Emergency Nurses' Perception of Geriatric Readiness in the ED Setting: A Mixed-Methods Study

Authors: Lisa A. Wolf, PhD, RN, CEN, FAEN, Altair M. Delao, MPH, Aaron J. Malsch, RN, MSN, GCNS-BC, Michael D. Moon, PhD, RN, CNS-CC, FAEN, Adam Perry, MD, and Kathleen Evanovich Zavotsky, PhD, RN, CCRN, CEN, ACNS-BC, FAEN, Schaumburg, IL, Milwaukee, WI, San Antonio, TX, New York, NY, and New Brunswick, NJ

CE Earn Up to 7.5 Hours. See page 473.

Contribution to Emergency Nursing Practice

- The current state of scientific knowledge on providing care to geriatric patients indicates that the geriatric population will increase substantially; emergency departments must be prepared to care for the complex medical and psychosocial needs of older patients.
- The main finding of this research is there are significant deficits in geriatric-specific screenings, accommodations, and communication with outside agencies in US emergency departments, deficits in geriatric-specific education, inconsistent use of early screening for frailty, and lack of resources to intervene appropriately.
- Key implications for emergency nursing practice from this research are that facilitators of excellent geriatric-focused care include education and access to resources; emergency departments should work to develop integrated systems to facilitate appropriate care of older patients.

Abstract

Introduction: The Centers for Disease Control and Prevention (CDC) reports 136.9 million ED visits in 2015, of which 21.4 million (15.6%) were by patients who were 65 or older. This US population demographic is expected to grow by 112% over the next 40 years, becoming just below 25% of the total US population. Emergency nurses will play an increasingly important part in the development of nursing care for geriatric patients. The purpose of this study was to explore emergency nurses' perception of their ability to care for geriatric patients in the emergency setting.

Methods: This was a mixed-methods sequential design using quantitative survey data and qualitative focus group data, which were analyzed separately and then given equal priority during the data-interpretation phase.

Results: Less than 50% of survey respondents (N = 1,610) reported geriatric-specific screenings, accommodations, and communication with outside agencies as "always available" in their care settings. Qualitative analysis (N = 23) yielded the categories of Triage/Assessment, Care in the Emergency Environment, Discharge Planning, and Facilitators and Barriers, which generally reflected the trajectory of care for the older patient. The overarching concern was keeping patients safe in both the community and in the emergency department.

Discussion: Emergency departments should develop integrated systems to facilitate appropriate care of older patients. Identified barriers to improved care include a lack of integration between emergency care and community care, deficits in

Lisa A. Wolf, *Member, Pioneer Valley Chapter,* is Director, Institute for Emergency Nursing Research, Emergency Nurses Association, Schaumburg, IL.

Altair M. Delao is Senior Associate, Institute for Emergency Nursing Research, Emergency Nurses Association, Schaumburg, IL.

Aaron J. Malsch, *Member, Milwaukee Area Chapter,* is Senior Services Program Coordinator, Advocate Aurora Health, Milwaukee WI.

Michael D. Moon, Member, *San Antonio Chapter,* is Associate Professor, University of the Incarnate Word, San Antonio, TX.

Adam Perry is Faculty Member, Geriatric Emergency Department Collaborative New York, NY.

Kathleen Evanovich Zavotsky, *Member, West Central Jersey Chapter,* is Assistant Vice President, The Center for Professional Development, Innovation and Research, Robert Wood Johnson Barnabas Health, Robert Wood Johnson University Hospital, New Brunswick, NJ.

This study was funded in part through the John A. Hartford Foundation and the West Heath Institute. Grant name: Developing a Geriatric Emergency Department Collaborative.

For correspondence, write: Lisa A. Wolf, PhD, RN, CEN, FAEN, 930 E. Woodfield Road, Schaumburg, IL 60173; E-mail: lwolf@ena.org.

J Emerg Nurs 2019;45:374-85.
Available online 28 March 2019
0099-1767

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https://doi.org/10.1016/j.jen.2019.02.004

geriatric-specific education, inconsistent use of early screening for frailty, and lack of resources in the emergency care environment to intervene appropriately.

Key words: Emergency department; Geriatric care; Emergency nursing; Geriatric readiness; Mixed methods

Introduction

The Centers for Disease Control and Prevention (CDC) reports 136.9 million ED visits in 2015, of which 21.4 million (15.6%) were by patients who were 65 years of age or older.[1] This US population demographic is expected to grow by 112% over the next 40 years, becoming just below 25% of the total US population.[2]

Vulnerable older adults have unique and complex care needs spanning medical, cognitive, emotional, social, and environmental domains.[3] Older adults often present atypically, even with significant disease, requiring nurses to be vigilant in their assessment and initial interventions. In addition, signs and symptoms for various illnesses can be markedly different (or absent) in this population, requiring emergency nurses and other health care providers to have specialized training and education.[4] Just as dedicated protocols and departments have advanced pediatric emergency care, development and continued refinement of the geriatric emergency care environment will be pivotal to the long-term prevention and mitigation of illness and injury in the elderly.

