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Community dwelling older adults' decision to, and experience of attending the Emergency Department during COVID-19: a qualitative study

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Abstract

Background The COVID-19 pandemic resulted in a decrease in emergency department (ED) visits, particularly among older adults. The objective of this study is to explore the experiences of older adults attending the ED during COVID-19.

Methods The study utilised a qualitative descriptive approach as part of a larger mixed-methods study. Data were collected at five different ED's in Ireland, which represented both urban and rural populations. The participants were all aged over 65 years. Semi-structured phone interviews were conducted up to 10 days after attending the ED and the interviews were audio-recorded. The interviews were transcribed and imported to NVivo software, and the data was analysed using reflexive thematic analysis.

Results 16 interviews were conducted with older adults over 65 years. Three themes were generated following thematic analysis: Complexity of decision making regarding the ED attendance (theme 1), Quality and timeliness of care in the ED (theme 2), Communication with and empathy towards healthcare staff in the ED (theme 3). The COVID-19 pandemic had a significant impact on the decision-making process and pathway for older adults seeking emergency medical care. Despite the challenges, older adults reported a positive experience in the ED. This was attributed to improved conditions, including shorter triage waiting times and the implementation of COVID-19 protocols. Participants demonstrated resilience and expressed gratitude for the care they received. However, for some participants it was noted there was a reluctance to express any dissatisfaction or complain about the care they received while in the ED. The study also highlighted concerns regarding discharge information and follow-up care for the older adult.

Conclusion The findings demonstrate that ED healthcare providers provided quality and timely care to older adults in the ED during COVID-19. However, the need for clear communication and information sharing from healthcare providers on ED discharge and across transitions of care was highlighted as an area needing improvement.

Keywords Emergency Department, Older adults, COVID-19, Qualitative

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Background

The healthcare system worldwide is expected to face significant challenges as the global ageing population is projected to rise from 12 to 22% in the next sixty years [1]. The rise in the ageing population will lead to a substantial increase in demand for ED services, with approximately one quarter of all ED visits being attributed to this ageing demographic [2].

Although the ED plays a crucial role in the healthcare of older adults, the traditional design and busy environment of an ED does not suit the needs of the older adult and their multi co-morbidities [3]. Older adults who present to ED often have multiple health conditions and take multiple medications which increase their care needs [4]. These needs include both physical and psychological support, access to food and water, and clear communication that considers any cognitive, visual, or hearing difficulties [4]. This necessitates that interactions with healthcare professionals should be slower and more accommodating [4]. Older adults assessed in the ED who have complex health issues and frailty have been shown to be at higher risk for hospitalisation, longer hospital stays, functional decline and mortality [5].

Unresolved symptoms such as drowsiness, depression, shortness of breath and anxiousness were found to be significant indicators of hospital readmission within 30 days for frail older adults living in the community with multiple health conditions [6]. Some of the significant issues highlighted by older people's experience of the ED include prolonged waiting times, unpleasant waiting conditions, such as lying on trolleys, crowded waiting areas, poor communication, lack of privacy and inadequate provisions of food, water and personal care [3, 7]. In addition older adults in the Netherlands expressed experiencing bleakness in the ambience of the ED as well as experiencing feeling vulnerable due to ED specific issues; inability to have personal belongings or clothing in the ED, having no sense of time, and feeling overwhelmed with numerous questions from different healthcare professional [4]. Older adults and their families emphasise the importance of having a family member accompany them in the ED to provide assistance with mobility, cognitive or sensory issues as these needs are not always met due to the busy nature and understaffing of the ED environment [7]. Older adults seeking emergency medical care have specific health outcomes in mind, these outcomes typically revolve around symptom relief and a desire to return to their previous state of health before they experienced the medical issue [8]. A qualitative evidence synthesis examining the transition of older adults from the ED to the community found that many older adults frequently reported experiencing ongoing symptoms upon discharge [9].

The healthcare system faced a new challenge on March 11, 2020, as a global pandemic status was assigned to the coronavirus disease 2019 (COVID-19) by the World Health Organisation [10]. Older adults were identified as an at-risk group and were advised to 'stay home' and isolate due to the increased risk of complications that may exacerbate their existing health issues, necessitating hospitalisation, invasive treatments, and even potential mortality [11, 12]. The older adult population, who faced social isolation during the COVID-19 pandemic, experienced a profound sense of distress as they grappled with the unknown and the fear of missing out on essential aspects of their daily lives [12].

Older adults who attended the ED during the COVID-19 pandemic mentioned that they particularly missed the presence of a family member as an advocate as they were not allowed to stay with them due to the COVID-19 pandemic [4]. There has been a significant and consistent increase in the number of ED attendees who have reported delaying seeking healthcare since the onset of the COVID-19 outbreak and a considerable portion of these delayed cases can be attributed to patient's fear of contracting COVID-19 [13]. These qualitative findings align with a quantitative cohort study by Howley et al. [14] examining the use of the ED by older adults in Ireland during the COVID-19 pandemic, the study found that there was a significant decrease in the number of older individuals seeking unscheduled care in the ED. This decline included cases of time-sensitive conditions like stroke or cardiac complaints [14].

