Recommendations for the care of geriatric patients in the emergency department

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Abstract

As global populations age, the Emergency Department (ED) increasingly becomes critical for addressing geriatric patients' complex needs. These patients often present with unique vulnerabilities, including multimorbidity, cognitive impairment, and social and economic issues, which require multifaceted and tailored approaches to care. Emergency geriatric medicine is a young and emerging field of emergency medicine. Bioethical considerations that should support the practice of geriatric emergency medicine and the essential role of a multidisciplinary approach in ensuring ethical and patient-centred care are addressed. Practical recommendations to improve care quality and equity include education of ED staff, interdisciplinary collaboration, early identification of frailty and comprehensive geriatric assessment, and policy reforms and implementation.

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Introduction

An aging population represents one of the most pressing challenges in healthcare systems worldwide. The elderly account for many ED visits, often presenting complex needs requiring rapid decision-making under a lot of pressure.[1] The acute care of the elderly poses unique challenges in balancing medical decisions and ethical considerations, as the threat of ageism among healthcare professionals and policies exists.[2] Ethics provides a framework to address the complexities of elderly care in the ED, enabling Emergency Physicians (EPs) to ensure quality and respect patient dignity. The American College of Emergency Physicians Code of Ethics and the European Society for Emergency Medicine outline EP responsibilities, highlighting patient welfare, unbiased care, recommending specialized geriatric pathways to address patients' requests, stressing the importance of advanced directives and identification of surrogate decision-makers.[3,4] EPs face ethical dilemmas, such as evaluating life-sustaining treatments or comfort care, ensuring equitable resource allocation, and respecting patient autonomy despite cognitive or communication barriers. Geriatric patients often present with multifaceted health issues and social vulnerabilities, which require a comprehensive and multidisciplinary approach. Recognizing these complexities has led to the development of Geriatric Emergency Medicine, where physicians increasingly employ specialized tools to characterize geriatric patients better and address their unique necessities.[5] The Clinical Frailty Scale (CFS), the Triage Risk Screening Tool (TRST), and the Identification of Seniors At Risk (ISAR) are used upon arrival to identify frailty and predict adverse outcomes.[6-9] Screening tests such as the 4AT assist in the early detection of delirium, which is prevalent yet frequently underdiagnosed in elderly patients.[10] Additionally, attention to pharmacological reconciliation ensures safer management of patients experiencing polypharmacy.[11] The dissemination of geriatric culture among EPs is essential to improve outcomes and to address systemic biases, such as ageism, which can compromise equitable treatment for elderly patients. Early geriatric evaluation in the ED is an ethical and patient-centred care procedure.[12] The Comprehensive Geriatric Assessment (CGA) is now integrated into several hospital ED protocols worldwide, offering a holistic evaluation of medical, psychological, functional, and social domains.[6] This approach not only tailors care to the individual but also aligns interventions with ethical principles, fostering patient dignity, safety, and well-being.

The key themes undermining optimal care for older patients in EDs are the absence of geriatric-specific pathways, high risk of discontinuity in care, lack of patient-centred approaches, and an ageist attitude among staff.[13] There is an urgent need for organizational and cultural changes that emphasize the integration of geriatric assessment, continuity of care, and a more holistic approach to improve outcomes for frail elderly patients admitted to the ED.

Core ethical principles in geriatric emergency care

Beneficence obliges clinicians to act in patients' best interests, prioritize interventions that alleviate suffering, and improve quality of life. In geriatric care, this principle often requires balancing aggressive treatment with symptom management and comfort care. Beneficence in the ED for geriatric patients is particularly critical, given the vulnerabilities of older adults, including frailty, cognitive impairments, and complex comorbidities. In practice, beneficence entails prompt and accurate assessments to tailor interventions to address acute medical needs and underlying conditions. It also involves safeguarding dignity by effectively managing pain, avoiding unnecessary procedures, and prioritizing care that aligns with the patient's values and goals. Ensuring continuity of care through effective communication with caregivers and post-discharge planning further reflects a commitment to beneficence, fostering better recovery outcomes and quality of life for this high-risk population.[14]

