Care of the Older Adult in the Emergency Department: Nurses Views of the Pressing Issues

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Purpose: The purpose of the study was to describe nurses’ views of the issues to be addressed to improve care of the older adult in the emergency department (ED). Design and Methods: An exploratory content analysis examined the qualitative responses of 527 registered nurses from 49 U.S. hospitals who completed the Geriatric Institutional Profile. Results: 5 central themes emerged from the analysis, representing a lack of older person hospital environment fit in the ED: (a) respect for the older adult and carers, (b) correct and best procedures and treatment, (c) time and staff to do things right, (d) transitions, and (e) a safe and enabling environment. The nurses offered solutions to address lack of fit, including modifications to the social climate, policies and procedures, care systems and processes, and physical design. Implications: The nurses’ descriptions of the pressing issues surrounding care of older adults in the ED provide useful information to consider when developing a senior-friendly ED. Results also illuminate solutions that can be taken to address issues. These solutions give direction for future intervention research.

Key Words: Acute/short-term care, Organizational and institutional issues, Qualitative research methods, Emergency care
communication problems, and cognitive impairment (Press et al., 2009; Salvi et al., 2007). There are also concerns about pain management (Hwang, Richardson, Harris, & Morrison, 2010), inadequate information sharing (Baillie, 2005; George, Jell, & Todd, 2006), and a workforce ill-prepared to care for older adults (Grief, 2003) in the ED.

As the number of older people continues to grow, so will their need for ED care. The demographic imperative combined with growing concerns around quality (Kelley, Parke, Jokinen, Stones, & Renaud, 2011; Wilber, Gerson, et al., 2006) compels an examination of the organization of ED care for older adults.

**ED Models of Care for Older Adults**

Several models of care have been examined for older adults in the acute care setting. Models of care are important because they provide conceptual elements that consider patient, provider, and system issues (Hickman, Newton, Halcomb, Chang, & Davidson, 2007). They also provide a guide to implement and evaluate quality improvement strategies. Considered together, existing models of care affect the quality of acute care for older people through the following interventions (Hickman et al., 2007): comprehensive geriatric assessment (CGA; Conroy, Stevens, Parker, & Gladman, 2011; Ellis, Whitehead, O’Neill, Langhorne, & Robinson, 2011), interdisciplinary team approaches with evidence-informed guidelines or protocols (Inouye, Bogardus, Baker, Leo-Summers, & Cooney, 2000), physical environments that are adapted to the needs of older adults (Barnes et al., 2012; Jayadevappa, Chhatre, Weiner, & Razino, 2006), and systematic approaches to discharge planning and care coordination across settings (Bradway et al., 2012; Coleman, Parry, Chalmers, & Min, 2006).

To a lesser extent, ED models of care for older adults have been examined. One randomized controlled trial found that early geriatric assessment provided by a nurse specialist had no effect on admission rates, length of stay, or functional decline (Basic & Conforti, 2005). In contrast, in a pre- or poststudy, a nurse dedicated specifically to discharge planning for older adults reduced the proportion of unscheduled ED return visits and facilitated the transition from ED back home and into the community (Guttman et al., 2004). Similarly, nurse-led case finding with formal linkage to community agencies was determined to be feasible and effective in promoting follow-up care in at-risk older adults (Mion, Palmer, Anetzberger, & Meldon, 2001).

A systematic review by McCusker and Verdon (2006) concluded that the use of CGA significantly reduced functional and cognitive decline and mortality, although there was an increase in ED use within the first month, attributed to the diagnosis of previously undetected problems. However, similar to studies of geriatric nurse practitioners, consultation services, and care coordinators (Hastings & Heflin, 2005), these studies lacked control groups.

The emergence of geriatric emergency rooms (Adams & Gerson, 2003) offers promise for better ED experiences and outcomes for older adults. Analogous to pediatric EDs, these units have separate patient care areas furnished with specialized equipment and amenities and staff specially trained in the needs of older adults. Their effectiveness and uptake of evidence-based practice are yet to be examined and to date no standards have been established. In fact, despite the frequency and sentinel nature of an ED visit in the life of an older adult, little research has focused on the organization of care within the ED.

To create standards for ED care of older adults, whether provided in specialized units or general ED settings, an understanding of the care environment for older adults is critical. Findings would support to the development of a comprehensive ED model of care, one that aligns the complex ED delivery system with the multifaceted needs of older adults. To that end, we report on a qualitative analysis of data collected from a national survey of ED nurses that engaged their views of the issues to be addressed to improve care of the older adult.

