he was eligible for low level hostel care.

After this four week intervention, the social worker referred Henry for Home Care. Because there is a delay in providing these services, a carer respite service was engaged to provide personal care assistance until the Home Care Services could begin.

Henry has not required admission to hospital since the OPERA community bed program was established six months ago.

What's good about this story

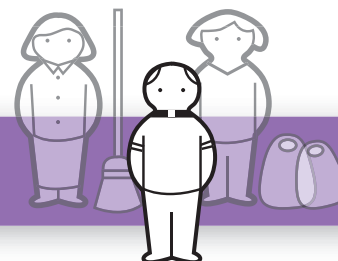
- Rapid assessment in the emergency department and transfer to the OPERA ward.
- Henry receives comprehensive specialist assessment within 24 hours.
- Community care and longer term support put in place.
- Henry has been able to avoid further hospital admissions.



The OPERA occupational therapist, physiotherapist and social worker visit Henry at home. Many of Henry's functional difficulties appear to happen when he is transferring between his flat and the communal space. The team suggest that Henry moves to the communal residence.



The physiotherapist visits Henry at home three times a week and he is also given a home based exercise program. The Social Worker completed an Aged Care Assessment Team (ACAT) assessment that determined he was eligible for low level hostel care.



After this four week intervention, the social worker referred Henry for Home Care. Henry has not required admission to hospital since the OPERA community bed program was established six months ago.

What is OPERA?



The Older Persons Evaluation Review and Assessment (OPERA) program at Westmead Hospital places the older person at the centre of the care pathway. The philosophy of OPERA is to supplement other aspects of health care to minimise the impact of disease and disability on the personal independence and autonomy of the older person.

OPERA is designed on the principles outlined in the 'Framework for Integrated Support and Management of Older People in the NSW Health Care System 2004/06'. Its purpose is to reduce the waiting and treatment time for older people, reduce access block and improve the process of care by giving older patients, their families and carers, options that are designed to maintain and restore an older person's function and independence.

The secondary gains of the OPERA program are to:

- Create a safe health care environment for older people.
- Improve access to aged care specialists and support services in the hospital and the community.
- Improve consumer satisfaction.
- Coordinate better care for older people.
- Obtain efficiency gains for the health system including management of the ED, hospital capacity and demand pressure.

The OPERA model of care works in conjunction with a range of other innovative and evidence based Models of Care at Westmead Hospital. These models are specifically designed to cater to the needs of older people.



How Does OPERA Work?

Key Components of OPERA

- Emergency Department Review
- Eligibility Criteria
- Multidisciplinary Review and Assessment
- Exiting the OPERA Ward
- Benefits

Emergency Department Review

The key component of OPERA is to provide older people with comprehensive geriatric assessment as early as possible. On presentation to the Emergency Department at Westmead Hospital, the ASET nurse rapidly carries out an assessment.

Patients suitable for OPERA are transferred to the OPERA ward as soon as practical.

Eligibility Criteria

An older person is eligible for admission to the OPERA program if on admission to the Emergency Department they are assessed as:

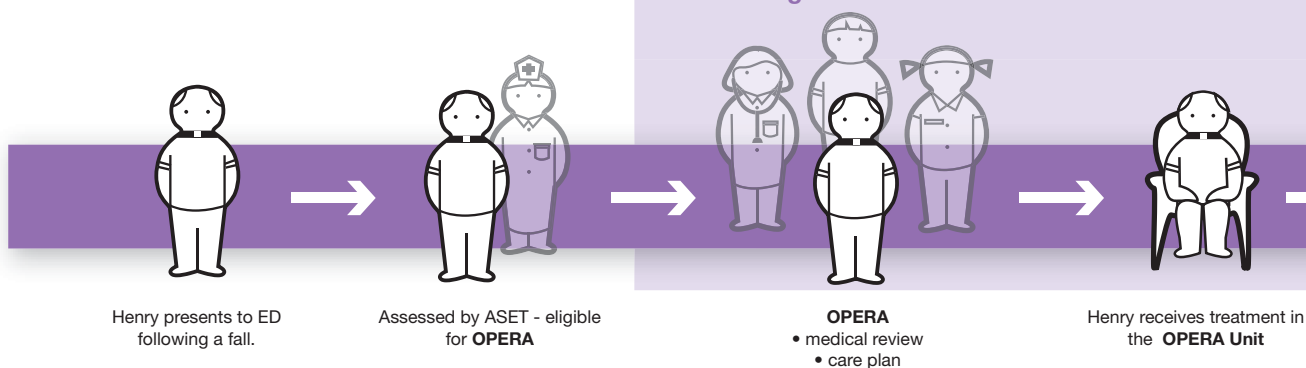
- Triage Category of 3, 4 or 5
- over 70 years of age
- not in need of speciality specific pathways such as cardiac pain, palliative care or procedural intervention.

