Original Article

A National Survey of Geriatric Emergency Health Care: Insights into Current Practice

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Abstract

Background: Emergency departments (EDs) are increasingly managing elderly patients who present unique clinical challenges. This study explores the current management practices for patients aged 75 years and older in Belgian EDs.

Methods: An electronic survey was sent to 105 heads of Belgian EDs. The Collected data underwent descriptive analysis.

Results: Geriatric protocols, adapted equipment, availability of geriatricians, and paramedical staff improve the quality of care for older patients in the EDs. However, the limited use of geriatric scores, prolonged stays in the ED, and lack of hospital beds are frequent problems that negatively impact quality of care.

Conclusion: Given the variable level of care provided to the elderly in the EDs, care protocols should be standardized and improved at the national scale.

Keywords

Elderly, emergency department, quality of care

Key learning points

1. Emergency departments (EDs) are increasingly managing elderly patients but the ED framework and functioning are not specifically designed to meet the complex needs of the elderly.
2. The concept of frailty for geriatric patients has emerged because of their specific health status, and tends to be increasingly considered in their treatment.
3. The consideration of geriatric principles may improve the skills of emergency physicians in managing non-acute elderly patients in the ED in addition to their own expertise.
4. Prolonged ED lengths of stay are current issues observed in most of the surveyed hospitals regardless of their care model.
5. The variability in geriatric care across hospitals highlights the need for standardized geriatric care protocols, further research, and ED policy interventions.

Introduction

Older adults constitute a growing proportion of patients admitted to the emergency department (ED).[1-3] According to Belgian statistics from 2018, 16.64% of all ED visits in Belgium involved patients aged 70 years and above, with a significantly longer length of stay than their younger counterparts.[3] This trend could be explained by the current ED framework and functioning, which are not specifically designed to meet the complex needs of the elderly.[4] To better understand the heterogeneous health status of the elderly, the concept of frailty has emerged as a reliable predictor of adverse health outcomes, and the use of frailty scores can help create personalized care plans for preserving patient autonomy, preventing functional decline, and avoiding iatrogenic harm.[5,6] The integration of geriatric principles into emergency medicine requires specialized paramedical staff, appropriate equipment, geriatric education, and standardized protocols.[7] This framework promotes a more supportive environment for optimal geriatric care and improved patient outcomes.[7]

In light of these considerations, this study explores the current geriatric care practices in Belgian EDs. The primary outcomes assessed the current state of geriatric issues in Belgian EDs, staffing levels, geriatric training, availability of specialized equipment, and the implementation of protocols, including frailty screening. As secondary outcome, the results were compared between university and non-university hospitals, as well as between large and small centers.

Methodology

Study Design

This national observational study was conducted between September 2022 and January 2023. A questionnaire concerning the care of patients aged

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75 and over was designed in collaboration with emergency physicians and geriatricians from hospitals affiliated with the Catholic University of Louvain (UCL). The comprehensibility of the questions was assessed by two ED heads to improve their clarity and appropriateness.

The questionnaire was divided into several sections relating to demographic data, limitations in the management of elderly patients, ED staffing, education, equipment, and protocols. Results were compared according to the university-affiliated status of the hospital and its size defined by the total number of daily ED admissions (<100 or >100 ED admissions per day). We used Google Form (Alphabet, Mountain View, CA, USA) for all the electronic surveys. As the survey did not involve any patients or personal data, ethics committee approval was only consultative. This study was written according to the STROBE guidelines. An English translation of the questionnaire is available (See questionnaire, Supplemental Content 1).

Participants

The questionnaire was sent to 105 ED heads from the 121 Belgian EDs listed by the Belgian Federal Public Service for Health Care.[8]

Data Collection and Statistical Analysis

The questionnaire was shared with the ED heads via email using an online Google Form. Two email reminders were sent to encourage participation. Data were collected in a Microsoft Excel spreadsheet (version 2306, Microsoft Corp., Redmond, WA, USA), and statistical analyses were performed by a statistician affiliated with UCL using SAS 9.4 for Windows. Observed proportions and associated 95% confidence intervals (CI) were computed for each category of response to each question based on the standard Wald (linear) confidence limits for proportions to account for the finite population design of the variance estimations. For group comparisons, the usual Fisher's exact test p-values are provided for the comparison of proportions.