However there is a dearth of qualitative studies exploring the experiences of community dwelling older adults attending the ED during the COVID-19 pandemic [4]. While previous research has primarily focused on older adults' experiences in the ED prior to the pandemic [3, 7], this paper focuses on community dwelling older adults decision to attend the ED and their experiences in the ED during the COVID-19 pandemic.

Methods

Aim

To describe the experience of attending the ED among community dwelling adults 65 years and older during the COVID-19 pandemic.

Study design

A qualitative descriptive approach was used [15] to capture the experiences of older adults attending the ED. This approach was aligned with our objective of providing a thorough and detailed synthesis of participants' experiences and perspectives, without relying on a theoretical framework [16].

The study is reported in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ)

guidelines [17] (see Supplementary File S1). This study is part of a mixed methods study that explored the profile and characteristic of adults presenting to the ED during a 24-hour period, as well as factors influencing the frequency of ED visits. Two papers reporting the quantitative findings of the study have been published [18, 19].

Setting

Data were collected over a 24-hour period at five different ED's in Ireland, representing a mix of urban and rural populations. The Midlands Regional Hospital Tullamore (MRHT) is the largest facility in the Midlands, catering primarily to a rural population in Offaly, Laois, Longford, and Westmeath. University Hospital Limerick (UHL), an academic teaching hospital in the Mid-West, serves a diverse urban and rural population in Limerick city and the surrounding counties of Limerick, Clare, and North Tipperary. St. Vincent's University Hospital (SVUH) is an urban academic institution located in south Dublin, while St. James's University Hospital (SJUH), also an academic teaching hospital, is situated in Dublin's inner city. Kerry University Hospital (KUH) provides acute care primarily for a rural population in the Southwest of Ireland. All data included in this study were collected after the initial lockdown phase between July 2020 and January 2021.

Table 1 Demographic profile of older adults included in the qualitative study ($n = 16$)

Demographics	Total n =16 N (%)	Demographics	Total $n = 16$ N (%)
Sex		Age	
Male	6 (37.5)	Mean	77
Female	10 (62.5)	Male	79.5
		Female	76
Marital status		Residential status	
Partnered/Married	7 (43.8)	Spouse/Partner	8 (50)
Separated/divorced.	3 (18.8)	Family/ Relative	2 (12.5)
Widowed	5 (31.25)	Living Alone	5 (31.25)
Never Married/Single	1 (6.25)	Other	1 (6.25)
Referral		Average time waiting in ED	
GP	9 (56.25)	<5 hours	2
Self	5 (31.25)	<12 hours	4
Other	2 (12.5)	<24 hours	10
Ethnicity		Participating ED sites	
White Irish	16	UHL	4
		UHK	2
		SVUH	6
		SJH	3
		MRHT	1

Recruitment and participants

The larger quantitative study included adults who were aged over 18 years, had capacity and willingness to give informed consent, and were medically stable according to the Manchester Triage system categories 2 to 5 [19]. Exclusion criteria were patients who had scheduled admissions to the ED, mental health presentations, altered capacity due to drug or alcohol intoxication or an inability to communicate sufficiently in English. Patients who were confirmed or suspected to have COVID-19 coronavirus infection were included [19]. All eligible participants were invited to take part in the study. Triage nurses, ED staff nurses, clinical nurse managers and administrative staff served as the study gatekeepers. The wider multidisciplinary were consulted with by the research nurses to ensure that participants routine care in the ED was not impacted by the study. Potential participants who were deemed unable to participate due to acute medical issues were re-assessed once they had received treatment. Once identified there was direct recruitment by research nurses onsite over the 24-hour period and written informed consent was obtained. A total of 94 older adults were recruited across the five sites as part of the larger study. For this qualitative study, we focused on older adult's experience of the ED across the five sites. Stratified random sampling using Microsoft excel was used to select the cohort of patients to contact for interview. Seven to ten days after the initial recruitment for the larger study, the older adults sample group ($n = 16$) were contacted via telephone to complete a semi-structured interview to explore their decision to and experience of attending the ED. The demographic of the participants was White Irish and over 65 years (Table 1).

Data collection

The interviews were carried out by two research nurses (LB and GC) over the telephone in accordance with public health guidance in place at the time of the study. Pilot interviews were carried out with three older adults to refine the qualitative interview guide, consequently additional prompts were added to assist with the interview process.