**Methods**

This secondary analysis used data extracted from Nurses Improving Care for Healthsystem Elders (NICHE) Geriatric Institutional Profile (GIAP) database. The GIAP survey/instrument is an 157-item, anonymous, self-report tool that provides benchmarked information for hospitals in key measures of institutional support, staff knowledge of the hospitalized older adult, and perceptions of the care environment (Boltz, Capezuti, Kim, Fairchild, & Secic, 2009). The GIAP is web based, with data entered via a secure web interface. The GIAP is administered to staff throughout a participating NICHE hospital; responses are
aggregated to provide information on the geriatric milieu by type of unit (ED, medical–surgical, critical care, etc.) to develop targeted action plans for improvement. The quantitative responses are supplemented with an open-ended question, “What are the most pressing issues you currently face in caring for older adults?” We conducted a content analysis of these narrative responses to address the research aim of better understanding the ED care environment for older adults.

**Conceptual Framework**

The elder-friendly hospital conceptual framework constructed by Parke and Brand (2004) guided the study, offering a social ecological view that purports that factors from both people and the context of their environments engage to produce reinforcing consequences (Stokols, 1992). The interplay between the older person’s acute health care crisis; the developmental phenomena associated with aging; the likelihood of chronic illnesses compounding both diagnosis and treatment; and the physical, social, and care environment of the hospital produce reinforcing consequences. Older person–hospital environment fit is central to this concept with four interrelated dimensions: social climate, policies and procedures, care systems and processes, and physical design. (See Table 1 for the dimensions and definitions.)

**Data Analysis**

We first examined the key characteristics of the nurse participants (age, sex, position, years of experience, tenure at the institution, as well as the bed size and teaching status of their institutions). We compared the characteristics of the nurses who responded to the open-ended question to those who did not respond, using chi-square tests and t tests as indicated.

We took an iterative approach to conduct a content analysis of the registered nurse responses to identify the major themes representing nurses’ views of care issues. Our approach adopted from Streubert and Carpenter (2011) involved three phases. The first phase of analysis focused on organizing the data to ensure accuracy and to generate provisional codes. This was performed independently by one researcher who extracted the data from the original Excel file, created a Word file, and organized the data for analysis. A second researcher independently audited this file to ensure accuracy of the data.

The second phase of analysis involved content analysis of the survey data by two independent researchers. The aim was a more in-depth analysis to understand key messages within the data. For this process, the researchers independently read the complete transcript and made notes of emerging ideas to get a sense of the whole and gain a general understanding of the range (maximum variation) in potential insights of nuances and potential gaps noted by the registered nurses. Then, a second read was conducted to break down the data, word by word and sentence by sentence, to identify registered nurses’ views of pressing issues to arrive at a set of preliminary codes. The codes were clustered to form categories.

In the third phase of analysis, the researchers together reviewed and reconfigured the categories to form themes. At this point, the substantive characteristics associated with each theme and their potential linkage to each other emerged. Only after the content analysis was completed with the survey data, the elder-friendly hospital conceptual framework (Parke & Brand, 2004) was applied to the themes arising from the data. This decision was made to provide theoretical understanding of issues arising from data analyzed in Phase 2. Differences were discussed until consensus was reached.

**Rigor**

Several measures were used to ensure trustworthiness. First, the authors strictly followed a

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<tr>
<th>Table 1. Descriptive Definitions for Older Adult–Hospital Environment Dimensions of Fit</th>
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<td><strong>Social climate:</strong> Experienced as milieu derived from interpersonal relationships and organizational influences; it is evident in the treatment of older people in hospital and the degree of conflict and stress experienced in the ED environment.</td>
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<td><strong>Policies and procedures:</strong> Expressed in the conduct of hospital staff, which is influenced by the explicit and implicit bureaucratic rules and regulations. The rules and regulations are culturally enforced and affect the autonomy of older people to act on their wishes.</td>
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<td><strong>Care systems and processes:</strong> The organization of clinical ED care and how work is completed in the provision of services; access to best practice to ensure the hospital meets its goals and objectives.</td>
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<td><strong>Physical design:</strong> The observable built environment and all its architectural features including equipment, furnishings, and decor that together enable or disable an older person’s independent functioning.</td>
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Notes: ED = emergency department. Adapted from Parke and Chappell (2010).
systematic implementation of content analysis methodology. Second, the data was de-identified, so the authors were not biased by knowledge of the hospital settings. Third, an audit trail of methodological decisions was maintained. Finally, peer debriefing and multiple data checks (Carspecken, 1996) ensured rigor. Analytical differences between researchers were discussed at regular meetings to arrive at consensus.

