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Evaluating a new emergency department avoidance service for older people: patient and relative experiences

Leanne Greene ¹, Rachel Lane,¹ Maria Crotty,¹ Craig Whitehead,¹ Elizabeth Potter,¹ Petra Bierer,² Kate Laver¹

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¹Rehabilitation, Aged and Extended Care, Flinders University, Adelaide, South Australia, Australia
²Rehabilitation, Aged and Extended Care, Southern Adelaide Local Health Network, Bedford Park, South Australia, Australia

Correspondence to

Dr Leanne Greene, Rehabilitation, Aged and Extended Care, Flinders University, Adelaide, SA 5042, Australia; leanne.greene@flinders.edu.au

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ABSTRACT

Background High emergency department (ED) usage by older individuals for non-emergencies is a global concern. ED avoidance initiatives have proven effective in addressing this issue. To specifically cater to individuals aged 65 and above, the Southern Adelaide Local Health Network introduced an innovative ED avoidance service. This study assessed the acceptability of the service among its users.

Method The Complex And RestorativE (CARE) Centre is a six-bed unit staffed by a multidisciplinary geriatric team. Patients are transported directly to CARE after calling for an ambulance and being triaged by a paramedic. The evaluation took place between September 2021 and September 2022. Semi-structured interviews were conducted with patients and relatives who had accessed the service. Data analysis was performed using a six-step thematic analysis.

Results Seventeen patients and 15 relatives were interviewed, who described the experience of 32 attendances to the urgent CARE centre between them. Patients accessed the service for several reasons but over half were associated with falls. There was a hesitation to call emergency services for several reasons, the primary being long wait times in ED and/or the prospect of an overnight stay in hospital. Some individuals attempted to contact their General Practitioner (GP) for the presenting problem but were unable to get a timely appointment. Most participants had previously attended a local ED and had a negative experience. All individuals reported favouring the CARE centre over the traditional ED for numerous reasons including a quieter and safer environment and specially trained geriatric staff who were less rushed than ED staff. Several participants would have appreciated a standardised follow-up process after discharge.

Conclusion Our findings suggest that ED admission avoidance programmes may be an acceptable alternative treatment for older people requiring urgent care, potentially benefiting both public health systems and user experience.

INTRODUCTION

High emergency department (ED) usage is a global issue.¹ In Australia, emergency healthcare demands are increasing,² with older Australians disproportionately presenting to ED for non-emergency conditions compared with other age groups.³ This trend appears to be international.^{4,5} A large proportion of older people have reported negative

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Older people disproportionately present to overcrowded emergency departments (EDs) for non-emergency conditions and frequently report negative experiences. Evaluations of new ED admission avoidance programmes for older people are required to understand acceptability.

WHAT THIS STUDY ADDS

⇒ In this qualitative study, we explored the views of patients and relatives accessing a specially designed geriatric ED admission avoidance programme. Overall responses were highly favourable.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The findings highlight older people's and their relatives' preferences concerning non-emergency treatment. Findings can inform the configuration of similar services.

experiences with EDs, leading to a reluctance to re-attend.^{6–8} Older people, particularly those with frailty, have reported that their unique needs are unmet in busy EDs and, although staff attitudes were positive, this was overshadowed by adverse experiences such as lack of assistance with eating, drinking and toileting and uncomfortable waits.^{7,8} There was also low satisfaction with communication and shared decision-making and fear of overnight stays.⁷ Over half of older people accessing ED will be admitted to inpatient wards⁹ and experience extended lengths of stay.^{10,11} Prolonged hospitalisations in older populations are associated with adverse risks,¹² and individuals remain at risk once admitted for future re-admissions.¹³

Evidentially, older people present with complex needs and conventional models of ED care may not be the most appropriate for treating urgent, but non-life-threatening, ailments.⁷ To combat this, a range of hospital admission avoidance programmes have been developed, typically centred around hospital-at-home services.^{14,15} Yet, there may be a proportion of patients who require multifaceted treatment (e.g. imaging, multidisciplinary input) that is not feasible to carry out at home but also does not require emergency services.¹⁶ The current study evaluates a new ED avoidance service (the

