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## Key Healthcare Providers' Perspectives on the Implementation of Senior-Friendly Emergency Department Care in Quebec

*Deniz Cetin-Sahin, MD, MSc, Francine Ducharme, RN, PhD, Jane McCusker, MD, DrPH, Mona Magalhaes, MA, Nathalie Veillette, OT, PhD, Paul-Andre Lachance, MD, MA, Sylvie Cossette, RN, PhD, Alain Vadeboncoeur, MD, Rick Mah, MD, T.T. Minh Vu, MD, Simon Berthelot, MD, MSc*

### ABSTRACT

<b>Introduction</b>	Senior-friendly emergency department (ED) care is emerging to address large numbers of older adults in healthcare and implementation is variable. We aimed to explore key healthcare providers' perspectives on factors affecting implementation of senior-friendly ED care during the first five years of Senior-Friendly Hospital Initiative in the Province of Quebec, Canada.
<b>Methods</b>	We conducted a descriptive qualitative study of four urban EDs. Key healthcare providers involved in care within the ED or after discharge to the community were purposefully selected. Semi-structured telephone interviews were conducted in participants' preferred language, English or French. Recorded interviews were transcribed. A deductive-inductive thematic analysis was performed focusing on factors affecting implementation at the three following levels: provider-level (ED frontline staff, multidisciplinary, geriatric, and community providers), organizational-level (ED and hospital), and structural-level (health system and policies).
<b>Results</b>	In total, 33 providers participated. The sample included 13 ED frontline nurses and physicians, 13 multidisciplinary and geriatric ED care providers, and seven community partners from the local government health centers working closely with these EDs. Analysis of participants' perceptions revealed one theme representing implementation at the provider level (attitude to senior-friendly care), six themes representing the organizational level (managerial support, staff training, protocols for care and tools, space and equipment, multidisciplinary support, hospital services support), and three themes representing the structural level (health information system, healthcare network, and staff and budget).
<b>Conclusion</b>	Healthcare providers identified themes that can inform the development, effectiveness, and sustainability of other senior-friendly ED programs. Overall, successful implementation of senior-friendly ED care primarily depends on providers' attitudes, but it requires a multidimensional approach and continuous support from organizations and healthcare systems.

### INTRODUCTION

Older adults are increasingly presenting to emergency departments (ED) with complex multifactorial problems, such as a decline in physical and/or cognitive functions or increased social needs.<sup>1</sup> In response to these complexities, various organizations have developed guidelines for age-appropriate ED care that is "senior-friendly".<sup>2,3,4-7</sup>

Quebec EDs began implementing senior-friendly ED care following dissemination of provincial guidelines in 2006 for adapting geriatric care to the ED context.<sup>8</sup> In 2011, Quebec health and social

services networks were mandated to promote the adoption of the “*Approach Adapted to the Elderly*” [Senior-Friendly Hospital Initiative (SFHI)<sup>9</sup>] for persons aged 75 and over, admitted to EDs or inpatient units.<sup>10</sup> The initiative focused on assessing and maintaining older patients’ autonomy and mobility, skin integrity, nutrition/hydration, elimination, cognitive status and behavior, and sleep.<sup>9</sup>

In a Quebec study of the implementation of evidence-based geriatric services from 2006 to 2014, based on information provided by key informants (ED chiefs and heads of ED nursing), there was a significant increase in the number of senior-friendly service components, such as the use of a high-risk screening tool, a designated coordinator of ED geriatric services, or a discharge planning protocol (from a mean of 2.8/11 to 6.0/11). Different stages of adoption (early, late, non-adoption) could be recognized; availability of a geriatric nurse clinician was associated with early adoption.<sup>11</sup> In order to harmonize adoption of geriatric principles in Quebec EDs, in 2021, Ministry of Health and Social Services released a practical guide.<sup>12</sup>