The first research nurse (GC) had over 25 years of experience in acute and medical services, including the ED and three years in research. The second research nurse (LB) had 15 years of experience in acute medical services, with over 6 years in research. These semi-structured individual interviews were directed by an interview guide (Supplementary file 2). The interviews ranged from 15 to 30 minutes with an average of 15 minutes. The interviews were audio-recorded, and both research nurses transcribed verbatim to ensure validity (LB and GC). To ensure participant privacy, interviews were conducted in a soundproof research room of a designated

Clinical Research Support Unit over a speaker phone. Participants were assured of their privacy when describing their experience and only the designated research nurse and participant were present for each interview. A total of sixteen interviews ($n = 16$) were conducted from the identified random sample and a staggered recruitment approach used until data saturation was reached. This was reached once no new themes emerged from the data. No repeat interviews were required, and no participant refused follow-up or wished to withdraw from the study upon contact for consent to interview. Field notes were taken by GC and LB and detailed the duration of the interview, relevant participant demographics and details pertaining to consenting processes undertaken as part of the qualitative interview process. These field notes informed the research nurses approach for subsequent interviews and allowed them to refine and enhance the interview process. Research participants were aware of the rationale for the study, the role, and qualifications of both research nurses and, to facilitate the interview process, a rapport was established between these nurses and participants during study recruitment and survey data collection in the initial stages of this mixed-methods study.

Data analysis

Reflexive thematic analysis [20] was employed in this study, which allowed for flexibility in interpreting the data while acknowledging the potential bias of the researcher (SR) who has a background in Gerontological nursing. For example, SRs background and expertise in caring for older adults were taken into consideration and discussed in peer debriefing sessions between SR and the research team (CF, RG and OD). This facilitated reflective practice through ongoing discussions and feedback among the research team. The six phases of reflexive thematic analysis were followed [20]. The first step focused on the process of familiarisation in this study, this involved repeatedly engaging with field notes and transcripts. Memos were created to capture initial key patterns, and these were noted in NVivo a qualitative analysis program. Initial theoretical and reflective thoughts were also documented to inform the next steps of the analysis. The second step included the generation of initial codes by SR through an open coding approach which involved systematically analysing and categorising the data from all the transcripts. SR recorded these codes from the data. Additionally, a select set of transcripts were chosen and coded by CF to review the initial coding and address any disagreements and discrepancies to assist SR (novice researcher). The third step involved the process of conceptualising themes, this involved identifying and analysing the collected codes to develop preliminary themes. This process included interpreting the data

and organising the codes into meaningful categories that captured the main ideas and patterns that emerged from the analysis. In the fourth step themes were reviewed and the identified themes were refined and further developed. This included a comprehensive analysis and understanding of the limits of each theme, along with thorough investigation to ascertain the adequacy of data supporting each theme. This stage was conducted in collaboration with other co-authors (CF, RG and OD) through peer debriefing sessions. As a result of this process, clear distinct differences between the themes were established, with supporting data for each theme. The fifth step was to define and name the themes. It was necessary to create clear and descriptive working definitions for each theme and any potential sub-themes. This process helped to clarify the scope of each theme and allowed for editing of the themes titles to accurately reflect the central concept of each theme. The final step in the analysis involved writing up the analysis findings into a comprehensive narrative report into the publication of a journal article.

Results

The sixteen participants in this study were older adults with a mean age of 77 years old, who attended the ED during the COVID-19 pandemic. One participant conducted the interview with his wife as he was hard of hearing. All participants shared their experiences of the ED and spoke about the impact that COVID-19 had on their decision to attend ED and the implication of COVID-19 measures in the ED on their experience. There was an overall positive experience from the older adults' experience in the ED setting. To capture and report the findings, three themes were produced (Fig. 1): Complexity of decision making regarding the ED attendance (theme 1), addressing the fear associated attending the ED with COVID-19 and their reluctance to attend. There was also a change from in person consultation with their general practitioner (GP) to virtual assessments in making the decision to attend ED. Quality and timeliness of care in the ED (theme 2), which appeared to have quicker triaging due to the COVID-19 measures however the delay in waiting for diagnostics and medical review were unchanged. The final theme was communication with and empathy towards healthcare staff in the ED (theme 3), which was evident in the satisfaction from this cohort and the reluctance to complain.

Complexity of decision making regarding the ED attendance

It was found that some participants mentioned that they reached out to their GP instead of going to the ED because they were concerned about the risk of COVID-19 in the ED.