Non-maleficence obliges health care providers to avoid harm. For geriatric patients, this principle is particularly relevant in minimizing the risks associated with polypharmacy, invasive procedures, and unnecessary hospitalizations.[15] Elderly patients often take multiple medications, increasing the risk of adverse drug events.[16] Clinical decision support systems that highlight potential drug interactions and emphasize comfort-focused care over aggressive interventions in patients with poor prognoses meet this principle. Early palliative care in the ED aims to shift the focus from aggressive, potentially futile treatments to those that focus on comfort and quality of life. Integrating palliative care earlier in the chronic disease path provides holistic, tailored care while improving family and clinician satisfaction and reducing healthcare costs.[17]

Justice ensures equitable distribution of healthcare resources. In the ED, this principle mandates that care be allocated based on clinical needs rather than age, socioeconomic status, or other non-clinical factors.[18] Implicit ageist biases may result in less aggressive care for older adults, whereas resource constraints can exacerbate inequities, particularly in overcrowded EDs.[2]

Autonomy is the patient's right to make lucid decisions, established by respect and informed consent. In geriatric patients, autonomy can be compromised by conditions, such as cognitive impairment. Advanced care planning and treatment preferences during primary care visits are encouraged to reduce ambiguity during emergencies. Advanced care plans are associated with lower in-hospital death rates, less aggressive medical care at the end of life, and earlier hospice referrals. A systematic review showed that 56% to 99% of the patients do not have advance directives during an ED visit and are at risk of receiving care inconsistent with their preferences and values.[19]

Vigilance is the most emblematic virtue of emergency medicine since in no other specialty physicians always provide immediate assistance. EPs must be alert and prepared to address unpredictable and uncontrollable requests. Virtuous EP practices impartiality by patients in an unbiased and unprejudiced way. Impartiality is most important in emergency medicine because many emergency patients are poor, intoxicated, or have few education or value systems that do not align with those of the operator. EPs must treat alleged perpetrators of violent crimes in the same way as victims. They must resist the temptation to use disparaging remarks and ridicule their patients. They must tolerate people from different races, cultures, habits, and lifestyle preferences.

Sick and vulnerable emergency patients are in a dependent relationship; they must rely on the EP to protect their interests through competence, informed consent, truthfulness, and the maintenance of confidentiality. EPs must be trustworthy, so that patients can trust that they will not be exploited for power, profit, or prestige.[20]

Finally, EPs must be resilient and remain composed, flexible, and competent amid clinical chaos. A tired, overstressed emergency department staff requires elasticity, optimism, and cooperation to avoid ageism, cynicism, resignation, disillusionment, and professional burnout. Resilience enables professionals to respond calmly to angry patients and their families' challenges or insults.[19,21]

Multidisciplinary and patient-centred approaches.

Evaluation of frailty

Assessing frailty in geriatric patients presenting to the ED is crucial for identifying those at increased risk of adverse outcomes. Integrating frailty screening into ED workflows supports personalized care by capturing multidimensional aspects, such as cognition, mobility, medication use, and social needs. Several validated tools are used for frailty screening in the ED, including CFS, [6] TRST, [7] and ISAR, [9] The CFS is a widely used, validated tool designed to quickly assess the level of frailty in older adults based on clinical judgment and characteristics such as mobility, energy, and functional independence. CFS offers a practical and efficient means of stratifying geriatric patients according to their vulnerability to adverse outcomes, including hospitalization, prolonged length of hospital stays, and mortality. CFS helps ED clinicians rapidly identify patients who may benefit from CGA and tailored interventions by assigning a score from 1 (very fit) to 9 (terminally ill).[6,22]

Early frailty identification improves the clinical outcomes, guides discharge planning, and reduces functional decline. Frailty screening is recognized as a vital component of geriatric emergency care to optimize resource allocation and improve patient-centred outcomes.[23] An ideal frailty screening tool for ED use should be brief (taking less than five minutes to administer), multidimensional, and capable of reflecting a patient's baseline status in the 2–4 weeks prior to presentation. Screening should be routine, prompt (ideally within four hours of ED arrival), and performed at the first point of contact. The key domains included in screening instruments are functional ability, mobility, cognition, medication use, and social factors.[24]

Comprehensive Geriatric Assessment (CGA)