Healthcare providers’ perspectives can be used to help other institutions as they implement or refine their senior-friendly ED programs. While key informants can provide basic information on adoption of new practices, a more complete picture can be provided by front-line staff. In a recent survey of nurses and physicians at 4 urban EDs, we found generally good consensus about those practices that can improve the quality of ED geriatric care; results suggested a need in particular for improving staff education and discharge processes.<sup>13</sup> Building on this survey, the purpose of this study was to explore key healthcare providers’ perspectives of the implementation of best practices in relation to senior-friendly ED care during the first five years of the SFHI in Quebec.<sup>14</sup>

## METHODS

We conducted a descriptive qualitative study<sup>15</sup> as part of a multi-phase interdisciplinary project of the ED care of older adults. Four university-affiliated EDs in two metropolitan cities in the Province of Quebec were purposively selected (described previously; key characteristics of the 4 EDs are in the Appendix 1).<sup>16</sup> Institutional Ethics Boards of all participating hospitals approved the study. Nurse and physician chiefs approved the conduct of the study in their EDs. We used Revised Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0)<sup>17</sup> and Consolidated criteria for Reporting Qualitative research (COREQ) checklists.<sup>18</sup>

### *Study Participants and Sampling Strategy*

Three groups of providers were recruited.

1. ED front-line clinicians were selected among 74 front-line registered nurses and physicians who had participated in the previous survey.<sup>13</sup> “Participants were stratified based on their perceived quality of geriatric ED care (4-item scale). To maximize variations in perspectives, nurses and physicians having the lowest and the highest perceptions of quality of geriatric care within each ED were targeted (extreme case sampling).
2. Multidisciplinary and geriatric ED care providers were selected purposefully among those who worked either full-time in the ED or on call in the hospital and played various roles in geriatric ED care (e.g., geriatric nurses, liaison nurses, pharmacists). Names and contacts of potentially eligible participants were provided by ED chiefs and key informants who were responsible for the SFHI implementation in the hospital. Potentially eligible participants were contacted by email or phone to explain the aim of the study and to invite them for an interview. During the interviews, participants were also asked if they could identify other providers who were knowledgeable about the topic (snowball sampling).
3. Community services coordinators (nurse, social worker, or occupational therapist) were those who were integrated from the local government health centers into ED teams to carry out patient assessments and follow-ups, to promote faster care for them in the community and, consequently, to reduce the length of stay, both in the ED and inpatient units.<sup>19</sup> Home care

nurses and community social workers were also contacted at the Local Community Services Centers (LCSCs) with which each ED related most frequently. The recruitment was done using the same strategy as for multidisciplinary and geriatric healthcare providers.

## Data Collection

Initially consenting participants were sent a detailed consent form prior to interviews to allow them to understand the study and their participation. Telephone interviews were conducted in participants' preferred language (English or French). Participants gave their verbal consent and received a signed copy of the form after the interview. Interviews explored factors affecting the implementation of an innovation at the provider, organizational, and structural levels according to definitions in a framework proposed by Chaudoir's et. al (Appendix 2).<sup>20</sup> Data collection and analysis occurred concurrently, giving us the opportunity to explore themes as they emerged.<sup>15</sup> Recruitment ended when there were no new ideas coming from the interviews. The interviews were tape recorded and transcribed.

