


# At Risk for Emotional Harm in the Emergency Department: Older Adult Patients' and Caregivers' Experiences, Strategies, and Recommendations

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## Abstract

**Background:** Emergency departments (ED) serve a critical role in addressing the health care needs of older adults, although organizational and provider characteristics can result in unintended negative outcomes for this population, such as emotional harm. This study aimed to describe the patient experience of older adults in the ED and generate recommendations for enhancing their experience. **Methods:** Data from focus groups and individual interviews of older adults and caregivers who had visited the ED were thematically analyzed. **Results:** Ten focus groups and individual interviews of 41 older adults and 15 caregivers were conducted. Health system and provider factors affecting the patient experience were identified. Participants negotiated their experience using diverse strategies. Recommendations for improving the ED experience were generated. **Conclusions:** Older adults attending the ED are at risk for health care-related emotional harm unrelated to their entrance complaint, which could be mitigated by addressing organizational and attitudinal factors.

## Keywords

older adults, emotional harm, emergency departments, patient experience, quality improvement

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## Background

The use of Emergency Department (ED) services by older adults has increased over time (Pines, Mullins, Cooper, Feng, & Roth, 2013), reflecting the growing number of older adults living with complex health needs (Gruneir, Silver, & Rochon, 2011). While EDs serve a critical role in the health care of older adults, these settings have long been recognized to be poorly equipped to adequately address the age-specific needs of this population (Adams & Gerson, 2003; Hwang & Morrison, 2007; Skar, Bruce, & Sheets, 2015). Compared with younger patients, older adults have a greater number of ED visits and higher acuity, higher ED costs, and higher risks of hospital admission (Chang et al., 2018). In addition, older persons visiting the ED are at greater risk for adverse events that jeopardize physical safety, such as missed diagnoses, return ED visits postdischarge, and medication errors, than younger severity-matched controls (Forster et al., 2004). Improving care of older adults in the ED has been recognized as one of the top 10 research priorities of the Royal College of Emergency Medicine (Smith et al., 2017).

The ED's social climate, policies and procedures, care systems and processes, and physical design (Boltz, Parke, Shuluk, Capezuit, & Galvin, 2013) can work synergistically to create unintended negative outcomes, such as emotional harm, for older adults and their family members. Emerging perspectives on patient safety increasingly recognize the importance of preventable emotional harm (Sokol-Hessner, Folcarelli, & Sands, 2015) that can result from human interactions within the microsystems, or immediate environment in which care occurs (Emanuel et al., 2008).

Emotional harm, defined as harms to a patient's dignity caused by failure to demonstrate adequate respect for the patient as a person, leaves patients feeling violated, damages the patient-provider relationship, and erodes trust (Sokol-Hessner et al., 2015). Emotional harm can

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also result from a lack of support for engaging in risky interpersonal behaviors, such as speaking up or asking for help (psychological safety; Edmondson & Lei, 2014).

The risk for emotional harm of older adults can be heightened in settings such as the ED by both organizational factors, such as time pressures and work climate, and provider characteristics, such as the capacity to respond sensitively to patient needs on an ongoing basis (Vaes & Muratore, 2013). Dehumanizing hospital policies and practices often reflect an organizational focus on efficiency at the expense of patient-centeredness (Haque & Waytz, 2012). At the provider level, health care professionals who deal with the relentless human suffering that characterizes a setting such as the ED may employ dehumanization as a strategy to avoid becoming emotionally overwhelmed (Haque & Waytz, 2012). Dehumanization involves stripping away the dimensions of either *experience* (the capacity to feel pleasure or pain) and/or *agency* (the capacity to plan, intend, and exert choice) of another human being (Gray, Gray, & Wegner, 2007).

Understanding the older adult patient experience in the ED allows for evaluation of the extent to which patients are receiving care that is respectful and respondent to patient needs, values, and preferences (Agency for Healthcare Research and Quality, 2017) and also as a means of identifying potential sources of health care-related harm. Patient experience can be defined as “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions, across the continuum of care” (The Beryl Institute, n.d.). While a number of conceptual frameworks describing the patient experience have been developed, the National Institute for Health and Care Excellence (NICE) Model of Patient Experience (Fitzpatrick et al., 2014) identifies the following key outcomes of a positive patient experience: (a) social, personal, and psychological factors are taken into account; (b) comfort; (c) coordinated, continued care; (d) information; (e) expressed preference and informed choice; and (f) the opportunity to self-manage. Patient experience-based evidence is increasingly valued for its contribution to improving the effectiveness, acceptability, and appropriateness of care (Staniszewska et al., 2014) and has been consistently proven to be positively associated with patient safety and clinical effectiveness across a wide number of settings and populations (Doyle, Lennox, & Bell, 2013).

