Geriatric Interdisciplinary Case Summary (GICS)

Practice Case on Mr. Hudson

Chief Complaints: Frequent falls

HPI: Mr. Hudson is an 87 y.o. African American man who was admitted to the Shands Jacksonville Hospital after having a fall. The patient states that he got out of the bed and tripped over an area rug when he walked from the bedroom to the bathroom. His daughter who was visiting Mr. Hudson from Atlanta, Georgia, reports that Mr. Hudson had just gone back to his bedroom to take a nap after having breakfast. Then, the daughter heard a big bang from the bedroom. In the bedroom, the daughter found Mr. Hudson lying on the floor. He was conscious but slow to respond to the daughter. The daughter called an ambulance and Mr. Hudson was sent to the Shands Hospital at Jacksonville.

In the ER, his electrolytes, cardiac enzymes, CT scan of the head and cardiac monitor are all normal except that his BUN was 32 and creatinine was 1.2. Daughter reports that Mr. Hudson rarely drinks any fluid between meals. Daughter also brought Mr. Hudson's medication bottles which include: 1) Glyburide 2) Metformin 3) Lisinopril 4) Terazosin 5) Digoxin 6) Metoprolol *) Clopidogrel 9) Naproxen as needed for arthritis. Mr. Hudson is subsequently admitted to a medical ward. Mr. Hudson receives IV fluid for treatment of dehydration.

After 3 days in the hospital, Mr. Hudson recovers and starts acting like his normal self. A physical therapist is called to evaluate his gait and mobility. After evaluating his gait and balance, the physical therapist reports that Mr. Hudson is weak and very dizzy when he gets out of the bed. He can get up from lying to sitting position, but requires one person to assist in standing up from the sitting position. He walks with slightly stooped posture and small shuffling gait. He almost falls backward when being asked to turn around. Mr. Hudson states that he has pains in both knees on standing up. He also states that his legs feel much weaker than they were before hospitalization. The physical therapist determines that Mr. Hudson is at a high risk for recurrent falls. The therapist recommends Mr. Hudson to try inpatient rehabilitation. On the next day, Mr. Hudson is discharged to the Transitional Care Unit of Shands at Jacksonville.

PMH: 1) Type II DM for 15 years 2) HTN 3) Coronary artery disease with stent placement 2 years ago 4) Macular degeneration 6) Mild congestive heart failure 5) Osteoarthritis of shoulders and knees 6) Benign prostate hypertrophy 7) Fractured right wrist from a fall 2 month ago when he slipped and fell when he stood up from a toilet commode in the bathroom. 8) Frequent falls

PSH: Cataract surgery of both eyes

Allergies: None

Medications prior to transfer to Transitional Care Unit: 1) Glyburide 2) Metformin 3) Lisinopril 4) Terazosin 5) Digoxin 6) Metoprolol 8) Clopidogrel 7) Naproxen as needed for pain 10) Diphenhydramine at bed time as needed for sleep. 11) Reglan 200 mg 30 minutes before meals as needed for nausea and early satiety 12) Propoxyphene N 100/APAP 650 mg 1 tablet every 6 hours as needed for severe back pain. 13) Lorazepam 5 mg three times per day as needed for anxiety.

Geriatric Interdisciplinary Case Summary (GICS)

Social History: Retired salesman. He graduated from high school. He smoked 2ppd but quit 2 years ago. He denies alcohol use. He lives alone in a rented apartment located on the second floor of the building. He has 3 other siblings and 4 children. His closest relative is his daughter who lives in Ohio. He receives a social security check with a monthly income of $1050. He spends $300 per month on the rent and $280 per month on prescription medication.

Family History: His 70 y.o. brother died from a heart attack. His 87 y.o. sister has Alzheimer's disease.

Functional Assessment prior to admission:

ADL's: He has no difficulty with bathing, dressing, toileting, transfers, continence or feeding.

Instrumental ADL's: He can use telephone, shop for groceries, prepare meals, clean his apartment, do laundry, riding a bus, taking medicine, or managing his money. He no longer drives a car. He rides a bus once a week to buy groceries.

ROS: Generally: Weight loss of 20 lbs in the last 6 months. No energy
Head: Lightheaded on standing and walking
Lung: Denies shortness of breath
Heart: Denies chest pain or palpitation
Abdomen: Denies abdominal pain. Constipated.
Extremities: No swelling, pain in the left foot and both knees
Mood: Feels bored.
Memory: Sometimes has difficulty with remembering names of people that he has just met.