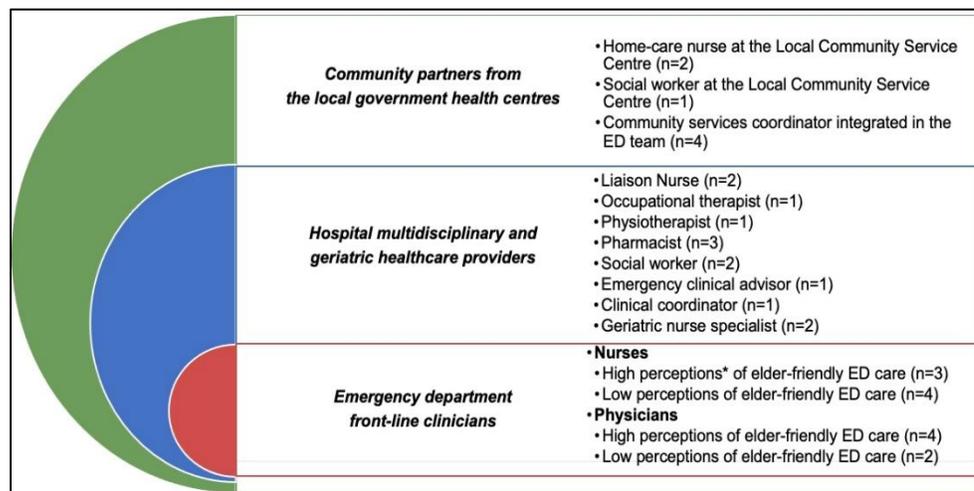
## Analyses

A hybrid approach of deductive and inductive thematic analysis was conducted through the systematic classification process of coding and identifying recurrent themes.<sup>21</sup> We retained the same three levels of the framework<sup>20</sup> to guide the deductive approach. The analysis also allowed for themes to emerge from the data using inductive coding.<sup>21</sup> With a view to informing practice and policies, the unit of analysis was the level at which the implementation was governed: provider (ED front-line, multidisciplinary, geriatric, and community), organizational (ED and hospital administration), and structural (healthcare system/policies).

Two bilingual researchers developed a coding manual and refined the themes through iterative discussions. Where applicable, the taxonomy used by the Effective Practice and Organisation of Care of health systems interventions was adapted to define the themes.<sup>22</sup> Themes were validated with team members until reaching consensus and explicitly linked to the original quotes. Selected French quotes were translated. QDA Miner 4.0 software was used for data management and analysis.

## RESULTS

33 providers participated (**Figure 1**). Analysis of participants' perceptions revealed one theme representing implementation at the provider level, six themes representing the organizational level, and three themes representing the



**Figure 1.** Description of Participants (n = 33)

\*Perceptions were measured using 4-item scale with mean scores ranging from 1 (not at all) to 5 (completely); 1-3 low, 4-5 high perceptions. The number in the parentheses represents the number of participants. ED: Emergency Department

structural level (**Figure 2**). We defined and explained the themes below and provided illustrative quotes in Appendix 3.

### ***Provider-Level Theme***

Attitudes to senior-friendly emergency department care: ‘Awareness and proactive application of senior-friendly care’. Providers’ awareness of senior-friendly care was perceived as the primary source of a passionate and dynamic team ready to improve practices. Inter-professional communication and regular meetings in the ED were found to be imperative to discuss needs for consultations, diagnostic tests, decisions for hospitalizations, and possible discharges. Family involvement at the stage of discharge was prioritized especially when a patient had cognitive deficiency. While front-line staff proactively optimized care, e.g., nutritional intake monitoring, proper use of restraints, or pain management, working with leaders was motivating for them.

### ***Organizational-Level Themes***

1. Managerial support: ‘Organizational culture and buy in from administration’. The presence of dedicated committees to implement SFHI recommendations was important. While some providers spoke about the changes made in previous years, acknowledged their committees, and appreciated the managerial support, others expected to see more tangible and sustainable committee work and administrative support. Hospital administration’s interest in improving wait times and length of stay was seen as a “bureaucratic” activity which was not always linked to the field. In one ED, a physician-led initiative in the context of a research project to promote better care for older patients was not maintained due to insufficient support. Participants felt that the SFHI committee should be more explicit about the definition of specific roles for each provider.
2. Staff training: Distribution to individuals, or groups, of educational materials to support clinical care, including courses, workshops, conferences, or other educational meetings. Initiated as part of a government mandate to implement the SFHI, in some EDs, hospital organizational committees facilitated and reinforced geriatric care training for providers. Some participants perceived a need for more staff training. This was particularly the case for physicians who expressed the lack of formal geriatric care programs specific to them. Considering the aging population, ED nurses voiced their need for increased training both in geriatrics in general and in specific conditions that are frequently seen among older patients.
3. Protocols for care and tools: ‘Clinical practice guidelines, care pathways, systems, or strategies for improving the communication between health care providers. Within this theme, there were four main subthemes.
  - *Medication Profile and Reconciliation*: Pharmacists created medication profiles at the ED arrival by contacting community pharmacies and speaking with patients and families. This process was followed by a medication reconciliation during ED stay to ensure appropriate prescribing in the ED or at discharge. This practice was perceived as being fundamental for the care of older adults who usually take many drugs and who are prone to medication interactions and adverse events. An area for improvement was that medication reconciliation was not generated for all patients. In one site, pharmacists