The objectives of this study were to (a) identify the health system and provider factors affecting the patient experience for older adults and their caregivers in the ED, (b) describe the strategies used by older adults to negotiate the patient experience in the ED, and (c) list key recommendations from older adult service users and their caregivers for enhancing the ED patient experience.

## Method

A qualitative, descriptive design was best suited to addressing our objectives, as this approach allowed for

an in-depth understanding of patient and caregiver perspectives (Barker, 2015).

## Sampling

A purposive sample of older adults was recruited. To ensure that a diverse set of experiences was represented, we aimed to recruit a sufficiently large and varied group of participants (Mason, 2010; Patton, 2015). Recruitment was conducted through announcements and postings from agencies whose users were comprised of primarily older adults, such as seniors’ service organizations and retirement homes. A Facebook posting was also used for recruitment, primarily with the intent of recruiting caregivers.

Eligibility criteria for older adult participants in this study were (a) age 65 or older, and (b) had attended an ED within an urban center with a population of 100,000 or more within the preceding 2 years. Caregivers who had accompanied an older adult to the ED within the past 2 years were eligible to participate, with no age restrictions.

## Data Collection

Written informed consent was obtained from all participants prior to the focus groups. Participants were provided with both a written and verbal description of the study and the opportunity to ask questions before providing their written consent.

The focus group method was employed to draw upon participants’ experiences, attitudes, beliefs, and reactions within a social context, following the approach of Krueger and Casey (2015). Each focus group was led by a research assistant with training in leading focus group discussions with older adults. All discussions were audiotaped and extensive field notes completed following each session. Ten focus groups were organized by the research assistant to accommodate the schedules of participants. Focus groups were conducted in public meeting rooms to ensure accessibility and ease of parking for participants. Two additional participants, who had attended an urban ED but resided outside of commuting distance, agreed to individual interviews.

Participants completed a brief demographic and ED use document immediately prior to the focus group. Data included identification as patient or caregiver; sex; age; approximate date and reason for seeking treatment at the ED; referred by general practitioner (GP); number of ED visits in the past 6 months; recall of approximate length of time until being seen by an ED physician; disposition (sent home, sent to GP, consulted with home care or community care resources); disposition following visits (sent home, admitted to hospital); and overall ratings of patient experience (on a 0 to 10 scale, where 0 was the worst experience possible and 10 was the best experience possible) in terms of quality of service.

**Table 1.** Participant Characteristics (*n* = 56).

	ED patients ( <i>n</i> = 41)	Caregivers ( <i>n</i> = 15)
Sex		
Female	34 (92.9%)	14 (93.3%)
Age		
Mean age	83.9 (6.73)	72.6 (13.1)
Self-reported reason for ED visit		
Cardiac	11 (9.7%)	5 (20%)
Fall	7 (17.1%)	2 (13.3%)
Respiratory	5 (12.8)	1 (6.7%)
Other (e.g., pain, mental health, GI, weakness, fainting)	19 (46.3%)	7 (46.7%)
Patient referred to ED by GP or NP	11 (26.8%)	5 (33.3%)
Mean number of hours between leaving home and seeing ER doctor	2.16 (2.66)	2.93 (2.38)
Mean number of patient visits to ED in past 6 months	1.46 (1.46)	1.07 (1.54)
Patient admitted to hospital	12 (34.1%)	7 (46.7%)
Satisfaction with ED care rating (0-10)	6.0 (3.26)	4.5 (2.71)

Note. ED = Emergency Department; GI = gastrointestinal; GP = general practitioner; NP = nurse practitioner.

The semistructured interview guide was comprised of six open-ended questions. The questions were developed to elicit data on key elements of the older adult patient and caregiver experience in the ED articulated in the Ontario Hospital Association's (2010/2011) Leading Practices in Emergency Department Patient Experience document and selected aspects of the interdisciplinary American College of Emergency Physicians (2013) Geriatric Emergency Department Guidelines. Question topics related to waiting time, access, expectations, triage process, communication with providers, comfort, information, and admission/discharge. Pilot-testing of the interview guide was undertaken with two older adult volunteers, with no changes to the guide suggested.