Vital Signs:

Lying down:	bp 145/90, pulse 88
Standing:	bp 115/80, pulse 98
Standing x 3 minutes:	bp 110/75, pulse 100

PE: **Head:** Abrasion over the right temple
Eyes: Visual acuity: R 20/200, L 20/50, Visual field is grossly full.

Ear: Unable to hear whisper from the left ear. The tympanic membranes are normal.
Oral: Edentulous. Not wearing any dentures
Neck: No bruit
Heart: Holo systolic murmur heard in the 2nd left sternal borner with radiation to the neck.
Foot Exam: Tigltly fitting shoes. A large callus in the sole of the left foot over the 2nd metatarsal joint.
Musculoskeletal: No deformity of joints. Crepitus in both knees on flexion and extension. Limited range of motion of the both shoulders
Neurological: Decreased pinprick and vibration senses of soles of the both

feet. Propioception is normal. Strength: Decreased (3/5) in both legs. Normal tone. +Romberg.

Get-Up-and-Go Test: Requires one-person to get out of the chair. He walks slowly with a stopped posture and shuffling gait. It takes 65 seconds to complete the test.

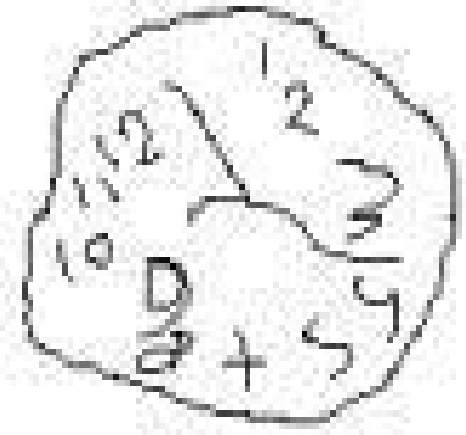
Nutrition: Nutrition Score: 7/ 21

He said yes to questions on having to change the kind of food he eats because he has no teeth, not always having enough money to buy food he needs, taking 3 or more different prescribed medications, losing 10 pounds unintentionally in the last 6 months.

Psych: Geriatric Depression Scale (GDS) – 8/15

MMSE – 26/30. Missed 1 question on orientation, 2 question on recall, and 1 question on copying.

Clock drawing test - See below. (Instruction: "Draw a face of a clock indicating 10 minutes after 11 o'clock.")



Formulate a Geriatric Interdisciplinary Care Summary by filling out a template. Identify any additional test needed and include them in the Geriatric Interdisciplinary Care Summary:

After completing a Geriatric Interdisciplinary Care Summary for Mr. Hudson, review the completed summary and compare to the answer key.

**USE WORD TEMPLATES IN STUDYCORE

GERIATRIC INTERDISCIPLINARY CARE SUMMARY

Patient Name: Jack Hudson **Age:** 87 yo **Gender:** male
Admission Date: 11/10/2014
Admission Diagnosis: Abnormal gait
Frequent falls

Other Major Diagnoses: DM, HTN, CAD, Macular degeneration, Mild CHF, OA of shoulders and knees, BPH

Student Name: John Doe **Date:** 11/11/2014 **Location:** Shands at Jacksonville Transitional Care Unit

Domain	Problem(s)	Disciplines to Address the Problem(s)	Treatment Goal(s)
Physical Med & Rehabilitation 	1. Hx of frequent falls 2. Immobility during hospitalization 3. Leg weakness 4. Imbalance 5. Abnormal Get-Up-And- Go test (Slow walking speed, stooped posture and shuffling gait) 6. Large callus in the sole of the left foot 7. Ill-fitting shoes	1, 2, 3, 4, 5 Physical therapist M.D. 6. Podiatrist 7. Podiatrist Family (to bring better fitting shoes from home)	1, 2, 3, 4 and 5 Physical therapy referral for gait, balance, and strength training 1 hour twice a day Explore treatable causes of falls and imbalance (vitamin D deficiency, testosterone deficiency, carotid stenosis, medications, benign positional vertigo) 6. Podiatry referral for filing of the callus 7. Ask daughter to bring better fitting shoes from home
Cognitive 	1. Abnormal clock drawing test 2. Problems remembering names 3. Moderately decreased MMSE	1, 2, and 3 Geriatric psychologist M.D.	1, 2 and 3. Psychology referral for further assessment to explore causes of cognitive impairment and non-pharmacological intervention (counseling)

