Understanding why older adults choose to seek non-urgent care in the emergency department: the patient's perspective

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CLINICIAN'S CAPSULE

What is known about the topic?
While EDs serve a critical role in the care of older adults, about 25% of visits made by older adults are classified as "non-urgent".

What did this study ask?
What are older adults' reasons for seeking non-urgent care in EDs?

What did this study find?
Comprehensiveness and convenience of diagnostic and treatment services in a single location were the primary motivations for older adults to seek treatment in the ED.

Why does this study matter to clinicians?
Novel partnerships between EDs, primary and community care are needed to better address the non-urgent care needs of older adults.

ABSTRACT

Objectives: Older adults make up a significant proportion of patients seeking care in the ED, with about 25% of these visits classified as "non-urgent." This study explored older adults' understandings, expectations of and self-reported reasons for seeking care and treatment provided in the ED.

Methods: This qualitative study involved semi-structured interviews with CTAS 4-5 patients conducted at randomly selected times and days during ED visits at three Saskatoon facilities in 2016. Thematic analysis was used to analyze interview data.

Results: 115 patients over age 65 years (mean age 79.1 years) were interviewed. While the majority had independently or with family made the decision to attend the ED, almost one-third of patients (31.6%) reported that they had been referred to the ED by general practitioners or specialists. Few respondents indicated the visit was the result of their general practitioner not being available. Most participants cited comprehensiveness and convenience of diagnostic and treatment services in a single location as the primary motivation for seeking treatment in the ED, which was especially important to those in poor health, without family supports, or with functional limitations, personal mobility and/or transportation challenges. Other common motivations were availability of after-hours care and perceived higher quality care compared to primary care.

Conclusions: Accessibility to comprehensive care, availability, quality of care and positive past experiences were key considerations for older adults seeking treatment of non-urgent concerns. Older adults will likely continue to use EDs for non-urgent medical care until trusted, "one-stop" settings that better addresses the needs of this population are more widely available.

RÉSUMÉ

Objectif: Les personnes âgées forment une partie importante des patients qui vont au service des urgences (SU), mais 25 % des consultations sont classées « non urgentes ». L'étude visait donc à mettre en évidence l'idée que se font les personnes âgées des soins et des traitements donnés au SU et leur attente à cet égard, de même que les raisons invoquées pour y aller.

Méthode: Il s'agit d'une étude qualitative, consistant en des entretiens semi-directifs réalisés avec des patients qui présentaient des troubles de niveau 4 ou 5 selon l'Échelle canadienne de triage et de gravité, à des jours et à des heures choisis au hasard, au cours de consultations au SU, dans trois établissements à Saskatoon, en 2016. L'examen des données recueillies durant les entrevues s'est fait par analyse thématique.

Résultats: Ont été rencontrés 115 patients de plus de 65 ans (âge moyen : 79,1 ans). La majorité d'entre eux ont déclaré avoir pris la décision eux-mêmes ou avec leur famille d'aller au SU, mais presque un tiers des patients (31,6 %) ont affirmé y avoir été dirigés par des omnipraticiens ou des spécialistes. Toutefois, peu de répondants ont indiqué qu'ils étaient allés au SU parce que leur médecin généraliste ne pouvait pas les recevoir. La plupart des participants ont invoqué l'offre et le

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caractère pratique d'un large éventail de services diagnostiques et thérapeutiques en un même lieu comme principal motif de consultation et de traitement au SU, point particulièrement important pour les personnes qui sont en mauvaise santé, qui n'ont pas de soutien familial, qui souffrent de limites fonctionnelles ou qui ont des problèmes de mobilité ou de transport. Ont également été invoquées la disponibilité des soins en dehors des heures habituelles de travail et la perception selon laquelle les soins donnés au SU sont de meilleure qualité que ceux fournis en milieu de soins primaires.

Conclusions: L'accessibilité des soins intégrés, la disponibilité de l'offre, la qualité des soins et des expériences antérieures favorables étaient les principaux motifs de consultation des personnes âgées au SU pour des troubles non urgents. Les personnes âgées continueront sans doute à aller au SU pour obtenir des soins médicaux non urgents à moins que l'on élargisse l'offre de soins dignes de confiance et groupés sous un même toit afin de répondre aux besoins de ce segment de la population.