## Data Analysis

Demographic and health care utilization data were entered into SPSS v. 24. Descriptive statistics were run to describe characteristics of the older adult patient and caregiver participants.

Focus group audiorecordings were transcribed verbatim by the Social Sciences Research Laboratory at the University of Saskatchewan and yielded 5,963 lines of text. Qualitative data were managed using word processing software. Using an inductive, text-driven approach to thematic analysis (Priest, Roberts, & Woods, 2002; Woods, Priest, & Roberts, 2002), two researchers independently, then collectively, reviewed, coded, and annotated the transcripts to ensure reliability of findings. Alternative explanations and discrepancies were cross-checked and discussed to achieve consensus (Barbour, 2001). A coding scheme was developed from meaningful statements, resulting in a qualitative codebook and code definitions. For each focus group, main points and topics were identified, along with the themes that best

illustrated the main points and topics, using the language of the participants as much as possible. Interaction among participants of the focus groups was described based upon field notes and transcripts. Collated codes were reviewed and sorted according to overarching themes (Braun & Clarke, 2006). The final form of each identified theme was summarized in chart form. Auditability was ensured by retaining raw data, field notes, and memos as an audit trail.

## Results

Data were collected in June of 2017 from 56 individuals in 10 focus groups, ranging from 3 to 12 participants in size, and through two individual interviews of participants who were unable to participate in the focus groups due to distance.

Table 1 displays the characteristics of patient and caregiver participants. The majority of both patient and caregiver participants was female. Patients ranged in age from 65 to 95 years old, while caregivers were between 45 and 90 years old. Self-reported reasons for ED visits were highly variable, with falls constituting the largest single reason to visit the ED. Approximately one third of participants indicated that they had been referred to the ED by a primary health care provider. The mean time to see a physician was 2 to 3 hr. Most participants were relatively infrequent users of the ED, having 1 to 2 visits in the previous 6 months. One third of patient participants were admitted to hospital after the visit to the ED, while caregivers indicated almost half of the older adults they accompanied were admitted to hospital. On a rating scale of 0 to 10, where 0 was the worst care possible and 10 the best care possible, patient participants rated their satisfaction with the ED at a mean of 6, while caregivers rated their satisfaction with the ED lower at 4.5.

## Health System and Provider Factors Affecting the ED Patient Experience of Older Adults

Participants highlighted an overall lack of responsiveness within the ED to both the experience and agency needs (Gray et al., 2007) of older adults. Negative attitudes and behaviors of health care providers toward older adults were consistently described as a key characteristic of the patient experience in all of the focus group discussions, generating animated sharing of experiences between participants. Table 2 provides quotes to illustrate the key themes.

Overt and implicit episodes of ageism, perceptions of abandonment (both while in the ED and at discharge), and a loss of dignity affected participants' perceptions of the care quality they received, their emotional and physical comfort, and their ability to obtain information. The need to adapt communication to compensate for age-related losses in vision and hearing was often not appreciated by providers, resulting in the older patient not receiving information critical to their care.

Discharge from the ED proved to be an event of particular concern for older adults, as many felt ill-prepared and uncertain about how to care for themselves upon returning home. Family caregivers were often not well-informed, or informed at all, about discharges of older family members from the ED if they were not physically present with the older adult, in spite of being the patients' main source of support in the community.

The physical environment of the ED had a significant impact on the patient experience of older adults. Lack of cleanliness, poor lighting, feeling unsafe because of the behaviors or characteristics of other patients, the chaotic environment of the ED, and a lack of privacy were frequently described by participants. These factors contributed to a suboptimal patient experience in the ED that left participants feeling dehumanized.

## Older Adults' Strategies for Negotiating the Patient Experience in the ED

The analysis of the qualitative data revealed that older adults used a range of strategies to attempt to negotiate the health system and provider challenges they faced when seeking care in the ED (Table 3). The need to assert personal agency with care providers in the ED, whether as the patient or with help from a family member, was repeatedly emphasized as a key strategy for negotiating the patient experience by participants. Assertiveness was especially important for accessing information.