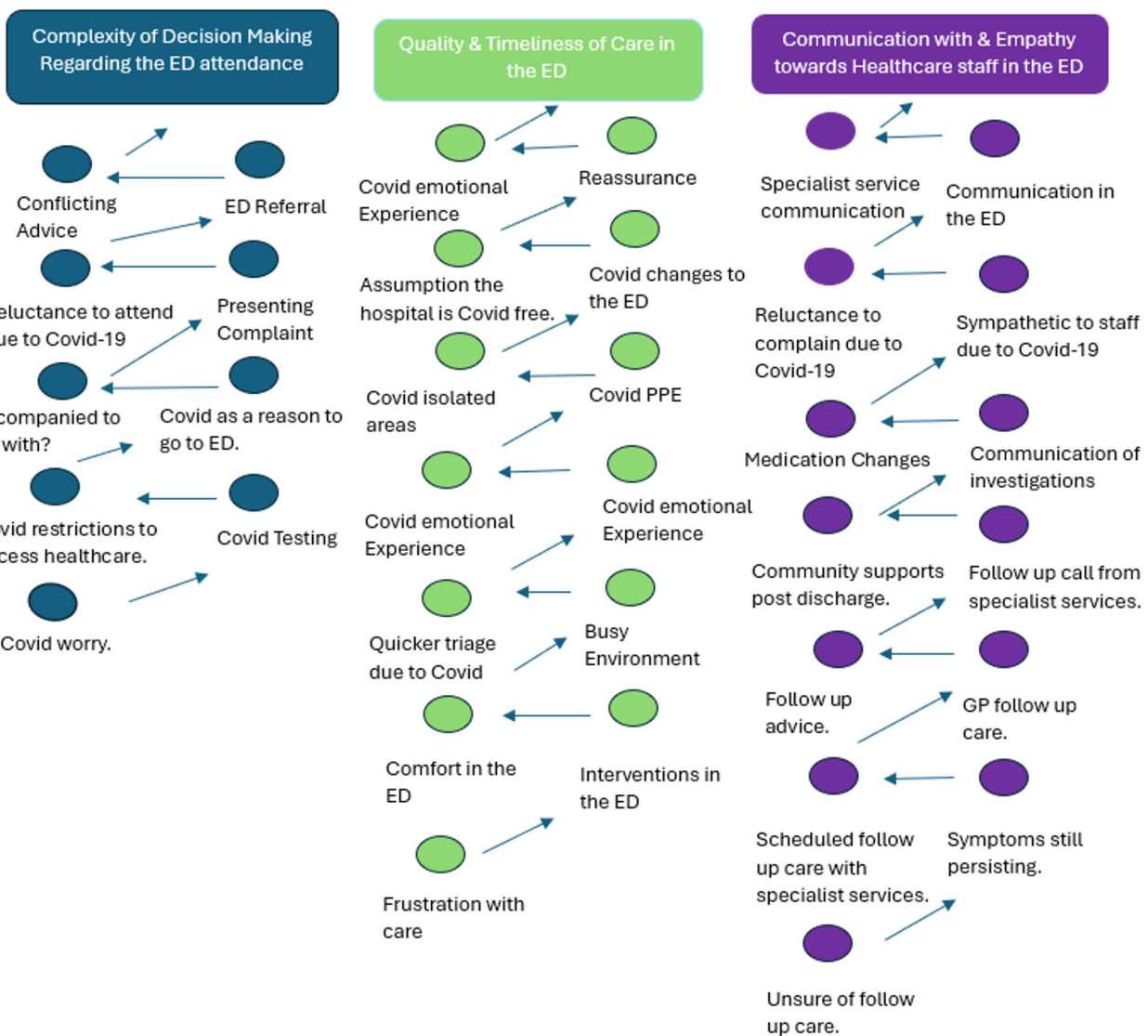


Fig. 1 Theme production; Overview of the production of themes

'I was hoping he [GP] would tell me I didn't need to go in, but he didn't...with everything going on you know you want to avoid it you know.... but I suppose to be safe he said go in just in case it could have been something more serious you know.' (190).

Participants expressed concern about attending the ED because they had been following COVID-19 isolation guidelines in the community and had concerns about being around other people.

'I think it did, I was more concerned going in you know because of all the people ...' (398).

On the other hand, one participant believed that they had been strictly following the COVID-19 guidelines in the community, which led them to feel confident that they

did not have COVID-19 and were not at risk of contracting it while in the hospital.

'No I didn't have any worries about it...I don't put myself around much you know when I'm outside only to occasionally go to the shop or something like that and I wear a mask all the time, but I didn't have any sort of worry about it in the hospital to be honest with you.' (268).

Several participants mentioned that, because of COVID-19 measures, they were directed to the ED without having an in-person consultation with their GP. Instead, their GP's were only able to assess them over the phone.

'But I contacted my GP...and he advised me to go ED..... Well yes, he said he couldn't see me because of the Covid you know and with the way I am with my health and history we couldn't take any chances, you know?..... So, yes that's it he advised me to go in' (190).

However, one participant experienced conflicting advice when they followed a referral from a virtual assessment with their GP to the ED. The ED doctors informed them that if they had seen their GP, it would have saved them a significant amount of time and that their presence in the ED was unnecessary.

'Oh well of course we had to and you know again our doctor wouldn't see us only direct us and give us advice over the phone and she gave us a letter for the ED you know what I mean, you know the way you're stuck and when we got in there then the girl that was there the consultant said you should have seen your own doctor and that our own doctor should have seen him to save him having to come all the way in he could have had a scan elsewhere. She just said instead of dragging him in to the ED, but you know the way you wouldn't know what to do would you.' (321).

Quality and timeliness of care in the ED

A common experience amongst participants was the prompt attention received in the ED and an efficient assessment in the ED triage area.