CGA is a multidimensional diagnostic process that evaluates medical, psychological, functional, and social areas to create personalized care plans, facilitates tailored interventions and reduces the risks of inappropriate treatments.[25] The components of the CGA evaluation are Mind, addressing cognitive issues; Mobility,

preventing falls; Medications, managing polypharmacy; Multicomplexity, assessing comorbidities and environmental needs; and What Matters Most, aligning care with patient goals and values, ensuring an ethical approach to each individual. The team develops a safe discharge plan for a frail elderly patient, including home support services and follow-up care.[6]

CGA has been successfully implemented in various clinical settings and has demonstrated improved patient outcomes and care efficiency. It is reported to enhance holistic, personalized care, streamlining workflows, leading to better health outcomes for older adults across care settings.[26]

Some examples of successful implementation of CGA in EDs include an intervention study in Italian EDs that demonstrated that patients allocated to CGA had a 9% lower hospitalization rate.[27]

Some EDs have embedded interdisciplinary teams including geriatricians, specialist nurses, occupational therapists, physiotherapists, and social workers to deliver CGA. These teams provide holistic assessments, medication reviews, functional evaluations, and discharge planning with community service referrals. Although high-quality evidence on mortality or readmission reduction is limited, these models have shown feasibility and improved patient-centred outcomes and care coordination.[27,28]

Evidence suggests that CGA in the ED can significantly decrease avoidable hospitalizations and functional decline, improve outcomes, and decrease ethical conflicts, while enhancing patient and family satisfaction. CGA reduced hospitalization by 9% and functional decline by 24% over 12 months. Integrating geriatric evaluations into ED workflows mitigates disparities in care by addressing systemic biases and promoting equity.[5,29,30] Multidisciplinary approaches ensure shared responsibility, enhance decision-making, tailor interventions to meet patients' needs.

Ensuring an emergency geriatric assessment with the effort to disseminate a culture that combats ageism is fundamental to advancing ethical care in the ED. The Carta of Florence highlights the moral imperative of addressing and eliminating ageism in healthcare, emphasizing that bias against the elderly undermines equitable access to care and diminishes the dignity of older adults.[2,31] By encouraging a culture that respects and values aging supported by CGA as a clinical tool, healthcare professionals can enhance outcomes and adherence to ethical standards. Reducing disparities in the ED and creating a more inclusive environment.

Palliative care in the ED

Early screening and identification of patients who are at risk of poor outcomes, such as those with advanced cancer, end-stage heart or lung disease, or severe neurological conditions, is essential. Criteria such as patient prognosis, quality of life concerns, and patient/family goals should be used to determine the eligibility for palliative care interventions. Ensuring that ED providers can recognize when palliative interventions, such as pain and symptom management, are more appropriate than aggressive life-sustaining treatments Collaboration between the ED team and palliative care specialists to help address complex symptom management, advance care planning, and discussions about the patient's goals of care.[32] Focus on improving symptom control rather than pursuing aggressive treatment in every case represents an ethically appropriate approach. Collaborations ensure that patients are discharged with appropriate follow-up care, whether at home with home health services or in a hospice or palliative care unit. Ensuring continuity of care and avoiding unnecessary readmissions is a pursued goal in the care of the elderly.[29]

Early palliative care can prevent unnecessary ICU admissions and costly, futile interventions, and patients can die with dignity, experience less suffering, and have a greater sense of control over their care decisions. Families appreciate the clarity about care options, and patients may feel more supported in their personal care goals.[33]

Strategies to improve elderly care in the ED

Specific training for the emergency department staff

ED staff should receive specialized training to address the unique needs of older adults. The key areas of training include the following: i) recognition of atypical presentations of common illnesses in older adults;[34,35] ii) assessment and management of delirium, dementia, falls, frailty, polypharmacy, pain, trauma, sepsis, and end-of-life care; iii) ED staff should be proficient in using standardized tools for frailty and risk screening, and in supporting CGA team;[36] iv) understanding the complexities of polypharmacy and use drug wisely while deprescribing when needed;[37,38] v) addressing the psychosocial aspects of care, including social support, abuse, and transitions of care;[39] vi) acquire communication skills with patient and caregiver to effectively discuss goals of care, advance directives, and end-of-life preferences.[33]

Effective education combines lectures, case conferences, simulations, clinical audits and supervised patient care. Training should be interdisciplinary, involving physicians, nurses, and health professionals, focusing on team-based care. Regular updates, re-education, and quality improvement reviews should be incorporated into staff development programs.