Multidisciplinary Review and Assessment

Once admitted to the 20 bed OPERA unit, patients are given a comprehensive geriatric assessment comprising of a medical and nursing assessment, followed by a multi-dimensional overview and multi-disciplinary assessment. This specialist OPERA ward, whose staff all have specific skills in caring for older people, provides this multidisciplinary assessment and review.

Over the term of the older person's stay in the OPERA Unit, a multidisciplinary care plan that includes plans for transfer from OPERA to other services is developed and

OPERA Community Bed Patient Journey



implemented. This may include transfer to another inpatient area, an OPERA community based bed, and/or reference to speciality clinics such as the fall or Dementia Clinics and ongoing community services, rehabilitation and/or day centres.

Exiting the OPERA Ward

On completion of the multidisciplinary assessment in the OPERA ward patient are either:

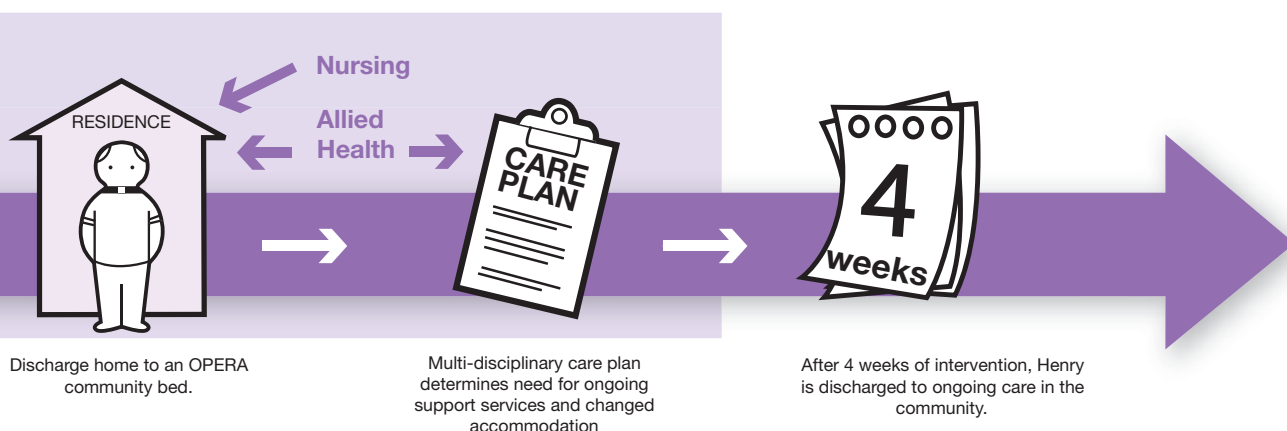
- discharged home
- transferred to an Acute Medical Ward (this may be the Geriatric Ward)
- transferred to rehabilitation either in-patient, home based, or transitional care
- transferred to an OPERA community bed.

Patients exiting the Geriatric Services at Westmead Hospital are also able to access a range of community based services and programs including:

- geriatric day hospital
- falls clinic
- dementia services.