The 2013 multidisciplinary geriatric emergency department guidelines developed by Kreshak et al[3] describe a more comprehensive, patient-centered approach to emergency care in vulnerable older adults. Since 2007, there has been a rapid increase in self-identified geriatric emergency departments (GEDs), with the American College of Emergency Physicians initiating a formal accreditation program in 2018.[5] Emergency nurses will play an increasingly important part in the development of nursing care for GEDs that involves the entire ED visit trajectory, from initial presentation at triage through discharge to appropriate ongoing care.

The purpose of this study was to explore emergency nurses' perceptions of their ability to care for geriatric patients in the emergency department, including identification of facilitators and barriers to safe care.

Methods

This was a mixed-methods sequential design,[6] using quantitative survey data and qualitative focus-group data. Quantitative survey data were collected first, and, from that data, focus-group questions were derived to explicate and interpret the quantitative survey data. Quantitative and qualitative data were analyzed separately and then weighted equally during the data-interpretation phase.

SAMPLE

A nationally representative sample of English-speaking emergency nurses above the age of 18 years was recruited via email from the membership of a large nonprofit organization for the survey arm of the study (N = 1,610). The demographic summary of the survey respondents revealed that 85% of the respondents were female, with 88% between the ages of 25 and 64 years and 56% holding bachelor's degrees in nursing. The majority (68.3%) were staff or charge nurses working in general or adult-only emergency departments (99.8%) in not-for-profit hospitals (68%). A quarter (24.9%) of the respondents reported they worked in critical access hospitals (CAHs). Two respondents worked in GEDs.

Focus-group participants were recruited by e-mail from a list of emergency nurses registered to attend a conference in September 2018. The 2 focus group samples comprised 23 emergency nurses who worked in the United States (86%), Canada (4.7%), and Hong Kong (9.5%). The focus groups were 90% female, with 72% between the ages of 45 and 64, and 81.4% held bachelor's degrees or higher in nursing. Thirty-two percent of the focus-group participants were staff nurses, with 24% of the participants working as clinical/nurse educators, 12% as directors, and 12% as charge nurses. The majority (84%) of the focus-group participants worked in general ED, non-government, not-for-profit hospitals (80%) associated with academic medical centers (40%) or serving as CAHs (48%). Table 1 provides a summary overview of the survey and focus group participants. Table 2 summarizes the facility characteristics of the survey and focus-group participants.

RESEARCH QUESTIONS

- Q1: Which emergency department resources and services are available to facilitate the care of geriatric patients?
- Q2: What screening practices are in place to facilitate the care of geriatric patients?
- Q3: Which community resources are available to facilitate the care of geriatric patients?
- Q4: What is the experience of emergency nurses in caring for the geriatric population?

TABLE 1
Participant demographics

	Survey (%) (n = 1,610)	Focus groups (%) (n = 23)
Gender		
Male	14.4%	8.7%
Female	85.0%	91.3%
Other	0.6%	0.0%
Age		
18-24	2.4%	0.0%
25-34	20.2%	17.4%
35-44	21.3%	13.0%
45-54	27.1%	26.1%
55-64	20.7%	39.1%
>64	8.2%	4.3%
Missing	0.0%	0.0%
Education		
LPN/LVN	0.1%	0.0%
Nursing diploma	4.3%	8.7%
Associate	14.2%	4.3%
Bachelor's	56.0%	30.4%
Master's	22.5%	52.2%
Doctorate	2.9%	4.3%
Primary ED Role		
Charge Nurse	12.4%	4.3%
Clinical Coordinator	2.0%	4.3%
Clinical/Nurse Educator	7.6%	0.0%
Clinical Nurse Specialist	2.0%	4.3%
Director	5.3%	8.7%
Manager	5.5%	8.7%
Nurse Practitioner	2.4%	8.7%
Staff Nurse	55.9%	43.5%
Trauma Coordinator	3.0%	0.0%
Other	3.8%	17.4%
Years of Experience, mean (SD)		
As a nurse in all areas	18.98 (13.6)	25.12 (13.2)
As an emergency nurse only	14.33 (11.2)	18.52 (11.7)
In current ED	8.35 (9.4)	11.81 (13.2)
In all areas of emergency care, excluding nursing (eg, tech)	6.72 (10.6)	8.94 (11.5)

SD, standard deviation.