			Obtain more history of cognitive impairment from family and friends Review all the medications taken by patients Order tests (TSH, RPR, CBC, Hgb A1C) and to screen for treatable causes of apparent dementia
Emotional 	1. Anxiety 2. Insomnia 3. Depression: GDS 8/15 4. Feeling "bored"	1-4. Geriatric Psychologist M.D.	1-4. Psychology referral for further assessment to explore causes of emotional problems and counseling (e.g. testosterone deficiency, hypothyroid, anemia, etc.) Discontinue or taper off medications which may destroy his sleep architecture (e.g. lorazepam, diphenhydramine).
Medical/Surgical 	1. Dizziness 2. Arthritis of both knees 3. Taking 5 prescription medications 4. Orthostatic hypotension 5. Decreased vibratory senses in the both feet 6. Significantly decreased visual acuity of the right eye 7. Inability to hear whisper from both ears	1, 2, 3, 4, and 5. M.D. 3. Pharmacist 6. Ophthalmologist/Optometrist Family (bring glasses from home if he has any) 7. Audiologist Family (Bring hearing aids from home if he has any)	1, 2, 3, 4 and 5. Explore treatable causes of dizziness and orthostatic hypotension (e.g. medications, cardiac, pulmonary, or neurological problems) Discontinue medications which may cause dizziness (Proxyphene N 100/APAP, lorazepam, diphenhydramine) 6. Eye clinic referral 7. Audiology referral

Nutritional 	1. No Denture 2. Low nutritional Score (7/21) 3. Unintentional weight loss of 10 lbs in last 6 months 4. No money to buy food he needs 5. Taking ≥ 3 prescription meds	1. Dentist Dietitian Family (Bring dentures from home if he has any) 2, 3. Dietitian M.D. 4. Social worker 5. M.D. Pharmacist	1. Dental Referral 2, 3. Dietitian referral for food preferences and adjust calories and protein content of diet Obtain albumin/prealbumin 5. Refer patients for 'meals- on-wheels' 6 Discontinue or taper off medications which are unnecessary.
Environmental 	1. Area rug on the floor 2. Living in an apartment on the second floor	1. Occupational therapist Family & friends 2. Physical therapist	1. Removal of the area rug from the floor Assessment of home safety in preventing falls 2. Physical therapy referral for assessment of his ability to climb up and down the stairs and daily training
Social/Caregiver 	1. Living alone 2. Closet family (daughter) living far from the patient	1, 2. Social worker/Case mgr Family & friends	1, 2. Explore different options for living arrangements (e.g. Moving in with his daughter or live with a friend)
Economic 	1. Limited income ($1050 per month) 2. Taking 7 prescription medications ($280 per month)	1, 2. Social worker/case mgr Family M.D.	1.2. Social worker referral to evaluate his eligibility for Medicaid and other state-sponsored prescription medication assistance programs Explore financial assistance from his family Switch brand-name medications to generic equivalents if possible

Barriers to the Treatment Goals:

Patient's goals after discussing the above Treatment Goals: **Date discussed:** _____

Family/Caregiver's goals after discussing the above Treatment Goals: **Date discussed:** _____

GERIATRIC INTERDISCIPLINARY CARE SUMMARY

Check one: ☐ **Initial Visit - Week 1**

Patient Initials: RL **Admission Date:** XX/XX/XXXX **Location: GEM Unit – Gainesville VA**
Admission Diagnosis: Resolving ARF w/ AMS and falls **Other Major Diagnoses:** multifactorial disequilibrium, parkinsonism vs disease

Student Name: XXXXX **Date: XX/XX/XXXX**

Domain	Problem(s)	Disciplines to Address the Problem(s)	Treatment Goal(s).
Physical Med & Rehabilitation 	1. Instability w/ chronic falls 2. Problems with ADL's/IADLs **Admission FIM – OT:** **ADLs:** Feeding: 6 (patient states he spills less food with fork than spoon) Bathing: 4 (veteran's wife dries back) Upper Body Dressing: 5 (wife/nursing/butto n aide) Lower Body Dressing: 4 (wife/nursing helps with socks and shoes) Grooming: 6-7 Toileting: 4-5	1. GEM Team (1, 2, 3) 2. Gait & Balance Clinic w/ Neurology (Dr. Nadeau) (1) 3. PT – via clinic and bedside visits (1 & 2) 4. OT –via clinic & bedside visits (1 & 2) 5. PM&R (3) 6. Nursing – walking program (40 ft w/ assistance) (1 & 2) 7. Pharmacy (3)	1. Improvement in function to level that he could progress to SNF near home (problem 1 & 2 inter- related). 2. ADL Progression to meet FIM level that reflects pt & caregiver goals → to be functional enough for transfer to SNF. Specific noted goals for OT are improving transfer safety and showering skills. 3. Continue current pain management with PRN medications as written.