Results

Of the 105 Belgian hospitals contacted to participate in the study, 58 ED heads completed the questionnaire, with a response rate of 55.2% and a maximum margin of error of 8.6%. There was no relation between the hospital type (university/non-university) and the center size defined by the number of daily admissions (>100 or <100 admissions per day) (p=0.0562). Table 1 presents the characteristics of the EDs, including the availability of paramedical staff, frailty screening and protocols, geriatric training, and specialized equipment.

Table 1. Characteristics of the emergency departments (EDs)

Characteristics	
Total respondents (N)	58
Center type (N (%))	
University	13 (22.4)
Non-university	45 (77.6)
Center size (N (%))[1]	
Large center (>100 patients/day)	35 (60.3)
Small center (<100 patients/day)	23 (39.7)
Localization (N (%))	
Brussels	4 (6.9)
Walloon Region	31 (53.4)
Flemish Region	23 (39.7)
Daily admission rate (N (%))	
<50 patient	2 (3.4)
50-100 patients	21 (36.2)
100-150 patients	11 (19)
150-200 patients	11 (19)
200-250 patients	6 (10.3)
>250 patients	7 (12.1)
Mean daily geriatric admission ratio (% (IQR))	30 (17.9)
Average of EP[2] Specialists in ED staff (N (%))	
Around 50 % of EP specialists	14 (24.1)
> 50% of EP specialists	29 (50)
< 50 % of EP specialists	15 (25.9)
Availability of paramedical staff in ED (N (%))	
Yes	44 (75.9)
No	14 (24.1)
Use of frailty score (N (%))	
Systematically performed	10 (17.2)
Sometimes performed	8 (13.8)
Performed if hospitalization required	11 (19)
Rarely performed	29 (50)
Geriatric protocols (N (%))	
Yes	37 (63.8)
No	21 (36.2)
Geriatric training (N (%))	
Yes	14 (24.1)
No	44 (75.9)
Geriatric equipment (N (%))	
Yes	54 (93.1)
No	4 (6.9)

1: Center size: based on the daily ED admissions, all ages included
2: EP: Emergency physicians

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Table 2. summary of the main results

Detailed results	N (%)
Paramedical staff type [1]	
Social worker	30 (51.7)
Nursing Assistant	22 (37.9)
Physiotherapist	15 (25.9)
Clinical pharmacist	14 (24.1)
Speech therapist	2 (3.4)
Occupational therapist	1 (1.7)
Geriatric liaison	10 (17.2)
No paramedical staff	14 (24.1)
Presence of geriatricians	
Telephone consultations	40 (68.9)
Clinically assessment in ED	15 (25.9)
Collaboration not required	3 (5.2)
Protocols [1]	
Falls	32 (55.2)
Proper use of urinary catheters	19 (32.8)
Analgesia and sedation in older adults	9 (15.5)
Delirium prevention	16 (27.6)
Functional decline prevention	6 (10.3)
Malnutrition screening	15 (25.9)
Medication management	20 (34.5)
Management of femoral neck fracture	2 (3.4)
Decision-making support for hospitalizing elderly patients (≥75 years)	1 (1.7)
Type of equipment or facility [1]	
Pressure-relieving mattresses	33 (56.9)
Adequate room lighting	32 (55.2)
Wall clocks	27 (46.6)
Systematic use of beds instead of stretchers	24 (41.4)
Presence of windows	23 (39.7)
Support bars or walking aids	20 (34.5)
Non-slip socks	10 (17.2)
Geriatric and transfer chairs	9 (15.5)
Soundproofing in calm rooms	4 (6.9)

