



Elder-friendly emergency services in Brazil: necessary conditions for care*

Serviços de emergência amigos do idoso no Brasil: condições necessárias para o cuidado
Servicios de urgencias amigos del anciano en Brasil: condiciones necesarias para el cuidado

Mariana Timmers dos Santos¹, Maria Alice Dias da Silva Lima¹, Paula Buchs Zucatti¹

How to cite this article:

Santos MT, Lima MADS, Zucatti PB. Elder-friendly emergency services in Brazil: necessary conditions for care. Rev Esc Enferm USP. 2016;50(4):592-599. DOI: <http://dx.doi.org/10.1590/S0080-623420160000500008>

* Extracted from the dissertation "Serviços de emergência amigos do idoso no Brasil: aspectos necessários para o cuidado", Programa de Pós-Graduação em Enfermagem, Universidade Federal do Rio Grande do Sul, 2015.

¹ Universidade Federal do Rio Grande do Sul, Escola de Enfermagem, Programa de Pós-Graduação em Enfermagem, Porto Alegre, RS, Brazil.

ABSTRACT

Objective: To identify and analyze the aspects necessary to provide an elder-friendly emergency service (ES) from the perspective of nurses. **Method:** This is a descriptive, quantitative study using the Delphi technique in three rounds. Nurses with professional experience in the ES and/or researchers with publications and/or conducting research in the study area were selected. The first round of the Delphi panel had 72 participants, the second 49, and the third 44. An online questionnaire was used based on a review of the scientific literature with questions organized into the central dimensions of elder-friendly hospitals. A five-point Likert scale was used for each question and a 70% consensus level was established. **Results:** There were 38 aspects identified as necessary for elderly care that were organized into central dimensions. **Conclusions:** The study's results are consistent with the findings in scientific literature and suggest indicators for quality of care and training for an elder-friendly ES.

DESCRIPTORS

Aged; Health of the Elderly; Emergency Nursing; Geriatric Nursing; Emergency Service, Hospital.

Corresponding author:

Mariana Timmers dos Santos
Rua São Manoel, 963
CEP 90620-110 – Porto Alegre, RS, Brazil
maritimmers@gmail.com

Received: 09/25/2015
Approved: 05/30/2016

INTRODUCTION

Population aging is associated with the prevalence of chronic diseases, generating more complex health needs, and greater utilization of health services by the elderly population, in particular in emergency services (ES)⁽¹⁾. International studies indicate that the use of ES by the elderly varies between 12% and 21% of total hospital care⁽²⁾. Nationally, this percentage ranges from 17% to 44% of total care in the ES⁽³⁾.

Admission to ES exposes the elderly to risks such as functional decline, polypharmacy, hospital infections, and decrease in quality of life. The problems are exacerbated by a prolonged length of stay, restricted mobility, and uncomfortable conditions caused by a busy, noisy, and not very private environment⁽¹⁻²⁾. Caring for the elderly in the ES presents a number of challenges: difficulties in assessment and diagnosis due to atypical symptoms; the presence of multiple comorbidities; communication difficulties; and changes in mental state⁽²⁾.

Given the complexity presented by these users, it is necessary to use alternative care strategies. It was for this purpose that in 2004 in Canada an approach to hospital care called the "Elder-Friendly Hospital" was proposed that considers the issues that permeate aging. Thus, the term "elder-friendly" refers to the commitment to respond to the common needs of this population⁽⁴⁾.

Nurses play a fundamental role in the ES because they provide and supervise the care and management of the services 24 hours a day. They are attentive to the needs of the patients and to the aspects involving the routine and care of each one. There are important initiatives in elderly care with the development of programs that highlight the role of nurses to improve health care for the elderly in these services⁽⁵⁾.

Canadian nurses have proposed a comprehensive theoretical model to promote the quality of services and support the creation of elder-friendly ES⁽⁶⁾. The "elder-friendly" care model is based on four central dimensions that cover the vulnerability of elderly patients: social climate; policies and procedures; care systems and processes; and the physical design. The social climate involves the behavioral and emotional atmosphere of the interactions between the professionals, the elderly, their caregivers, and the organizational influences, which implies respect, sharing of information, support for patients and their families, and the degree of conflict and stress experienced in the ES environment. The policies and procedures describe the rules and policies of each institution that guide the health teams. The physical design involves physical and architectural features that reflect the safety, comfort, orientation, and maintenance of the elderly's functional skills. The care systems and processes influence the quality of the institution's care because they are related to the organization and provision of clinical care in ES, to access to the best health practices, and to the partnerships between the institution and its communities⁽⁶⁾.