	IADLS: Finances/bills: 1 Cooking/Meals: 1 Housekeeping: 1 Driving:1 Splints required: none **Admission –** **PT:** Bed Mobility: 6, uses rails Transfers: 5 Wheelchair Locomotion: 1 Ambulation: 2. Vet ambulated 12' with a wheeled walker and min. assist Stairs: 1 3. Chronic R shoulder and left knee pain.		
Cognitive 	1. Mild Dementia: 16/30 MOCA (neurology consult on prior admission), Clock Drawing Test (correct number placement, incorrect drawing of hands and echopraxia) 2. Delirium 2/2 ARF (likely medication induced complicated by dehydration)	1. GEM Team (1 & 2) 2. PCP: via reference to notes looking at baseline cognitive function, possibility of depression (see emotional) (1) 3. Pharmacy (1 & 2) 4. Neurology (1)	1. Continue to maximize depression and RLS treatment per neurology recommendations in an effort to treat diagnoses that can appear to be dementia. Continue to include updates in notes so PCP can f/u on persistent symptoms of dementia after depression/RLS treatment so can continue acetylcholinesterase tx if

			desired. 2. Continue hydration protocol as described in nutrition, reorientation to person/place/date daily, maintaining regular bowel/urine regimen, keeping patient mobile, and continually re- evaluating polypharmacy to proactively prevent delirium.
Emotional 	1. Depression (hx consistent with depression, non-responsive to current medication regimen)	1. GEM Team 2. Geriatric Psychology 3. Pharmacy 4. Neurology (Dementia vs depression ddx)	1. Continue to monitor for treatment response to current change in depression regimen. Also, evaluation for possible change in depression medication before discharge pending new research on Citalopram dosage.

Medical/Surgical 	1. Resolving Delirium 2/2 ARF 2. Parkinsonism vs Parkinson's Disease 3. RLS 4. Diabetes – previous day's accuchecks → 108 → 279 → 229 (asymptomatic) 5. HTN – BP's 123-136/55-81) 6. Hypothyroidism 7. Open-Angle Glaucoma 8. Burning Eyes	1. GEM Team (all) 2. Nursing (all) 3. Nutrition (4) 4. Pharmacy (1, 2, 3, 4 → involved w/ all but active mgmt with these) 5. Neurology (for 2&3)	1. Continue hydration via diet order changes, continue to avoid polypharmacy that can worsen kidney function. 2. Update problem list and notes to reflect absence of parkinsonian/PD diagnosis or symptoms 3. Monitor for therapeutic response and need for titration of medications 4. Continue ISS to help fluctuations as noted in problem list, if ISS continues to be necessary → add in home regimen of metformin in effort to improve glucose and place pt back on home regimen in preparation for d/c 5/6/7. Stable, continue meds 8. Continue saline eye drops TID.

Nutritional 	1. Diabetic (glucose levels noted above). 2. Additional oral fluid intake	1. GEM Team (1 & 2) 2. Nursing (monitoring of glucose/ISS and extra fluids) (1 & 2) 3. Nutrition: helping to "flood" diet tray with extra fluid (1 & 2)	1. Help maintain appropriate blood glucose via diet low in sugar in conjunction w/ meds noted above (glyburide + ISS, possibly metformin in next week) 2. Continue to provide additional oral fluids to aid in rehydration s/p kidney failure, prevention of dehydration and risk factor for delirium
Environmental	1. Home: <10 feet to bathroom, 20 ft to kitchen, & living room, 1 story house of house (mobile home), no other steps in house and wheelchair ramp to get into home outside; patient has electric chair for outside and walker for inside → can roll walker into shower, detachable shower head, bars and seat via home eval	1. OT	1. No further recommendations for environmental changes or assistive devices as all needs were addressed.