TABLE 2
Facility characteristics

	Survey (%) (n = 1,610)	Focus groups (%) (n = 23)
ED patient population		
General emergency department	85.6%	87.0%
Adult only	13.2%	13.0%
Geriatric only	0.1%	0.0%
Facility Type		
Non-government, not-for-profit	68.0%	65.2%
Investor-owned, for-profit	17.5%	4.3%
State or local government	9.3%	17.4%
Federal Government/VA/ military	4.2%	13.0%
Academic medical center	34.8%	26.1%
Critical access hospital	24.9%	13.0%
Free-standing emergency department	7.6%	0.0%
Geographic distribution		
Midwest (IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI)	21.5%	25.9%
Northeast (CT, MA, MD, ME, NH, NJ, NY, PA, RI, VT)	21.1%	17.3%
Southeast (AL, AR, DC, DE, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV)	20.3%	21.6%
Southwest (AZ, NM, OK, TX)	11.8%	8.7%
West (AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY)	26.3%	13.0%

DATA COLLECTION

The mixed-methods sequential design of this study employed a survey for quantitative data collection and in-person focus groups for qualitative data collection. Survey data were collected before the focus groups, allowing further exploration and clarification through the focus-group discussion.

Survey

The survey was based on current literature and modifications made to the Pennsylvania Emergency Department Geriatric Readiness Survey.[7] The modified survey included 26 items, divided equally between demographics (personal and facility) and content items. The modified survey was reviewed for face and content validity by 8 emergency nursing experts who were members of advisory councils for the Emergency Nurses Association (ENA). A study description and informed consent were provided to survey participants before they began the survey.

Focus Groups

A total of 23 emergency nurses participated in the 2 focus groups held at a national conference of emergency nurses.

The study was deemed to be exempt from oversight by the Chesapeake Institutional Review Board. Focus-group participants were provided with the study information and informed-consent documents at the time they registered online for the focus group and then presented with hard copies of the informed consent at the time of the focus-group session. Participants were informed that they could withdraw their consent to participate at any time. In addition, participants were advised that a certificate of confidentiality had been obtained from the National Institutes of Health to provide participants the confidence that their identifying information and/or information that they disclosed during the focus-group discussion could not be "discovered" or provided for use in any federal; state; or local civil, criminal, administrative, legislative, or other legal proceeding. Focus-group sessions lasted approximately 1 hour each, were audiorecorded, with all 6 researchers taking field notes during the sessions. The data set comprised the transcribed recordings and field notes. At the end of each focus-group session, the primary investigator (PI) summarized the discussion for the participants, allowing them to add or clarify any comments while also allowing the researchers to determine if saturation had been met.

To answer research Q4 (*What is the experience of emergency nurses in caring for the geriatric population*?), qualitative data were gathered using a semistructured interview format to answer the following questions:

1. What are your thoughts and feelings about your ability to safely care for geriatric patients?
2. What resources/services are necessary to ensure safe triage/care/discharge for these patients?
3. Are there protocols to guide decision making? On what are they based?

DATA ANALYSIS

Quantitative and qualitative results were interpreted separately, then triangulated for comparison, further interpretation, and final analysis.

Survey

Survey data were exported to an SPSS database (IBM Corp, Armonk, NY). Descriptive analysis was performed.

Focus Groups

The transcribed focus-group data were analyzed using qualitative content analysis[8] by the PI and all 6 members of the research team individually and then a second time as a team to discuss thematic understanding of the data and to achieve consensus on the final categories and themes. Later in the process, those qualitative findings were presented to focus-group participants by e-mail, with a final opportunity to add, amend, or clarify their comments and to confirm that our interpretation was valid. Eleven of the 23 participants responded to the e-mail and confirmed the validity of the qualitative findings.

Maintenance of Rigor

In addition to member-checking the qualitative findings by focus-group participants, the final manuscript was reviewed by all authors and by 3 members of the Institute for Emergency Nursing Research Advisory Council who were not involved in data collection or analysis. Three more experts in emergency nursing also reviewed the manuscript for veracity and fittingness.

Results

Q1: *Which ED resources and services are available to facilitate the care of geriatric patients?*

TABLE 3
Access to resources (N = 1,610)

Resources	Always available	Sometimes available	Never available	Don't know
Ambulatory aids (walkers, canes, etc)	48.9%	36.2%	14.4%	0.4%
Bed alarms	30.7%	21.7%	45.8%	1.7%
Blanket warmers	93.5%	4.8%	1.5%	0.1%
Color contrast environment/decor	21.7%	18.1%	42.0%	18.2%
Commodes/bedside toileting	71.8%	26.0%	2.0%	0.2%
Communication (dry erase) boards in rooms	70.2%	10.1%	19.1%	0.6%
Nonskid, nonglare floors	40.9%	12.6%	36.5%	10.0%
Pressure-reducing mattresses	21.9%	38.3%	33.8%	6.0%
Railings on walls in rooms/hallways	35.3%	30.1%	33.5%	1.2%
Safety mats (next to beds)	2.8%	10.9%	80.2%	4.2%
Sensory (hearing and vision) aids	9.7%	24.8%	58.3%	7.2%
Case management (RN)	23.8%	53.5%	20.2%	2.5%
Case management (social worker)	26.0%	59.0%	13.3%	1.7%
Dedicated pharmacist for medication management	27.5%	45.7%	25.6%	1.2%
Elder abuse services	39.9%	34.6%	17.0%	8.4%
Hospice evaluation	24.4%	52.7%	17.5%	5.5%
Palliative care consultation	24.8%	48.8%	20.9%	5.5%
Physical/occupational therapy evaluation	16.6%	54.2%	25.7%	3.4%
Psychiatric evaluation	57.8%	31.4%	10.4%	0.4%
Sexual assault nurse examiner (SANE)	38.7%	31.6%	27.8%	1.9%
Telesitters (direct observation)	27.1%	35.9%	33.3%	3.7%

