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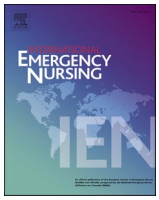

What are the needs of frail older patients in the emergency department? A qualitative study

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ABSTRACT

Background: There is an increase in the number of frail elderly patients presenting to the emergency department. Diagnosis and treatment for this patient group is challenging due to multimorbidity, a-typical presentation and polypharmacy and requires specialised knowledge and competencies from healthcare professionals. We aim to explore the needs and preferences regarding emergency care in frail older patients based on their experiences with received care during Emergency Department admission.
Method: A qualitative study design was used, and semi-structured interviews were conducted after discharge with twelve frail older patients admitted to emergency departments in the Netherlands. Data collection and analysis were performed iteratively, and data were thematically analysed.
Results: The analysis enfolded the following themes; *feeling disrupted, expecting to be cared for, suppressing their needs* and *wanting to be seen.* These themes indicated a need for situational awareness by healthcare professionals when taking care of the participants and were influenced by the participants' life experiences.
Conclusion: Frail older patients feel disrupted when admitted to the emergency department. Because of this, they expect to be cared for, lessen their own needs and want to be seen as human beings. The impact of the admission is influenced by the extent to which healthcare professionals show situational awareness.

1. Background

There is a trend of global ageing and longevity [1] due to increased healthcare quality and better living conditions [2]. This increase is logically followed by a rise of frail older people in parts of the world where the above-described social conditions exist [1,3,4]. In the Netherlands, four million people will be over 65 years old by 2030, including one million older people with frail health condition [2]. Frailty is described as an accumulation of deterioration of functioning in the physical, psychological, social and cognitive domains [5,6]. When disturbed, this deterioration creates a delicate balance and puts frail older people at a higher risk of developing an acute problem and referral to the emergency department [2,7–9]. Worldwide, a quarter of all patients admitted to the emergency department are elderly [3,10]. For the Netherlands, this is even a third of all patients [11].

The illness presentation of frail elderly in the emergency department is often a-typical, combined with multimorbidity and polypharmacy, presenting challenges in diagnosing, treating, and managing care for frail older patients [3,6,9,10]. Therefore, caring for frail older patients requires specialised knowledge and competencies [12]. Furthermore, vision or hearing loss, which often accompanies physical and cognitive decline, requires slower interaction and communication between healthcare professionals and patients [3,6,13] and may counteract the fast and action-oriented communication in the emergency department [14]. In addition, there is limited time and attention for non-technical skills and caring [7] due to the emergency departments' primary focus

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on diagnostic decision-making and eliminating acute medical problems [6]. And lastly, the "high stimulus" environment may trigger or worsen confusion, dementia, or delirium [13].

Two qualitative studies into healthcare professionals' experiences working in the emergency department show that caring for frail older patients requires specialised knowledge of the population and better understanding and acting on the patient's situation [7,13]. Healthcare professionals are even concerned that the emergency department is not the right place for this patient population [6,7].

There might be a discrepancy between the care provided to frail older patients at the emergency department and the essential care this patient group needs. This indicates that the care for frail older people in the emergency department may not align with their specific needs.

Although there is literature available on the perspectives of health care professionals [7,12,13] and recommendations from policymakers on how to adjust the emergency department to the growing population of frail older patients [3,15,16], little is known about the experiences and perspectives of frail older patients themselves. Information and in-depth insight into the experiences of frail older patients with emergency care and to what extent their needs are met will provide crucial knowledge for developing patient-tailored programmes [17–19] to better align emergency care to the specific needs of frail older patients. Therefore, this study explores the needs and preferences of frail older patients based on their experiences with received care during emergency department admission to guide the development of patient-tailored interventions at the emergency department.