Complex And RestorativE (CARE)) for older people requiring urgent care. The service aimed to reduce ED presentations and address the concerns of older people so often reported in the literature.^{6–8}

Flinders Medical Centre (FMC) is a 600-bed tertiary hospital based within the Southern Adelaide Local Health Network (SALHN). The hospital services a catchment area of 380 000 people and the ED is one of the busiest emergency departments in Australia. The CARE Centre, opened in September 2021, is housed in a separate building and operates separately from the ED during the hours of 08:00 am to 22:00 pm, 7 days a week. Patients attending the centre will have called an ambulance, and a paramedic will have triaged the patient based on the CARE inclusion criteria (see online supplemental figure 1) and transported them directly to the centre. The centre provides non-emergency but urgent care to older individuals in a six-bed treatment space. The service is patient-centred and geriatrician-led with access to medical imaging on site. Staffing typically includes one level 3 registered nurse for triage and on the ward one level 1 registered nurse, one enrolled nurse, two level 3 physiotherapists, two level 3 occupational therapists and one social worker (see online supplemental figure 1 for triage pathways). This qualitative study reports on the experiences of older people and their relatives who were treated at the CARE centre as an alternative to ED, a perspective that is crucial to providing person-centred care for this population.^{7 17}

METHODS

Design

This qualitative work is a component of a larger service evaluation considering the efficacy and economic outcomes of a new ED avoidance service that offers rapid healthcare for older people. In line with the SALHN Human Research Ethics Committee regulations, this was a service evaluation and as such was exempt from ethical review. The project has been registered on the SALHN Quality Register.

Setting and participants

The setting was the CARE centre, and the evaluation took place between September 2021 and September 2022. Service users (patients and/or relatives) were asked to complete an evaluation survey on discharge and were asked if they would agree to being contacted for future evaluation activities. For the purposes of the qualitative study, purposive sampling was used to try to represent the population (e.g. sex, presenting problem, age, satisfaction level). Involving relatives ensured that patients with impaired cognitive function were represented. Participants were informed by telephone of the research by one of the evaluation team and

informed consent was taken before the interview. Recruitment continued until data saturation was attained.¹⁸

Data collection

Data were collected via semi-structured interviews. An interview guide was developed to elicit positive and negative experiences (online supplemental file 1). Interviews were conducted remotely via telephone and lasted approximately 30 minutes. All interviews were audio-recorded and transcribed verbatim by a professional transcribing company.

Data analysis

Qualitative descriptive analysis¹⁹ was performed using a six-step thematic analysis,²⁰ underpinned by grounded theory,²¹ allowing an inductive approach to study older people's experiences of the CARE centre. NVivo²² was used to assist with coding data and mapping themes. The overall service evaluation is grounded in the Centres for Disease Control and Prevention Framework for Program Evaluation in Public Health.²³ See table 1 for the analysis steps and online supplemental file 2 for an illustration of the coding.

Patient and public involvement (PPI)

The evaluation is supported by the involvement of a lay consumer advocate who is a key member of the research team and ensures that public voices remain at the centre of the research. The design of the evaluation and the research questions were developed in collaboration with PPI.

RESULTS

During the evaluation period, 1489 patients were referred to the CARE service. In total, 32 interviews were conducted. Seventeen interviews were with patients (11 women, 6 men) with a mean age of 83.2 (range=71–93) and a mean length of stay in the CARE centre of 3 hours 39 min (range=1 hour 43 min – 7 hours). Fifteen interviews were with relatives (nine daughters, four sons and two wives). No interviewees identified as Aboriginal or Torres Strait Islanders. Most presentations to the CARE centre were for acute symptoms, primarily falls, but also headaches, general pain, high blood pressure, chest pain, shortness of breath, and panic attacks. Some presentations were associated with chronic conditions such as chronic obstructive pulmonary disease, diverticulitis, and Hodgkin's lymphoma. The key themes from the interviews included a reluctance to attend ED, positive experience of the new CARE centre, appreciation of specially trained staff, and confusion around who managed future care.