Question 1 was answered using survey data. Fewer than half of respondents reported that resources such as ambulatory aids; bed alarms; color-contrast décor; nonskid, nonglare flooring; pressure-reducing mattresses; railings on walls in rooms or hallways; safety mats; and hearing or vision aids were *always available* in their departments (Table 3). Fewer than one third of respondents reported that human resources, such as a dedicated pharmacist (27.5%) or case management by nurses (23.8%) or social workers (26.0%), were *always available*. Hospice-evaluation services, physical therapy evaluation, and palliative care were also noted to be *always available* by fewer than 25% of respondents; psychiatric evaluation services were reported as being *always available* by 57.8% of respondents (Table 3). In terms of available geriatric resources, survey participants were asked if they were aware of collaborative, educational resources, and guidelines published by various medical and nursing organizations. More than half reported that they had no previous knowledge of the Geriatric Emergency Department Guidelines or Geriatric Emergency Department Accreditation. Sixty-five percent of the participants reported knowledge of the Geriatric Emergency Nursing Education course, but only 17% had accessed it. Nearly 75% reported no previous knowledge of the Geriatric Emergency Department Collaborative or the Hartford Institute for Geriatric Nursing.

Survey participants were asked to rank order their top 5 priorities to optimize care of geriatric patients in the emergency department; they responded that nursing education specific to emergency care of geriatric patients was the top priority, followed by treatment and assessment protocols, case-management services, geriatric-friendly equipment, and adequate ancillary support. Survey respondents reported that 27.8% had received geriatric-specific education in the previous 12 months (not including nursing school); 56.5% reported they believed that their colleagues are not sufficiently well trained to care for geriatric patients.

Q2: *What screening practices are in place to facilitate the care of geriatric patients?*

Question 2 was answered using survey data. More than 70% of survey respondents reported that geriatric patients

TABLE 4
Screening practices (N = 1,610)

Screened for:	Yes	No	Don't Know
Abuse and neglect	92.9%	6.4%	0.7%
Activities of daily living (ADL)	57.0%	39.8%	3.3%
Advance directives	83.7%	14.8%	1.5%
Alcohol or other substances	91.3%	7.9%	0.8%
Caregiver stress	16.8%	74.9%	8.3%
Cognitive impairment	70.1%	26.6%	3.4%
Delirium	58.5%	37.9%	3.6%
Depression	73.4%	24.2%	2.5%
Dementia	54.2%	42.1%	3.7%
Fall risk	96.5%	3.1%	0.4%
High risk for adverse outcomes	27.0%	53.0%	20.1%
Indications for urinary catheters	77.9%	19.6%	2.5%
Indications for use of chemical restraints	73.3%	23.7%	3.0%
Indications for use of physical restraints	78.6%	18.8%	2.5%
Intimate partner violence	73.0%	23.1%	3.9%
Instrumental activities of daily living (IADL)	36.8%	52.8%	10.4%
Potentially inappropriate medications	32.8%	55.2%	12.0%
Repeated ED visits	73.4%	23.6%	3.0%
Repeated hospital admissions	77.7%	19.6%	2.7%
Risk of malnutrition	49.3%	44.8%	5.9%
Sexually transmitted diseases	30.0%	60.4%	9.6%
Suicidality	89.9%	9.9%	1.2%

are screened routinely for abuse/neglect, substance use/abuse, cognitive impairment, depression, fall risk, intimate-partner violence, and suicidality (Table 4). Fewer than 50% of survey respondents reported that geriatric patients are screened for risk for malnutrition, sexually transmitted diseases, potentially inappropriate medications, and activities of daily living (Table 4).

Q3: *Which community resources are available to facilitate the care of geriatric patients?*

Question 3 was answered using survey data, in terms of the ease with which emergency nurses could communicate and connect with community resources for geriatric patients. Fewer than 50% of respondents reported that it was *easy* or *somewhat easy* to communicate with home-based services; hospice agencies; nursing facilities (about a received patient or a returning patient); primary care physicians; specialists, palliative care, or rehabilitation; respite; or nursing facilities when the patient is being admitted directly from the emergency department (Table 5).

Q4: *What is the experience of emergency nurses in caring for the geriatric population?*

Question 4 was answered using data collected during 2 focus groups. Analysis yielded the categories of *Triage/Assessment, Care in the Emergency Environment*, *Discharge Planning*, and *Facilitators and Barriers*, which generally reflected the trajectory of care for the older patient.

