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RESEARCH ARTICLE

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Understanding the psychosocial well-being of people older than 65 years during emergency department admissions: A qualitative analysis of patients' accounts of their experiences

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Abstract

Objective: Little is known about the psychosocial care of older people presenting to the emergency department (ED), or whether their psychosocial well-being during and after an ED admission can be enhanced. People over the age of 65 years experiencing psychosocial distress and mental health concerns have higher rates of ED admission than those without. As part of a larger mixed-methods study investigating the relationships between older people's psychosocial well-being and emergency care, this study aimed to explore the experiences of older people in ED and their influence on patient psychosocial well-being.

Methods: Participants aged 65 years or older receiving care in a large Australian public hospital ED were invited to participate in a telephone interview soon after discharge. Interviews were audio recorded and transcribed. Transcripts were analysed thematically.

Results: Eleven people (five women) aged 68–87 years participated in semi-structured interviews. Analyses revealed three overarching themes: 'interpersonal interactions', 'quality of care' and 'physical environment'. The theme 'interpersonal interactions' had two subthemes: 'communication' and 'human contact'. The three subthemes of 'quality of care' were 'appropriate care', 'psychological

care' and 'unmet needs'. Physical environment referred to participant impressions of the ED setting.

Conclusions: We found that staff sensitivity in their interactions with patients and their efforts to promote patients' physical comfort and protect their privacy influenced the psychosocial well-being of older adults in the ED. Based on the findings, we present a set of recommendations for enhancing the psychosocial care of older adults during ED admission.

KEYWORDS

aged, hospital emergency service, mental health, qualitative research

1 | INTRODUCTION

Older people, defined as people aged at least 65 years, have complex health needs distinct from younger health-care consumers.[1,2] Compared to the broader population, complex health needs and other psychosocial issues can result in older adults interacting more frequently with health-care systems.[3–5] Consequently, the number of older adults utilising emergency health care is rapidly increasing.[4] Not only are emergency department (ED) admissions associated with a physical complaint increasing, but so are psychosocial-related presentations in adults aged 65 years and over.[3,6] In Australia, almost a quarter of ED presentations are made by adults older than 65 years, with adults over 85 years having the highest number of ED mental health-related presentations.[7,8]

Psychosocial well-being refers to the physical, social, economic and emotional factors that influence health.[9] Admissions to the ED can put psychosocial well-being at risk.[10,11] Several aspects of the ED, including the noisy and chaotic ED environment, staff workloads, limited staff training and experience, and atypical presentations can affect a patient's psychosocial well-being.[10] Older people presenting to the hospital with symptoms of depression and loneliness report a high frequency of non-specific symptoms, such as chest pain, fatigue, back pain and dizziness, all of which may complicate the initial assessment and obscure the underlying diagnosis.[12,13] This results in psychosocial issues, including those related to mental health, being frequently under-detected in the ED or hospital presentations.[6,10] Therefore, the risk of adverse effects, including iatrogenic injury and functional decline, is heightened. One study demonstrated that of older people admitted to a medical ward, those with symptoms of depression experienced higher 30-day mortality compared to those without depressive symptoms.[3]

Additionally, studies of mental health and psychosocial well-being in ED frequently exclude older people[14] or are conducted only in emergency psychiatric care settings.[15] There is thus limited evidence about the barriers and enablers to the provision of optimal emotional and psychological care for older people in a time-pressured environment, such as ED. To address these gaps, this study aimed to explore the experiences of older people in ED and their influence on patient psychosocial well-being.

Policy impact

Sensitive, respectful staff behaviours, attention to patients' physical comfort and protection of privacy benefit the psychosocial wellbeing of older adults in emergency departments. These can be achieved through training that incorporates patient stories, and improved design for privacy and minimisation of discomfort from noise, light and cold.

Practice impact

Emergency departments can improve the psychosocial wellbeing of older patients through increased attention to non-clinical aspects of care. These include optimising staff sensitivity and responsiveness to comfort and privacy and having volunteers to assist with wayfinding, providing companionship and practical support and connecting patients with staff.