2. Method

A multicentre qualitative study was conducted. The population consisted of frail older patients admitted to the emergency department. A purposive sample of participants was drawn from one university medical centre and three general hospitals in the middle of the Netherlands. Patients were eligible for inclusion if they were Dutch-speaking, aged $\geq$ 70 years, and had a positive score on one or more of the Dutch Safety Management System criteria for early recognition of the risk of deterioration [20]. These criteria include the following health problems; an increased risk of delirium, falling, malnutrition and physical limitations concerning daily activities [20]. Patients were excluded from the study if they were cognitively impaired (i.e., inability or difficulty to talk, understand, dementia, Alzheimer's, delirium), either established by the healthcare professionals working in the emergency department or based on the eighteen years of nursing experience throughout the career of the primary investigator working with elderly patients in surgical wards and emergency care.

Recruitment days were scheduled with the contacts at the participating emergency departments. During these recruitment days, healthcare professionals working in the emergency department (i.e., emergency nurses and doctors) identified potential participants based on the in- and exclusion criteria. The healthcare professional asked the patient for permission to be approached by the primary investigator. After approval, the primary investigator provided verbal and written information on the nature of the study. Contact information was exchanged if the patient was willing to participate. Twenty-one patients gave verbal consent during recruitment days and were contacted the following days to weeks after emergency department admission. Due to various reasons, nine patients were unable or unwilling to participate (patient recruitment is shown in Fig. 1). Finally, twelve frail older patients gave written informed consent and were included. Participants were recruited until data saturation was reached [21].

2.1. Data collection

Semi-structured face-to-face interviews were conducted using an interview guide (Supplementary file A). The topics (Table 1) of the interview guide were based on previous studies concerning older patients' experiences during hospital admission [22–25], information on geriatric emergency wards [1,3,6,15], and guided by the physical,

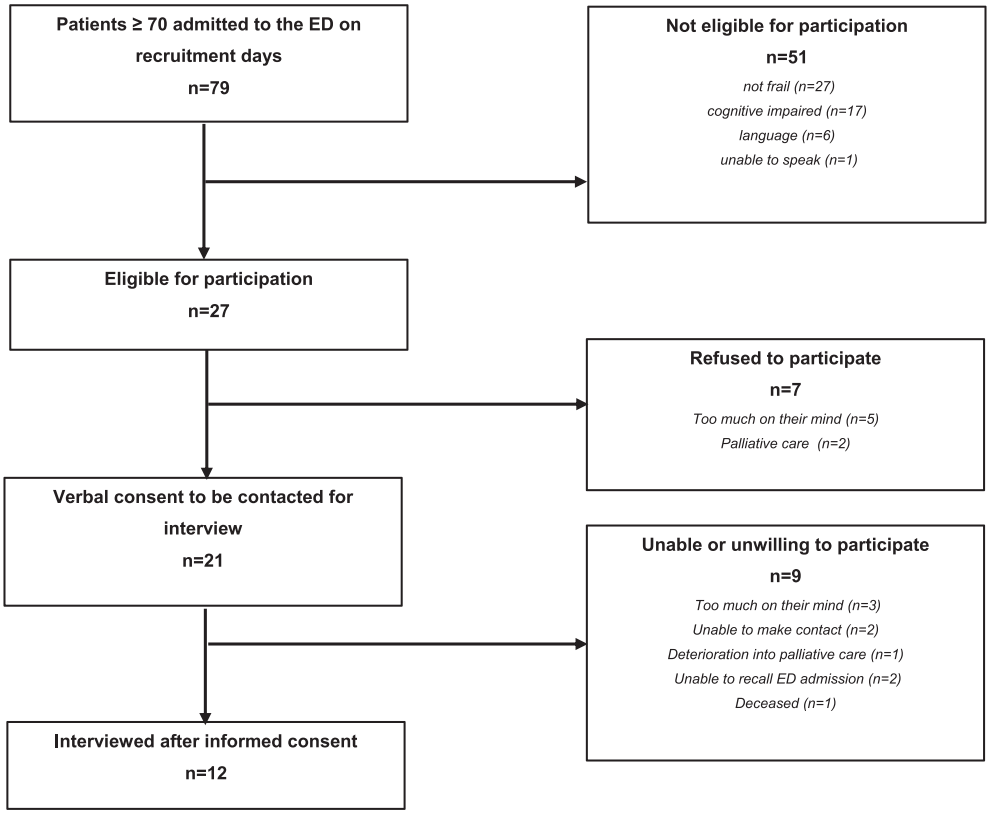

Fig. 1. Participant recruitment.