However, the knowledge related to this subject, particularly at a national level, is still incipient. A few studies have been developed in order to assess the ES from the perspective of a care that is more friendly for the elder. Therefore, it becomes

important to analyze aspects that must be addressed to provide better care for the elderly population in the ES in the Brazilian reality. This study aims to identify and analyze the aspects necessary for an elder-friendly care in the Brazilian emergency departments from the perspective of nurses.

METHOD

This is a descriptive, quantitative study using the Delphi technique in order to obtain a convergence of opinion from a group of specialists on a particular problem through responses to structured questionnaires that circulate in one or more rounds while preserving the anonymity of the individual responses⁽⁷⁾.

A questionnaire was prepared to collect the data with questions aligned to the objectives of the study based on the review of scientific literature on the subject, as recommended for use with the Delphi technique⁽⁷⁻⁸⁾. The questionnaire was divided into two parts. The first had questions related to information about the participants, and the second part was prepared considering national and international recommendations and criteria necessary for improving the care for the elderly in the ES^(5-6,9-11). The questionnaire contained 35 structured questions in four sections based on the central dimensions of an Elder-Friendly Hospital⁽⁶⁾: social climate; policies and procedures; care systems and processes; and physical design. A Likert scale was used next to the questions with scores from 1 to 5: 1-Strongly disagree; 2-Disagree; 3-Neither agree nor disagree; 4-Agree; 5-Strongly agree. The questionnaire was made available online through the Google Drive[®] platform.

The selection of participants was carried out according to the criteria of the Delphi technique, which consists of the respect and value of experience and knowledge of the specific area of study⁽⁷⁾. A search on the Lattes Platform was carried out for the selection of the sample, which is the database of curricula vitae and institutions in the fields of science and technology of the Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq). A simple search tool was used by subject with the words "emergency department" AND "nursing." The curricula were evaluated and selected considering the inclusion criteria: Brazilian nurses with professional experience in ES, and/or researchers with publications on the theme and/or conducting research in the study area.

Five judges who had expertise related to emergency departments or care for the elderly carried out a validation of content and appearance of the questionnaire and were not part of the sample. A pretest was carried out with four specialist nurses to check the operational characteristics of the questionnaire, avoiding weaknesses when filling it out, and using the Google Drive platform.

Data collection was conducted from October 2014 to March 2015, with the questionnaire being applied in successive rounds until a consensus was reached.

In the first round, the invitation was sent to 216 selected specialists by e-mail with a link for an online access that directed them to the Informed Consent Form, which had to be filled out in order to open the questionnaire in the

three rounds. In the first questionnaire, in addition to the 35 structured questions, an open question was presented as an option at the end of each section. In this way the nurses could suggest aspects they thought might be necessary to be added in the next questionnaire.

After 48 days of data collection there were 72 questionnaires answered, which is when the first round of the panel was closed due to the long period of time it consumed. The data were inserted into a Microsoft Excel® spreadsheet and a descriptive statistic was sequentially applied. The consensus was regarding the agreement of answers to the alternatives 4 and 5 on the Likert scale on each question, considering a level of 70%⁽⁷⁾. The answers to the open questions were analyzed according to the similarity of the topics addressed and their relevance, comparing them to the content given in the questionnaire. From the suggestions of the specialists, the data were compiled into five items that were added in the second questionnaire.

In the second round, in January 2015, the questionnaire was sent to the 72 respondents from the first round. The questionnaire was restructured, the items that obtained consensus were removed, and five items were included from the responses of the previous round. Six questions were restated that did not reach consensus in the first round, with the response percentages obtained. The specialists could reassess their opinions on the statistical presentation of the group's answers in the first round. This process was carried out in order to reduce the differences. The second questionnaire had only structured questions without the possibility of including new questions. After analyzing the data, two questions continued without consensus, which made it necessary to carry out a new round of the panel.

In the third round, the questionnaire was presented in a restructured form containing no consensus questions in the second round or their respective response percentages. Moreover, the alternatives to the answers on the Likert scale were reduced from five to four alternatives, excluding "neither agree nor disagree," which corresponded to 10.2% of the answers in the second round. The reduction in the alternatives aimed to facilitate the decision of the respondents and decrease the dispersion of data⁽⁸⁾. In February 2015 a questionnaire was sent to 49 respondents from the previous round. After 24 days, the third and final round was closed, with 44 respondents.