2 | METHODS

This was a qualitative study involving semi-structured interviews with patients attending a large, metropolitan Australian ED. Qualitative methods are the most appropriate way to elicit and understand human perspectives.[16] Throughout this study, researchers reflected on

their assumptions and experiences to ensure appropriate steps were taken to improve quality and reliability. This study was approved by the Peninsula Health Human Research Ethics Committee (approval number: LNR75361PH2021).

2.1 | Setting

The CIty of Frankston and Mornington Peninsula shire, encompass a geographical area of approximately 850 square kilometres in Victoria, Australia. Peninsula Health comprises two hospitals, each with an Australasian College for Emergency Medicine (ACEM) accredited ED. Peninsula Health 'Removed for review' services a population of over 300,000 people, which can grow by up to a third during summer holiday periods. This population is older than the Australian average, with ~30% aged >60 years, and has a wide spread of socioeconomic positions.[17] In 2022/2023, Peninsula Health had over 99,000 presentations to ED.[18]

2.2 | Recruitment

Eligible patients were those aged 65 years and older who had presented to ED regardless of their reason for presentation, could speak English and had the cognitive ability to participate in an interview. An ED physician on the research team approached prospective participants before their discharge to discuss the study and obtain written informed consent. To support informed consent, patients were given oral and written information to establish willingness to be interviewed after discharge about their experiences in ED. To achieve sufficient information power, we used a narrow study aim, recruited a highly specific group of participants, undertook a case analysis and ensured strong rich dialogues with participants.[19]

Participants were recruited up until the point where information power was deemed adequate.[19]

2.3 | Data sources

Based on the literature, their clinical experience working in ED and with older adults and their research experience in public health focusing on aspects of psychosocial care and healthy ageing, the research team developed a semi-structured interview guide (see File S1). The interview guide was designed specifically to be neutral to enable older adults to share both positive and negative experiences of ED admissions. It included questions regarding patients' experiences and impressions of ED and their psychosocial well-being during their ED admission. All questions were open-ended and invited participants to describe their experience in the ED in their own words. The interviewer asked follow-up questions to allow for further elaboration when required.

2.4 | Procedure

Telephone interviews were conducted from July to November 2021, by NL, an academic Occupational Therapist with a background in public health and care of older adults. Interviews lasted between 45 and 80 min and were conducted within a fortnight of participants consenting. All information about the participants' circumstances was collected by directly asking them, including about their age and living situation (i.e. living in residential care or community). No information was collected from participants' medical records. The interviewer inferred binary sex from the context and content of each interview. Interviews were audio recorded with participants' permission and were professionally transcribed. Transcripts were not returned to participants for comments. No additional field notes were made.

2.5 | Data analysis

NVIVO (1.5.1) and Microsoft Excel were used to manage the anonymised transcripts. Data were analysed thematically by 'Removed for review' following the method described by Braun and Clark.[20] Following data familiarisation, codes were inductively generated to identify themes, and were subsequently reviewed and refined.

3 | RESULTS

In total, 15 people agreed to participate. Four later declined to be interviewed, stating they were too unwell or no longer available. Restrictions due to COVID-19 that were in place for the duration of the study included wearing face coverings in almost all settings, having limits on hospital visitors and being unaccompanied during ED presentations. On completion of these interviews and following analysis, many emerging themes began to repeat.

Data were contributed by five women and six men aged 68–87 years living in the community who had attended the ED in the preceding fortnight. Length of stay in ED varied from several hours to short-stay admissions of several days. All reported that they had recovered from the acute state that

took them to hospital, and several were undergoing further investigations or management after their ED presentation.

Three overarching themes were identified: 'interpersonal interactions', 'quality of care' and 'physical environment'. The theme 'interpersonal interactions' had two subthemes: 'communication' and 'human contact'. There were three subthemes in 'quality of care': 'appropriate care', 'psychological care' and 'unmet needs'. Physical environment referred to patient impressions of the ED setting. Overall, women and men reported similar experiences and attitudes, although the number of participants makes comparisons inappropriate.