Table 1
Topic list.

General	Overall impression of admission
	*Needs**
Arrival	Referral and transportation to the ED
	How was the patient welcomed on arrival?
	*Needs**
Diagnoses/Treatment	Time
	Personal care
	Explanation/information
	Diagnosis
	Food/drinks
	Family support
	Staff
	Knowledge
	Communication
	*Needs**
Discharge	Time used for explanation
	Discharge information
	Patient capability to go home
General	Opinion on the healthcare quality
	Recommendations for the future
	How would an ED admittance be in an ideal world

*Removed after pilot interview.

psychosocial, social and cognitive domains [5]. The interviews focused on respondents' experiences during the different phases of the emergency department admission; arrival, treatment, and discharge. A pilot interview was conducted by the primary investigator and the first participant and discussed by the primary and the principal investigator, after which minor adjustments were made to the topic list.

In addition to the interview, a set of baseline characteristics was obtained to determine the sample's variation and provided information on the severity of frailty. After every interview, memos were made on the situation and global ideas. All interviews were audio-recorded, transcribed verbatim using F4 transcription software, and conducted by the primary investigator. Data collection took place from February through May 2021. Interviews were held at participants' homes within an average period of 17 days (range 6–29) after emergency department admission.

2.2. Data analysis

Three researchers participated in the data analysis process; the primary investigator has twelve years of experience working as a nurse in the emergency department caring for frail older patients and is now working as a nursing educator and researcher; the principal investigator, who worked for over fifteen years as a nurse in the emergency department caring for frail older patients and is now working as a nursing scientist; and a peer reviewer who is an expert on qualitative data analysis. Data were analysed using Braun and Clark's six steps of thematic analysis [26,27]. First, each interview was transcribed verbatim by the primary investigator and actively read multiple times to get familiar with the data. During this phase, initial thoughts and ideas were written down. Second, interview texts were systematically coded fragment by fragment by the primary investigator, collating relevant components to each code. Third, collected codes were combined based on similar meanings, and potential themes were identified. Fourth, the primary and principal investigators reviewed the potential themes related to the first coded fragments and the whole data set, resulting in a preliminary framework of themes. Fifth, the primary investigator refined, named, and described themes in detail. Sixth, the final report was written, selecting quotes, relating the themes to the research question, and literature to provide a broad story of the analysed data, thoroughly discussed between the primary and principal investigator and afterwards peer-reviewed by an expert. Quotes were translated by the primary investigator and checked by a bilingual Dutch (native) and English interpreter. The qualitative analysis program ATLAS.ti (Scientific Software Development GmbH v.8.4.24 released 2020) supported the data analysis. After writing, the report was sent to those participants who had requested to receive the report. The participants gave no feedback.

The first three interviews were coded independently by the primary and the principal investigator to increase the reliability of the analysis; differences were discussed until a consensus was reached. The peer reviewer independently analysed three interviews, after which a thorough discussion was held with the primary investigator about the relevant themes and categories. Memos were made during the analysis process for the traceability of the methodological steps. Data collection and data analyses were performed in an iterative process. Two additional interviews were conducted after data saturation was reached to ensure no new themes were identified [21].

2.3. Trustworthiness

Criteria for evaluating qualitative research were used to enhance trustworthiness [28]. All the interviews were conducted by the same researcher, enhancing consistency. Pilot testing of the interview contributed to the credibility of the data collection. Researchers' triangulation during data analysis and peer debriefing of the analysis by a qualitative research expert enhanced the interpretation's credibility and confirmability. During data collection and analysis, memos supported the research process, enhancing dependability and confirmability.