Findings

The responses of 1,191 ED registered nurses from 49 acute care hospitals in the United States that administered the GIAP survey from January 2006 until December 2010 were examined. The hospitals representing 26 states, ranged in bed size from 25 to 998; 11 (22.4%) were small (0–200 staffed beds), 21 (42.9%) were medium (201–400 staffed beds), and 17 (34.7%) were large (401 plus staffed beds) facilities. The breakdown of teaching status was as follows: 5 academic medical centers, 21 teaching hospitals, and 23 nonteaching hospitals. Almost half (49%; \( n = 580 \)) of the nurses responded to the open-ended question, “What are the most pressing issues you currently face in caring for older adults?” The responses of those nurses who worked in pediatric emergency (\( n = 4 \)) or who responded “none” or “none-applicable” (\( n = 49 \)) were excluded yielding a sample of 527 responses for analysis. The responses varied in degree of response as follows: 35% (\( n = 184 \)) short phrase, 36% (\( n = 188 \)) one sentence with explanatory text, and 29% (\( n = 155 \)) multiple (two–five) sentences.

The majority of nurse respondents were white (\( n = 427; 81\% \)), female (\( n = 474; 90\% \)), staff nurses (\( n = 391; 74.2\% \)) with a mean age of 42.7 (±10.6). The nurses reported 15.8 (±9.4) mean years of experience as a nurse and 8.4 (±8.7) years of tenure at the hospital. The proportion of basic education was as follows: associate degree (\( n = 187; 35.5\% \)), bachelor’s degree (\( n = 183; 34.7\% \)), and diploma preparation (\( n = 105; 19.9\% \)) and masters’ degree (\( n = 52; 9.9\% \)). The key characteristics of the nurses who responded to the open-ended question (\( n = 527 \)) did not differ in statistically significant ways from those who did not respond (\( n = 611 \); Table 2).

Five central themes emerged that represent a lack of older person–ED environment fit: (a)

| Table 2. Characteristics: Respondents Compared With Nonrespondents |
|---------------------------------|-----------------|-----------------|
|                                 | Respondents (\( n = 527 \)) | Nonrespondents (\( n = 611 \)) |
| Age, years (SD)                | 42.7 (± 10.6)     | 41.4 (±11.6)    |
| Sex, % (\( n \))               |                  |                 |
| Female                         | 90 (474)         | 88.4% (540)     |
| Male                           | 10 (53)          | 11.6% (71)      |
| Race/ethnicity, % (\( n \))    |                  |                 |
| White non-Hispanic             | 81.0 (427)       | 78.6 (480)      |
| African American               | 7.3 (39)         | 7.8 (48)        |
| Asian American                 | 7.1 (37)         | 8.2 (50)        |
| Hispanic American              | 2.5 (13)         | 2.6 (16)        |
| Other                          | 2.1 (11)         | 2.8 (17)        |
| Position, % (\( n \))          |                  |                 |
| Staff nurses                   | 74.2 (391)       | 68.9 (421)      |
| Nurse manager                  | 7.4 (39)         | 9.9 (61)        |
| Advanced practice nurse clinician | 1.1 (6)       | 1.1 (7)         |
| Nursing faculty                | 9.1 (48)         | 9.8 (59)        |
| All other (patient educator, staff educator, administrator) | 8.2 (43) | 10.3 (63) |
| Education: at least a bachelor’s degree, % (\( n \)) | 44.6 (235) | 46.2 (282) |
| Years experience as a nurse (SD)| 15.8 (±9.4)      | 14.2 (±9.1)     |
| Hospital bed size, % (\( n \))   |                  |                 |
| Small                          | 11.4 (60)        | 12.8 (78)       |
| Medium                         | 68.2 (359)       | 68.9 (421)      |
| Large                          | 20.3 (108)       | 18.3 (112)      |
| Hospital teaching status, % (\( n \)) |            |                 |
| Academic medical center        | 16.5 (87.0)      | 14.2 (87)       |
| Teaching hospital              | 46.0 (242.0)     | 51.0 (311)      |
| Nonteaching hospital           | 37.5 (198.0)     | 34.8 (213)      |

Note: All \( p \) values ≥ .05.
Respect for the Older Adult and Carers.—Respect for the older adult and carers was described as critical, evident in the interaction between ED staff and the patient and family. As one nurse said, “We need geriatric standards for the ED, including the standard of respect for older adults.” Respect was described in four categories of pressing issues. The first related to poor communication, related to barriers to communication including staff attitudes (lack of compassion), ageism (we yell at them and think they are deaf), and patient related (communicating with patient’s who are hard of hearing and patients with dementia or aphasia). One nurse described, “I believe that many elderly are just ignored because they can’t communicate or are confused.” Nurses expressed particular concern about receptive abilities (e.g., Do they really understand and hear their instructions?)