1 Several centers have selected multiple items, resulting in a cumulative total exceeding 100%.

Regarding the collaboration between emergency physicians and paramedical staff, the main partnerships reported by the surveyed hospitals involved social workers, nursing assistants, and physiotherapists. The presence of physiotherapists was found to be significantly greater in university centers (p=0.0022). Concerning the collaboration between emergency physicians and geriatricians, 40 ED heads expressed the belief that telephone consultations with a geriatrician as opposed to their physical presence in the ED are sufficient for providing help with care where necessary. Additionally, for 14 ED heads (24.1%), the limited availability of geriatricians hinders optimal care delivery. Regarding geriatric screening, half of the centers used a frailty score during the medical assessment of patients. The most frequently cited frailty scores were the Identification of Seniors At Risk (ISAR) (N=12), the Clinical Frailty Scale (CFS) (N=4), and the Geriatrisch Risico Profiel (GRP) (N=2). Concerning geriatric related-protocols, the vast majority concern fall-related procedures and proper use of urinary catheters. Note that one center did not specify the purpose of its protocols. The presence or absence of specific protocols for the management of geriatric patients showed no statistically significant difference between university and non-university hospitals and between small and large centers, except for the protocol for urinary catheter placement, which was used more significantly in non-university centers (p=0.0426). Among the hospitals offering training sessions or case reviews focused on geriatric care, it is primarily addressed to all staff members (N=8), trainee doctors (N=2), or medical personnel (N=3). One center mentioned providing this type of training but without specifying the intended recipients. Concerning the specific infrastructure and equipment available, pressure-relieving mattresses were most common followed by adequate room lighting and wall clocks. When comparing large and small centers as well as university and non-university hospitals, the only significant difference was the more frequent presence of walking aids in large centers (p=0.0467). Table 2 details these results.

Regarding the issues for optimal geriatric care in the ED, 48 ED heads (82.8%) identified time as the main constraint. Based on the responses of 34 ED heads (58.6%), the average duration of an elderly patient's length of stay in the ED was between 3 and 6 hours. Eleven respondents (19%) reported longer durations with an average stay ranging from 6 to 9 hours, while 13 (22.4%) reported average stays of less than 3 hours. When comparing the length of stay with the size of the centers, these long stays seemed to be independent of the ED admission rate with no statistical significance. Furthermore, 45 centers (77.6%) reported different issues with the hospitalization of geriatric patients, with 37 (63.8%) stating that these issues influence the length of stay and ED efficiency. Other limiting factors included lack of beds for hospitalization (N=31, 53.4%), insufficient staff training for the management of non-acute geriatric patients (N=23, 39.7%), scarcity of resources such as access to complementary tests (N=17, 29.3%), limited availability of geriatricians (N=14, 24.1%), and lack of staff motivation and involvement in the care of geriatric patients (N=11, 19%). The overall difference is insignificant when comparing university and non-university hospitals, although a significant

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difference was observed between large and small centers regarding the availability of geriatric beds (p=0.0314, limiting for large centers) and access to complementary tests (p=0.0391, limiting for large centers). Among the centers with an observation unit (N=36), 14 reported initially hospitalizing the majority of elderly patients in this unit. This situation was significantly more frequent in university hospitals (p=0.0299).

Discussion

In the Belgian geriatric care program proposed in a Royal Decree approved in 2007, all patients aged 75 years and older requiring hospitalization (in geriatric or non-geriatric units) have to be assessed by a mobile geriatric consultation team.[9] Although there is no obligation for elderly patients presenting to the ED to consult a geriatrician, this approach underlines the need for a collaborative approach that takes into account the specificity of this population. The use of screening scores for frailty or at-risk elderly patients was still relatively uncommon. It is important to underline that providing a frailty score during the hospitalization of patients aged 75 years and more is also a legal obligation following the Royal Decree.[9] Recent systematic reviews and meta-analyses suggest that the predictive accuracy of the ISAR score for detecting patients at-risk of adverse health outcomes following an ED visit is only moderate.[10,11] The predictive ability of the Triage Risk Screening Tool (TRST, english version of the GRP) to identify ED returns, hospital admission, or long-term care placement is also deemed moderate, suggesting that it should not be used in isolation as a risk stratification tool.[12-14] Studies suggest similar outcomes for the TRST and ISAR when evaluating the risk stratification of elderly ED patients, the risk of functional decline and the risk of prolonged ED length of stay and hospitalization.[15-17] Both scores are proposed as triage tools in the Belgian Royal Decree for the care of older patients.[9] As a frailty assessment tool, the CFS has demonstrated accurate and reliable results for predicting short-term mortality in emergency patients, as evidenced by a recent systematic review and meta-analysis.[18] This score is recommended by the European Task Force for Geriatric Emergency Medicine (GeriEM), among others, to assess frailty in geriatrics.[19] Despite the clear recommendation to use these frailty scores, the variety of available scores may reflect a lack of consensus in the literature about the application of a single validated score. However, regardless of the selected score, the use of the same instrument over time is recommended for monitoring progress and consistency at follow-up.[20]