Benefits of OPERA

- Better care processes for both patients and staff.
- Early access to specialist aged care.
- Less time spent in emergency departments for older people.
- Reduced access block for hospitals.
- Better outcomes for older people.
- Creates linkages with other service providers to improve access.
- Can improve key performance indicators.



OPERA Day

At 8.30 am each morning the Registrar, Allied Health and Nursing staff meet around the Bed Board to discuss each patient's care plan. The constant focus is on facilitating timely exit from the ward into an appropriate Model of Care.

The team have a complex patient to deal with today.

Monday 6:00 PM

Bob is admitted and the OPERA team quickly establishes that he is very disorientated, frail and has limited capacity to complete activities of daily living. Bob has frequently been unwell over the last three months and he has a history of chronic obstructive pulmonary disease (COPD)

Tuesday 9:00 am

Shirley who is Bob's wife and primary carer arrives at the hospital. The medical team undertakes a full medical review and treatments are begun.

Tuesday 10:30 am

The social worker interviews Bob and Shirley to discuss their current living arrangements, challenges and concerns. They explore all aspects of Bob and Shirley's lives, and together identify a need for more domestic assistance as Shirley needs some extra help.



Tuesday 12:00 pm

The occupational therapist talks to Bob and Shirley about Bob's previous and current levels of physical functioning. The occupational therapist also performs a shower assessment and mobility assessment.

Tuesday 1:00 pm

Bob's confusion is resolving and the medical team believe he was suffering from a UTI. He is referred to a specialist for review while the geriatrician, the OPERA multidisciplinary care team and Shirley start to plan for Bob's return home. All agree that Bob would benefit from a short burst of rehabilitation to assist him to regain his strength.

Tuesday 5:00 pm

Bob is transferred to the rehabilitation ward with the goals of improved function in activities of daily living and increased exercise tolerance.

Tuesday 5:30 pm

All of Bob's notes that have been collected by the OPERA team are handed over and discussed with the Rehabilitation Team. The geriatrician maintains ongoing responsibility for Bob's care.

What's good about this Model of Care?

- Bob is quickly removed from the Emergency Department to a ward that has substantial expertise and is especially focused on the needs of older people.
- Bob and his wife Shirley are included in every stage of his assessment and care planning.
- An accurate diagnosis is ascertained and managed in conjunction with a holistic view of needs established and acted on.
- The need for rehabilitation is identified and rapidly instigated.

Key Components

Multidisciplinary Care

The OPERA team includes nursing, social workers, physiotherapists, and occupational therapists backed by senior medical input. This team is capable of developing a comprehensive care plan with a range of community linkages. This can include linkages to community health (generalist nursing), ACAT assessment, aged care psychiatry, community aged care packages, dementia support, respite services, meals on wheels, and linkages to community groups such as Aboriginal and Torres Strait Islander and culturally and linguistically diverse community groups.

Linkages and Partnerships

Ideally the OPERA unit is based physically close to the emergency department as it works in close partnership with the Emergency Department using its reception, clerical and triage processes. OPERA consultants have the same delegated authority as the senior Emergency Department staff to determine if, after careful review, a patient would be more appropriately cared for by another clinical unit.

In addition to the Emergency Department point of entry, the OPERA unit is linked into the Westmead Integrated Aged Care Service (WIACS). This is an integrated program that includes ACAT, domiciliary care, interdisciplinary rehabilitation, dementia advisory team, a rapid response team, and geriatric day hospital together with the inpatient program. Older people with needs assessed to be clinically urgent are currently directed to the emergency department. There is potential for selected cases accessing the WIACS system to 'by-pass' the ED and present directly to OPERA. This close functional relationship to the Geriatric Medicine Ambulatory Care system is critical for comprehensive management of the OPERA patients who do not receive hospital admission.

Quarantined Beds

To ensure rapid turnover and bed availability, OPERA beds are quarantined from non-OPERA admissions at all times. OPERA beds can only be used for non-OPERA patients with the authorisation of the unit director, the Geriatrician on call or the Director of Clinical Operations. Surge bed patients can only be transferred to OPERA beds after discussion with the Nursing Unit Manager and the approval of the Unit Director. In these circumstances priority is given to patients of the Department of Geriatric Medicine.