### **Provider-Level Theme**

1. Attitudes to senior-friendly emergency department care

### **Organizational-Level Themes**

1. Managerial support
2. Staff training
3. Protocols for care and tools
4. Space and equipment
5. Multidisciplinary support
6. Hospital services support

### **Structural-Level Themes**

1. Health information systems
2. Healthcare network
3. Staff and budget

**Figure 2.** Emerging Themes from Thematic Analysis

developed a tool for physicians to help them make decisions for when to request a pharmacist consultation to identify medication-related problems.

- *Screening and assessment:* High-risk screening for functional decline often prompted geriatric teams to make further initial assessments to ensure that patients' acute care stay was optimized and that their orientation and cognitive function were well documented. There were, however, some inconsistencies in these practices. In some EDs, screening was left to the judgment of the triage nurse, or in-depth functional assessments were completed only for patients aged 75+ or those who were confused.
- *Patient/family education:* While ED nurses provided education to patients/families as needed, pharmacist consultations were requested if patients/families requested explanation on prescriptions. Community nurses provided education especially for families having a relative with chronic conditions such as dementia. For some participants, though, the variety and quality of the informational materials to be used at discharge could be better. They desired to have materials with images to help patients/families understand and recall instructions after discharge.
- *Other care practices:* Providers made efforts to optimize some other practices such as mobilization, hydration, nutrition, or use of restraints. Orderlies took action to avoid the use of incontinence briefs, helped patients go to the bathroom, or encouraged them to do physical activities to maintain muscular tone in the ED. Emergency department nurses felt that increasing family presence at the patient's bedside would reduce the risk of delirium and deconditioning following immobilization.

4. Space and Equipment: 'Changes to the physical or sensory healthcare environment, by adding or altering equipment or layout'.

In 2 EDs, renovations made the layout user-friendly and addressed overcrowding. One of these EDs had the opportunity to collaborate with an inpatient "Geriatric Assessment Unit" designed to provide a full geriatric assessment, optimize patients' functionality, and increase their ability to return home or semi-autonomous residences. The other 2 EDs had specific layouts: A re-evaluation room dedicated to patients who needed in-depth assessment after triage, and three ED rooms adapted for older patients.

Limited ED space and equipment were a challenge for some participants who thought that placing older patients with their physical and cognitive vulnerability in hallways was unacceptable. Sometimes, the lack of closed ED doors was forcing providers to use restraints to prevent patients from wandering and falling. Some suggestions were made to increase the comfort of the ED. Regarding equipment, providers reiterated a need for more armchairs, geriatric chairs, commode chairs, recliners, and restraints. Other ED providers stressed the need for a dedicated unit for geriatric patients who required more focused care. A suitable place for older patients who needed less surveillance was also desired, especially when there were delays with discharges in evenings due to transport issues.

5. Multidisciplinary support: 'Creating and delivering care through a multidisciplinary team of healthcare workers.

Many examples were provided of the support received by multidisciplinary staff. Pharmacists supported the ED team via consultations or systematic monitoring. Physiotherapists helped with early identification of patient needs. Occupational therapists organized the aids/equipment which would be used at home. Social workers made sure all service requests were evaluated timely (e.g., for loss of autonomy, dementia, or mental health issues). Access to a geriatric team and coordinators of geriatric services were appreciated. A geriatric nurse specialist assessed patients aged 75+ before discharge, facilitated communications between the ED team and patient's families, and helped link patients with community resources.

A liaison nurse coordinated nursing services, e.g., intravenous antibiotics, dressings, injections, oxygen therapy or palliative care at home, when patients were returning to the community. Community services coordinators based in the EDs acted as a resource person for planning discharge, organizing services, and delivering the equipment needed at home.