'Well when I went in, I got dropped in and I was brought in straight away to the rooms there (Triage) and that was very fast and I had the information with me (GP Letter) and the nurse took my blood pressure and all the other bits and she said that it was high there and she said that I would be going up to another place in the hospital...for the doctor to see me...' (190).

Of interest, the pre and post COVID-19 experience was often highlighted by participants, reflecting an enhanced experience in the ED during COVID-19 as opposed to pre-pandemic, as recalled by having to wait for a significant amount of time to be attended to prior to the COVID-19 pandemic.

'Well, I would yes...I would because it's near to us yes, I would. And you're not delayed there that long at all now, one time you'd be sitting in admissions room for nearly a few hours but ya, I was seen and I went in very quick (Post Covid)' (201).

While several participants reported being promptly triaged, some expressed their frustration of having to wait several hours before being seen by medical staff after being triaged.

'Well, the nurses were great I was seen to straight away but it was a few hours before the doctor came to see me.' (190).

'The only thing that I found that everything was perfect and the nurses and all were great and supportive... but when you are waiting for the doctor to come back to you to give you all the results of the bloods...it takes them so, so long to get back to you and give you the results of the bloods.' (201).

The implementation of a new independent pathway for COVID-19 patients and non-COVID-19 patients in the check-in area of the ED provided reassurance to patients attending the ED.

'Oh I did ya and the whole front was different, and you had to check in outside with your symptoms and then either you go into the left or right if you have a cough or temperature.' (359).

Some participants expressed their initial concern about the risk of contracting COVID-19 while in the ED. However, due to the urgency of their situation, they did not have time to dwell on this fear, once they arrived at the hospital and observed the layout and the strict implementation of infection control practices, their worries were alleviated, and they felt reassured.

'Ah I didn't have much of a chance to think about it.... yes I would have worried about it...about catching Covid in there but you saw what it was like.... very safe, good layout and we were all separate in a few places in there' (336).

Infection control practices were shown to provide reassurance to patients, with the implementation of physical distancing measures in the ED highlighted. This involved maintaining a safe distance between patients to minimize the risk of COVID-19 transmission.

However, one participant expressed their initial concern about transmission risks due to the ED close proximity environment. Nevertheless, upon attending the ED and observing the separation of patient's and the visible presence of infection control signs as well as additional infection control measures as hand sanitisation, this helped alleviate their worries and made them feel reassured in the emergency department.

'But when I went in the first time, I saw how good they were about keeping us separate and keeping us safe.... they have always been good about that and that's what I worry about the most...being near someone with it and getting it.....I really wasn't around anyone while I was in there..... they had the signs all over and the gel for the hands.' (359).

Overall, participants found reassurance in the infection control practices implemented in the ED, including the use of personal protective equipment (PPE) by the healthcare staff. Some felt staff's adherence to these measures demonstrated their competence and knowledge in handling the situation.

'Very reassured by infection control practices in the ED. Mask wearing and a very short time in the waiting room and everyone wearing the gear they all seemed like they knew what they were doing you know but sure we ended up with it anyway.' (274)
'You could see the masks the gloves all over so safe as we could be in there' (336).

While most participants felt reassured and safe in the ED with the use of PPE, it is worth noting that one participant had a different experience regarding communication challenges due to PPE use. While describing their experience, they highlighted the barrier PPE had in clear and personable communication, presenting a difficulty in communicating with some healthcare staff who were wearing masks and gowns. They found it challenging to identify and connect with the healthcare professionals, which led to a lack of reassurance for them.

'With everybody in there with masks and gowns it was hard to keep track of everyone and everything going on....Yes, sort of but it was just I couldn't tell you really how I felt because I was a bit all over the place myself not being able to see people, it was a bit difficult....I can honestly understand why but yes I wasn't particularly reassured as a result' (241).

There was generally a sense of reassurance felt by the change in the ED environment, specifically the presence of healthcare staff wearing masks which was not the case during their previous visit (pre COVID-19).

'Yes previously there was the nurses and the staff and the catering and all that am they were not wearing masks on the last two occasions, yes everybody who came into the ward was wearing masks' (240).
'They were nearly all wearing masks.....and some had the full gear on (PPE). We were all kept away from each other too as much as possible...' (190).

Similarly, participants shared that they felt secure in the ED by wearing their own masks.

'I had my mask on and I was confident enough that I was safe' (201.)

Communication with and empathy towards healthcare staff in the ED

Several participants acknowledged that care staff took the time to explain the COVID-19 adaptations to them, which helped alleviate their concerns and provide reassurance.

'The nurse in triage explained about how we were separate and that was what I was worried about, but I didn't have to be worried, and I did feel very assured by what I was seeing which was good. I have to say, while I was in there, there was nothing they didn't explain to me. They were very good really.' (336).

It was also identified that staff members made sure to inform patients about the specific pathway they would be taking due to COVID-19 protocols.