TRIAGE/ASSESSMENT

Triage/Assessment described challenges in the initial assessment and acuity decisions for the geriatric patient. Two main themes emerged from this category: *pushed to the side* and *challenging presentations. Pushed to the side* refers to the report that elderly patients are often not recognized as being quite ill and are undertriaged, their vague complaints mistaken for anxiety, depression, or loneliness.

These little grandmas and grandpas are getting pushed off onto the side that come in that are not feeling very well today,

TABLE 5
Ease of communication with community resources to care for geriatric patients (N = 1,610)

Resource	Easy	Somewhat easy	Neither easy nor difficult	Somewhat difficult	Difficult	Don't know
Home-based services (visiting nurse, personal care assistants, home physical therapy)	7.1%	21.4%	12.8%	26.6%	23.7%	8.3%
Hospice agency consult/follow-up	12.2%	25.7%	15.3%	25.0%	9.4%	2.9%
Nursing facility (regarding received or returning patients)	15.0%	32.2%	15.3%	25.0%	9.4%	2.9%
Outpatient follow-up with primary care physician	13.7%	27.3%	19.3%	21.1%	8.4%	10.1%
Outpatient follow-up with a specialist	11.4%	27.3%	18.7%	22.0%	10.7%	9.9%
Palliative care consult/follow-up	11.9%	24.4%	15.9%	19.4%	13.7%	14.7%
Rehabilitation, respite, or nursing facility for placement directly from the emergency department	6.0%	16.6%	10.4%	23.2%	34.2%	9.7%

I just had this generalized weakness for a couple days, or the UTI symptoms. They [the nurses] don't want to take care and those ones get pushed off to the side and those are the ones that sit in triage 'cause those are the Level 3s, those are not the Level 1s and Level 2s that we put right back. (CSNF)

I think that's one of the big concerns is that a real common chief complaint is weak and dizzy, and we see that all the time, and we have to be careful not to fall into the trap that they're just weak and dizzy. I had a gentleman who came in quite unkempt and he ended up being in cardiogenic shock, but we had to look past his unkempt condition and his being seen yesterday and recognize that he was acutely ill. And I think it's easy to fall into the trap of not looking. (SSNF)

We get our elderly that come in with a psych label, and the reason why I joined this [focus] group was a specific incident that happened very recently, (I) think she was 78-79 years old, had fallen and was found between the toilet and the wall, and somehow somebody called 911.Well, she refused to come in. So they got the police involved and put her on a 51-50 because she refused to come to our emergency department. Now because of that label of the 51-50, she was put in our psychiatric room, and she proceeded to die. She died about an hour and a half later because she was being watched simply by a psych tech and they had done some workups and some labs and things, but nobody really recognized that the reason why she fell behind the toilet was because she was having an MI, not because she was psychiatric. And so, we had absolutely no geriatric training in my department in my hospital that even mentioned it, and we do see a very large geriatric and geriatric psych on top of our regular psych population. So, it's a big problem. (C2SNF)

Challenging Presentations

Our participants reported that because older patients can have vague complaints, a long medication list, and confounding symptoms, it can be difficult to separate out critical etiologies. Participants in rural areas report that their patients may have not received any medical care for years, and thus what might be an acute episode may also be several (unmanaged or untreated) chronic problems overlapping each other. Other concerns were for communities that tended to not vaccinate or communities that access traditional medicine practices before coming to the emergency department, with the result being that patients arriving at emergency departments are very sick.

I think a lot of times it's just giving the nurse that time to be able to assess them fully because I know we probably all had patients that come in with weakness and then we find that they have cancer and they have CHF or something like that 'cause they've never had any kind of medical care. In my community hospital I have a lot of rural areas around me, so several times we get elderly patients that come in, who have never had medical treatment. And, for whatever reason, they come in for something that is acutely wrong, and then we just find a cascade of things that are wrong with them. (JSNM)

The other thing is that we also work in a rural area that has a lot of the Amish community. The Amish community—young or old—is at big risk. They don't believe in vaccinations, so you, basically, when you have somebody that's febrile, in abdominal pain, whether they're young or old, they're likely to be very sick. So, culturally, that can be a consideration also. (C3SNF)

In some emergency departments, recognition of this phenomenon is so common that "little old lady workups" are standard. Even though our participants described the common under-recognition of the elderly ill patient, there was an understanding that older patients are complex and that seemingly benign presentations can be misleading. However, there was some concern that older patients were evaluated dependent on the specialty of the emergency department or hospital: for example, nurses from an emergency department with a cardiac center reported that patients were assumed to have a cardiac etiology for their vague complaints. Similarly, reports from nurses who worked in high profile stroke centers reported similar diagnostic pathways for vague complaints that involved stroke workups.