Some participants, however, felt that multidisciplinary support should be increased because ED care for older adults required more expertise to gather relevant information and provide optimal care. The need was more noticeable during the evening/night shifts and weekends when multidisciplinary care providers were absent. There was a perceived need for having more geriatric expertise, e.g., geriatrician, geriatric nurse, or mental health nurse.

6. Hospital services support: ‘Availability of consultations, tests, and imaging’.

In one ED, increasing radiology capacity and operating hours helped ED providers. The availability of geriatric consultations in the ED was important. It was commonly thought that processes for consultations, diagnostic tests, or imaging could be fast-tracked for seniors, which would help reduce their anxiety levels.

### ***Structural-Level Themes***

1. Health information systems: ‘Health record and health management systems to store and manage patient health information, for example electronic patient records. Technology-based methods to transfer healthcare information and support the delivery of care’.

Participants experienced barriers with existing medical records systems, particularly those that would facilitate two-way communication between the ED and other healthcare settings. They desired to have an electronic tool through which they could share all medical records, such as medication lists, comorbidities, and allergies, mainly with community services.

- *Home-care services*: Participants reported a lack of a local, regional, or national standardization of the types of information to be exchanged with community healthcare centers. This barrier impeded the teamwork between ED front-line nurses and physicians, hospital multidisciplinary staff, geriatric teams, and community representatives to ensure a safe discharge. It was recommended that ED staff have a checklist for patients’ needs and specify why a patient’s situation is precarious when communicating with the LCSC.
- *Pharmacies*: Participants felt a need for structured and systematic way of transmitting the medication information to community pharmacists.
- *Family/treating physicians*: There were problems with communication processes with family/treating physicians in the community. ED physicians spoke about the inconsistent use of a written discharge summary, which was meant to ensure the continuity of care by explaining what was done in the ED and what should be done next. A geriatric specialist nurse mentioned that they had to contact family physicians to get referrals for patients’ external geriatric assessments.
- *Residential Facilities*: Participants thought that the information coming from residential facilities was usually insufficient to inform ED care. Front-line staff was transmitting the information to residential facilities via a form if patients were aged 75+ or confused. When needed, they were making phone calls to the residence nurse to verify the patient’s return address and to advise them about the ED procedures and treatments, but they did not always have a contact person or number to reach nurse at the facility.

2. Healthcare network: ‘Policies for how multiple organizations work together; governance arrangements for coordinating care across multiple providers.’

Emergency department care providers expressed a need for optimizing older patients' trajectories between care settings. Challenges existed with older adults who do not have family physicians as well as getting access to an external geriatric consultation in the community.

Providers working in the community ensured that, at each admission, data on the activities of daily living, finances, and medications were collected. If the patient accepted, a request for home-care support was made. However, extra attention was needed so that service requests do not "fall between the cracks" due to managerial problems with community services. LCSC nurses felt that administrative inefficiencies and annual assessments sometimes reduced the time that they could dedicate to direct patient care. There were efforts made in the past years where various community stakeholders working with seniors were invited to become acquainted with diverse community organizations, yet it was perceived that acute care staff was not fully informed about the available community services. There were periods when ED providers admitted patients to a hospital ward due to their concerns about potential delays in home care services in the community or the lack of alternative care facilities (e.g., rehabilitation centers, assisted living facilities, long-term care homes).

3. **Staff and budget:** Availability of human and financial resources.

Both ED nurses and physicians voiced time constraints due to the heavy workload and overcrowding. Especially during nights, weekends, and holidays, there was insufficient staffing. Transport systems adapted to older adults were needed to facilitate safe discharge especially in evenings and nights. Nurses also felt budget limitations while providing bedside care.

## DISCUSSION

In this descriptive qualitative study, we explored key healthcare providers' perspectives of implementing senior-friendly ED care in Quebec. Findings suggest that implementing senior-friendly ED care depends most directly on providers' attitudes towards such care, but its sustainability requires support from organizations and structural systems. Ten themes that emerged from the analysis were tabulated in **Table 1** followed by suggestions and illustrations to point out the way about how this research can help other EDs as they initiate and develop their senior-friendly ED programs.