Specialized training and protocols improve the competencies of emergency physicians in managing geriatric situations and also guide the follow-up of these patients,[4,7,21] but only a few validated training programs for geriatrics are aimed at emergency physicians.[22] Although the actual attendance of these programs remained unknown, which highlights an opportunity for improvement, it is important to observe that training even a few members of the ED team can give the whole team a dynamic and a new way of thinking about geriatric care. EDs are also trying to be better equipped to care for geriatric patients. The impact of the environment on elderly patients is twofold: it not only influences their emotional experience, making it pleasant or distressing, but also affects their health outcomes. A calm and well-equipped ED helps reduce stress, anxiety, fall incidents, and risk of delirium in older adults.[23-26]

Concerning the main geriatric issues for optimal care in the ED, the reported average length of stay in EDs points to the complexity of geriatric cases and their management. These durations were notably longer than those indicated in the official national data by a margin of approximately 2 to 4 hours.[3] For elderly patients, long hospital stays should be avoided for several reasons. First, long stays can lead to cognitive impairment, functional decline, delirium, and nosocomial infections.[27-30] Second, in material terms, they can represent a potential financial loss for hospitals and exacerbate the shortage of beds in geriatrics or temporary hospitalization units.[31] Finally, having more elderly patients in observation units may also relate to the lack of available geriatric beds, although it may reflect the intention to avoid unnecessary hospitalization by observing these patients and, where indicated, discharging them with external follow-up with the family physician or a geriatric day hospital.

Limitations

Despite a response rate of 55.2%, this study shows a notable heterogeneity with an underrepresentation of large university centers in the Dutch-speaking region. The survey notably targeted ED heads as opposed to all emergency physicians, which may have impacted the detail of the responses and led to selection bias. Second, the responses to the numerical questions such as length of stay were presented in ranges, meaning that they are likely estimations rather than precise values. The percentage of geriatric admissions was estimated by calculating the median of geriatric admissions as a percentage of the median of total admissions for each center. Furthermore, the primary evaluation criterion for the quality of care focused on staffing, frailty screening, protocol usage, education and equipment. This potentially overlooks other significant factors that may influence the quality of geriatric care. Lastly, the study was limited by missing data, with incomplete

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responses to some of the questions. Despite these limitations, this is the first study to assess geriatric care in the ED in Belgium. The results provide a snapshot of our Belgian practices and illustrate the overall concern for improved geriatric care among ED heads.

Conclusion

Given the coming surge in the aging population, it is imperative to devise efficient care strategies to prevent the current care issues such as prolonged ED length of stay and limited hospital capacity, which were observed in most of the surveyed hospitals regardless of their care model. This study also underlines the significant variability in geriatric care across hospitals in Belgium, thus reflecting the lack of a unified approach in emergency healthcare coupled with the diverse body of literature on geriatric practices in the ED. To meet this geriatric challenge in Belgium, the training of emergency physicians and frailty screening should be made a priority. This initial assessment should also raise awareness about elderly patients in the emergency community, leading to further studies or national campaigns to improve geriatric care in the ED. Understanding the implications of structural changes on care delivery, patient outcomes, and overall healthcare system performance is crucial as we navigate the challenges of geriatric emergency care in the future.

Statements and Declarations

Competing Interests

The authors declare that they have no competing interests.

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Supplemental Content 1

Questionnaire "Management of elderly patients in Belgian emergency departments: Current situation and discussion"

In our questionnaire, a "geriatric" patient is defined as any "patient aged 75 years and older."