The second category was lack of information regarding the medical condition, treatment, coping, and medication use, provided to both patients and families. The information deficit contributes to older peoples’ “feelings of loss of independence and control” and “bounce back admissions.” At discharge, in particular, the nurses described the need for “correct information and seeing that they have good follow-up care and the caregiver understands medication usage . . .” Information on community resources including transportation was emphasized. The goal according to one nurse is, “older patients taking responsibility for their healthcare by having medical information.”

The third category was inadequate support of decision making for the older adult patient. Decision making was described by a nurse as “respect for participation in care and their wishes about the care treatment they want to receive . . .” A nurse reported, “Many doctors speak directly to the family and not the older patient about code status, feeding tube, etc. They (older adults) need to be supported to make the decisions when possible.” Another nurse opined, “One big issue with elders is coming to a conclusion about who is the proper person to make healthcare decisions, especially in the early stages of dementia when it’s not so clear what their capability is. . . .”

The final category associated with respect was not acknowledging families, both their role in care delivery and the family carer’s need for support and resources. The nurses reported reliance on family to “know the baseline . . . mental status and medical history.” Additionally, the ED visit was recognized as a critical opportunity to support family caregivers. One nurse stated, “Older people are living longer with more medical conditions and are living with their families; we need to help them cope and care for loved ones.”

Nurses views on solutions. Nurses reported that administrative support for staff education, along with expectations for positive communication were critical, described as a “patient, non-hurried approach,” and “showing that you value and care about the person.” They also emphasized the need to adapt communication for the person with cognitive impairment or hearing loss, and to “have (available) hearing amplifiers, and quiet spaces that provide privacy.” The use of volunteers, available to talk with patients who were lonely or anxious and provide comfort measures was described as a benefit. (As one nurse said, “I also feel many older people need more time spent with them because they are lonely or just in need of contact other than strictly medical attention.”)

The need for information to be presented to patients and families in understandable language, in both verbal and written form (large font), and discharge follow-up, was underscored. The advisability of a “policy to easily determine the older adult’s ability to make their own decisions” and method to assess and monitor the family’s role in decision making (“Who’s in charge?”) was offered. The social work role was considered an important intervention for families, providing counseling, support, referral, and resources including respite services.