We're able to order that CBC, BMP, urine, EKG (sic) right up front with those base symptoms and so, you know, the doctors have already said you can order anything in these power plans that we've done, and so that's the one that they want us to do; we do that, and that allows them to go in there and kind of narrow where they're going, if that patient has been unable to really narrow down their symptoms and are very vague about it. (S2SNF)

Our basic rule, there's no such thing as a [ESI] Level 4 over the age of 65, like that's the minimum number for us:3 and up; there's too many comorbidities. They can have that sprained ankle, but then their blood sugar will be 875, and they'll have a troponin of like 17.2, and they're a hot mess express. (MSNM)

CARE IN THE EMERGENCY ENVIRONMENT

In the next category, participants described themes of *keeping patients safe*, *higher workload,* and *maintaining dignity for elders*.

Keeping patients safe was discussed almost entirely in the context of fall prevention. Participants described various ways their emergency departments addressed this particular risk for older patients while they were in the ED environment. Interventions were targeted at the patient such as special floor mats to aid in depth perception, and at providers, such as identifying patients at risk for falls via visual cues.

One of the things is a black mat put down next to the bed so that people don't think, are afraid to step out of bed because it looked like nothing was there. When they see the black mat, it changes their visual perception of what's below the bed. (KSNF)

In the emergency room we put yellow bands to alert that they are high risk for falls, and also on the floor they use this lime color blanket to alert staff that this patient is high risk for falls. (LSNF)

Higher workload emerged as a theme as participants discussed the experience of caring for this population. They acknowledged that the cognitive impairments and physical limitations common in the older patient resulted in a significantly longer process of not only initial assessment and determination of acuity but also routine preparatory care such as getting the patient undressed or getting a urine sample. Participants reported that the extended care time could result in older patients waiting longer to be seen and voiced concern that there were often inadequate resources for this care to be provided safely and with dignity. In addition, the higher workload also refers to the need for social intervention, leading to frustration for nurses who see huge gaps in the social fabric that leaves patients unable to be cared for at home. Our participants made a connection between the higher workload and the need to maintain dignity for the elderly, recognizing that the lack of autonomy inherent in a health care setting and the frustration of the prolonged care needs time could result in a lack of respect for older patients.

I think elders at our facility are triaged the same as everybody else; you know, abdominal pain is abdominal pain, you know. Heart failure is heart failure, but people don't really want to take care of them because a triage is a 3, the same as every other abdominal pain, but you know that at 3, you're going to have to be getting them onto the commode and off; disposition is going to take a long time. You can't just say, "time to go"; you have to have rides and stuff. So I think they triage for acuity but not for the amount of work that they are; they're kind of the last ones to get picked up because of the work involved. And we have a social worker on staff days, and that's about our only resource. They can make referrals to adult protective services or make some phone calls for you, but it's really not much. (PSNF)

And that gets really frustrating, and it gets—it makes you honestly get angry—it's like, especially if they were here yesterday, and they've been in hospital for 3 weeks, and they went home last night, and they're back this morning because they're still weak and dizzy. It's like, I can't fix that. Then, when you've taken a whole bunch of my time that I don't have, so I think it's really hard not to get angry and frustrated because I think what's missing in our culture, or whatever, that allows these people to have a quality of life at home, that they have to come to the emergency department. (SSNF)

I've seen them treated like children or worse by nursing staff and doctors. I think that with education, understanding of the need, and the fact that, you know, young people aren't always around grandparents and stuff, like they used to be. And, the population that is coming up now, many of them lived through the Great Depression and have true fear of being without and that brings them in, respecting where they've been, the fact that they've lived lives, some of them have been very important people, and now they're down to the place where they can't even toilet themselves. That's a far fall, and I think a lot of times our nurses forget that when we're disrespectful of them when they have to go to the bathroom, especially, because like you say, that half an hour it takes to get them off, do all that stuff, clean them up, go, it's just, it's so humiliating for them, and I would like to see the respect returned to that population. (DSNF)

DISCHARGE PLANNING

The two previous categories considered assessment and care while stressing safety. The themes that emerged from this category were keeping people safely at home and assessing activities of daily living (ADL). There was discussion around the outcomes metrics for successful discharge planning, accounting for the more complex medical and social needs of older patients, both in the emergency department as well as in planning for care in the community. The focus of discharge planning was to prevent repeat visits, so participants stressed the need for careful assessment and intervention to address logistical needs such as rides home, meal planning, and access to pharmacies.

The quality metrics that we're looking at are 72-hour returns, because we're hoping that would be geriatric screens. First we notice they're at risk, and then we're addressing it appropriately, so they're not coming back for one thing this day, one thing that day, and it actually turns out they're a fall risk, and then they come in for the broken hip, and you know how that cascades. So, we're hoping to reduce 72-hour revisits. We're going to look at 30-day rehospitalizations; we're going to look at door-to-doc time for these geriatric patients because if we're identifying them immediately in triage, then, hopefully, even if they have to wait in the waiting room, the social worker will go out and see what resources are needed. (ESNF)