Geriatric emergency department

The GEDA, or Geriatric Emergency Department Guidelines, are guidelines for improving the care of elderly patients in the ED. These guidelines were created to provide a standardized approach to managing the unique needs of a growing number of geriatric patients.[39] The GEDA document consists of specific recommendations in six general categories: staffing, transitions of care, education, quality improvement, equipment, supplies, policies, procedures, and protocols. Staffing includes recommendations for the medical director and nurse manager and accessibility to specialist ancillary services. Transitions of care include discharge processes, large-font instructions, and appropriate collaboration with home health services and home safety assessments. Quality improvement recommendations include monitoring the prevalence and prevention of falls. The section on equipment and supplies focused on the availability of mobility aids, reclining chairs, and pressure-redistributing foam mattresses.[40]

An observational study by Gettel and colleagues compared Geriatric Emergency Departments (GEDs) with matched non-GEDs across the United States. GEDs had higher diagnosis rates for key geriatric syndromes and demonstrated shorter median emergency department lengths of stay for older adults, suggesting greater efficiency in care delivery. Discharge rates were comparable for patients aged 65–74 years but slightly higher in non-GEDs for those aged 75 years and older. These findings provide important benchmarks for process outcomes in geriatric emergency care and support the value of GED accreditation and specialized protocols for enhancing the recognition and management of geriatric syndromes while maintaining care efficiency.[41]

The emerging themes and future directions in the development

of Geriatric emergency departments are integrating geriatric EDs at the health system level, developing targeted care processes (especially for conditions such as delirium, falls, and polypharmacy), implementing minimum standards for geriatric emergency care, and establishing a robust research agenda to guide ongoing improvements. The importance of workforce education, adoption of evidence-based protocols, and international collaboration is based on reports that Geriatric EDs have demonstrated effectiveness in improving care quality and outcomes in older adults.[42]

Ethnogeriatrics

Ethnogeriatrics integrates aging, health, and ethnicity to improve healthcare outcomes for older adults from diverse cultural backgrounds. It emphasizes cultural competence in healthcare delivery, ensuring that providers are sensitive to the unique health beliefs, traditions, and experiences of elderly immigrants.[43] Cultural competence involves recognizing one's biases, understanding patients' explanatory models of illness, and adapting care approaches to meet diverse cultural needs. Key components included adequate interpreter services, culturally adapted health materials, and interdisciplinary teams with cultural mediators. A holistic approach involves addressing the social determinants of health and providing acute medical care as well as emotional, psychological, and social support. Programs in Italy have proposed using nurse case managers, cultural mediators, and partnerships with community organizations to enhance follow-up care and continuity.

Fundamentals and challenges of emergency geriatric medicine

The following are the areas of interest and the implementation of a geriatric emergency medicine program: i) train EPs in evaluating decision-making capacity and navigating surrogate decision-making processes; ii) incorporate palliative care consultations in ED workflows; iii) tailored interventions using CGA; iv) train in communicating about goals of care, prognosis, and treatment options in a sensitive, compassionate way; use empathetic communication to help families understand care goals and outcomes; culturally competent interview skills are recommended for elderly immigrants; v) avoid diagnostic tests or interventions with limited benefits or disproportionate risks (overtreatment); vi) at triage, develop protocols for early recognition of frailty and risk stratification using scores and tests; vii) support and promote institutional reforms to improve access to geriatric specialists and palliative care services; viii) provide regular training on bioethics, CGA, and communication skills; ix) engage caregivers throughout the ED stay, discharge planning, and follow-up; their involvement can enhance the adherence to discharge instructions and provide a support network for patients: include the caregiver in decision-making, explain clearly, be sensitive to cultural and religious background, and develop caregiver support programs to enhance family involvement in care; x) ensure safe transition of care; a safe transition protocol specifically designed for geriatric patients in the ED can significantly reduce hospital readmissions, enhance patient satisfaction, and improve overall outcomes by addressing the unique needs of this vulnerable population; xi) involve an interdisciplinary team that may include ED nurses, physicians, geriatric team, pharmacists, and palliative care specialists: this approach ensures that all the aspects of patient care are considered; a multidisciplinary approach helps to determine the most appropriate discharge plan based on the patient's risk profile; xi) implement evidence-based protocols tailored for the geriatric population, addressing areas like falls and dementia; standardized procedures can reduce variability in transitions from the ED to other settings; xii) implementing electronic health records accessible to EPs to provide instant access to advance directives and ensure alignment with patient preference; utilize shared electronic health records to ensure accurate communication and continuity of care among healthcare providers: they facilitate comprehensive documentation, medication reconciliation, and post-discharge follow-up coordination.