3.1 | Interpersonal interactions

It was apparent that participants valued respectful and timely interactions with staff that included human contact through warmth, humour and non-clinical touch. Conversely, lack of communication or human contact left participants feeling angry and alone.

3.1.1 | Communication

Participants valued frequent incidental verbal contact. Some participants explained how good communication made them *[feel] like a very important person* (Helen, aged 82), akin to being private health insurance patients. Establishing a line of sight between themselves and staff was important in ensuring that participants felt they had agency and could get staff attention if needed: *The curtain was open at the front so I could see people walking past—well, nurses walking past me. If I needed anything I just had to ask* (Fatima, aged 80).

In contrast, participants remarked that a lack of communication left them feeling alone and isolated: *That would really help with just feeling a bit better, because you've got no one to talk to* (Sue, age not provided).

A lack of communication or miscommunication from staff contributed to unpleasant patient experiences. When staff did not introduce themselves, answer questions, explain the context for their actions or report information correctly, participants were left feeling apprehensive, misunderstood and distressed.

> The worst part about this, when I looked at my discharge summary, everything was wrong about it. ... They got the story wrong, and I am pretty clear in my communication. ... It's a bit scary. What happens if I wasn't with it and I wouldn't know that?
>
> (Aviva, aged 68)

3.1.2 | Human contact

Participants used different terms to describe signs of caring support or positive attitudes from staff, such as *courtesy, respect* and *manners*. Interactions with staff were perceived as positive when conversations were empathic, and staff provided additional comfort following discussions about the patient's health.

> A doctor came to tell me that I had bowel cancer and the nurses gave me a hug and said, 'I hope you'll be alright'. I just thought, how human is that? How lovely is that they do that? ... With COVID going around and all, you know.
>
> (Anne, aged 75)

Additionally, participants remarked that nursing staff were *just excellent* when they provided additional practical help, such as providing access to water, food or phone chargers. These acts were described as going *above and beyond* and comforted participants during their ED visit.

A lack of human contact contributed to poor patient experiences. The COVID-19 restrictions prevented visitors and support persons from attending the ED and stopped a volunteer service from running. One participant recalled past experiences in the ED with volunteers who supported wayfinding, connected patients with staff, and generally provided both company and practical help, such as getting water. Participants spontaneously noted that the ED can *[feel] lonely*, especially as a result of the COVID-19 restrictions:

> Before Covid you could've had someone like family there, so if I needed a drink someone could get it for me, where this time it was a bit of calling out for someone to come, or someone was going past and I had to call out if I could get a glass of water.
>
> (Sue, age not provided)

3.2 | Quality of care

Participants recalled their time in ED as complex, at times confusing, and often hard to manage when feeling unwell: *My experience of the hospital overall was very good. ... It was only that anxiety of not knowing how long before I was going to be treated and no contact* (Bob, aged 75). In spite of this, eight of the 11 participants described staff providing high-quality care during their stay.

3.2.1 | Appropriate care

All participants reported that staff had large workloads, with other patients seeming *needy* and often challenging: *There was somebody in emergency in the waiting room that was playing up and you could hear it ... It was a little bit disturbing* (Fatima, aged 80). Despite this, participants praised staff for their ability to provide *marvellous* care and were understanding of how workloads may affect wait times. Some participants described being in the hospital as helping to reassure them that they were receiving care for their illness.

> We are more comfortable when you're ill with people around you, especially people who have the expertise that you're sick in. It's just mentally reassuring, I suppose.
>
> (Bob, aged 75)

Continuity of care was valued by participants. They felt supported when they interacted with the same nurse for the duration of their care. During shift changes, participants remarked that handovers between staff and the introduction to the new care team made them feel comfortable and supported in the ED.

> When they were changing shifts the original nurse introduced me to the other nurse – the next nurse. ... It makes you feel more confident in the staff and, you know, you appreciate their thoughtfulness.
>
> (Fatima, aged 80)

3.2.2 | Psychological care

When asked about ED experiences, participants did not mention receiving any formal psychosocial assessment upon arrival. However, one participant recalled psychologically sensitive care when asked psychosocial questions.