Keywords: Older adults, non-urgent care, Emergency Department, accessibility

INTRODUCTION

As a system already burdened by overcrowding and long wait times, the emergency department (ED) serves a critical role for the growing population of older adults seeking treatment. The proportion of older patients who use ED services has increased over time, reflecting the demographic shift in the Canadian population and creating a growing demand for ED services.[1] A recent analysis of administrative and clinical records for 35,000 visits by older adults found that 25% of these were classified as non-urgent.[2]

While there has been significant effort expended to profile the medical characteristics of older adults seeking care in the ED using administrative data, there are gaps in our understanding of the self-reported reasons for older adults who seek non-urgent treatment in the ED. Few studies have allowed older adults to describe in their words how they decided to visit the ED, as noted in a qualitative review of literature by Langer et al.[3] In particular, there has been an absence of an investigation of the contextual forces that constrain or shape the use of unscheduled care such as EDs.

The overall aim of this qualitative study was to explore how and why older adults who present with non-urgent (Canadian Triage and Acuity Scale [CTAS] 4 and 5) conditions to the ED decided to seek treatment in this setting. Our specific objective was to describe older adults' understandings, expectations of, and self-reported reasons for seeking care and treatment provided in the ED.

METHODS

Design

A qualitative, descriptive design was used to address our aim and objective. This approach afforded the opportunity to gain an in-depth understanding of the patient perspective.[4] A thematic analysis was used to identify key themes in the data.[5]

Setting

This project was conducted in the three EDs located within the city of Saskatoon. The latest available administrative data (2014–2015) indicated that 3,672 adults aged 65 years and older who were classified as CTAS 4 or 5 and attended the Saskatoon EDs during this reporting period. Of these, one-third were aged 85 years and older, with direct referrals from their general practitioner for consultation in the ED, constituting the largest reason for attendance (20%). More than one-third (36%) arrived by ambulance. Between 33% (patients aged 65–74 years) and 53% (patients aged 85 years and older) of this cohort was admitted to the hospital.

Study population/ethics

Eligibility criteria for this study were: 1) aged 65 years and older; 2) triaged as non-urgent (CTAS 4–5); 3) spoke English; and 4) had sufficient cognitive capacity to answer the interview questions. A formal cognitive evaluation was not conducted, but the extensive professional experience of the research associate who was a retired geriatric social worker allowed for discernment of those patients who were able to respond to the questions meaningfully. If family members accompanied eligible patients, they were also invited to contribute to the interview, with the consent of the older adult participant.

Ethical approval for this project was granted by the University of Saskatchewan Behavioural Research Ethics Board (BEH 16-181).

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Data collection/study procedures

Using the sampling technique successfully adopted in an ED setting by Stevens, study enrolment was conducted during 30 four-hour blocks randomly selected to begin at 0900, 1300, or 1800 and scheduled over 15 weeks.[6] Random selection of times and sites was performed using a simple computer algorithm.

The research associate was notified by the triage nurse or registration clerks of patients who met the eligibility criteria. The research associate provided a verbal explanation of the project to eligible patients, a written information sheet, and requested verbal consent to proceed. The most private space available in the ED at that time (e.g., a quiet room) was used for the interviews.

Hand-written notes of participant responses were kept as a less intrusive means of data collection than audio recording would have been in this stressful environment. The training for the research associate to use field notes as a data collection strategy focused on the importance of accurate and contemporaneous documentation of data and recording the exact phrases of the participants, whenever possible, in keeping with accepted practices for using field notes as data.[7]

Data analysis

Demographic and health data were entered into SPSS (v. 24). Chi-square analyses were conducted to compare the distributions of sex, self-rated health, independence in self-care, arrival by ambulance, fall-related visits, the presence of family, and independence of decision to visit the ED among three age groups of older adults (65–75, 76–85, and older than 85 years). Notes were transcribed by a second research assistant and reviewed and revised for accuracy by the RA conducting the interviews. Transcripts of the qualitative data were reviewed, annotated, and coded by two team members using the approach of Braun and Clarke for thematic analysis.[5] The codes identified features of the data relevant to the research question, with the collated codes then sorted according to over-arching themes by discussion and consensus. Themes with insufficient data were discarded. Data were refined at two levels: 1) ensuring coded data formed a coherent pattern; and 2) considering the coherent patterns in relation to the dataset as a whole.[5] Further coding took place to ensure no codes were missed. The final stage involved choosing representative examples of data to illustrate important elements of the themes.