Social/Caregiver	1. Only consistent caregiver he will let help him is wife – caregiver tired/burnout. Son and grandson live nearby but busy and patient does not like to let wife call them for help.	1. GEM Team 2. Social Worker	1. Continue with d/c planning via SW and GEM team to allow for patient d/c to SNF near his home, so wife can visit but remain rested. Provide wife with information for Respite Care (Lake City) as well as Home Health Aid (12 hours/wk) should patient be transferred back home so she can have rest from patient care.
Economic	1. Patient Insurance Medicare & Tricare – per wife/caregiver, pt has no copays for medical stays or medications, they both receive social security (wife 1200/month and pt ~1400/month); expenses are $100 for medicare/month and then food/transportation costs which she could not quantify but she states is taken care of with their income 2. No house payments (per wife)	1. Social Worker	1. Continue to give patient and caregiver active feedback throughout placement process regarding any financial burden they might incur so that they can be prepared for what may happen and/or refuse service if they desire.

1. **Barriers to Treatment Goals:**
    a) Caregiver need for rest
    b) Complicated patient presentation regarding diagnoses that interact and need appropriate medication management and follow-up in order to accomplish goals.
    c) Patient lack of initiative in therapy likely 2/2 depression and possibly dementia.
    d) Family dynamics: difficulty to establish treatment goals when there is lack of open communication between husband/wife

2. **Patient's goals after discussing above Treatment Goals:**

    Patient conveys wishes for:
    a) Return to his ability to move, though slowly, around the SNF
    b) Relief of his RLS at the lowest dose of medication possible
    c) Relief of his depression at the lowest dose of medication possible
    d) Discontinuing of any medication not absolutely necessary to his care
    d) Help his wife rest while still being able to take care of him, transfer to SNF near home asap

3. **Family and/or caregiver's goals *(wife's goals)* after discussing above Treatment Goals:**

    a) Caregiver would like to have more opportunities to rest and to be able to have time with her friends → whether that be via pt transfer to SNF or use of Home Health Aide for 12 hrs/wk and Respite Care 2 wks/year if patient is transferred back home
    b) Would like for the patient to be able to get himself out of bed without help and come to the dinner table and to other rooms without assistance, especially if patient is transferred home
    c) Would like for him to be able to receive the proper medication and regimen that helps his mood and RLS as she feels this will improve how he treats her (hopefully) and his motivation to move around for himself

4. **Social Worker/Case Manager's goals after discussing above Treatment Goals:**
    For patients who do not have an active or present family/caregiver.

    Social Worker's goal → help pt get placed in SNF on d/c to maintain care of patient while also helping with caregiver stress by providing her rest from 24 hr care responsibilities

GERIATRIC INTERDISCIPLINARY CARE SUMMARY

Check one: ☐ **Initial Visit - Week 1**

Patient Initials: JP **Admission Date:** XX/XX/XXXX **Location: GEM VA**
Admission Diagnosis: TLKA rehab **Other Major Diagnoses: Lower back pain, obesity, HTN**

Student Name: XXXX **Date: XX/XX/XXXX**

Domain	Problem(s)	Disciplines to Address the Problem(s)	Treatment Goal(s).
Physical Med & Rehabilitation 	1. Obesity with BMI of 46 kg/m2 2. Left knee surgery immobility with ~75% flexion 3. Moderate endurance with 120' with wheeled walker before needing rest 4. FIM scores bathing 3, upper body dressing 6, lower body dressing 2, grooming 6, and toileting/bowel management 5.	**1, 2, 3,4,5- PT, OT, RT** (both PT and OT work with increasing overall functioning and performance of the body so they either directly or indirectly affect all of these problems together)	**1,3-** improve cardiovascular endurance and caloric consumption by encouraging daily ambulation wheeled walker with goal of 200' without resting and participation of 45-60 minutes of recreational therapy 2x week **2 -** daily PT to improve flexion and extension of knee, e.g. 8" step ups, roller skate stabilizers, and hand rail walking. Also use continuous passive motion (90°) machine while laying **4.** Discharged from OT. Learned how to use leg lifter, dressing kit, and energy saving techniques.