The study was compliant with the guidelines and regulatory standards for research involving human beings and was approved by the Ethics Committee of the Universidade Federal do Rio Grande do Sul under protocol number 721,216.

RESULTS

In the first round, the nurses who participated in the study sample were predominantly female (n=55, 76.4%), with specialization (n=12, 16.9%), master's (n=30, 42.2%), doctorate (n=26, 36.6%), and post-doctorate (n=3, 4.2%) degrees. As for the years of experience in their current jobs, 9.7% had been there less than one year, while 23.6% had been in their current job for one to four years. Most participants in the first round had five to 10 years of experience in their current jobs, representing 30.5% of the sample. Furthermore, 20 nurses had more than 10 years of experience, which represented 20.7% of the sample in the first round.

The study included participants from all regions in the first round, but the southern region (RS, SC, PR) was predominant with 31 participants (43%), followed by the southeast (SP, MG, RJ), which had 20 participants (27.8%). The northeast (BA, CE, AL, PE, RN, PI) also had a good share in the study, corresponding to 25% of the sample in the first round. The Midwest (GO, DF) had two participants (2.8%) and the north (AM) had one participant (1.4%).

As for the areas of professional experience, most worked in public institutions. In the first round, there were 32 participants (44.4%) that worked in public hospitals and 30 (41.7%) from public educational institutions. Private educational institutions were represented by 16 nurses (22.2%). In addition, six nurses (8.3%) worked in emergency care units, four in emergency mobile medical services (5.6%), four in philanthropic hospitals (5.6%), and two in private hospitals (2.8%). It should be noted that many participants worked in more than one area, such as in a hospital and in an educational institution. Furthermore, seven participants mentioned that they worked in other areas such as the Ministry of Health, in coordination of the health of the elderly, and in graduate study institutions.

In the first round, 33 questions reached a consensus. The second questionnaire included five new questions and two that had not reached a consensus. At the end of the second round of the panel, of the seven items presented, five reached a consensus, which became the new questions. Two questions related to care systems and processes, restated in the third round, again did not reach a consensus.

The aspects identified by the nurses are shown in Chart 1 by dimensions of care. The last columns indicate the percentage of agreement reached for each question, which is the sum of the percentages of answers 4 and 5.

Chart 1 – Aspects needed for providing elder-friendly care in the ES from the perspective of the participating nurses – Brazil, 2015.

Aspects needed for providing elder-friendly care in the ES		%
Social Climate	It is necessary to have support from the hospital in providing training and capacity-building for professionals, monitoring, and availability of resources aimed at therapeutic communication when providing care for the elderly and their families.	97.2
	Caring for the elderly in the ES requires willingness and patience on the part of the professionals to listen to the elderly.	98.6
	Tolerance is necessary on the part of the professionals, considering the natural communication difficulties of the age group and other related difficulties (e.g., dementia, aphasia, etc.).	98.6
	Professionals in the ES need to establish an effective, compassionate, and respectful dialog with the elderly and their families/caregivers, promoting the expression of their needs.	100

continued...