Correct and Best Procedures and Treatment.—The nurses reported the need to care for the older adult “by using the correct and best procedures and treatment.” One nurse reported, “In the ED, there has been a slower adoption of geriatric principles into practice to prevent/address common problems.” Two categories represented the
<table>
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<th>Dimension of elder-friendly hospital</th>
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<th>Categories of pressing issues</th>
<th>Sources of poor fit</th>
<th>Suggestions for action</th>
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<tbody>
<tr>
<td>Social climate</td>
<td>Respect for the older adult and carers</td>
<td>Poor communication</td>
<td>Staff attitudes and knowledge deficits</td>
<td>Organizational support for therapeutic communication (training all staff/shifts, monitoring, and availability of resources)</td>
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<td></td>
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<td>Lack of information</td>
<td>Patient factors: aphasia, cognitive impairment, hearing loss, anxiety</td>
<td>Specially trained volunteers to provide support and assistance</td>
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<td></td>
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<td>Patient and families not informed of condition, options for treatment, and self-care</td>
<td>Systematic education regarding the medical condition, medication use, and community resources: • verbally and in writing • adapted to education and literacy level • adapted to low vision acuity</td>
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<td>Inadequate support of decision making</td>
<td>Follow-up care after discharge</td>
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<td></td>
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<td>Not knowing who should be the decision maker</td>
<td>Method to: • assess decision-making capacity • family and others’ role in decisions • monitor decision-making processes</td>
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<td></td>
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<td>Not engaging the patient views and preferences</td>
<td>Concise information and education</td>
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<td></td>
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<td>Not addressing the family desires/needs for inclusion and support</td>
<td>Social worker for family support and follow-up care</td>
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<td>Policies and procedures</td>
<td>Correct and best procedures and treatments</td>
<td>Lack of evidence-based protocols</td>
<td>Inadequate work up and “slower adoption of geriatric principles”</td>
<td>Evidence-based protocols, embedded in electronic medical record that address: • cognitive impairment/delirium • medication use • fall prevention and management • skin care • nutritional support • prevention of catheter-associated urinary tract infection • elder mistreatment</td>
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<td></td>
<td></td>
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<td>Inefficiency</td>
<td>Long waits place the older people at risk for complications</td>
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<tr>
<td>Care systems and processes</td>
<td>Time and staff to do things right</td>
<td>Limited time and staff</td>
<td>Inadequate time/manpower to address the complex needs of older adults</td>
<td>Trained volunteers, Patient care technicians, Social workers available onsite, Geriatric nurse practitioner, Separate staff for older adults who are high touch but not high acuity</td>
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|                                      | Transitions | ED misuse | Two types of avoidable transfers:  
• delayed detection or prevention of complication in nursing homes (ED transfer could have been prevented)  
• problem could have been treated in the nursing homes (ED transfer unnecessary) | Waiting for transport (unnecessary time in ED) | Shared training and protocols: nursing homes and acute care, ED managed transportation |
|                                      | Unsafe discharge | Insufficient home resources and nursing home care | | Social workers or case managers to provide teaching, resources, and postdischarge follow-up |
|                                      | Ineffective handoffs | Inadequate admission information from long-term care facilities | Need standardized validated handoff tools |
| Physical design                      | A safe and enabling environment | Nonelder friendly plant design, Lack of equipment | Physical environments that do not promote safety, function, and comfort, Lack of aging-specific assistive, adaptive equipment | Environmental modifications that address age-related changes, Access to necessary supplies |
issues related to correct and best procedures and treatment: lack of evidence-based protocols and inefficiency.

Lack of evidence-based protocols was described related to emergent care and preventive care (i.e., prevention of iatrogenic problems). The nurses recognized that the ED environment could be “delirium inducing,” exemplified by the following statement: “In the ED we often have to work quickly with the patients and that can lead to their not being fully aware of what we are doing, leading to increased confusion.” Other common geriatric complications were addressed, related to medication use (concern over multiple drug use renal clearance of these drugs—drug interactions missed adverse reactions), pressure ulcers, urinary tract infection, and pain. One nurse reported, “It is very difficult to prevent certain complications, such as UTI and skin breakdown even with proper turning and use of air mattress; nutritional status and vascular problems compromise greatly affect this problem.” Another nurse reported, “(the) most pressing issue is falls . . . and I believe we under-medicate for pain and sometimes overmedicate for behavior.”

Another category that addressed procedures was related to inefficiency. The nurses described prolonged triage and throughput. “Triage takes a large amount of time due to entering multiple medications and long lists of PMH (past medical history) and PSH (past surgical history). . . .” The nurses further reported that older adults often wait a long time to be discharged home or transferred to another unit. “More often than not the ED waits long hours to place a patient on the inpatient unit . . . .” Sources of inefficiency were described: “the documentation process is tedious and does not flow. Lengthy med reconciliation forms take too much time.” Delays in receiving diagnostic reports and disorganized communication with inpatient units and discharge sources were also reported.

Nurses views on solutions. Nurses described the need for protocols to guide assessment of cognitive impairment and to “deal with confusion without utilizing restraints or psychoactive medications.” The advisability of standards addressing inappropriate medication use was discussed and guidelines for indwelling catheter use including “avoiding them whenever possible and establishing a plan to get them out quickly.”

The nurses also recognized the screening and timely response to mistreatment of older adults as a vital ED function. They described the need for clinical practice guidelines to detect and prevent skin breakdown as well as systematic interventions (including surveillance and low beds) as fall prevention strategies that are alternatives to physical restraints. The nurses emphasized that assessment tools must be efficient with redundancy eliminated. A nurse opined that “including staff in plan to streamline documentation has been helpful . . . especially triage and transfers to the floor and other facilities.”

Time and Staff to do Things Right. There were two categories of issues related to the pervasive theme, time and staff to do things right. The first was limited time and staff. One nurse said, “Older patients can be difficult to care for . . . (with) complex, multisystem issues . . . we at times don’t have the time/manpower to address their needs.” Competing demands included “other patients who may be sicker” and documentation requirements. Consequently, nurses described the tendency to prioritize, to address the acute medical problem, but not having the time for additional needs such as preventive care (including skin care and mobilization), teaching, and psychosocial support. As one nurse stated, “When it is extremely busy it is impossible . . . we are concentrating on immediate needs and they have ongoing needs that are very important.”