The organizational themes identified in this study map well onto a tool previously developed by our team for self-assessment of the quality of geriatric ED services.<sup>23</sup> Only 2 items in our senior-friendly department assessment tool<sup>23</sup> were not identified as themes in our current study: quality improvement initiatives and monitoring of administrative data. These are care components implemented at the management level; front line staff are less likely to be aware and value these aspects.<sup>13</sup> This current study therefore provides a cross-validation of the key organization-level components identified in the previous study.<sup>23</sup> What this study adds, is first, a richer understanding of ways that best-care practices can be implemented, and second, the identification of structural-level facilitators of improved care practices.

Our participants were enthusiastic about adopting and promoting senior-friendly ED care but expected more clear directions and continuous support. A "geriatric champion model" was described in the United States (US), which relied on a physician or nurse with expertise in geriatric ED care to lead initiatives and multidisciplinary care coordination.<sup>24</sup> This model was reported to be feasible in any ED provided that coordination between the ED geriatric champion, community resources, and outpatient clinicians was sustained.<sup>24</sup>

Table 1: How the Themes Can Inform Other EDs Initiating or Developing Senior-Friendly Care		
Themes	Suggestions	Illustrations
<b>Provider-Level Theme</b>		
Attitudes to senior-friendly emergency department care	Create institutional and staff awareness of the importance of geriatric care by adopting quality metrics for older adult care. Develop a roster of senior-friendly ED success stories.	"I saw a lot of willingness from staff, such as the medical, nursing, rehab, social, to develop an approach adapted to the elderly" (Community services coordinator based in the ED-FR)
<b>Organizational-Level Themes</b>		
1. Managerial support	Align positive outcomes for older adults with strategic goals of organization. Support key front-line providers.	"There was a kind of management, like a committee. They tried to promote care to the elderly, for the staff, with pictograms, stickers, things to make people more sensitive to elderly needs" (ED Physician-FR)
2. Staff training	Increase educational mandates and educational offerings for discipline specific geriatrics care and interprofessional team care.	"Training in dealing with geriatrics, how to be with the ones that have dementia, use of restraints. That's the biggest thing in ED. If a patient is demented at night and is sundowning, we restrain him in bed" (ED nurse)
3. Protocols for care and tools	Standardize medication reconciliation. Adopt specific screening tools and assessment framework. Adopt patient facing-materials with visuals and graphics. Prioritize other senior-friendly ED care as needed.	"I think it [discharge summary sheet] is an essential tool because what we realize is that no matter how much we explain to the elderly –even a person, in fact, not old, a normal person who does not have cognitive problems – very often, 75% of the information is not remembered" (ED Physician-FR)
4. Space and equipment	Renovate or reorganize physical space to facilitate front-line providers' implementation of senior-friendly ED care and to increase safety and comfort for older adults and their families.	"Space-wise better, lighting is better, tables, access to computers...very, very nice. Pleasant. There's enough room for me to challenge a patient's ability to get out of bed into the chair or get off the chair and ambulate" (Physiotherapist)
5. Multidisciplinary support	Make a comprehensive multidisciplinary support available to front-line ED providers around-the-clock (24/7).	"A geriatric nurse really has a special view, perspective on, how cognition could influence the rest of their function. So, I wish that. Could there be a group of geriatric nurses who are trained to work in the emergency?" (Occupational therapist)
6. Hospital services support	Increase the availability of existing hospital resources to support front-line ED providers' implementation of senior-friendly ED care.	"We obviously have access to geriatricians, specialists, all that, so that we are quickly able to alert the right people precisely to come as reinforcements" (Clinical coordinator-FR)
<b>Structural-Level Themes</b>		
1. Health information systems	Merge Electronic Medical Records in a way that it enhances informational and managerial continuity of geriatric care.	"We sometimes work on night shifts, evening shifts, I imagine that [community] doctors are not always present. The best way to solve this problem is to have a system of Electronic Medical Records that are all merged" (ED physician-FR)
2. Healthcare network	Reorganize the way that healthcare network function to increase the efficiency of geriatric care providers and to improve older patients' care trajectories	"The outpatient geriatrics team works for patients who cannot return home due to our concerns. There will be a reference made to that team. This is a point that could be improved. I think that it could be a much simpler form so that the medical teams can refer situations to that team. Because currently, it must go through the liaison nurse who sends the documents to the system. So, I find it like spending money on the health network" (Social worker-FR)
3. Staff and budget	Allocate staff and budget for geriatric care across the healthcare continuum and beyond (living arrangement in the community).	"The level of financial aid to help discharge comes in waves. So, it is according to budgets given by the ministry. If we had the money, they would already be in a living environment instead of being in a hospital center" (Social worker-FR)