'Ah they did...it was the girl in the triage who told me that now I would be going to another area because of Covid...' (190).

A sense of empathy and understanding towards the nurses and doctors was common, with participants acknowledging the challenging circumstances facing ED staff during the COVID-19 pandemic. Participants showed a strong sense of awareness that ED healthcare professionals were working diligently to care for the public, and this increased their appreciation for their efforts.

'Ah....no, only just they do their best to mind us... people are hard on the nurses and doctors....most do their best especially with everything we weren't used to, all of us.' (359).

This sense of awareness of the ED staff challenges during COVID-19 was reflected by the reluctance to raise issues regarding patient's experiences.

'Oh and I'm not complaining, I understand that especially with everything that is going on at the minute it is even worse you know...'(190).

Another participant expressed their willingness to give a higher rating for the care they received during the COVID-19 pandemic, attributing it to the belief that the staff were doing their best in the challenging circumstances.

'Yea no I would say they are doing their best god if it wasn't for the Covid I would probably give it a 7.5..... But because of Covid you have to take that into consideration.' (241).

Several participants shared positive experiences with the level of communication they received from the ED staff in relation to their results and felt their questions and concerns were addressed in a timely and respectful manner.

'Ah well they were very good now I have to say they explained everything, and I had an ECG as well and they were all good I have to say...I couldn't find any fault with any of the nurses.' (201).

There was a sense of reassurance felt as all staff members they encountered were welcoming and comforting.

'Well can I say how good everyone was to me there, the porters, the kitchen staff everyone now. I must have looked very worried because everyone was talking to me.' (101).

In terms of discharge experiences, follow-up linked to community care teams visits at home after being discharged from the ED was found to be a reassuring aspect of the patient discharge plan. Additionally, they found it reassuring to receive a follow-up phone call confirming their appointment.

'Oh God ya I did, sure it is so nice to know I can call them especially with the cast. She made the appointment for the fracture place too and rang me with it and the community people then came out to me for the first week to check on me and give me a hand when I had the cast because of me being over 65 so I was pampered.' (336).

Communication relating to discharge information involved a strong GP focus, with many patients being forwarded to their GP, and patients were expected to depend on their GP to inform them about the treatment plan and the results of certain tests.

'Well they were to send everything back to my GP and I need the machine on and another scan I think but I don't know...my GP will do all that I think..... there was a nurse who said she would ring me too... I need to have other scans too...'(190).

Some dissatisfaction with the follow-up discharge process was expressed, particularly around a lack of confidence that the presenting symptoms had not improved as a result of their ED attendance. The involvement of the

GP was meant to include a discharge plan and this was a challenge for some participants, who reported that on attending their GP a discharge summary had not been provided which meant that the GP had insufficient information to assist them with the patient's symptoms.

'Only to go back to my GP for follow-up and they would send a letter. Well no, they didn't tell me to go back to my GP, I went back because I was sick, they just said they would send a letter and...Surprise, surprise..... No, no letter came, and my GP was no better off either. So, he is sending me for a scan and then I will go back to him, but I am no better' (112).

Generally, discharge information received by most participants was by verbal communication, which presented some challenges in terms of patients understanding. Some participants reported that they received a follow-up call from a nurse after being discharged from the ED. This follow-up call was more common for those who were already connected to a specialist service such as oncology or if their injury meant that they had been referred to a specialist nurse such as orthopaedics on discharge. Participants found this follow-up call reassuring, as they were able to ask questions about their discharge plan and receive further guidance.

'The nurse does that too, she rings me after then to check me.... this time too it was my stomach...' (359).
'it is so nice to know I can call them especially with the cast. She made the appointment for the fracture place too and rang me with it (Advanced Nurse Practitioner)' (336).

Discussion

This study produced three main themes which represented the older adults experience of the ED during the COVID-19 pandemic, Complexity of decision making regarding the ED attendance, Quality and timeliness of care in the ED and Communication with and empathy towards healthcare staff in the ED.

This qualitative descriptive study explored older adults' experience of the ED during COVID-19. Our findings show that the complexity of decision-making regarding ED attendance was heightened due to COVID-19 transmission concerns. Our research indicates that some of the participants were referred to the ED following a virtual consultation by their GP's. Virtual assessments were done as a response to the COVID-19 pandemic and involved GP's conducting telephone or video consultations to review and triage patients remotely [21]. This new method of assessment had positive and negative views from both patient's and GP's. Patients

acknowledged the importance of virtual health assessments for non-urgent matters and managing chronic illnesses, especially when regular follow ups were necessary, and their GP was familiar with their condition [22]. However, when it came to acute issues, some patients found virtual health assessments challenging. They had to describe their symptoms over the phone to their GP and felt uncertain about receiving an accurate assessment without a physical examination [22]. Similar views of concern were noted by some GP's in particular for older adults, it was observed that they felt that the inability to perform physical examinations during virtual consultations was a disadvantage for some older people as they may have had sensory difficulties such as hearing difficulties and also some did not know how to use digital technology, therefore older adults were at risk of misdiagnosis, incorrect treatment or inappropriate referrals during the COVID-19 pandemic [23]. In our findings, some participants reported that if they had received a physical assessment from their GP, they may have been able to avoid going to the ED. A study carried out in Italy, which examined non-urgent admissions to the ED, revealed an increase in the access of non-urgent patients during the pandemic [24]. The research indicated that the increase could be linked to a decline in visits to GP's, prompting patients to opt for the ED rather than choosing a virtual consultation [24].