Sample size

Determination of the sample size of 115 was guided by the principle that the number of participants should be sufficiently large and varied to elucidate the aims of the study in a manner that allows for responsible analysis.[8,9] The concept of "information power," which incorporates considerations of sample specificity and quality of dialogue for determining the sample size of qualitative research, underscored the importance of collecting sufficient qualitative data to adequately reflect the experiences of a diverse group of individuals in a dynamic and busy environment.[10]

RESULTS

In total, 140 patients met the eligibility criteria during the data collection periods. One hundred fifteen patients aged 65–98 years (mean age 79.1 years) were interviewed, along with 72 family members who were accompanying the patients. Data from family members were captured as a component of the older adult's interview. Interviews lasted between 10 and 40 minutes. Table 1 provides a profile of participants stratified by age group (65–75, 76–85, and older than 85 years). The most common reasons for ED use by this group were:

Table 1. Profile of participants (*N* = 115)

	Age 65–75 years $n=45$ (39.1%)	Age 76–85 years $n=41$ (35.7%)	Age >85 years $n=29$ (25.2%)
Female sex	26 (57.8%)	23 (56.1%)	19 (65.5%)
Self-rated health			
Very good or excellent	15 (33.3%)	12 (29.3%)	5 (17.2%)
Good	13 (28.9%)	11 (26.8%)	12 (41.4%)
Fair or poor	17 (37.8%)	18 (43.9%)	12 (41.4%)
Self-care			
Independent	37 (82.2%)	27 (65.9%)	12 (41.4%)
Required assistance	8 (17.8%)	14 (34.1%)	17 (58.6%)
Arrived by ambulance, yes	10 (22.2%)	13 (31.7%)	13 (44.8%)
Fall-related visit, yes	6 (13.3%)	11 (26.8%)	5 (22.7%)
Family present, yes	19 (42.2%)	23 (56.1%)	18 (62.1%)
Decision to attend ED	45	41	29
Decision made by patient and/or family	30 (66.7%)	30 (73.2%)	19 (62.1%)
Referred by GP	8 (17.8%)	5 (12.2%)	6 (20.9%)
Referred by specialist	7 (15.6%)	6 (14.6%)	4 (13.8%)

ED = emergency department; GP = general practitioner.

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fall-related injuries (19.1%), pain (17.4%), and non-fall-related acute injuries (14.8%). More than three-quarters (78.3%) of the participants had attempted to manage the symptoms on their own through rest, comfort measures such as heat or ice, or previously prescribed medications. Only three patients indicated that they chose to visit the ED because their general practitioner was not available.

Older adults' understanding and expectations of care and treatment provided in the ED

Table 2 elaborated on the four key themes (accessibility, availability, quality of care, and previous experience) identified in our analysis and provides exemplar quotes illustrating each theme. The most commonly cited reason for older adults to seek non-urgent care in the ED was ease of access to comprehensive medical, diagnostic, and multidisciplinary services available in a single location. This was especially important for older adults in poor health, without family supports or with functional limitations, personal mobility, and/or transportation challenges. Five respondents who had attended the ED for scheduled procedures such as dressing changes indicated their family general practitioner did not provide this type of treatment.

The older adults in this study clearly understood that the ED was not the most appropriate setting in which to seek care for non-urgent concerns, but none felt there were satisfactory alternatives. Most participants felt that they had exhausted their own repertoire of possible solutions to their health issue and now needed additional help. The availability of after-hours care in the ED was critically important to the older adults interviewed, who frequently felt there was no real decision to be made about where to seek care outside of regular business hours. The majority of respondents believed that the quality of care and expertise offered in the ED were superior to the primary care setting and offered better continuity of care if they had a complex medical history involving previous surgeries, diagnostic tests, or hospital admissions. Familiarity with the ED was a component of the trust expressed by some participants as a factor in deciding to visit the ED. Past experiences of attending primary care and inevitably being sent to the ED also influenced many older adults' decisions. If asked to describe alternative settings in which the care the respondents were seeking could be provided, very few respondents felt there were other options. Respondents were generally prepared to exercise patience during a wait in the ED, with only a few negative comments made about wait times.

Several family member participants of patients with dementia, however, expressed concerns about the appropriateness of the environment and willingness of ED staff to recognize their unique concerns. For those patients with dementia or confusion, family members typically felt the range of services required to manage these conditions effectively were only available in an ED setting that had access to both community and hospital resources. Three family members of patients with dementia indicated that having a physician in the community who did house calls would have prevented their visit to the ED.