> I think they're certainly relevant issues and those sorts of things need to be established, those sorts of questions were asked, you know: Am I living on my own? What support have you got at home? Etc. etc., all appropriate, I didn't think any of them were intrusive.
>
> (Glenn, aged in his eighties)

Seven participants did not comment on psychological care, and those who did felt care was necessary but provided at the wrong time: *It's not really time to be talking about that [psychosocial care], ... so to have some sympathy* (Lee, aged 82).

3.2.3 | Unmet needs

Feeling as if basic needs were unmet contributed to participants' distress. Participants expressed frustration with difficulties accessing necessities, such as food, drink and washing themselves. Several participants commented on the difficulties they experienced when the timetable of meals was at odds with their medical management: *[on the] very first day nobody asked if I needed any food* (Sue, age not provided). Similarly, not being able to wash was distressing:

> No-one came up and said, would you like to wash? ... Here you are, like having, trying to sleep in hospital, ... and you don't feel comfortable.
>
> (David, aged 81)

3.3 | Physical environment

The busy ED environment with its complex equipment, *lights flashing [and] constant burping of monitors*, was distressing for some. Participants described the unfamiliar equipment and processes as draining and unpleasant:

> I found the very act of being hooked up to one of those monitors to be really constricting... don't like it at all.
>
> (Lee, aged 82)

The ED was described as an *alien environment* that contributed to stress upon arrival. Several participants described feeling lost when they first arrived and needing orientation from staff to make sense of the environment. This left some participants feeling uncomfortable, lacking agency, and as if they *[were] not in control* (Mark, aged 82).

Lighting and temperature were often mentioned as contributing to the discomfort participants felt during their time in ED.

> In the afternoon they wanted everybody to be quiet, so they would lower the lights, but that didn't help, because when they shut the curtains, sort of three quarters of the lights were shining above the curtains. So, people that are really sick and needed rest, they had lights shining in their eyes.
>
> (Sue, age not provided)

Participants also described how the ED environment lacked privacy, recalling overhearing discussions between medical staff and other patients.

> The curtain was open and the doctor was ... standing in front, talking. ... [The patient] had a bowel operation and I thought, God where's the privacy?
>
> (David, aged 81)

4 | DISCUSSION

This study is one of the first to provide insight into older Australians' experiences of ED admissions. The findings suggest that people aged at least 65 years who present to ED can have experiences that may be either beneficial or detrimental to their psychosocial well-being. This study identified key factors affecting psychosocial well-being as patient-staff interactions and the ED's physical environment.

One of the strengths of this study was that we sought the voices of older adults seeking care in the ED. This population interacts with the health-care system more frequently than younger people and is underrepresented in research.[4,5,14] Understanding the experiences of older adults within the ED environment can help ensure their needs are addressed and care is improved.

However, we acknowledge some limitations. The organisation of interviews during COVID-19 restrictions was challenging, as in-person interviews could not occur, and some patients who initially agreed to participate ultimately did not. This also poses a generalisability limitation, as COVID-19 restrictions may have impacted participants' ED experience. Although the provision of care has changed following the end of COVID-19 restrictions, we believe our findings remain relevant in the post-pandemic era, as many of the experiences described by older people we interviewed are still being described in the literature.[21–23] Additionally, we acknowledge that it would have been preferable to provide an opportunity for participants to indicate their own (potentially non-binary) gender identity.

Participants had both positive and negative experiences during their time in ED. They reported improved psychosocial well-being when care was perceived as high-quality, with calm, respectful and timely communication. Similar findings have been reported in the literature, with respectful and courteous interactions critical to positive patient experiences.[24] These findings are not unique to older adults but add to the existing evidence on patient experience in ED. Similar to Mwakilasa and colleagues (2021),[22] this study reported that older adults understood that staff workloads could impact care. However, while Mwakilasa et al. (2021)[22] reported that long waits were a significant issue, this study did not.