The big focus that we had with them was sepsis and bounce-back, and in order to work on the bounce-back aspect, our clinical nurse specialist came up with the idea—as we have an outpatient pharmacy—when people are discharged, if there's any inkling at all that they won't be able to get ahold of those medications or afford those medications, we'll go over to the pharmacy and fill them and send [them] home with [their] medications. That way somebody doesn't go home expecting to take, you know, Augmentin for pneumonia, when we can, you know…even if they can't pay for it—$4 versus the repeat visit of, you know—whatever, $400,000. How much can that cost if they go septic at home? So we were giving people the medication—we still are— even from inpatient and from the emergency department, we will do that sometimes. (MSNM)

[We need] more time spent with discharge planning, and say, you know, "You need to weigh yourself, take these medicines prescribed, have a follow-up appointment, follow this low-sodium diet," whatever. You can't just say that to an elderly person and expect that. Do they have a scale? Do they have a way home? How are they going to get their medicines? Do they understand the diet? I think there's a lot more assessment for discharge needs as well as teaching for the elderly. (PSNF)

FACILITATORS AND BARRIERS

This final category describes issues our participants saw as encouraging or challenging specialized geriatric care in the emergency setting.

Barriers

A commonly noted barrier was time constraints due to patients' cognitive impairments, their physical limitations, or high ED patient loads.

You just know it's going to be very time consuming. Sometimes the patients have difficulty focusing and explaining what their problem is. They're probably on a whole boatload of medications that we need to go through and assess. (D2SNF)

One of our problems with the older folks coming in is triage; they get stuck in triage, and they almost—if they're older—they always seem to be incontinent, and then there's extra time to take care of them, so they often sit and get overlooked, and, you know, in soaked clothes and sheets and stuff, so… And also, on the other side of it, when they're going up to the floor or they've been in the department for a long time, they can, you know, they'll often be incontinent again and not get the care that they need as promptly as they need. (KSNF)

Another barrier noted by participants was interest in the care of the geriatric patient. They reported that, owing to the vague complaints of older patients and the extended time required to assist them with ADLs, newer nurses who had not received training as certified nurse assistants (CNAs) had lower interest and comfort levels with older patients, whereas nurses who had received that training were reported as being excellent nurses for the geriatric population. Participants reported a clear preference for nurses who had had some CNA training and who were comfortable caring for older patients.

I sometimes perceive that, with some of the staff, it's not as interesting or exciting as some of the other things, so they don't have the commitment to that patient. (D2SNF)

On another note, we've had 18 new grads this year, and they do not want to take care of the older population because they are not as cool and have all the whistles that we're doing. They don't do the ADLs, and they don't take care of their med list; that's not interesting to them (CSNF)

We are also finding that a lot of the new grads are TCNAs or were aides in nursing homes before they even came to the emergency department. And I'm going to tell you those are probably some of the best geriatric nurses that we have, and we—as older nurses—can learn from that. (C3SNF)

The last barrier noted was that of education. Participants reported that, with a few exceptions, geriatric care was not provided as a special population update or population-specific initiative and was dependent on previous training or personal interest on the part of the individual nurse.

I think they're well cared for, but they're not a focus of review or continuing education, or, you know, we're not looking at that special population. We don't have any special training to go along with that (MSNF)

There is a real gap there with the ability of our nurses to do a geriatric assessment. It sounds like you [the VA hospitals] have a great tool; you guys are way ahead, I think, of many of us, but it's that gap of, "How do I assess this patient?" (MSNM)

Facilitators

Facilitators were reported as institutional support for education and resources including adequate CNA staff as well as individual passion for the care of this population.

My boss bought 20 GENE (Geriatric Emergency Nursing Education) courses for different emergency departments, so she gave out 2 to each emergency department. So we picked a couple of nurses from each place who could take the course, and I think that really helped some awareness of the differences in the geriatric population. Now, we don't have the resources for social work, and a lot of them don't have resources for geriatric-specific populations, but I think those nurses kind of took on the champion, as such, and tried to give some education to the other nurses about different things that the geriatric population was facing. (JSNM)

Discussion

This was a mixed-methods study using survey and focus-group data to describe the state of nursing care for geriatric patients in US emergency departments. The multidisciplinary geriatric ED guidelines[5] consist of 40 specific recommendations in 6 general categories—staffing, transitions of care, education, quality improvement, equipment/supplies, and policies/procedures/protocols—with the Society for Academic Emergency Medicine task force putting forward additional quality indicators[9] in the areas of cognitive assessment, pain management, and transitions of care. Our findings suggest that there are significant deficits in adhering to these guidelines.

Our focus-group participants discussed the safety of geriatric patients—both in the emergency department and at home—as a primary concern. They focused on falls as a problem of interest; falls are associated with both increased care costs and higher morbidity in the geriatric population.[10] Pfortmeuller et al[11] reported that falls at home during ADL were the main class of falls for geriatric patients, with falls caused by medical conditions (ie, syncope) most likely to result in mild traumatic brain injury. Huded et al[12] reported that the emergency department is an appropriate place for nurses to screen geriatric patients for fall risk using the Timed Get Up and Go Test, using both ED-based and community-based resources to mitigate risk. Survey respondents identify geriatric-friendly equipment, such as assistive devices, as a high priority for their emergency departments; although more than 70% of our survey respondents reported screening for fall risk, fewer than 25% reported the availability of ED-based physical therapy, and fewer than half reported that assistive devices were *always available* in their emergency departments. Our focus-group participants noted this gap as a specific area of need in terms of both in-hospital assessment and care and as a critical component of discharge planning.