Participants unanimously agreed on the importance of having a family member present during visits to the ED whenever possible. Family members served important functions as advocates for older patients to mitigate

threats to experience and agency, as allies who could help to access important comfort measures, and as sources of information in the event the older adult was challenged to hear or understand what was being said to them by providers. Some participants relied upon narratives and advice from older adults' friends and family who had recently visited the ED as a means to enhance their own experiences.

Recording notes of discussions with providers was another strategy that proved helpful to older adults during their ED visits. Some kept notebooks detailing important discussions and complex information.

Some older adults and family members believed that patients who arrived by ambulance received faster access to treatment. There was agreement within the focus groups that this was an appropriate strategy if older adults felt rapid attention was warranted, although participants were acutely sensitive to not misusing the ED for minor complaints. These older adults also acknowledged that they felt more secure knowing that a paramedic would be accompanying them to the ED. Several participants agreed that they felt more comfortable having someone with medical expertise assist them to navigate the ED and advocate on their behalf, if necessary.

## Key Recommendations for Enhancing the Older Adult Experience in the ED

Participants articulated a list of eight key recommendations that they believed would foster an improved patient experience for older adults and their caregivers in the ED. The recommendations (Table 4) include (a) educating older adults on the items that would be most helpful to bring with them on their visit to the ED; (b) increasing the focus on basic comfort measures; (c) providing access to volunteer assistance, particularly when family members are not available to accompany the older adult; (d) providing and reviewing written information and instructions in plain English, possibly using an ED-issued notebook in which older adults could record their questions and which could incorporate discharge instructions; (e) improving quality of signage to promote way-finding; (f) enhancing provider-patient communication, including adoption of respectful, non-ageist discourse that took into account sensory deficits that may be present, and at a pace comfortable for older adults; and (g) attending to important aspects of the physical environment, such as cleanliness, lighting, and privacy.

## Discussion

Findings from this study revealed that emotional harm, resulting from both organizational and/or provider factors, is often an unintended consequence for older