DISCUSSION

Accessibility, availability, perceived quality of care, and satisfactory past experiences with ED care were key

Table 2. Exemplar quotes of key themes

Accessibility	"This is where I can get an x-ray and quickly. If I go to my doctor's, I have to go to other places to get lab work and x-rays and then it takes time to get all the information together and then to me."
	"They are excellent here—respond quickly. I've seen a physiotherapist, dietician, many people."
Availability	"Where else would you go? Especially in the middle of the night, as happened to me?"
	"Doctor's offices aren't open Saturdays and Sundays—and Mondays are so booked up."
	"It's so slow! But it's the only place available."
Quality of care	"The ED has the expertise I need now. An ordinary doctor doesn't."
	"I'm here because I'm scared and I know I can get good care here. There are so many doctors with different expertise here."
	"[ED physicians] narrow the problems down really fast and then you get the proper treatment."
Previous experience	"We've come to [this hospital] for 50 years. We know what's here."
	"Because usually if you go to a doctor's office with something like [this], they send you to the hospital anyway."
	"ED will also have the records of my previous visit and my surgeries."

ED = emergency department.

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considerations shaping the decision of older adults to seek non-urgent treatment in the ED. Participants cited comprehensiveness and convenience of diagnostic and treatment services in a single location as the primary motivation for seeking treatment in the ED. Older adults experiencing health, functional, or social challenges found it particularly burdensome to coordinate services that were geographically dispersed across the city. Given that after-hours care was typically not available, many older adults perceived the ED as the only option. Perceptions that care in the ED was superior in quality to primary care were supported by the participants' previous experience of care in the ED setting. Almost one-third (31.6%) of these non-urgent patients had been referred to the ED by either their family physician or a specialist, although the majority of patients (62.6%) did not seek advice from others on whether to attend the ED.

Previous work by Durand and colleagues that assessed non-urgent ED patients of all ages also found that convenience and barriers to primary care were important factors affecting the "rational choice" to seek care in the ED.[11] The importance of the perceived expertise in ED settings, as compared with primary care, as a consideration for seeking care, was identified as a reason that individuals with long-term conditions sought care in the ED.[12] Our finding that positive previous experiences were a key factor for older adults deciding to attend the ED for non-urgent concerns is supported by some studies,[13,14] although others have found that older patients frequently leave the ED dissatisfied.[15,16] Given the higher rates of chronic disease and multimorbidity,[17,18] as well as the greater likelihood of functional impairment[19] among older adults, Gruneir and colleagues suggested that disproportionate ED use by older adults is most reflective of the greater need for ED care of older adults, as compared with younger patients.[15]

LIMITATIONS AND MITIGATING FACTORS

While collecting real-time data during participants' ED visits lessened the risks of recall bias inherent in interviews conducted following these visits, this strategy also imposed a number of constraints. The use of field notes, rather than an audio-taped recording of the interviews, was deliberately chosen as a strategy most likely to be acceptable to participants, given that note-taking is common practice in health care encounters. The use of field notes may have resulted in some loss of data or inaccuracies in recording, although this risk was mitigated by the careful review of transcribed field notes by the RA. Additional information on the final disposition of patients after their ED visit would have been helpful.

Clinical implications

In a statement endorsed by Canadian Association of Emergency Physicians (CAEP),[20] the ED is recognized to be uniquely positioned to play a pivotal role in improving care for geriatric populations. Older adults trust and appreciate the unique contribution of EDs to their health care, despite the well-recognized challenges in implementing truly "age-friendly" care in this setting.[21] The fact that almost one-third of the participants in this study reported being referred to the ED by a general practitioner or a specialist suggests gaps in the range of community care available for non-urgent concerns that require practice and policy solutions to bridge these gaps.[15] Hwang et al. suggested that the ED should evolve as a partner in care coordination while retaining its role as a critical care provider.[22]

Research implications

The need to better address the requirements of older adults figured prominently in the research priority setting conducted by the Royal College of Emergency Medicine, in collaboration with clinicians, patients, family members, and the public.[23] To support the development of innovative care strategies that better address the non-urgent care needs of older adults, future research should incorporate a system-wide approach to understanding older adults' utilization of the ED for non-urgent concerns. Such an approach should include primary and community care providers, rather than examining the ED in isolation. Research comparing the reasons for attending the ED for non-urgent care among different age cohorts would help to understand if, how, and why the motivations of older adults differ from those of other age groups. Finally, examining patient and system outcomes for dedicated geriatric EDs is needed.

CONCLUSIONS

As the population ages and demands for patient-centred health care grows, it becomes increasingly imperative to

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understand the patient experience. By eliciting the perspectives of older adults seeking non-urgent treatment in the ED, this study contributes a much-needed window into patient understandings, expectations of, and self-reported reasons for these visits. Accessibility to and availability of comprehensive care, perceptions of higher quality of care than was available in primary care settings, and positive past experiences were key considerations for older adults seeking treatment for non-urgent concerns. Older adults will likely continue to use EDs for non-urgent medical care until trusted, "one-stop" settings that better addresses the needs of this population are more widely available.

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