Managerial support mostly via SFHI committees established in each organization played an important role in achieving implementation goals. Staff training for implementing core aspects of the SFHI was perceived to be fundamental. There was a need to sustain the continuity and consistency of the activities and provide training targeted to ED physicians. This finding explains the significant variations in the ratings of ‘staff education’ scale between ED front-line nurses and physicians who were previously surveyed in the four EDs.<sup>13</sup> Our findings are consistent with a 2019 systematic review of geriatric education programs for ED providers which reported that common barriers related to learners included competing educational demands, the level of enthusiasm for geriatric care, and scheduling program activities within existing duty hours and rotations.<sup>25</sup> The SFHI urges that all health professionals and emergency responders undergo training in order to adapt their approach to this vulnerable population.<sup>12</sup>

Established care protocols and processes enabled best practices, but there were some inconsistencies in their use. This finding is consistent with the perceptions of hospital nurses who reported an important factor improving ED care for older adults would be by defining best practices.<sup>26</sup> While EDs serve older populations with different needs, standardizing essential SFHI elements would be important for high-quality and efficient ED care. For instance, systematic screening of adults 75 years and older in the ED to identify patients who are at high-risk of functional decline should be followed by in-depth assessments to identify unmet needs and to implement appropriate follow-up interventions in the hospital or the community.<sup>27</sup>

Beyond having reconstruction to improve ED space, our study identified two examples of geriatric units perceived to be best practices. One large ED having similar patient volumes from different age groups (i.e., pediatrics, adults, and seniors) dedicated three rooms to geriatric patients. A similar US model included a “geriatric ED unit” allowing dedicated space, equipment, and specialists to better assist older adults with mobility and reduce risk of delirium.<sup>24</sup> In another ED, patients were admitted to the inpatient Geriatric Assessment Unit until a safe discharge could be secured. A similar “geriatric-focused observation unit” was described in the US where patients could be assigned to observation status for 8 to 24-hour period in any bed of the ED for a full interdisciplinary geriatric assessment.<sup>24</sup> This model uses the hospital’s inpatient services (e.g., geriatrics, physical therapy, speech therapy, occupational therapy, pharmacists) for ED patients, eliminating the need to hire ED-based staff. Challenges with this model included the additional time needed in the ED setting while waiting for services outside of operational hours and efficiently identifying patients who would most benefit from this model of care.<sup>24</sup>

Multidisciplinary support was perceived to be of paramount importance in senior-friendly ED care. In a comparable US “geriatric practitioner model”, the ED adopts a geriatric-focused approach that may include structural changes, screening with geriatric assessment tools, and available geriatric expertise (geriatric nurse, nurse practitioner, allied health specialist, or geriatrician) embedded in routine ED care.<sup>24</sup> This model might reduce admission rates although finding and paying for geriatric practitioners to work full-time in an ED setting could be difficult.<sup>24</sup>