3. Results

The twelve participants had a mean age of 82 years old (range 78–89), and the interviews lasted an average of 42 min (range 14–68). Participant characteristics are presented in Table 2.

The analysis of the interviews led to four main themes based on the participant's experiences with received care during emergency department admission; at first, participants were *feeling disrupted,* which led to the themes of *expecting to be cared for, suppressing their needs* and *wanting to be seen.* Six subthemes were identified, describing the main themes in detail. The results uncovered healthcare professionals' need for **situational awareness** when caring for the elderly at the emergency department.

How being admitted to the emergency department was experienced is influenced by the participants' **life experiences**. Participants expressed themselves by telling stories about the past during the interview. These stories were about their experiences in life, the war, upbringing, work, how they had to deal with loss and previous encounters with healthcare. These stories also revealed information about the participant's character, norms, and values and made it clear that every patient has their own needs based on their experiences in life. These life experiences influenced how participants value life and want to be treated.

A results model is provided in Fig. 2, and Table 3 provides insight into the analysis. Supplementary file B provides a schematic display of all codes.

3.1. Feeling disrupted

Suddenly being admitted to the emergency department made participants feel disrupted and vulnerable. The feeling of disruption is caused by not having a sense of time, not having personal belongings or clothing with them, being asked many questions and seeing multiple healthcare professionals. *"Well, you have nothing else with you; you have been put on a stretcher at home. You have no jacket, no shoes, and nothing else with you. I was put on a stretcher, wrapped around in a blanket, and taken to the hospital. That's how I lay there." (Participant 1). "It all happened so suddenly, and you are so scared." (Participant 9).* This feeling of disruption was enhanced by the time of day participants were admitted to the ED and the long waiting time. *"You feel deserted, you just*

Table 2
Patient characteristics.

No	Age	Gender	Marital Status	Caregiver	ED Referral	ED	ED Transport	Living conditions	ED Discharge	VMS
P1	80	M	Married	Spouse*	GP	MMCA	A	Home	Home	3
P2	89	M	Widower	Children	A	UMCU	A	Home	HA	2
P3	85	F	Married*	Spouse*	GP	MMCA	A	Home	HA	2
P4	80	M	Married	Spouse*	A	MMCA	A	Home	HA	2
P5	84	F	Married	Spouse*	GP	UMCU	A	Home	HA	2
P6	81	F	Divorced	Friend	GP	DH	A	Home	HA	3
P7	79	M	Married	Children	NA	AH	A	Nursing Home	HA	4
P8	85	M	Married	Friend/Spouse*	GP	AH	OT	Home	Home	2
P9	84	M	Widower	New partner*	GP	AH	A	Home	Home	2
P10	78	M	Married	Spouse*	A	AH	A	Home	HA	2
P11	79	M	Married	Spouse*	GP	DH	A	Home	HA	2
P12	85	F	Widow	NA	GP	DH	OT	Home	Home	1

No = Number **P** = Participant **M** = Male **F** = Female **NA** = Not Applicable **A** = Ambulance **GP** = General Practitioner **MMCA** = Meander Medical Centre Amersfoort **UMCU** = University Medical Centre Utrecht **DH** = Diaconessen Hospital **AZ** = Antonius Hospital **OT** = Own transportation **HA** = Hospital Admittance * partner present during the interview, not actively involved.