PART 1: Epidemiology

1. **In which region is your hospital located?**
- Brussels
- Brabant Flamand
- Brabant Wallon

2. **Your emergency department is part of a:**
- University hospital
- Non-university hospital
- Other: ……

3. **Among the physicians working in the emergency department, what proportion are specialized in emergency medicine?**
- Less than 50%
- Around 50%
- More than 50%

4. **On average, how many patients are admitted to your emergency department(s) on a daily basis?**
- Less than 50 patients
- 50 to 100 patients
- 100 to 150 patients
- 150 to 200 patients
- 200 to 250 patients
- More than 250 patients

5. **On average, how many geriatric patients are admitted to your emergency department(s) on a daily basis?**
- Less than 25 patients
- 25 to 50 patients
- 50 to 75 patients
- 75 to 100 patients
- More than 100 patients

6. **What is the average length of stay of a geriatric patient in the emergency department?**
- 1 hour
- 1 to 3 hours
- 3 to 6 hours
- 6 to 9 hours
- 9 to 12 hours
- More than 12 hours

PART 2: Management of elderly patients in the emergency department

7. **Do you regularly encounter difficulties with the hospitalization of geriatric patients?**
- Yes, without any impact on the general patient flow and average length of stay in the emergency department
- Yes, with an impact on the general patient flow and average length of stay in the emergency department
- No

8. **If your emergency department uses a triage system, do you calculate a frailty score or perform specific screening for geriatric patients during triage?**
- Yes, systematically
- Yes, sometimes
- No, never or very rarely
- We do not have a triage system

9. **If geriatric screening is performed at triage, which score(s) do you use?**

10. **If your emergency department has a temporary observation unit, among all patients admitted to this unit, what proportion is aged 75 years and older?**
- A minority
- A similar proportion to the youngest population
- A majority
- Our service does not have a temporary observation unit

11. **During the medical management of a geriatric patient, do you calculate a frailty score?**
- Yes, systematically
- Yes, sometimes
- Yes, if hospitalization in geriatrics is required
- No, never or very rarely
- Other: ……

12. **If a frailty score is calculated, which score(s) do you use?**

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13. **Which paramedical specialists are available in the emergency department to help with the care of elderly patients?**
- Physiotherapist
- Pharmacist
- Speech therapist
- Occupational therapist
- Social worker
- Nursing assistant
- Nutritionist
- No paramedical staff are available in the emergency department
- Other: ……

PART 3: Training of health professionals

14. **Which geriatric situations are the subject of a specific management protocol established by your institution?**
- Falls
- Proper use of urinary catheters
- Analgesia and sedation in geriatric patients
- Prevention of delirium
- Prevention of functional decline
- Routine screening of malnutrition
- Proper drug management, "start and stop" protocols
- We do not have any pre-defined protocols
- Other: ……

15. **Do you organize regular training courses or conduct case reviews relating to the management of geriatric patients?**
- Yes, only for the trainee medical staff (residents and medical students)
- Yes, for all medical staff (including attending physicians)
- Yes, for all medical staff/nurses/other
- No
- Other: ……

PART 4: Equipment

16. **Does your emergency department have some of the following geriatric-friendly equipment?**
- Wall clock (to provide a temporal reference)
- Systematic use of beds (instead of stretchers)
- Pressure-relief mattresses
- Support bars or walking aids
- Geriatric and transfer chairs
- Soundproof rooms, calm environment
- Sufficient lighting
- Presence of windows
- Non-slip socks
- Other: ……

PART 5: Recommendations and discussion

17. **Do you think that the physical presence of a geriatrician in the emergency room is necessary during working hours?**
- Yes, all patients aged 75 years and older should be clinically evaluated by a geriatrician
- No, telephone consultations are sufficient
- No, the opinion of a geriatrician is not necessary in the emergency department
- Other: ……

18. **In your view, what are the limiting factors for the optimal care of elderly patients in the emergency department?**
- Limited time
- Limited means (including access to complementary examinations)
- Lack of staff training
- Lack of staff involvement or motivation
- Unavailability of geriatricians in the emergency department
- Lack of hospital beds for the geriatric population
- Other: ……

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