The second category was too little knowledge regarding care of older adults regarding the specialized needs of older adults, “to do things right.” An example of this shortfall was described, “Older patients are frequently under-triaged. Not all staff realize that older patients can have a more acute response to injury.” The nurses expressed concern regarding the knowledge base of all staff, including physicians.

Nurses views on solutions. Solutions offered to the problem of limited human resources include the availability of “techs/ nursing assistants to assist us in turning, bathing, feeding, bathroom care” and “volunteers to sit with people.” Also, the benefits of a social worker and geriatric nurse practitioner’s clinical expertise were appreciated. Education of staff regarding age-related psychological and physical changes and evidence-based care to detect and prevent geriatric syndromes were described as foundational to providing quality care (One should be knowledgeable and educated in the aging process.). Finally, nurse champions who are “geriatric experts (that) train and consult with other staff” were described as a source of knowledge.
Transitions.—There were three categories related to the theme, transitions: ED misuse, unsafe discharge, and ineffective handoffs. ED misuse represents nurses’ views regarding the proper utilization of the ED by older adults. They expressed concern that older adults are often transferred unnecessarily to the ED. For example, “nursing homes that are ‘skilled’ but send patient’s to the ER for UTIs.” In addition, there was concern that nursing home residents are not transferred back to the nursing home in a timely manner due to transportation issues and/or unavailable family. Finally, responses indicate that, “many arrive with untreated/unrecognized UTI’s/pneumonia which have progressed to sepsis” suggesting that in some cases, ED admissions are for acutely ill nursing home residents who have experienced a delay in receiving medical treatment. The nurses identified the “problem” of licensed practical nurses in nursing homes providing assessments (as opposed to registered nurses) as well the need for clinical protocols and training of both acute care and nursing home staff.

The nurses reported that unsafe discharge was associated with lack of support at home requiring referral to appropriate resources including home care and social service agencies (e.g., homeless shelters, help for substance abuse). Of particular concern was the patient who lived alone or who experienced frequent ED admissions. As one nurse stated, “Due to the fast pace of the ED there is not always time to investigate and set up for post-ED care for the older patient at discharge.”

The final transitions category, ineffective handoffs described problems acquiring complete information when receiving a nursing home resident. As one nurse explained, “getting patients from nursing homes without receiving adequate information about their normal ADL’s, cognition, advance directives, etc.” In turn, the issue of efficiently communicating information regarding the ED treatment, response, and recommended follow-up care to inpatient units and other discharge sites was discussed.

Nurses views on solutions. The need to collaborate with nursing homes to develop reliable tools and methods for handoffs was reported by the nurses. As one nurse said, “We need to transfer patients to SNF or to a hospital floor with the right information, in a timely fashion” as well as “discharge planning to make sure the patient is safe where they reside.” Nurses reported that ED-based social workers or case managers who provided discharge teaching, planning, and postdischarge follow-up were essential to facilitate discharge. Transportation provided by the ED department was offered as an important service to facilitate timely discharge in some cases.

A Safe and Enabling Environment.—The nurses described two categories nonelder friendly physical plant design and lack of equipment as important issues influencing the older adult's safety and well-being. One nurse reported her concern for safety:

Working in the ER the safety of the elderly is a concern for me. The set up of the rooms aren’t exactly accident safe, you can’t always see the elderly all the times and the risk of them climbing out of the stretcher is a concern

Additionally, there was concern over the “lack of toileting facilities” and the “noisy, hectic environment.” Equipment issues were described:

We do not have proper stretchers; they do not go low to the ground . . . we only have 2 pressure-relieving mattresses when all should be equipped . . . we hardly have pillows to offer patients or for turning . . . we have very few bedside commodes.

Nurses views on solutions. Desirable design features included access to toileting facilities, adequate lighting, noise control, handrails throughout the unit, shock-absorbent flooring, adequate seating, and access to overnight accommodations for families. Important equipment cited included pressure-relieving mattresses and incontinence products to prevent skin breakdown, and wider stretchers or access to beds to promote repositioning. The availability of hearing amplifiers and nutritious snacks and fluids were also described as practical supports and comfort aids.

Discussion

This study, by describing ED nurses’ views on pressing issues surrounding older adult care, provides insight into the organization of the geriatric ED environment. We discuss the insights in relation to the thematic findings.