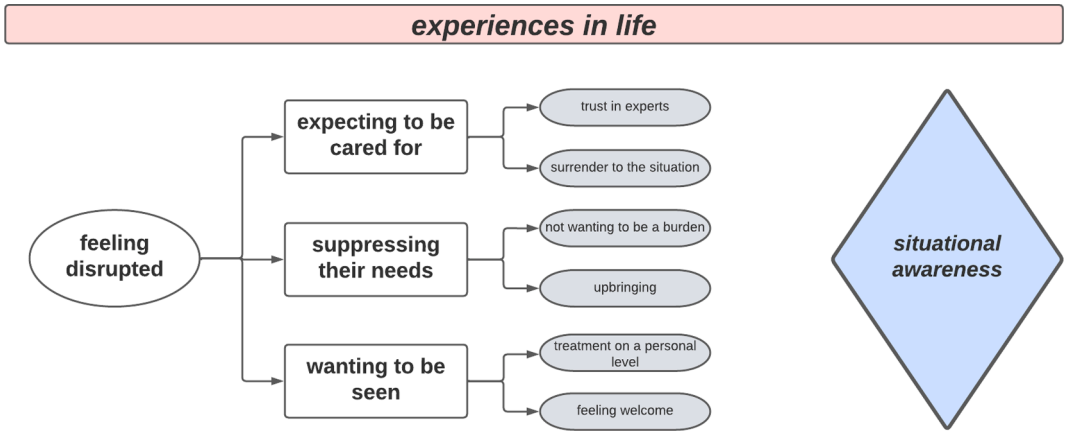

Fig. 2. Results model.

Table 3
Coding strategy examples.

Quotation	Code	Subtheme	Theme
"At that moment, nothing else interests me, and I want them to…. Look, if I want to get my car fixed, I will tell the mechanic, can you fix my car? He will say yes, and everything else will come later" (P9)	Only wanting to be fixed	Trust in experts	Being cared for
"… the most important suggestion is to approach people with kindness because they are all out of their minds. Healthcare workers probably don't always, but you see a lot of older people, and one does this, and the other does that, but it all starts with a little kindness. That makes all the difference" (P8).	Kindness	Treatment on a personal level	Wanting to be seen
"[..] and that they don't, um, say you should take it easy, you shouldn't talk so much or anything. My environment is telling me to rest and stuff. Well, I don't like that" (P6).	Take it easy		Situational awareness

*P Participant

sit there, and nothing happens." (Participant 1).

This feeling of disruption caused a mental state wherein the participants will let everything happen, even when they are usually empowered enough to stand up for themselves. *"Maybe I let myself be taken by surprise again by being in the hospital, like a pathetic bunch of human beings. No, I just said I didn't open my mouth, I'm sure of it" (Participant 12).* Some participants said, *"If you had not asked, we would not have said anything" (Participant 5).*

3.2. Being cared for

Participants expressed that, due to the sudden admission to the emergency department, they found themselves in a situation where they expected healthcare professionals to take good care of them and help them get better. Because of this expectation, participants completely trust the experts at the emergency department and surrender themselves to the situation. *"They (healthcare professionals) do what they think is necessary, and you don't really care, you just want to get better. And I assume they know what they are doing. You just surrender to it" (Participant 1). "At that moment, nothing else interests me, and I want them to…. Look, if I want to get my car fixed, I will tell the mechanic, can you fix my car? He will say yes, and everything else will come later" (Participant 9).* They believe healthcare professionals are experts, knowledgeable, and capable because of their training. *"I just leave it into their hands, well you have to, if you don't trust the doctor, you shouldn't go there" (Participant 7).* Because of this trust, participants felt the experts could best decide whether to undergo multiple examinations. *"I just let it come over me. I am not a physician, I know nothing about health care, and I don't want to know either"*

(Participant 10).

Although participants surrender to the situation and would not express their needs actively, there are things they expect during their admission. Being provided with information about examinations and feedback on results underline the feeling they are being cared for and that they were right to put their trust in the experts. *"Just let the doctor […] come by to tell me this and that, and that is why we do what we do" (Participant 4)*. Getting a positive result also has a reassuring effect on the participants. Participants also expect healthcare professionals to be truthful when talking about options. *"Well, they should tell you exactly how things are. Tell you the truth" (Participant 2)*.