**Table 2.** Health System and Provider Factors Affecting the Patient Experience of Older Adults.

Theme	Illustrative quotes
Ageism	<p>The doctor said to me, “Well, you know, she’s old.” And then I blew up. I said, “Her age has nothing to do with this. She is in pain, she can’t walk, she hurts.” (Caregiver)</p> <p>When you’re older, they don’t expect you to know anything . . . and they discount you immediately. (Patient)</p> <p>Talked down to you as if you’re a child. That’s right, yes. You’re a responsible adult. You understand perfectly well what’s going on. They should treat you as such. (Patient)</p> <p>There’s a stigma to dealing with older seniors . . . that we’re going to die anyway. So, minimal service. (Patient)</p>
Abandonment	<p>You feel like you’re being abandoned . . . You just feel like nobody cares. Everybody’s just passing you by and nobody cares. (Patient)</p> <p>I think they forgot about me. Nobody came. And they shut off the lights at the desk that was down at the end and I think they moved into that observation room or holding cell, as I called it. (Patient)</p> <p>If you’re alone, you have to go in by yourself and you’re in a strange place. Like I was in here for three days and I was in the emergency, had nobody with me. (Patient)</p> <p>If you do not have a family member to come in and help you, you do not get a bath, you do not get shaved, you do not get washed. (Patient)</p>
Loss of dignity	<p>I thought, “Well, where’s the call button?” Well, the call button was behind the bed, so that wasn’t very successful. I ended up having to pee in my pants, and then I felt really bad. (Patient)</p> <p>I almost felt like I’d been degraded, like I was stupid and didn’t know what these drugs did to me. (Patient)</p> <p>They made me sit there on the commode and the hallway’s right there the curtain is open. And I’m on this commode and I have to go so bad, I don’t care who’s seeing me. And people are going by and they look. There’s no privacy. And then when I was finished, it took them so long to come and get the commode. It was just absolutely terrible. (Patient)</p> <p>We both were in that waiting room for about seven hours and he just continually was throwing up and they never did anything—it was sad but it was also hard on me to watch . . . finally, they saw me. But, if they would just check if he needed a clean dish . . . And I thought, “This is not even human.” (Caregiver)</p>
Communication	<p>They just rushed in, rushed out, rushed back. Just hurry, hurry, hurry a lot. And you know, “Don’t worry, we’ll talk about that later. We’ll explain that some other time, but this has to be done now first.” And it was a lot of pressure. (Patient)</p> <p>When they start knocking these terms off, well they’re all Dutch to me. Let’s put it—my ignorance is, kind of slow to some of that stuff. And also their speech if they speak too fast, I don’t grasp it. (Patient)</p> <p>It was about two weeks after [discharge from the ED] that I noticed a piece of paper with all those instructions. Now they had not read them to me, and no one here did. I thought, “Oh, I’m supposed to be doing this and I was supposed to be doing that.” So, make sure the patient is talked to again. Not just, “Here’s a paper. Go.” (Patient)</p> <p>You have 90 year old people taking their husband or their wife to the emergency room, and they’re just lost. They get no help, they get no respect, they get nothing . . . nobody explains things to them properly. (Caregiver)</p>
Failure to accommodate for age-related changes	<p>I also can’t see very well, I’m told. I have macular and a hearing aid . . . [providers] have to make sure they can hear and you have to make sure they can see . . . They hand you something and leave, they’re gone. So you sit there with a paper in front of you and don’t know what to do. (Patient)</p> <p>You need to figure out if they’re deaf or if they’ve forgotten their hearing aids, and that like they might not be answering you but just because they cannot hear. (Patient)</p> <p>If it’s somebody who’s deaf, or whatever there, needs to be somebody, a family member or somebody there. (Patient)</p> <p>Sometimes the writing you can’t read the writing, okay and that’s the simple answer. Sometimes it’s those words, what does this mean? And then you know, and the instructions are given to you verbally . . . that’s not how most people remember things. (Patient)</p>
Lack of responsiveness to the discharge needs of older adults	<p>Well, they’ve done what they can for you, they’ve told you what to do. And if you can’t do it well, too bad. (Patient)</p> <p>My feeling was that discharge was actually a punt. And so they kicked me out, and then okay, now that’s my problem and I don’t even know what the playbook is. (Patient)</p> <p>So you’re on your own when you go out [discharge]. You look after yourself the best you can. (Patient)</p> <p>One o’clock in the morning, out of a dead sleep, we get a phone call. “Your father in-law can go home.” There just doesn’t seem like there’s any understanding about the other end of the deal. (Caregiver)</p>
Physical environment	<p>I decided that is such a filthy washroom I don’t want to go in there at any time. (Patient)</p> <p>I couldn’t see nothing. It was always dark and there’s nothing more confusing than that. That should not be. (Patient)</p> <p>If you have someone chained there from the jail, they’re right beside you [in the ED] . . . And that made me feel really uncomfortable. (Patient)</p> <p>No privacy for end of life decisions. And you’re—it’s being done in passing, with other people around, within earshot. There’s times in your life when you need some privacy. (Patient)</p>

Note. ED = Emergency Department.

adults seeking care in the ED. Ageism, perceptions of abandonment, loss of dignity, challenges with communication, failure to accommodate for age-related

sensory changes, insensitivity to the unique challenges faced by older adults upon discharge, and an unpleasant physical environment compromised the patient

**Table 3.** Older Adults' Strategies for Negotiating the Patient Experience in the ED.

Assertiveness	<i>If you stand up for yourself, [providers] either admire you, or they think you're a problem. (Patient)</i> <i>[Following a diagnosis of a serious illness] "The doctor said, 'Well, you lived your life.'" "Yes, I am 90," he says, "but I'm gonna be here at 102." (Caregiver)</i> <i>It was hell trying to get that screening done. But in the end we did, but I had to push and I had to be kind of a bitch. (Caregiver)</i> <i>Sometimes when you take it in your own hands, they know you mean business. (Patient)</i>
Role of family members	<i>If you have an advocate, you can go out and tap the nurse on the shoulder, but the person that's alone, in emergency, it's tough. (Caregiver)</i> <i>I like having family with me, because if I don't remember everything that's being said to me, which can happen when you're—got things going on, there's always one of them that's going to remember. (Patient)</i> <i>You have to use your common sense once in a while, too. That sure helps. And to have a daughter that's very pushy. (Patient)</i>
Understanding the system	<i>The best way to get into any emergency department is by ambulance. Because I mean, obviously, if you've called an ambulance you are in pretty strong state of stress and, you get taken and you get in and you get looked at, much more quickly. (Patient)</i> <i>And if you need a barrage of X-rays, like why would you go to some of the clinics that maybe don't have those things available? And then you have to end up waiting or going back to the hospital to do it. (Patient)</i> <i>If she goes into emergency, she doesn't have to pay for any of the treatment. Wound, materials, meds. At home, the first thing she said, "How much is it going to cost me?" (Caregiver)</i>
Record-keeping	<i>So, I mean I will be more careful about writing, but they could help me out by writing things then. (Patient)</i> <i>Sometimes [providers] show up and drop the piece of paper and leave. Well, that's not very helpful. So I go back with a piece of paper and get them to explain everything they've written down. (Patient)</i> <i>We actually have a book that we write everything down in. (Patient)</i>

Note. ED = Emergency Department.