In our research, the choice to visit the ED involved a complex decision-making process.

The participants in this study expressed feelings of hesitation and anxiety about attending the ED during the COVID-19 pandemic, likely stemming from isolation, protective measures like cocooning, and fears of contracting the virus. However, participants were shown to place trust in advice from their GP in terms of the need to attend the ED as they felt that this was necessary for their well-being. This initial reluctance and fear surrounding COVID-19 contributed to a decrease in older adults seeking unscheduled care at the ED during the pandemic as evidenced in a study in Ireland looking at trends of ED use by older adults during the first lockdown [14]. In a qualitative study, it was found that the majority of patients visiting the ED had concerns about contracting the virus [25]. However this study also reported that where patients were informed about the safety measures being implemented at the hospital to mitigate the risk of COVID-19, anxieties about going to the ED were alleviated [25].

This study found that most older adults had a positive experience during their time in the ED, reporting feeling reassured and safe due to the implementation of COVID-19 measures. Most participants were not intimidated by COVID-19 PPE and adapted well to mask wearing seeing it as a necessity to beat the virus. This ease of adaptation

to the COVID-19 measures could have been drawn from lived experiences. A Canadian study that explored the experiences of older adults during the COVID-19 pandemic found that these individuals drew upon their past experiences of hardship, trauma, plague and times of economic recession to navigate and cope with the challenges brought about by the pandemic [26]. They found perspective enabled them to accept the current circumstances of COVID-19 and acquire new skills, foster personal growth, engage in self-reflection, and exhibit creativity [26].

Findings from this study also identified a high satisfaction rating with the shorter triage time, noting that waiting times were longer before the pandemic. It has been observed [8] that older adults tend to tolerate and expect long waiting times in the ED, however if they are not provided with regular updates about their status, it can negatively affect their satisfaction in care as patients. The positive experience noted from our study, aligns with previous studies that have shown older patients are more likely to report a positive experience in the ED and overall hospital experience compared to younger patients [3, 27]. The positive experience of older adults in the ED may be attributed to their tendency to downplay their own needs and avoid burdening others by seeking help or expressing complaints [4, 28]. This corresponds to a qualitative study conducted in New Zealand where older adults' were hesitant to provide feedback that could be perceived as a complaint [29].

Our study also found that there was a vast amount of empathy shown towards the healthcare workers from participants, acknowledging the busy work environment. This supports findings from previous studies where older adults were empathetic to the busy and challenging conditions faced day to day in the ED [3]. This empathy was further intensified during the COVID-19 pandemic, as seen by some participants who were hesitant to express any dissatisfaction considering the stressful months the staff had to endure. According to a study in Switzerland [30] on older adults who were hospitalised during the pandemic they expressed their admiration for healthcare staff. They acknowledged the challenges faced daily during the COVID-19 pandemic and recognised the strength it takes for them to show up for work every day, putting their own lives at risk. While older adults in this study and previous studies have been noted to show positive feedback towards healthcare staff and a reluctance to complain, it has been highlighted, that some older adults provide limited information about their journey in the ED department and their involvement in the decision-making process. This could be attributed to their acute illness, which may result in impaired recollection of events or limited awareness of their surroundings and circumstances due to their presenting complaint [29].

Some older adults in our study felt that having a discharge pathway or communication with someone post discharge was beneficial, while others reported that they were not aware of their discharge plan and relied heavily on their GP for this information. An evidence synthesis examining the experience of older adults transitioning to the community from the ED highlighted the prevalence of fragmented care from the ED to the community. Specifically, there were issues with both informational continuity and management continuity in the transition process [9]. To enhance outcomes for the older adult, it has been recommended that EDs offer supplementary care transition support to older adults upon discharge from the ED [31].

The older adult's experience of the ED revealed a fragmentation of discharge care from the ED as there was a lack of discharge communication such as what they were to do next, and who to contact or if they required follow up tests. Additionally, the way discharge information was provided was found to be ineffective. A systematic review found that verbal guidance alone may not be enough for patients, and incorporating written or video information into discharge instructions yielded positive outcomes [32]. Furthermore, a recent study has found that the safe transition of care for older adults is greatly influenced by their comprehension of discharge instructions [31]. Healthcare professionals should not assume that all individuals attending the ED have literacy skills, and it has been highlighted in a national report by the National Adult Literacy Agency (NALA) that health literacy poses a challenge with the public and written instructions should be in plain English and simple, easy to use terms [33]. An evidence synthesis emphasises the importance of providing older adults with written discharge instructions that address their specific needs [9]. These needs include challenges such as not having the opportunity to ask follow-up questions or seek clarification, not understanding medical terminology, receiving conflicting instructions or advice from healthcare professionals, and not having their sensory deficits accommodated for.