3.3. Suppressing their needs

Participants suppressed their needs because of the perceived business at the emergency department. They felt compassionate toward the busy healthcare professionals of the emergency department, who put in great effort to provide the necessary care. *"When I see how busy they all are and stuff, no, I'm not the type to ask. No, no, I will not do that easily, and if I think so, I will not say it yet. Well, that's your nature" (Participant 3)*. Suppressing their needs was reinforced by not wanting to be a burden to their children or other family members. *"The children have a busy life; you know that yourself. You can't ask them for everything; that is just how it is" (Participant 3)*. Participants also expressed that other patients needed attention due to a more severe health condition. *"Look, I understand it can be swamped at the emergency department, and there are patients in a worse condition than me, you see" (Participant 5)*.

Participants elucidated suppression of their needs by their experiences in life, living through or being born in the second world war. After surviving the war, their upbringing focussed on working hard, not complaining, pushing through and respecting their parents and people in hierarchal positions. *"Yes, certainly the generation, we had to work hard at home, very hard; my father died very young and left my mother with three young children. So we all had to work hard, but that was normal. You tackled everything. And you didn't complain; it just happened" (Participant 3)*. Because of this, they found it difficult to go to a doctor for help. *"We are used to a lot, we are used to working hard, and if you are sick, you don't immediately run to a doctor, at least not me" (Participant 9)*.

Even though they would not ask actively, participants would like healthcare professionals to provide clarity or information about the course of the emergency department admission. *"They don't tell you how or what, and I find that annoying…they should give you a sense of how long things will take; now we are running these examinations, and the results will be known in three hours" (Participant 5)*. This information would help to manage and adjust their and their caregivers' expectations and allow participants not to burden their families unnecessarily. *"Then you have to call your brother-in-law or son-in-law to come and get us, but he has to get up again at five o'clock in de morning" (Participant 9)*.

3.4. Wanting to be seen

The impact of the emergency admission is influenced by how participants were treated. Participants wanted to be seen as human beings and like healthcare professionals who were kind, thoughtful, empathetic, radiated tranquillity, took time, acted normal and made them feel welcome. *"… the most important suggestion is to approach people with kindness because they are all out of their minds. Healthcare workers probably don't always, but you see many older people, and one does this, and the other does that, but it all starts with a little kindness. That makes all the difference" (Participant 8)*. For participants, this made them feel they were seen as human beings, not as a disease. *"Well, it indicates to me that even though you are transferred to the emergency department as a patient, they still consider you a person. And that person sometimes has a few broken parts, well there is no shame in that" (Participant 11)*. Participants expressed that the need to be seen is reinforced by the feeling of being discarded as an older person. *"And I think that's also a bit of self-preservation of you being put aside anyway" (Participant 12)*.

Participants felt the ambience at the emergency department was bleak, and they missed the presence of their families, who were often not allowed to stay with them due to the Covid pandemic. *"You're missing someone beside you who knows exactly what is going on" (Participant 11)*. Feeling welcome would help participants cope with their vulnerable situation, and can be established by the presence of a positive and warm atmosphere, the provision of food and drinks and the possibility of distraction during the long wait (i.e., magazine, television). Combined with the presence of a caregiver who can help answer or ask questions, remember information and provide a distraction during the long wait. *"It is nice to have someone with you. They can help me remind things or can correct me if I downplay the situation. That is what my son always does. Two can remember more than one, and he asks questions I do not think of. I find that helpful." (Participant 12)*.