...continuation

Social Climate	It is necessary to provide training for all the ES employees, whether health staff, management, and others, on awareness about aging in order to promote an elder-friendly culture in the activities provided by the service from the different teams.	95.8
	It is necessary to establish priorities together with the elderly and their families, while involving them in the process of care.	94.4
	It is necessary in the ES to have a social assistant for family support and follow-up with the elderly at their time of discharge.	98.6
	The presence of a companion with the elderly receiving care at the ES is of great importance and, therefore, it becomes necessary to ensure this during the elderly person's period of stay in the department.	91.7
	* It is necessary to begin, upon admission of the elderly individual into the department, with the education of the family members and caregivers, in order to plan the discharge and give support to the family members.	95.9
	* It is necessary that the ES take on a multidisciplinary approach when caring for the elderly and their families in order to give support to the ES team in the different issues surrounding aging aside from the illness that caused the elderly person to be admitted into the department.	91.8
Policies and Procedures	It is necessary to integrate into the hospital's strategic plan, vision, and mission the commitment to provide an "elder-friendly" care.	87.5
	It is necessary that the professionals in the ES work with respect to the principle of comprehensiveness, viewing the elderly individual in his/her totality and in context.	98.6
	It is necessary to incorporate into the routine of the ES a satisfaction assessment of elderly users in relation to the care received in the emergency department.	86.1
	It is necessary to develop an interdisciplinary continuing education program for healthcare professionals to address the best practices in health and aging.	97.2
	It is necessary that the hospital institutions provide financing for the development of interdisciplinary research related to the actions and practices on aging in the ES so as to improve the quality of care provided.	90.3
	It is necessary to train health care professionals in the ES in knowledge regarding the existing health programs in the city, the policies for the health of elderly people, and their rights.	97.2
	It is necessary to give support in decision-making involving the participation of the elderly and respecting their choices and desires in relation to the care and treatment received if they have a capacity to decide.	94.4
	It is necessary to guide and assist the elderly in the case of referrals to other services, obtaining medications, and marking appointments, exams, and other procedures.	98.6
	* It is necessary to strengthen the integration between the hospital and other healthcare services for the continuity of care.	98.0
	* A humanization policy is necessary in the ES for a more humanized care of the elderly.	95.9
Care System and Processes	The ES must use strategies to improve communication between the emergency team and the community health services team.	97.2
	It is necessary to train the healthcare professionals in the ES to identify situations of frailty of the elderly, including those related to violence.	97.2
	It is necessary to carry out triage through protocols by the nurse in order to expedite the real emergencies in elderly patients.	94.4
	It is necessary to implement geriatric assessment protocols in the ES routines (e.g., risk of falls, assessment of functional and cognitive capacity, pain control, polypharmacy, prevention of ulcers, etc.) in order to establish best practices based on evidence and guidance toward the care plan that is the most appropriate for the individual's needs.	97.2
	It is necessary when planning the discharge of the elderly to carry out a risk assessment using a validated instrument in order to identify those most at risk of returning to the ES or new hospitalizations; thus, the professionals can better guide the elderly when they are going home (or being referred) concerning the care necessary and the prevention of further adverse events.	91.7
	The discharge plan is of utmost importance for the continuity of care for the elderly and therefore it needs the accompaniment of either a responsible nurse or a properly trained professional to provide the necessary guidance for all elderly patients being discharged from the ES and/or their family members/caregivers.	98.6
	It is necessary to have a professional responsible for communicating with the elderly person's referral health team at the time of discharge, transmitting the information by telephone, e-mail, or other technologies available regarding the admission and stay of the user in the ES and the continuity of the care in the primary care service (referral and counter-referral system).	94.4
	It is necessary that the primary care services use means to transmit the information about the elderly users in any returns and readmissions in ES (strengthening the referral and counter-referral system) to facilitate the care in the ES.	100
	It is necessary that the orientations given at discharge be provided and also clarified in writing and delivered to the elderly individual or their family/caregiver together with other relevant information about the care received.	100
* It is necessary to review the size of the nursing team considering the overcrowded conditions of the ES in order to better care for the elderly.	95.9	
Physical Design	It is necessary to use the appropriate languages and signs in order to better guide the elderly in the orientation of the space in the ES.	98.6
	The healthcare professionals in the ES, in their different categories, should be easily identified by means of ID badges and uniforms.	98.6
	The ES environment needs to have access to equipment such as walkers, canes, and wheelchairs that can be adapted to the elderly.	97.2

continued...

...continuation

Physical Design	The ES environment should be organized for the safety of the elderly and to promote their autonomy through lighting, noise reduction, signage, free hallways, and other "elder-friendly" elements such as handrails and grab bars.	94.5
	The rooms in the ES should have adequate furniture to promote the safety, autonomy, and comfort of the elderly.	97.2
	The physical design requires equipment that provides for the privacy of the elderly such as curtains and screens.	98.6
	It is necessary that the environment have a non-slip floor in order to reduce the risk of the elderly falling.	98.6
	It is necessary that the environment have the infrastructure and resources available to support the ES teams such as computers, access to databases and to current literature, and reference tools for health evaluation.	98.6

* Questions inserted in the second round.

DISCUSSION

All of the questions related to the **Social Climate** dimension received high levels of agreement. Sensitization to aging for professionals and teams in the ES and promoting an elder-friendly culture suggests a new perspective in caring for the elderly. There is still not very much training geared toward the needs related to aging; however, these aspects should be valued in one's professional experience. This sensitization is a major challenge because of the culture of these services, which involves very dynamic processes in which the "priorities" are subject to constant changes in addition to a fast, precise, and efficient assessment⁽¹²⁾.