**Table 4.** Older Adults' and Caregivers' Recommendations for Improving the Patient Experience in the ED.

Educate older adults on preparation for an ED visit	<i>What do they want the senior older adult to bring with them to the emergency room? Be it, information on their—well they ask, what drugs? Why do I take my bag full of drugs? Or do I go to the pharmacy and pick up the list? Does everybody know about that? (Patient)</i>
Increase focus on basic comfort measures	<i>There should be water offered because there's no place to get it . . . you don't wanna leave the room, because that's the very time they'll call you. (Patient)</i>
Access to volunteers when family unavailable	<i>There should've been volunteers there to go with me, to be with you when you come in especially when you come in alone like that. (Patient)</i>
Provide written information in plain English and of appropriate font size	<i>If you could, with each emergency visit, get a discharge sheet that says what you are in there for, what—they did an EKG they did—you know, CT scan. And, a follow-up of medication or what their diagnosis result was. That would be nice.</i>
Follow-up as appropriate	<i>I had a number of follow-up calls from different people. They gave me excellent information, they provided me with all kinds of resources.</i>
Improve quality of signage	<i>Just good signs that are very readable and good enough size so that you know they're important. And an arrow that tells you which way to go. And then when you get to wherever, still give them another sign. (Patient)</i>
Enhance provider-patient/family communication	<i>Most important to me is the more support and communication for the patient's families from the doctor. Better ideas and communication with regards of what the care is. (Caregiver)</i>
Attend to the physical environment	<i>If there's blood and stuff, do they not have somebody come quickly to tidy that up? I think cleanliness should be real at the top. (Patient)</i>

Note. ED = Emergency Department; EKG = electrocardiogram; CT = computed tomography.

experience for older adults and their family members. The strategies used by older adults to mitigate the challenges, and a set of patient-generated recommendations for improving the patient experience of older adults in this setting, were described. The use of a qualitative approach allowed us to capture the multidimensional experience of patients and family members.

EDs are uniquely positioned to play a pivotal role in improving care for geriatric populations. In spite of the well-recognized challenges in implementing truly "age-friendly" care in these settings, older adults generally

trust and appreciate the unique contribution of EDs to their health care (Nairn, Whotton, Marshal, Roberts, & Swann, 2004). This contribution, however, can be compromised by the generalized failure to address and account for the particular physical, emotional, and care needs of this age group, including dignity and basic comfort described by participants in this study that resulted in preventable emotional harm.

Multiple examples of the challenges to both the experience and agency needs of older adults and their family members with respect to communication were noted in

this study, including pervasive ageism and a lack of information with which to make informed choices about self-management. Communication constitutes an important aspect of care over which providers exert significant personal autonomy. Participants in this study recognized that the system itself imposed constraints on providers' time, ability, and willingness to communicate effectively with older adults and family members. Other studies of older adult experiences in the ED have highlighted the ways in which staff-patient interactions (Kihlgren, Nilson, & Sorlie, 2005; Kihlgren, Nilsson, Skovdahl, Palmblad, & Wimo, 2003; Nikki, Lepisto, & Paavilainen, 2012; Nyden, Petersson, & Nystrom, 2003; Nystrom, Dahlberg, & Carlsson, 2003) led to older adults feeling unimportant, ignored, and forgotten (Parke & Chappell, 2010), as well as their perceptions of being time pressured and basic needs being ignored (Bridges & Nugus, 2009).