Structural-level factors include the role of the ED as an interface between community and acute care settings, requiring improved health information exchange systems between the ED and other healthcare settings. First, more efficient electronic medical records system would enhance continuity of care, prevent adverse outcomes, and improve the quality of care.<sup>26</sup> Second, operations of the healthcare network could be more geared for high-need older adults, especially for their post-discharge follow-up pathways.<sup>28</sup> In 2020, the COVID-19 pandemic emerged and brought geriatric emergency care to the front-lines for older adults who were at highest risk of COVID-19 infection and mortality.<sup>29,30</sup> As such, in the light of constantly changing circumstances and aging population, proactive whole person care strategies are necessary.<sup>31</sup> Incorporating psychosocial components of care (e.g., social isolation, financial management) to healthcare (e.g., activities of daily living, medications) would improve older adults’

health trajectories. Finally, increased human resources and budget allocation would allow sufficient time to provide senior-friendly care in both the ED and the community.<sup>26</sup>

### **Strengths, Limitations, and Future Directions**

The main strength of this study was that our sample included different front-line professionals providing care to older adults across the healthcare continuum. This approach provided a comprehensive portrait of senior-friendly ED care from varying points of view of those who provide care in the ED and following up in the community.

This study was conducted in one geographical area where the system allowed for members of the local government health centers to be embedded in EDs, potentially facilitating community service integration. Although few EDs in other countries may have a comparable mechanism, our study provides an innovative example. Indeed, few health systems may have the support of senior-friendly hospital initiatives. For instance, while some US locations are adopting Age Friendly Health System practices, this is primarily voluntary (“Do-It-Yourself participation”).<sup>32</sup> Unless such practices are linked to health system priorities, which are frequently financial, their implementation might be limited.

Our study sample could still be considered to be limited as we did not include other community healthcare providers, such as family physicians or pharmacists. Future research might consider exploring how community counterparts would characterize bidirectional communication with EDs. A key feature of geriatric syndromes and functional decline, however, is the need to find solutions that reach far beyond medical healthcare services. Building communities around the care of older adults will need voices from patients, caregivers, other communities such as faith communities and community councils.

### **CONCLUSION**

This study identified themes that can provide direction to EDs that aim to develop and implement more senior-friendly practices. It validated the themes that were also identified in various published geriatric ED guidelines and provided key quotes from front-line providers that dramatically illustrates them. Successful implementation of senior-friendly ED care primarily depends on providers’ attitudes, but it requires a multidimensional approach and continuous support from organizations and healthcare systems. In resource-limited organizations, it is important to focus on priorities. This paper can help front-line providers identify those priorities, inform organizations and systems on how to support front-line providers, and guide further research.

### **KEYWORDS**

Geriatric medicine, emergency medicine, health services research, qualitative methods, senior-friendly care

### **AFFILIATIONS**

Deniz Cetin-Sahin, MD MSc	Research Associate, Department of Family Medicine, McGill University, Canada
Francine Ducharme, RN PhD	Professor, Faculty of Nursing, Université de Montréal, Canada
Jane McCusker, MD DrPH	Professor Emerita, Principal Scientist, CIUSSS Ouest-de-l’Île-de-Montréal, St. Mary’s Research Centre, Canada
Mona Magalhaes, MA	Project Manager, CIUSSS Ouest-de-l’Île-de-Montréal, St. Mary’s Research Centre, Canada
Nathalie Veillette, OT PhD	Associate Professor, Faculty of Medicine, Rehabilitation School, Université de Montréal, Canada
Paul-André Lachance, MD MA	Clinical Professor, Department of Family Medicine and Emergency Medicine, Université de Montréal, Canada
Sylvie Cossette, RN PhD	Professor, Faculty of Nursing, Université de Montréal, Canada

Alain Vadeboncoeur, MD	Clinical Professor, Department of Family Medicine and Emergency Medicine, Université de Montréal, Canada
Rick Mah, MD	Assistant Professor, Department of Emergency Medicine, McGill University, Canada
T.T. Minh Vu, MD	Clinical Assistant Professor, Geriatric Medicine, Université de Montréal, Canada
Simon Berthelot, MD MSc	Assistant Professor, Department of Family Medicine and Emergency Medicine, Université Laval, Canada

## CORRESPONDING AUTHOR

Deniz Cetin-Sahin, MD MSc

Email: [deniz.sahin@mail.mcgill.ca](mailto:deniz.sahin@mail.mcgill.ca)

## CONFLICTS OF INTEREST

The authors have no conflicts to report.

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