The consensus on the questions involving attitudes such as willingness and patience to listen to the elderly person, tolerance in the face of the difficulties encountered, and a respectful dialog with the elderly individual and his/her family are consistent with the findings in the literature^(11,13). Agreement with the statement: *It is necessary to establish priorities together with the elderly individual and their families, while involving them in the process of care*, denotes the importance given to the social climate. The literature suggests that a lack of information from the elderly and their family members in relation to the care and treatment contributes to a sensation of loss of control, of independence, and also return to the ES. Respect is also necessary in support when making decisions, which means that the elderly should participate in the care and their wishes regarding treatment should be considered, as many professionals address the family member or caregiver directly without dialoging with the elderly person⁽⁶⁾.

The specialists considered that the presence of a companion with the elderly in the ES is of great importance, and therefore it is necessary to make sure this is done during their stay in the department. However, it is difficult to ensure adequate conditions and the right for a companion for the elderly due to the overcrowding of the services. Therefore, it is important to ensure and encourage the presence of family members/caregivers, especially for those elderly who are frail and at a higher risk. Considering that they will return to their families, we need to rely on the family's support and also give them the necessary support to care for their loved ones and return to their households, communities, or homes.

In the **Policies and Procedures** dimension, the nurses agreed (87.5%) that the commitment to providing an "elder-friendly" care should be integrated into the hospital's strategic plan, vision, and mission, confirming the

recommendations made in the evaluation of an ES in Canada⁽⁹⁾. The diverging answers can be related to a lack of understanding of the term "elder-friendly," which is relatively new in Brazil, but also to a vision that elderly people do not need a differentiated service, with no distinction because of the age group, but instead to the clinical condition.

The consensus as to incorporating a satisfaction evaluation of the elderly in the care provided by the ES is consistent with other studies^(10,14). Satisfaction is an indicator of the quality of the care and, for elderly people, this is related to better results in planning the discharge. This routine is relevant in order to identify the factors that contribute to satisfaction in order to propose actions that meet the elderly individual's expectations.

The need for interdisciplinary programs of continuing education addressing best practices in aging reaffirms the recommendations found in the literature^(5-6,9,11). Continuing education is critical for the development and improvement of professional skills while following local agreements on the programs and flows in each city or state to better target the elderly in the referrals that are necessary.

In the dimension of **Care Systems and Processes**, the triage through protocols was considered as necessary for streamlining emergency care for the elderly. However, this classification may mean more waiting time and risks for elderly people, who often have complex social needs as well as clinical complaints regarding their care. Due to an atypical presentation of the symptoms and the difficulty in explaining them, many are evaluated as low risk and are submitted to long waiting periods, longer admission times, and higher risks of readmissions⁽⁵⁾.

Studies suggest the need for a more comprehensive geriatric assessment and its implementation in the ES^(10,15). Consensus was reached regarding the implementation of geriatric assessment protocols (e.g., risk of falls, pain control, risk for pressure ulcers, etc.) in the ES, corroborating the recommendations described in different countries^(10,15). One study⁽⁶⁾ expressed a concern about nurses in the ES regarding the need for cognitive assessment protocols and management of delirium, and guidelines on best practices for detecting and preventing skin lesions and preventing falls. Thus, geriatric assessment is essential for identifying risks, planning care, effectiveness of the treatment, recovery, and guidance on the discharge plan for the elderly.

Regarding the discharge plan, the need for monitoring by a responsible nurse or a professional properly trained to give the necessary orientations to the elderly and/or their caregivers was identified. This corroborates the results

obtained in assistance program experiences targeting elderly people in the ES that promote geriatric assessment, do the monitoring, and plan the discharge with support in communication with family members and referral services. Most programs have a multidisciplinary approach, but the nurses stand out as the professionals who often coordinate and carry out the activities^(5,16). Still, providing the guidelines in writing at discharge as well as information about the care obtained a 100% agreement and is considered an evaluation indicator of an elder-friendly ES⁽¹⁰⁾. Healthcare professionals justify this aspect given the difficulties in caring for the elderly and the lack of information about their health when they arrive in the ES and when they return to the referral service^(5-6,9).

The transition of care^(6,15) involves a set of actions to promote a safe and timely passage of the users between different care sectors and healthcare services. For elderly people, this process is relevant because the elderly often have multiple diseases with different treatments while accessing different healthcare services as needed. The difficulties, or even the lack of support during the transitions, have been related to the elderly returning to the ES, new hospitalizations, and adverse events⁽²⁾.