Table 1 The six steps of reflexive thematic analysis with individual author's roles

Steps	Description
Interviews Familiarising with the data	EP conducted all interviews remotely via telephone. EP had no established relationship with participants before study commencement. Participants received a comprehensive participant information sheet outlining the research before consenting. The number of people who refused to take part was not documented by the care staff. No participants withdraw after consenting to take part. RL and LG separately read full transcripts to get a thorough overview of the data and made general and reflexive comments (i.e. noting researcher bias—see online supplemental file 3).
Generating initial codes	Both RL and LG began to systematically organise data into initial inductive codes before reviewing and comparing the coded data (with continued reflexive journaling).
Generating themes	RL, LG and KL reviewed codes to identify patterns and generate themes.
Reviewing themes	RL, LG and KL iteratively compared themes against the original data set to confirm themes.
A. Defining and naming themes	RL, LG and KL defined and named each theme, formulating how it aided the understanding of the data.
Writing up	All authors helped with the interpretation of the results alongside recent literature. Participants did not provide feedback on the findings.

There was a subtheme of participants acknowledging that there was a 'system failure' within the Australian healthcare.

Reluctance to attend ED

Several participants debated about calling emergency services for reasons such as not feeling like a priority or fear of long wait times in ED.

There's other people worse than me I keep thinking, so I don't like to put the ambulances, all you people out. You've got enough problems with the way the chaos, the medical system is these days, lack of staff and lack of doctors, and lack of space. (Patient, 1128)

And then eventually they told me to press the emergency button for an ambulance, which I was a bit loathe to because I didn't want to go and be ramped. (Patient, 1245)

Others tried contacting primary care services for advice but found they were either unable to get an appointment or wait times were too long for their needs.

The reason I never rang my GP is because I can't get an appointment, and I was in so much pain and I couldn't drive anyway. (Patient, 1177)

Positive experience of the care centre

Participants did not express any initial reluctance when offered the opportunity to try the new service. Participants reported feeling positive about being taken to the CARE centre compared with ED and expressed feelings of relief at the prospect of being seen quickly.

So, when he said you'll get looked at very quickly at the other place, absolutely we'll go there. (Relative, 2001)

Both patients and relatives were pleased with an alternative option to attending ED.

I thought it was great because it helped us to get mum to hospital. I think if she had been going to (the usual ED), I think she may have objected. I think the fact that they said it was – she wouldn't be kept in overnight, I think that was enough reassurance for mum. (Relative, 2007)

All participants reported favouring the CARE centre over traditional EDs. Most participants mentioned a fear of ramping, that is, having a prolonged wait in an ambulance on arrival at ED because of overcrowding.

We would have been there two, three, four, five – the paramedic was saying the day before they were ramping in the ambulance for eight or 9 hours...Then you get stuck in there and it's stuck in a corridor and everyone's walking past, and no one's really taking care of you. Then you start to get stressed that you're going to get locked in there overnight. It's not a good place, so the CARE centre was just paradise. (Relative, 2001)

It was noted that EDs are often very busy. Patients are faced with long wait times, and tests booked during late hours. There were reports of EDs being 'full on' and 'too much'. Participants appreciated that it was a 'system' problem rather than a fault of the ED staff who were often commended for their work.

There's people everywhere, on chairs, in beds, and they can't – it's impossible for them to do everything straight away. I'm not blaming the hospital for that, it's the system that's the problem. (Patient, 1128)

Participants frequently commented on the physical CARE environment. Many participants noted that the patient's name

was already on the door of a private room before arrival, giving the impression that the centre was prepared and efficient.