We found several factors that contributed to declining psychosocial well-being during an ED admission. These included a lack of communication, privacy or access to food and water, as well as the ED's physical environment. Unsurprisingly, the COVID-19 pandemic also negatively affected patients' psychosocial well-being and experiences. Difficulties communicating or accessing food and drink have been reported to contribute to unsatisfactory patient experiences.[22,25] Similarly, the findings of this study and existing studies[21,22,26] suggest that high-stimulus ED environments contribute to sensory overstimulation and a lack of privacy may contribute to unpleasant patient experiences, reducing patients' ability to cope in ED settings. There may be a limited understanding of the psychosocial needs of older adults, as a key finding of this study was the lack of investigation of factors outside of primary physical complaints during their ED admission. A recent review[23] has described the importance of considering patients' ED presentation in the context of their psychosocial needs, as without assessment or appropriate psychosocial care, the psychosocial well-being of older adult patients may deteriorate during an ED admission.

Understanding how the physical and social environment of the ED can impact psychosocial well-being can inform strategies to improve older Australians' experiences. The ED environment presents various modifiable and non-modifiable health risks. This study has identified several modifiable factors that influence psychosocial well-being, including, poor quality of interactions with staff, loneliness during admission and aspects of the physical environment. These risks can be addressed with training, supervision and health system changes, resulting in improvements to older people's psychosocial well-being and ED experiences.

Decreasing loneliness while improving comfort may enhance the psychosocial well-being of older adults in ED. Volunteer programs may be beneficial as they can provide patients and their families with extra support, such as assistance accessing food and drink, wayfinding and general company. 'Removed for review' currently runs a volunteer program in one of its EDs, which was paused during this study due to COVID-19 restrictions. Ellis et al. (2020)[27] and Sanon et al. (2014)[28] investigated volunteer initiatives in ED settings designed to improve patient experience. These two volunteer programs use a variety of strategies to train volunteers, including delivering training by an interdisciplinary team, providing volunteers with the skills required to identify older patients needing additional assistance and sharing activities to promote patient well-being.[27,28] These volunteer programs benefited older adults and their families by increasing patient satisfaction and potentially decreasing patient decline during ED admission.[27,28]

Improving the physical ED environment may enhance patient experience and psychosocial well-being. Emergency departments are designed to ensure clinicians can view and treat patients rapidly, and to enable a quick turnover of patients.[29] Older adults have unique health-care needs; thus, the design of EDs should consider specific spaces for this population.[23,29] For this reason, geriatric EDs have started to appear as a care model designed specifically to meet the needs of older adults.[23] These EDs allow for older adults to receive assessments and referrals they may not otherwise receive in general EDs, as clinicians may have more appropriate training and skills to provide specialised care to older adults.[23]

The findings of this study suggest that improving ED environments and volunteer programs can promote patient psychosocial well-being during an ED admission. Enhanced use of trained volunteers may improve comfort and overall experience of older adults in ED. Assessing and subsequently adapting ED environments may improve privacy as well as reduce aspects of the physical environment that cause discomfort during an ED admission. Additionally, future research should investigate the potential benefits of digital health technologies in ED settings. Digital health technologies, such as apps, are increasingly used in the care of older adults in ED as developments in technology and improvements to accessibility allow their integration into emergency care.[30] These technologies may enhance communication between patients and staff and reduce problems associated with lack of communication or miscommunication.

5 | CONCLUSIONS

This study has furthered understanding of the factors influencing the psychosocial well-being of people aged 65 years and older seen within the ED. Data from participants emphasised the importance of sensitivity in interactions with staff and considerations of comfort and privacy to optimise the quality of clinical care and the psychosocial well-being of older adults in the ED. These findings provide clear directions as to what is working and can be improved to minimise psychosocial distress and to uphold psychosocial well-being during ED admissions. Such data can inform future changes to the social and physical environments of EDs to improve care and patient experience.

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CONFLICT OF INTEREST STATEMENT

No conflicts of interest declared.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

This study was approved by Peninsula Health Human Research Ethics Committee (approval number: LNR75361PH2021).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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