The first theme, respect for the older adult and carers, describes the social climate in the ED, consistent with that defined by Parke and Chappell (2010). Respect is apparent in observable communication between staff, older patients, and family members. The attitudes that staff display during their interaction with patients, such as promoting privacy and expressions of empathy, are important factors in supporting a sense of well-being in
older adults (Webster & Bryan, 2009). In particular, given the relatively brief time spent in the ED, educational efforts that emphasize the importance of first impressions and maximizing every contact with the older adult to support this sense of well-being have been suggested (Baillie, 2003). The nurses also acknowledged the older adults’ right to be informed and in control of their care, similarly expressed by nurses in other research (Baillie & Gallagher, 2011).

Nurse respondents identified the need for education on age-related changes as a building block to positive interactions with older adults. This could be supplemented with operational modifications (Boltz, Capezuti, & Shabbat, 2010). In the fast-paced ED that prioritizes efficiency, examination of the staff roles and processes that support patient psychological comfort, choice, and self-direction, as well as their clinical efficacy, are warranted. Future research will ideally include the vulnerable person with cognitive impairment who is often excluded from research that investigates the impact of the social care environment (Parke, Beaith, Slater, & Clarke, 2011).

Our study findings also suggest that ED nurses recognize the key role that families play in providing critical information and input into decision making for older adults and areas to investigate with interventional research: (a) efficient methods of identifying the need for a surrogate decision maker and the person who represents the preferences of the older adult, (b) methods of identifying patient/family units that are at risk for adverse patient events and/or family stress postdischarge, and (c) efficiently deployed follow-up and support after discharge from the ED.

The second theme, correct and best procedures and treatments reflects nurses’ desire for interdisciplinary, evidence-based protocols to prevent, detect, and manage geriatric syndromes and ongoing aging-specific education for all disciplines. This theme expands the policies and procedures dimension offered by Parke and Chappell (2010) to include clinical practice guidelines.

Nurses described difficulty with cognitive assessment, a pervasive challenge (Parke et al., 2011), where cognitive impairment is present in 15%–40% of older adults (Chiovenda, Vincetelli, & Alegiani, 2002; Hustey, Meldon, Smith, & Lex, 2003) admitted to the ED. The consequences of failing to recognize dementia include avoidable delays in diagnosis and treatment, poor patient follow-through on discharge instructions, and increased morbidity and mortality risk (Salvi et al., 2007). Similarly, the all-too common failure to detect delirium (Press et al., 2009) constitutes a missed recognition of an underlying medical condition and explains a higher risk of hospital admissions, return visits to the ED, and mortality in older adults (Inouye, 2006). The need for efficient, evidence-based care pathways that promote early prevention, detection, and management of delirium in the ED is critical, given it is present in nearly 10% of older adults admitted (Hustey & Meldon, 2002).

The older adult’s physical function did not receive the attention that cognitive status received. This finding is consistent with those of Wilber, Blanda, and colleagues (2006) who found that functional status was ignored in 75% of ED admissions, an alarming fact given that functional decline arising from initial symptoms was the critical factor that led to their coming to the ED. Failure to address functional status predisposes the older adult to an unsafe discharge home, or if admitted to the hospital, a missed opportunity to mobilize function—promoting interventions and functional recovery. Three additional clinical areas targeted by the nurses—pressure ulcers, falls, and catheter-associated urinary tract infections may reflect a heightened awareness of the impact of their practice on “nurse-sensitive outcomes” as well as the administrative expectations to avoid financial penalty for these conditions. The use of specially trained unit-based champions has been effective in implementing clinical practice initiatives (Boltz et al., 2008) and warrants further evaluation in the ED.

The nurses’ description of protracted length of stay in the ED is consistent with research that older adults stay 19%–58% longer than patients in other age groups (Gruneir et al., 2011). Although this is often attributed to the more extensive diagnostic workups that older adults experience (George et al., 2006), the nurses’ responses indicate that attempts at timely treatment and discharge may also be encumbered by inefficient assessment and communication processes. The use of an efficient, valid, and reliable triage tool, such as the Emergency Severity Index (Baumann & Strout, 2007) would minimize the risk of under-triage. Additionally, patient-owned portable records that can be efficiently accessed may promote efficient evaluation and treatment.