3.5. Situational awareness

Participants would like healthcare professionals to consider their situation without asking for it specifically. *"I would like a bit more guidance, but I don't want to ask for it" (Participant 11)*. *"I would much rather they say stay here tonight so we can observe you for a while, and then you can go home in the morning. Then the person who picked me up could have brought him a coat and so on, and then you would have just worn more comfortable clothes" (Participant 1)*. And to be aware of what participants find essential. "*[..] and that they don't, um, say you should take it easy, you shouldn't talk so much or anything. My environment is telling me to rest and stuff. Well, I don't like that" (Participant 6)*. Doing so makes participants feel like they are being taken care of, they don't have to be a burden to anyone by asking themselves, and it makes them feel seen. Participants expressed their preferences on how and what they want during emergency department admission will depend on the difficulties they encounter regarding their physical, social, and mental health. *"[..]but that just depends. And it may just depend on how you are yourself, doesn't it?" (Participant 1)*. Most participants wanted the experts to make the decisions about their treatment, *"[..] that is not important to me at all. He is the professional, he shouldn't ask me how to operate" (Participant 10)*, and others wanted to be consulted regarding their treatment. *"Yes, it is. It is always nice to have a choice" (Participant 4)*.

4. Discussion

These results show that suddenly being admitted to the emergency department made participants feel disrupted. Because of this, they expected to be cared for, suppressed their own needs and wanted to be seen as human beings. Participants would have liked healthcare professionals to show situational awareness while caring for them. Their personal preferences were influenced by their experiences in life.

The participants' experiences in life were shared by telling stories about the past during the interviews. This storytelling can be defined as narrative identity and influences patient well-being. A study by Adler et al. shows that every human being is unique and distinguishes themselves from others by their life experiences, which can be expressed by telling stories about the past [29]. The importance of telling stories is confirmed by Erikson, the founder of the life course theory [30]. Telling these life stories is especially useful for older people. In the last phase of their life, telling stories will help give meaning to the present; it will help identify what people still want and expect from life [31]. For healthcare professionals, it is crucial to be aware of the background of the older care recipients and to understand their norms and values; this will help healthcare professionals to respond better to the patient's needs and will help to tailor their care to the individual patient [30]. This patient-centred, or sometimes even referred to as person-centred, care is not a new approach in healthcare. It is characterised by allowing the patient's personal needs, norms, values and ideas to guide clinical decisions respectfully and responsibly [32]. This corresponds to the need for

situational awareness by healthcare professionals working in the emergency department expressed by participants in the current study.

Although there is a need for situational awareness, not being able to express their needs actively due to the feeling of disruption, trust in experts, and suppressing their own needs may challenge the shared decision-making process. Shared decision-making focuses on collaborative decisions between the patient and healthcare professionals. This challenge is also described by Godolphin, who states, "a good level of shared decision-making occurs 10 % of the time" [33]. And can be explained by the multiple steps needed to accomplish a good partnership between healthcare professionals and patients, for which insufficient time and continuity are available in daily practice. Furthermore, shared decision-making can be especially challenging in older patients with multiple chronic conditions due to their difficulties understanding information, interpreting test results and communicating about the benefits and risks of procedures [34,35].

Furthermore, the feasibility of shared decision-making with frail older patients in the specific setting of the emergency department may be challenging due to the primary focus on saving lives and restoring vital signs. However, understanding older patients' views on the ageing process help to understand personal goals and expectations [36], which is crucial for shared decision-making. These findings led to the development of a dynamic communication model to guide geriatric doctors to uncover what frail older patients find important [37]. This model's applicability within the emergency department setting is unclear [37]. To transform this model to the emergency department setting, the need and importance of changing the communication between patients and healthcare professionals must be clear [38,39], and it might ask for a shift in practice from an urgent physical perspective to a more holistic patient-centred approach [40]. Flynn et al., who researched the process of shared decision-making in the emergency department, underline the importance of adequate shared decision-making in the emergency department and urge the development and testing of decision-support interventions [41]. Therefore, geriatric emergency departments were developed to manage the increase of frail older patients admitted to the emergency department, the complexity of health care needs, and the provision of high-quality care [3,15,16,42]. Unfortunately, the patient hardly participated in the development, leaving it unclear whether these improvements meet the needs of the frail older patient admitted to the emergency department. Involving patients' perspectives enables us to better understand the underlying patient problems and improves the compatibility between scientific research and clinical practice [18,19,43,44].