Cognitive	1. No cognitive problems with a score of 30/30 on MMSE		
Emotional  	1. PTSD from Vietnam. PTSD 4Q with score of 4. Has nightmares, flashbacks, triggers, vigilance, enjoys isolation. 2. Questionable depression with a 5/15 on GDS but 3 on PHQ2 3. Past history of passive suicidal ideations	**1, 2,3-** MD, geriatric psychologist, social worker	1,2,3- Continue to provide daily support and therapy. Patient is not currently on any SSRI's, but would like to discuss this option at his upcoming mental health appointment.
Medical/Surgical 	1. Obesity 2. Chronic LBP 3. Previous left knee surgery 4. Low testosterone 5. HTN 6. Low vitamin D	**1,2,3,4,5,6-** MD, 1-dietary, **2,3-**PT	**1.** Dietary needs to advise regarding healthy eating habits **2,3.** PT 5x a week with strengthening legs which should decrease back load. Baclofen 10 mg prn spasm. **4.** Testosterone patch daily to improve energy and muscle strength. Will take weeks to see effects. **5.** Keep BP below 140 **6.** Give vitamin D and calcium, will recheck on Monday.

Nutritional 	1. Unhealthy eating habits, e.g. a lot of juices and red meat 2. Does not cook, a lot of packaged foods	**1,2-** dietary, MD	**1,2-** continue to educate on healthy eating habits and cutting out sweet foods on regular diet
Environmental 	1. Rents a 2 bedroom/2 bath mobile home with 3 steps and wooden hand rails for entrance. Grab bars and shower hose available in showers. 2. Cinder block to get into bathtub and cooler to sit on. 3. Low toilet	**1,2-**social worker, PT/OT, MD	**1-**continue 8" steps as tolerated and move to 10" Continue daily strengthening of quads 2,3- Educate and demonstrate proper use of shower tub bench**,** elevated toilet seat, and hand held shower head.
Social/Caregiver 	1. Lives alone 2. Next of kin is a son who lives in AZ	**1,2-** social worker and MD	**1**,2- he now says his son will come from AZ if he needs significant amount of help. He plans on getting a house care sitter to come occasionally for cooking and cleaning.

Economic 	1. Has no economic problems: retired $1450.00/month VA compensation $1050.00/month social security 2. He is 60% service connected and has Medicare to pay for his 4 prescription drugs (cyclobenzaprine, amlodipine, ms contin, and Percocet) 3. Over 7 million dollars in assets including properties and gold/silver/guns		

1. Barriers to Treatment Goals:

As per last week's GIC, the patient's biggest barrier to full rehabilitation is his obesity which exacerbates his maneuverability and endurance. He has adequate enthusiasm and dedication to physical therapy, but his weight makes it difficult for execute therapies to their full potential. He says he is open to eating healthier but living alone and not cooking makes this difficult given his preference for prepared foods. Exercise and physical therapy of his knee is difficult with his low back pain, low energy from low testosterone, potentially weak bones from low vitamin D, and chronic low back pain. We have addressed all these comorbidities (baclofen for back pain, testosterone patches, calcium/vitamin D supplements) and hopefully allow him to achieve greater rehabilitation of his knee. Another barrier to treatment is, even if he has maxed out services and therapy at the GEM unit, he is at increased risk of falls given the stairs of his mobile home and cinder blocks to get into his tub. OT and social services can educate him on how to use the hand rails and shower benches, but his adherence will be crucial. Finally, his last barrier is that he will be alone once he goes back to his mobile home so no one will be watching after him. He claims that he has had a house care sitter before who cooked and cleaned and will get her help again if he needs it. His son will also move out to Florida from Arizona if need be.

2. Patient's goals after discussing above Treatment Goals:

Patient is completely satisfied with his current treatment goals. He is dedicated to therapy and wants to strengthen his ability to walk up stairs and become independent. He doesn't want to go home until he has the ability to perform ADL's and IADL's without assistance, but is open to occasionally asking the help of a home care individual if need be. He thinks testosterone will help his energy and wants to start the patch. He also is open to suggestions for eating healthy but says he really enjoys juices and red meat a lot and doesn't know if he can change at this age.

3. Family and/or caregiver's goals after discussing above Treatment Goals:

Patient says we do not need to call and have conference with son because he calls him frequently to update him on his status. The son is very committed to his father and has agreed to move to Florida if the patient needs his help.

4. Social Worker/Case Manager's goals after discussing above Treatment Goals:

The anticipated goal of the social worker is to ensure the patient has adequate resources available to prevent any further falls and accomplish ADL's and IADL's. The patient had significant financial resources as per his report, so he said paying for a house sitter/care taker is not a problem and he has done it before. He has service connection 60%, social security, and medicare so his medications and healthcare are no problem. He has a son in Arizona who he is very close to and can always call if he has an emergency and needs.