The theme, time and staff to do things right, suggests the need to consider not only the

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number of staff but also the adequacy of preparation, role scope, and deployment. In addition to nursing staff, physicians and social workers and paraprofessionals require specialized aging-specific training. This theme adds substantively to the characteristics of an elder-friendly hospital put forward by Parke and Chappell (2010) by including role scope and deployment of human resources as a critical component of the ED care system. The need to deploy staff in a manner that does not “compete” with the needs of other emergency patients has been addressed by the emergence of senior EDs (Adams & Gerson, 2003), which utilize separate staff in a separate, specially prepared environment. However, there are no empirically tested standards for these units; their feasibility as well as clinical and cost-effectiveness is an important area for future investigation.

The theme transitions, underscores the need for systems and processes to incorporate discharge planning, case management, and safe handoffs into the operational policies of an elder-friendly ED (Parke & Chappell, 2010; Terrell et al., 2005). The nurses’ concern that nursing home residents are often transferred unnecessarily is consistent with recent research wherein long-term care clinicians commonly rated hospitalizations as potentially avoidable (Ouslander et al., 2011). INTERACT II, a quality improvement program that aims to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities has demonstrated trends toward avoiding avoidable hospitalizations. Randomized controlled trials are warranted to determine its effects on rates of avoidable hospitalization and related morbidity, mortality, and cost (Ouslander et al., 2011). Additionally, transitional care programs that support safe discharge to home through care coordination provided by an advanced practice nurse (Bradway et al., 2012) and transitions coaches (Coleman et al., 2006) warrant replication and investigation in the ED setting.

Finally, the theme, a safe and enabling environment demonstrates a salient awareness of the influence of the ED physical environment on the older adult’s cognition, safety, and function. Although person–environment fit has been a goal of Acute Care for the Elderly (ACE) units, creating environments that accommodate age-related changes and functional challenges is a relatively new focus in the ED. In addition to improved patient experience and outcomes, other potential benefits of elder-friendly design in the ED may include improved staff satisfaction and effectiveness.

Older Adult–ED Fit

The five themes arising from the analysis conceptually align with Parke and Chappell’s (2010) dimensions of an elder-friendly hospital: social climate, policies and procedures, care systems and processes, and physical design (Table 3). In our analysis, we were able to draw characteristics relevant to each theme and the corresponding dimension of fit.

In addition to adding contextual features to the concept of elder-friendly EDs, our study provides suggestions for action drawn explicitly from nurses working in the clinical field (Table 3). Table 3 illustrates the link between the dimensions of an elder-friendly ED (column one), themes drawn from the data (column two), and the categories of pressing issues (column three) that we report in our findings. The sources of poor fit are found in column four along with corresponding actions to address the pressing issues in column five. The table’s fifth column represents ways to adjust the ED for improving quality care for older adults. It draws on the idea of an “adjusted acute care” (Parke & Chappell, 2010) by integrating the suggestions made by participants to the themes and dimensions found in the original elder-friendly hospital concept (Parke & Brand, 2004). These suggestions serve as examples of how current ED clinical interventions and systems might adjust to improve fit at the local hospital level.

Limitations and Strengths

This study was limited to nurses who work in NICHE sites, hospitals that have committed to improving the care of hospitalized older adults. In this regards, results are not transferrable to all hospitals. There is also the possibility that the respondents may have experienced survey fatigue when answering the open-ended question posed at the end of the survey. Further, the qualitative data are drawn from a single open-ended question that is not the main focus of the survey without the benefit of the researchers to directly explore in greater detail the full scope of meaning in the respondents’ comments.

This qualitative analysis represented a large sample of nurses from hospitals of diverse size and
teaching status. The brevity of responses did not offer the depth afforded by a small sample that yields thick qualitative data. The large sample from multiple states, however, provides value by virtue of its breadth and the serendipitous findings related to possible solutions offered by the nurse respondents. The nurses’ responses suggest that they may be an untapped resource for ED unit-based problem solving and program development for older adults. The themes and recommended changes they have offered are applicable in many cases, to patients, in general. However, because older adults carry baseline vulnerabilities that increase their risk for negative experiences and adverse events in the ED, the results are particularly compelling for them.

**Conclusion**

As hospitals continue to respond to the specialized needs of the ever-growing number of older adults, the ED will be a key focus for program design during strategic planning. The nurses’ descriptions of the pressing issues surrounding care of older adults in the ED, and potential solutions, provide useful information for quality improvement activity including organizational initiatives aimed at creating senior-friendly EDs.

Findings also illuminate areas for future research, considering as Fealy and colleagues (2009) have opined, the pragmatic implications of assessment and referral interventions that often detect latent and undetected physical, psychological, and social challenges in the older adult.

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**References**