Table 1 summarizes the focus areas for successfully addressing the care of frail elderly patients in the ED.

Integrating geriatric emergency protocols into EDs is essential for improving care for older adults, but several significant challenges impede widespread adoption. The most prominent barriers include staff shortages, funding limitations, and resistance to change.

Several factors contribute to staffing shortages in healthcare. As the elderly population grows, the demand for healthcare services increases, leading to a surge in the need for healthcare professionals, while a significant portion of the existing healthcare workforce is reaching the retirement age, creating a challenging gap to fill. This phenomenon disrupts the continuity of care and strains existing staff, making it challenging to implement new protocols that often require additional personnel, training, and time. Furthermore, the lack of staff with specific geriatric expertise further complicates the efforts to provide age-appropriate care.

Healthcare professionals should offer competitive salaries, benefits, flexible schedules, and career advancement opportunities to attract and retain staff, reducing burnout and turnover. In addition, implementing telemedicine, electronic health records, and

Table 1. Key competencies in geriatrics for ED staff.

Competence	Focus Areas
Clinical	Atypical presentations, comorbidities, frailty, delirium, falls, pain, polypharmacy
Bioethics	Beneficence, non-maleficence, autonomy, justice
Communication	Goals of care, advance directives, end-of-life discussions
Caregiver	Involvement, valorisation, support
Interdisciplinary Collaboration	Team-based care, CGA, multidisciplinary approach
Education	CME, simulation, case reviews, mentoring
Environmental Adaptation	Geriatric-friendly equipment, mobility support
Protocols and Pathways	Standardized risk assessment, care pathways for common geriatric syndromes, standardization of urinary catheterization, limitation of constraint
System Integration	Transitions of care, early palliative care involvement

artificial intelligence can streamline workflows and reduce administrative burdens, allowing the staff to focus more on direct patient care.

Establishing mentorship programs, wellness initiatives, and addressing workplace stressors improve job satisfaction and retention among ED staff. Recruiting and training dedicated geriatric emergency nurses or practitioners who can lead care coordination and education within the ED enhances expertise without requiring large increases in the overall staffing. Creating dedicated geriatric ED units or cohorting older patients can optimize resource use and improve care efficiency, potentially reducing staff strain by focusing on expertise and workflow.

Supporting policies that fund healthcare workforce development and training programs in geriatric emergency care will ensure a sustainable pipeline of qualified professionals.[44]

Cultural and organizational resistance to change are prevalent barriers. Emergency medicine has traditionally focused on rapid diagnosis and treatment of acute issues, often overlooking the complex, multifactorial needs of older adults. Integrating geriatric protocols requires a shift toward more comprehensive, multidisciplinary, and patient-centred care models. This transition can be slow and incremental, as the staff may be reluctant to adopt new workflows, documentation requirements, or assessment tools. A lack of awareness or training in geriatric principles can lead to scepticism about the value of these protocols, further slowing adoption.[45,46,47]

Conclusions

Bioethical considerations are central to providing high-quality patient-centred care in geriatric ED. By incorporating CGA and fostering multidisciplinary collaboration, the EP can better navigate the complexities of geriatric care. The tailored interventions aligned with bioethical principles ensured equitable and compassionate outcomes. Institutional commitment to education, systemic reforms, and research is pivotal in meeting the growing demands of the aging population. Decision-making in the ED must integrate patient autonomy, prognosis, and ethical considerations, particularly for end-of-life care. A holistic geriatric approach in EDs improves patient outcomes by reducing unnecessary interventions and adverse events and by addressing unmet patient and caregiver needs. Prioritizing geriatric care in emergency settings is essential for addressing the vulnerabilities and complexities of older patients. Integrating CGA and age-sensitive protocols can significantly enhance outcomes, reduce healthcare burden, and ensure patient-centred care. There is a growing need to invest in workforce development, foster a culture of continuous improvement, and prioritize education on the unique needs of geriatric patients. Only through coordinated efforts can EDs move from aspirational guidelines to consistent high-quality geriatric emergency care.

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