The availability of human resources is essential to provide proper care. A need was identified to review the dimensioning of the nursing team considering the conditions of the ES for a better care for the elderly. This reinforces the findings⁽¹⁷⁾ in which the nursing dimensioning is a major concern for managers because it involves multiple facets of an extremely dynamic type of work that is difficult to measure. This is also a problem of international scope because the lack of staff and high workloads were mentioned by professionals, the elderly, and their caregivers as aspects that need to be improved in order to provide an elder-friendly care in the ES⁽⁹⁾.

The nurses did not reach a consensus on the availability of a nurse with specialized training being responsible for the application of geriatric assessment instruments and protocols. This can be a difficult demand in the Brazilian context, but nurses do have a general education and therefore knowledge and skills to provide assistance in different situations of health and age groups. The emphasis on the training of the professionals inserted in the services through continuing education programs can meet this demand and meet the need for implementing geriatric assessment in the ES.

Another aspect that may be suggested considering the answers is that these routines are not the responsibility of nurses, considering that they agree on their implementation in the ES in relation to the dimensioning of nursing and workload⁽¹⁷⁾. Although the experiences of other countries have found positive results with the implementation of practices by nurses, it should be pointed out that they are linked to a multidisciplinary approach and, for the most part, are inserted into care models and welfare programs geared toward the elderly^(5,16,18).

Another question that did not reach consensus was related to the need of a specialized interdisciplinary team in gerontology/geriatrics to support cases of high-risk and

fragile elderly people. This suggests once again the relationship with specialized training in Brazil, considering that in the second round a consensus was reached on the need for a multidisciplinary approach to care for the elderly and their families to give support to the ES team.

The experiences described by care programs have demonstrated that, through appropriate geriatric assessments, identification of risks, and support strategies in the transition of the care, it is possible to reduce the return of the elderly to the ES, avoid admissions, obtain greater satisfaction, and reduce hospital costs^(5,16,18-19). Therefore, these studies offer different examples that can encourage new practices in the ES together with the reality of each institution.

The dimension related to the **Physical Design** reached a consensus on the questions asked. The elderly may have various physiological changes that involve visual, hearing, cognitive, and musculoskeletal disturbances along with ones resulting from polypharmacy. For these reasons, aspects were identified aimed at organizing the ES environment so that the safety and autonomy of the elderly can be enhanced through good lighting, noise reduction, free hallways, and other "elder-friendly" items. However, what is observed is an inappropriate and unsafe environment for the elderly because it is busy, noisy, and overcrowded, where the elderly are often not within the view of professionals, and there is a concern with falling^(2,6,9,20).

Aspects were identified aimed at preventing falls, such as using non-slip flooring and the placement of adequate furniture for promoting safety, autonomy, and comfort for the elderly, thus confirming results reported in studies^(6,21). Recliners, thick mattresses, and chairs with armrests are cited. It is recommended to avoid furniture with casters at the base because they may not offer support and firmness^(20,22). Using equipment that contribute to the privacy of the elderly, such as curtains and screens, was also identified by the nurses. Maintaining privacy is very important because, in an ES environment, spaces, even including toilets, are often overcrowded and shared among users. For the elderly, lack of privacy, plus the hectic environment, can lead to disorientation, a feeling of disability, and loss of autonomy⁽⁶⁾.

Cognitive disturbances such as decreased memory, difficulties in communication and orientation, a slower processing of information, and others found in stages of dementia are common in the elderly⁽²⁾. Therefore, a need was identified to use signs in ES sectors such as posters, calendars, clocks, etc., and the identification of professionals through badges and uniforms. These answers are consistent with the recommendations described in the literature⁽²¹⁻²²⁾. The need for the adaptation of equipment in the ES, such as walkers, wheelchairs, and other equipment that facilitates the mobilization and access of the elderly, also reached consensus. These equipment options are needed, considering musculoskeletal disorders such as decreased muscle strength, less fine motor coordination, and loss of balance, which are common in elderly. The availability of this equipment is one of the indicators for evaluating an elder-friendly ES⁽¹⁰⁾.

The aspects identified for the physical design are described in accordance with recommendations described and,

in general, favor the other users in the ES, in addition to the elderly^(6,9-10).

CONCLUSION

The aspects to be considered in the care provided in the ES of elder-friendly hospitals were identified and grouped into central dimensions that are interrelated. However, they bring up elements that are also related to other dimensions.