Very comfortable. Very quiet. It's not chaotic. It was nice. As in emergency it's chaotic. It's always...It's crazy. And it was nice. For elderly, it was quiet, it was peaceful. (Relative, 2016)

Participants valued that the CARE centre was a day service only and that issues were resolved there and then.

In comparison to when I've had falls and gone to (the usual ED), I know they're very busy there and of course I've had to wait and stay the night. Here it was all resolved in that day. (Patient, 1081)

Many participants described anxieties about staying in hospital overnight, this was especially true for individuals with impaired cognitive function.

I've got to stay with her because of the dementia. If she stays overnight, I've got to sleep with her, because I can't leave her alone. I can't go to (the usual ED) because they don't allow you to stay with them. (Relative, 2016)

Several participants mentioned that traditional EDs can be distressing.

I would have been more concerned to be sat with her up in that emergency section at (the usual ED) ... – there were people with mental health issues, there were people who were inebriated, there were people who were on drugs. (Relative, 2004)

Appreciation of specially trained staff

Staff were described as careful, understanding, respectful, patient and professional. Participants appreciated how present and available the staff were.

I thought we were just looked after so well, and the staff were so caring. Yeah, and they were just so beautiful to Mum. They treated her with so much respect. (Relative, 2003)

Additionally, having personable friendly staff put participants at ease.

I like the fact that when they came, they introduced themselves by giving me their first names. (Patient, 1066)

Numerous participants mentioned how beneficial it was to have a specially trained geriatric team.

Well, the fact that I think they're trained to treat old people, and they know we've got fragile bones and they treated me accordingly. (Patient, 1233)

This was particularly apparent when relatives were worried about their loved ones' sensory or cognitive impairments.

Like he's hearing impaired and visually impaired as well... the way they were able to communicate to him against what he'd experienced in the other settings, they were able to talk to him very clearly. And yeah, showed real care to him, and they respected that, whereas historically they haven't respected his impairment, and it's caused a lot of confusion, and a lot of anxiety for him. (Relative, 2005)

Participants explained how they were made to feel comfortable and safe.

I saw Dad there, he was very comfortable, he had a lot of attention around him, and they were all looking after him, and he seemed very, very comfortable. It was a very controlled and calm setting, which was very unusual for me to see that, which was lovely, so that was very reassuring. (Relative, 2005)

Participants noted how the team practised person-centred care and would take sufficient time to patiently explain everything to the patient and relative (if present) and ask their opinions.

Well, like I said, they were courteous, they were patient to explain everything. They didn't just make those decisions and we had to follow; they actually sat and discussed it with us. (Relative, 2014)

Future care

Some participants were disappointed that there was not a standardised follow-up process in place after discharge.

It would be so wonderful if the hospital after this kind of thing had somebody to do some follow-up, just to ring up and say, "We know that you're at home. Is everything going okay or if not, how can I help?" (Patient, 1066)

The outcome for participants varied. Some were discharged home, some were required to attend ED on the same day or a few days later, others received referrals to specialists and one patient was taken to respite. CARE staff organised community care or rehabilitation for several patients post discharge. Some participants felt that the onus of their care was handed back to them, even though many were ill and frail.

They did ask me to ring them back in a couple of days and tell them how I was going, and I just haven't got around to doing that yet. (Patient, 1217)

Others were confused about who their care now lay with.