Care in the emergency setting was also discussed in terms of screening for various issues particular to the geriatric population: namely, delirium, dementia, and functional decline/ADL. In their systematic review of frailty screening tools, Warnier et al[13] conclude that between 50% and 80% of geriatric patients admitted to the hospital are considered frail, and approximately 30% to 60% of hospitalized older people lose the ability to perform relevant ADL, compared with their pre-admission levels of functioning. This decline can contribute to negative short- and long-term health outcomes, prolonged hospital stays, readmission to inpatient care or to a nursing home, and increased mortality. Both our survey and focus-group participants report that a majority of geriatric patients are screened routinely for abuse/neglect, substance use/abuse, cognitive impairment, depression, fall risk, intimate-partner violence, and suicidality but are screened for risk for malnutrition and compromised ADL far less often. Given the reported lack of ease in connecting with community resources, such as primary care and home-based services, even the screening that is done is challenging to act upon. Focus-group participants in this study said that they believed patients were being turned back out into the world, and because their needs cannot be met in the community, they will be returning to emergency departments.

The policy statement put out jointly by the American College of Emergency Physicians, the Society of Academic Emergency Medicine, and the Emergency Nurses Association in 2014, on Optimal Older Adult Emergency Care, posits that the "management of geriatric adult emergencies requires reliable communication between primary care, inpatient and outpatient medical and surgical specialists, rehabilitation medicine, case managers, social work, pharmacy, and nursing professionals."[5] Discharge planning is challenging for this reason; a lack of access to community resources impedes transitions of care, which are critical to the safe and effective care of geriatric patients. Of concern is that the majority of emergency nurses participating in this study did not know about the existence of guidelines for geriatric care, and only 26% of survey respondents reported that case management to facilitate care transitions was always available in their emergency departments.

Focus-group participants identified significant barriers to implementing recommended care, including lack of resources—such as social work and case management—and a need for extra ancillary staff that can help with the longer time frame for ADL that geriatric patients may require; these were also identified by survey participants as being a high priority and fall within the areas covered by the geriatric guidelines.[5] Both survey and focus-group participants identified components of better geriatric care including education, interdisciplinary collaborators such as social work, and a focus on transitions of care so people are safer in the hospital and at home. Focus-group discussions around quality of ED care suggested that care of older patients can improve when patients are treated with respect and dignity and understanding for not just the physical limitations but also the psychological sequelae of those limitations.

Our focus-group participants also reported desired outcomes of improved geriatric emergency care as improving sepsis screening, reducing unnecessary wide net testing, reducing falls, and reducing revisits and bounce-backs. The single most enthusiastically discussed intervention to improve geriatric care was postdischarge follow-up, which our participants suggest may reduce bounce-backs and allow for more reinforcement of discharge teaching, which can be impeded owing to the space and time constraints that characterize the emergency care setting.

Limitations

This study sample comprised emergency nurses working in the United States, Canada, and Hong Kong. Both the survey and focus-group samples were self-selected and may not represent all the responses available. The differences between nurses who chose to participate and those who chose not to participate cannot be determined, and thus potentially important differences between the groups cannot be ascertained.

Implications for Emergency Nurses

Older adults often present atypically, with multiple vague complaints in the context of complex medical and psychosocial issues. Efficiently and effectively managing this complexity requires the collaboration of medicine, nursing, social work, and case management. Emergency nurses play an important role in the initial identification of the at-risk patient and can improve care by championing geriatric-specific education and advocating for physical and administrative interventions that are geriatric specific. The use of appropriate staffing—including both RNs and ancillary staff—is also an important implication, given the extra time and care required to provide safe assessment and intervention in this population.

Conclusions

Population aging mandates that emergency departments evolve into sites of acute comprehensive assessment and care coordination for vulnerable older adults. This important role requires that they develop integrated systems to facilitate appropriate assessments and acuity decisions, ensure safe transitions among sites of care, maintain function within the emergency environment, and discharge patients back to the community with appropriate supports in place to prevent readmission.

Identified barriers to improved care include a lack of integration between emergency care and community care, deficits in geriatric-specific education, inconsistent use of early screening for frailty, and lack of resources in the emergency care environment to intervene appropriately. Future research should focus on clinical and administrative interventions that increase the availability of resources, both in the emergency department and the community, to reduce unnecessary admissions and facilitate care in the community.

Acknowledgments

The authors would like to acknowledge the contributions of the Geriatric Emergency Department Collaborative in preparing the survey for deployment and Ms. Leslie Gates, for her work with this project.

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