As for the social climate, it is considered that the culture of the ES is not favorable for the elderly, but that attitudes such as respect, involvement of family members in the care, and sensitization of the workers contribute to more positive experiences. For policies and procedures, commitment was reinforced to an elder-friendly care that is integrated to the strategic plans of the institutions. Epidemiological changes due to aging are reflected in health practices and therefore they should be included in the training of the professionals. Investments in continuing education are therefore essential.

The aspects of the physical design indicate a need to make adaptations for the safety and autonomy of the elderly, such as preventing falls through appropriate lighting and signaling, noise reduction, and equipment for privacy and mobilization, in view of the inadequate organization of the ES for this age group. As for care systems and processes, practices were reinforced for evaluating the functional capacity of the elderly and maintaining autonomy. Support for the elderly and their families in the transition of care should be strengthened in order to overcome weaknesses in communication between the services and the care network.

The insertion of nurses into management, planning, and assistance enables potential for improvements in the quality of care. However, the importance of an interprofessional approach to care for the elderly should be highlighted, and developing studies that include other health professionals is suggested. The results suggest indicators of quality of care for the elderly in the ES, which can be used to build a checklist and assessment tools and to strengthen public policies for the elderly.

RESUMO

Objetivo: Identificar e analisar aspectos necessários para um atendimento amigo do idoso nos serviços de emergência (SE), na perspectiva de enfermeiros. **Método:** Estudo descritivo, quantitativo, com utilização da Técnica Delphi, em três rodadas. Foram selecionados enfermeiros com experiência profissional em SE e/ou pesquisadores com publicações e/ou desenvolvendo pesquisas na área de estudo. A primeira rodada do painel Delphi contou com 72 participantes, a segunda com 49 e a terceira com 44. Foi utilizado questionário *on-line*, baseado na revisão da literatura científica, com questões organizadas em dimensões centrais de hospitais amigos do idoso. Foi utilizada uma escala de Likert de 5 pontos para cada questão e estabelecido nível de consenso de 70%. **Resultados:** Foram identificados 38 aspectos necessários para o atendimento ao idoso, organizados em dimensões centrais. **Conclusões:** Os resultados do estudo são consistentes com os achados na literatura científica e sugerem indicadores para qualidade do cuidado e para formação de SE amigos do idoso.

DESCRITORES

Idoso; Saúde do Idoso; Enfermagem em Emergência; Enfermagem Geriátrica; Serviço Hospitalar de Emergência.

RESUMEN

Objetivo: Identificar y analizar aspectos necesarios para una atención amiga del anciano en los servicios de urgencias (SU), desde la perspectiva de los enfermeros. **Método:** Estudio descriptivo, cuantitativo, con utilización de la Técnica Delphi, en dos ruedas. Fueron seleccionados enfermeros con experiencia profesional en SU y/o investigadores con publicaciones y/o desarrollando investigaciones en el área de estudio. La primera rueda del panel Delphi contó con 72 participantes; la segunda, con 49; y la tercera, con 44. Se utilizó cuestionario en línea, basado en la revisión de la literatura científica, con cuestiones organizadas en dimensiones centrales de hospitales amigos del anciano. Se llevó a cabo una escala de Likert de cinco puntos para cada cuestión y se estableció nivel de consenso del 70%. **Resultados:** Fueron identificados 38 aspectos necesarios para la atención al anciano, organizados en dimensiones centrales. **Conclusiones:** Los resultados del estudio son consistentes con los hallazgos en la literatura científica y sugieren indicadores para calidad del cuidado y formación de SU amigos del anciano.

DESCRIPTORES

Anciano; Salud del Anciano; Enfermería de Urgencia; Enfermería Geriátrica; Servicio de Urgencia en Hospital.

REFERENCES

1. Schnitker L, Martin-Khan M, Beattie E, Gray L. Negative health outcomes and adverse events in older people attending emergency departments: a systematic review. *Australas Emerg Nurs J.* 2011;14(3):141-62.
2. Gruneir A, Silver MJ, Rochon PA. Emergency department use by older adults: a literature review on trends, appropriateness and consequences of unmet health care. *Med Care Res Rev.* 2011;68(2):131-55.
3. Carret MLV, Fassa ACG, Paniz VMV, Soares PC. Características da demanda do serviço de saúde de emergência no Sul do Brasil. *Cienc Saúde Coletiva.* 2011;16 Supl 1:1069-79.
4. Parke B, Brand P. An elder-friendly hospital: translating a dream into reality. *Nurs Leadersh (Tor Ont).* 2004;17(1):62-76.
5. Baumbusch J, Shaw M. Geriatric emergency nurses: addressing the needs of an aging population. *J Emerg Nurs.* 2011;37(4):321-7.