Finally, putting trust in the expert opinion of the healthcare professional and lessening their own needs corresponds with trades of the silent generation [45], people born between 1929 and 1940, of which most participants are part. This generation is all about hard work, living frugally and being faithful to order and authority [46]. They were lucky to have survived the war and therefore have no reasons to complain [30,47]. However, the participants had implicit expectations from healthcare professionals, such as taking good care of them, providing clarity and considering their situation. The need for clarity on the results of examinations and the course of the emergency department admission is underlined by Shankar et al., who address negative experiences from older patients regarding not receiving updates on their condition and the absence of information about the trajectory of their stay [48]. The participants' feelings about not wanting to be a burden might contradict the desire to be seen as a human beings. However, another study substantiates these results in which patients expressed wanting to be seen as individuals with their own needs and wants, next to not wanting to blame the busy staff [49]. Corresponding to the current study's findings on participants' preferred treatment, Lyons and Paterson show a caregiver needs to demonstrate empathy, concern, and understanding to give patients the sense of being seen [49].

5. Strengths and limitations

Strengths concerning this study include; all interviews were recorded and transcribed verbatim by the primary investigator to enhance the reliability of the analysis. Due to this procedure, the primary investigator increased her understanding of the narrative and provided a reflection on interviewing skills. The researcher is an experienced emergency department nurse who provides extensive insight into conversing with frail older patients and a better understanding of the setting and vulnerability experienced during emergency department admission. This resulted in a thick description of the data [21], which was enhanced by face-to-face interviewing [50].

Potential limitations of this study are; wearing a facemask during the interviews possibly influenced non-verbal communication [51]. The effect of the mask may have been reduced by the investigators' awareness and taking enough time to build rapport with the participant [52]. The emergency nurse background of the primary investigator could have influenced the patient to participate; however, at the time of the study, the primary investigator was not working in the emergency department or involved in the treatment of the participants. The results of this study may not apply to cognitively impaired patients as they were excluded from participation in the study.

6. Conclusion

Being admitted to the emergency department made frail older patients feel disrupted. They expect to be cared for, put all their trust in experts and surrender to the situation. They suppress their own needs due to how they were raised and because they do not want to be a burden to others. They want to be seen by feeling welcome and treated like a human instead of a disease. The impact of emergency department admission is influenced by the extent to which healthcare professionals tend to their needs, providing information and clarity during the admission, treating patients kindly and thoughtfully, providing food and drinks and the possibility for a caregiver to be present. Healthcare professionals must show situational awareness to care for frail older patients without patients explicitly asking for it. To do so, they need to understand the patient's situation and how life experiences influence their values and how they want to be treated. The next step will be to investigate what is needed in practice to meet this need for situational awareness and the influence on shared decision-making and patient-centred care in the emergency department. It will guide the development of an intervention to help healthcare professionals in the emergency department meet the needs of older patients with frail health conditions.

Ethical statement

This study followed the principles of the Declaration of Helsinki [53], the Medical Research Involving Human Subjects Act [54], and the guidelines for medical research on the elderly [55]. The study was approved by the medical ethical research comity of the University Medical Centre Utrecht (METC number 21–002/C). The Dutch National Institute for Public Health and Environment guidelines concerning COVID-19 were regularly reviewed.

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CRediT authorship contribution statement

Dorien Venema: Conceptualization, Methodology, Software, Validation, Investigation, Resources, Data curation, Writing – original draft, Writing – review & editing, Visualization, Project administration. **Sigrid C.J.M. Vervoort:** Validation, Data curation, Writing – review & editing. **Janneke M. de Man-van Ginkel:** Validation, Writing – review & editing. **Nienke Bleijenberg:** Validation, Writing – review & editing. **Lisette Schoonhoven:** Validation, Writing – review & editing. **Wietske H.W. Ham:** Conceptualization, Methodology, Validation, Data curation, Writing – review & editing, Supervision, Funding acquisition.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendices A and B. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ienj.2023.101263.

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