These communication challenges may be fostered by an organizational culture that reinforces an imbalance of power between providers and patients (van der Riet, Higgins, Good, & Sneesby, 2009), as well as ED providers' personal and professional values. The ageism experienced by participants in this study may reflect reports that ED providers view older patients as mostly dependent individuals (Bulut, Yazici, Demircan, Keles, & Demir, 2015) who may not be worthy of ultimately futile, time- and resource-consuming treatment (Fry, Gallagher, Chenoweth, & Stein-Parbury, 2014; Hillman, 2014). The pervasive presence of ageism in health care is corroborated by findings from a longitudinal analysis of data from the nationally representative Health and Retirement Study (Rogers, Thrasher, Miao, Boscarding, & Smith, 2015), in which one in five adults aged over 50 years experienced discrimination in health care settings, and one in 17 experienced frequent health care discrimination.

Providers faced with workplace issues such as overcrowding, staff shortages, and lack of training of staff who are at risk for fatigue and exhaustion (Bulut et al., 2015) may place the needs of older adults low on their list of priorities. Several studies have noted that ED personnel believe their primary role is that of saving lives as opposed to caring for the nonlife-threatening needs of older adults (Elmqvist & Frank, 2014; Person, Spiva, & Hart, 2012). Dealing with the needs of older adults was noted to result in feelings of resentment and frustration among some staff (Muntlin, Carlsson, & Gunningberg, 2010; Sbaih, 2002). Nonmedical needs of older adults in the EDs are often subordinated to technical aspects of medical care (Parke & Chappell, 2010; Wiman & Wikblad, 2004), accounting for the perceptions of lack of attention and communication reported by participants.

In spite of the fact that most participants were not frequent users of ED services, there was agreement that strategies such as assertiveness, the presence of family members, a basic understanding of the rules

governing health services, written instructions, and record-keeping were helpful in negotiating the multiple challenges they faced in the ED. Participants generated a list of simple, low-cost recommendations that they believed would optimize the patient experience in the ED for older adults.

The importance of family member presence and support for older adults in the ED was highlighted by participants in this study and has been previously identified (Bridges & Nugus, 2009; Gordon, Sheppard, & Anaf, 2010; Nikki et al., 2012; Paavilainen, Salminen-Tuomaala, Kurikka, & Paussu, 2009). Fry et al. (2014), however, noted that family members were not always welcomed by ED nurses, who perceived that family members could get in the way of assessment and treatment, and could limit open communication with the patient. Clukey, Hayes, Merrill, and Curtis (2009) reported that family caregivers valued feeling listened to and were highly sensitive to staff nonverbal behaviors (e.g., pace, tone of voice, and the force of actions being undertaken). Resolving this tension between family members' perceptions that they need to be vigilant and serve as advocates for older adults must be reconciled with providers' care priorities to improve the patient experience.

Legible and personalized written instructions for older adult patients and their family members were considered critical by participants in this study. Hall, Graham, McGowan, and Cheng (2018) recently found that only 9.2% of patients discharged from the ED had received written instructions. Following implementation of a written discharge summary protocol, the proportion of patients who understood new symptoms increased from 70% to 94%, with 97% of survey respondents finding the written instructions helpful.

While accountability for preventing emotional harm and promoting a positive patient experience during a visit to the ED ultimately rests with frontline providers and leaders (Sokol-Hessner et al., 2015), our findings illustrate that older adults make active use of strategies to promote their own experience and agency during a visit to the ED and are willing to be active care partners, if given a reasonable opportunity. Mate, Berman, Laderman, Kabcenell, and Fulmer (2018) suggest that, in an age-friendly health care system, health care-related harms to older adults could be "dramatically reduced and approach zero; older adults get the best care possible and are satisfied with their care; and value is optimized for everyone."

While a qualitative approach was most appropriate to address our objectives, several limitations should be noted. Focus group participants were recruited on the basis of interest in this topic, raising the possibility that older adults with positive experiences in the ED did not volunteer to participate. In spite of this limitation, the challenges described in this study suggest that there is significant room for improvement in the care of older adults with the ED. Inclusion of a comparison group of

middle-aged ED users would have allowed us to directly compare patient experiences and determine similarities and differences that might have associated with different age cohorts.

## Conclusion

Older adults attending the ED are at risk for emotional harm unrelated to their entrance complaint. Ensuring the emotional safety of older adults in the ED requires a standard of attention equivalent to that taken for the prevention of physical harm. Addressing both the organizational and provider factors that contribute to emotional harm, as well as developing effective strategies to better support providers to care for and respect older adults using age-friendly approaches, will help to ensure no harm is done to patients seeking care in the ED.

## Authors' Note

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