I haven't received any information...I haven't heard from her (GP), so I don't know whether she got them or not, and I haven't heard anything about what the blood results were. (Patient, 1245)

There were reports of conflicting medical opinions between the CARE centre staff, GP and specialists, leaving patients and families feeling a bit confused.

a doctor said to me, "I'm taking too many fluid tablets, that I really should cut them back." But I've spoken to my GP about it, and he seems to think that that is best, because the specialist put me on them. (Patient, 1196)

DISCUSSION

Overall, individuals reacted positively when given the option of attending the CARE centre compared with ED. For many, the decision was based on being seen quickly and avoiding long wait times in ED. Some participants' previous experience with ED had made them hesitant to access emergency services, potentially worsening symptoms. Participants valued the same-day care as many feared overnight hospital stays, a finding which is consistent with existing literature.⁷

Participants liked that the setting was small and quiet with many commenting that ED is usually chaotic. These concerns are echoed in the literature where ED settings have been considered unsafe and stressful for older adults.^{6-8 24} Participants benefited from the geriatric expertise in terms of physical health (i.e. being gentle) and communication (i.e. sensory and cognitive impairments). This was unsurprising as older adult care requires specialist skills^{25 26} and highlights the need for tailored settings to treat older people's complex health and social needs.⁷

Participants were disappointed that there was no standardised follow-up process after discharge. Sometimes, after discharge, the onus of care was handed back to the patient who was often ill and frail, or their relative. Discharge advice also involved seeking primary care support, even though many of the participants had accessed emergency services because they were unable

to get an appointment with their GP. There were also a few cases where medical opinions differed between GPs, specialists and the CARE staff, and participants were left confused as to who to listen to. Participants were also aware of how strained health services were and sometimes did not promptly access care because they did not want to feel like a burden, even if symptoms were worsening.

As over half of older people accessing ED are admitted to a ward,⁹ and prolonged hospitalisation in this population are associated with adverse risks¹² and future re-admissions,¹³ rapid assessment and treatment models of care could be beneficial for global public health systems that are experiencing high ED usage in general,¹² but also specifically in terms of treating older people.³⁻⁵ The introduction of specialised geriatric urgent care services could also improve patients and relatives user experience and may mitigate some of the concerns older people report regarding accessing acute care.⁷

Limitations

Although we endeavoured to recruit a varied sample, a limitation of the study is the risk that our method of recruitment attracted participants who had a positive experience of the service. Individuals who had negative experiences may have declined to participate in which case our analysis may be lacking these perspectives. Additionally, most participants had previous negative experiences with EDs, meaning their perception of an alternative service may have been positively skewed from the outset. The evaluation would benefit from talking to those who either declined the offer of attending the CARE centre or those who had a less positive experience. This could be achieved through anonymous online and pre-paid open-ended questionnaires. It may also be valuable to interview individuals who do not have prior ED experience, although this may be challenging with an older population. While our constructivist interviews explored our participant's views and experiences of a new ED avoidance service for older adults requiring urgent care and provided a good evaluation baseline, future research could employ a realist methodology to investigate propositions about how, where, when, and why new care models do or do not work for certain older populations.

CONCLUSION

The new ED avoidance programme was well accepted as an alternative treatment for our participants over the ED. Participants appreciated being seen quickly and valued that there were no overnight stays. Participants valued the specially trained geriatric staff and person-centred care. Better follow-up after discharge was called for, particularly as this population encounters barriers to accessing primary care. The findings from our study have been relayed to the CARE staff for quality improvement opportunities.

Contributors The concept for the evaluation was conceived as part of the wider Medical Research Future Fund with inputs from MC, CW, PB and KL. EP conducted the interviews. LG, RL and KL analysed the data. LG prepared the manuscript for publication with input from RL, MC, CW, EP, PB and KL. All authors contributed to subsequent revisions and approved the manuscript prior to its submission. CW is the guarantor. Thank you to all stakeholders and PPI members for their contribution to the research.

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Competing interests MC and CW have dual roles with Flinders University and South Adelaide Local Health Network. PB works for South Adelaide Local Health Network.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants but this research is a service evaluation in line with the SALHN Human Research Ethics Committee regulations and, as such, was exempt from an ethical review. The project has been registered on the SALHN Quality Register. exempted this study. Participants gave informed consent to participate in the study before taking part.

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ORCID iD

Leanne Greene <http://orcid.org/0000-0002-5383-4362>

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