Identify Gaps and Blocks

Identifying the potential gaps and blocks in the delivery of health care to older people that impact directly on other key performance areas is essential. The OPERA program recognises that geriatric medicine is the solution to, not the cause of problems with the health care of older people.

Staffing

The OPERA program has made a deliberate attempt to promote and retain young talent and to promote the development of a workforce with specialist skills in the care of the elderly. The focus of OPERA staff is to emphasise the strengths of the program and to work collaboratively to overcome the weaknesses in the program. A successful OPERA program will include:

- Consultant, registrar and junior medical officer.
- An allied health complement to each team that includes both senior and junior staff.
- Trained nursing staff.

Sustaining OPERA

To sustain the OPERA model it is important that there is:

- A recruitment policy that recognises the importance of aged care staff skills.
- Good training for staff in the care of the older person.
- Realistic goal setting.
- Realistic workloads/rosters/on call systems.
- Adequate resources - equipment and staffing.
- Remuneration consistent with the workload and contributions required.
- A sense of pride and appreciation in the work.
- Appropriate physical spaces to allow recuperation for older people.
- Acknowledgement of the contributions by public expressions from authority figures.

Implementing OPERA

Process Map

Visit the online version of this process map on the ARCHI website at www.archi.net.au/elibrary/build/moc

Here you will be able to access more information on each of the steps in implementing the model. You will have access to tools and templates as well as hints and lessons learned by others who have implemented the model.

	Planning Where are you now?
Governance	<ul style="list-style-type: none"> • Identify leaders • Develop a process map • Establish a steering committee
Patient Journey	<ul style="list-style-type: none"> • Map the patient journey
Policies and Protocols	<ul style="list-style-type: none"> • Identify and review current policies and protocols affecting the care of older people • Identify gaps in existing policies, protocols and guidelines • Identify eligibility criteria and referral points
People	<ul style="list-style-type: none"> • Stakeholder analysis • Engage GPs, residential aged care facilities, ward, ED clinical staff, senior management, nursing and allied health champions • Develop a staff profile
Resources	<ul style="list-style-type: none"> • Survey current resources • Identify the resources needed to establish and maintain OPERA
Communication	<ul style="list-style-type: none"> • Develop communication plan

Preparing Making it happen	Operationalise Make it stick
<ul style="list-style-type: none"> • Develop a Governance Plan • Recruit a project officer • Develop a project management plan • See the SESIAHS Lessons Learnt - Project and Program Management • Develop key performance indicators 	<ul style="list-style-type: none"> • Monitor and evaluate against the KPIs • Provide regular reports and updates
<ul style="list-style-type: none"> • Identify changes that need to happen to improve the patient journey. • Document 'new' patient journey. • Include the perspective of carers and family 	<ul style="list-style-type: none"> • Monitor and remap the patient journey
<ul style="list-style-type: none"> • Develop policies and protocols. • Develop the operational structure • Develop referral systems • Develop agreements with other service providers. 	<ul style="list-style-type: none"> • Use protocols • Have an ongoing review mechanism for all policies and protocols • Refine as required • See the SESIAHS Lessons Learnt - Risk Management
<ul style="list-style-type: none"> • Work with community based organisations to develop seamless care processes • Develop competencies • Develop position descriptions for staff 	<ul style="list-style-type: none"> • Implement competency standards • Develop a review process
<ul style="list-style-type: none"> • Deliver required resources • Establish a referral system • Implement third party agreements 	<ul style="list-style-type: none"> • Monitor use of resources and modify as required
<ul style="list-style-type: none"> • Tell people about OPERA at every opportunity • Identify how results will flow back to key stakeholders • See the Baxter Awards 2006 where OPERA was a finalist in the Innovation category. 	<ul style="list-style-type: none"> • Ensure that there is a feedback and review process • Monitor and review communication plan

Resources

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