Strengths and limitations

This study employed a qualitative approach to gather the experiences of older individuals. While quantitative studies are highly valuable, they often overlook many aspects that this qualitative method can capture. A strength with this study was that it was carried out across five hospitals in Ireland and has viewpoints from participants in both urban and rural hospitals. The promptness of follow-up interviews (7–10 days) post discharge suggests that patients' recollections of events should be strong which is also a strength. However, this could also be a limitation as patients could be still recovering from their illness and may not have had the appropriate follow up by that time.

In response to the COVID-19 pandemic, the research team adhered to COVID-19 guidelines and conducted interviews over the phone. However, this method of conducting interviews may have implications for the findings as the research team had limited ability to establish a rapport with patients, which could have provided further insight into the experiences of the older adult if the interviews were conducted in person. The length of the interviews was an average of 15 minutes, longer interviews might have provided more depth and detail to the participants' experience. Furthermore, the views of family members' experience of their loved one attending the ED and the fact that they were not able to be present with the participant were not represented here and may have added a further dimension to the findings. Another limitation in this study was the demographics of the participants. All participants were exclusively white Irish, including a more diverse sample in terms of ethnicity and socioeconomic status would enhance the generalisability of the findings for other locations. Consequently, the experience of older adults from other ethnic groups were not represented in this study. These limit the generalisability of the findings.

Clinical and policy implications

These data were collected in 2021 and since then there has been an introduction to a new Integrated Care Programme for Older Person's (ICPOP) throughout Ireland [34]. This programme aims to benefit older adults by providing a person-centered approach to their care. It will also develop and implement multidisciplinary pathways for older adults with complex and social needs from the ED which will aid transitioning of care ensuring the needs for the older adults are met and effective follow-up from the ED is implemented [34].

Given the circumstances of COVID-19 in the ED it appeared to create a positive experience for the older adult as the environment was not overcrowded and the triage times were quicker. Therefore, it may be necessary for policy makers to look at the COVID-19 protocols in place and see how they can be continued long after the COVID-19 pandemic is over. It may also be worth noting that for future health pandemics, educating and advising the public on the importance of attending the ED if they are unwell and creating awareness of the infection control precautions that are in place in the hospital may relieve public anxiety about attending the ED.

Areas for future research

This study emphasised the positive experiences of older adults in the ED amid the COVID-19 pandemic. Future studies examining the experience of older adults in the ED outside of a pandemic context, and conducting face to face interviews might provide deeper insights into

their experience. Subsequent studies could focus on the experiences of carers or family members of older adults who attended the ED during this period. The study also pointed out that follow-up care and discharge information were disjointed upon discharge from the ED. Therefore, future research could explore effective discharge methods, care integration, and the sharing of information about older adults from the ED to the community. There also may be scope for further research to explore the impact of virtual care on the older adult.

Conclusion

COVID-19 impacted the decision and pathway for older adults to attend ED during the pandemic. Older adults identified a positive experience in the ED during the pandemic due to improved conditions and shorter waiting times because of the implementation of COVID-19 protocols. These older adults demonstrated empathy towards health care providers. However, there were issues with discharge information and follow-up care, highlighting the need for improvements in this area.

Abbreviations

ED	Emergency Department
GP	General Practitioner
ICPOP	Integrated Care Programme for Older Persons
HSE	Health Service Executive
NHS	National Health Service
NALA	National Adult Literacy Agency

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12877-025-06401-x>.

Supplementary Material 1.

Supplementary Material 2.

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Author contributions

RG conceived the study. LB created the interview template. LB and GC carried out the interviews. LB and GC transcribed the interviews. SR and CF conducted the data analysis. SR drafted the manuscript, with RG and OD reviewing. All authors reviewed the final manuscript, contributed with amendments, and approved the final version.

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Data availability

The datasets analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics

Ethics approval was obtained from the University Limerick Hospitals Group Research Ethics Committee at University Hospital Limerick (Ref. 122/19), Health Service Executive Midlands Area Research Ethics Committee for Midland Regional Hospital Tullamore (Ref: 231019CG), St Vincent's Health care Group Ethics and Medical Research Committee for St Vincent's University Hospital (Ref. RS20-004), Tallaght University Hospital/St. James's Hospital Joint Research Ethics Committee for St James's University Hospital (Ref. 2020-04) and the Clinical Research Ethics Committee of Cork Teaching Hospitals for University Hospital Kerry (Ref. ECM 4 (J)/ECM 4 (bb)). Informed written consent was provided, and participant identities were protected by using a pseudonym to protect anonymity.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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