6. Boltz M, Parke B, Shuluk J, Capezuti E, Galvin JE. Care of the older adult in the emergency department: nurses views of the pressing issues. *Gerontologist*. 2013;53(3):441-53.
7. Hsu CC, Sandford BA. The Delphi technique: making sense of consensus. *Pract Assess Res Eval*. 2007;12(10):1-8.
8. Scarparo AF, Laus AM, Azevedo ALCS, Freitas MRI, Gabriel CS, Chaves LDP. Reflexões sobre o uso da técnica Delphi em pesquisas na enfermagem. *Rev Rene*. 2012; 13(1):242-51.
9. Kelley ML, Parke B, Jokinen N, Stones M, Renaud D. Senior-friendly emergency department care: an environmental assessment. *J Health Serv Res Policy*. 2011;16(1):6-12.
10. McCusker J, Verdon J, Vadeboncoeur A, Lévesque JF, Sinha SK, Kim KY, et al. The elder-friendly emergency department assessment tool: development of a quality assessment tool for emergency department-based geriatric care. *J Am Geriatr Soc*. 2012;60(8):1534-9.
11. Witt RR, Roos MO, Carvalho NM, Silva AM, Rodrigues CDS, Santos MT. Professional competencies in Primary Health Care for attending to older adults. *Rev Esc Enferm USP [Internet]*. 2014 [cited 2015 May 15];48(6):1018-23. Available from: <http://www.scielo.br/pdf/reeusp/v48n6/0080-6234-reeusp-48-06-1020.pdf>
12. Taylor BJ, Rush KL, Robinson CA. Nurses' experiences of caring for the older adult in the emergency department: a focused ethnography. *Int Emerg Nurs*. 2015;23(2):185-9.
13. Skar P, Bruce A, Sheets D. The organizational culture of emergency departments and the effect on care of older adults: a modified scoping study. *Int Emerg Nurs*. 2015;23(2):174-8.
14. Coffey A, McCarthy GM. Older people's perception of their readiness for discharge and postdischarge use of community support and services. *Int J Older People Nurs*. 2013;8(2):104-15.
15. Hwang U, Shah MN, Han JH, Carpenter CR, Siu AL, Adams JG. Transforming emergency care for older adults. *Health Aff*. 2013;32(12):2116-21.
16. Aldeen AZ, Courtney DM, Lindquist LA, Dresden SM, Gravenor SJ. Geriatric Emergency Department Innovations: preliminary data for the Geriatric Nurse Liaison Model. *J Am Geriatr Soc*. 2014;62(9):1781-5.
17. Schmoeller R, Gelbcke FL. Indicativos para o dimensionamento de pessoal de enfermagem em emergência. *Texto Contexto Enferm*. 2013;22(4):971-9.
18. Street M, Considine J, Livingston P, Ottmann G, Kent B. In-reach nursing services improve older patient outcomes and access to emergency care. *Australas J Ageing*. 2015;34(2):115-20.
19. Asha SE, Ajami A. Improvement in emergency department length of stay using early senior medical assessment and streaming model of care: a cohort study. *Emerg Med Australas*. 2013;25(5):445-51.
20. Ramos CV, Santos SSC, Barlem ELD, Pelzer MT. Quedas em idosos de dois serviços de pronto atendimento do Rio Grande do Sul. *Rev Eletr Enf [Internet]*. 2011 [citado 2015 maio 15];13(4):703-13. Disponível em: https://www.fen.ufg.br/fen_revista/v13/n4/pdf/v13n4a15.pdf
21. Woo J, Mak B, Yeung F. Age-friendly primary health care: an assessment of current service provision for older adults in Hong Kong. *Health Serv Insights [Internet]*. 2013 [cited 2015 May 16];6:69-77. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4089682/>
22. Parke B, Friesen K. Code plus physical design components for an elder friendly hospital [Internet]. 2nd ed. Canadá: Fraser Health Hospital/ British Columbia; 2015 [cited 2015 May 15]. Available from: http://www.fraserhealth.ca/media/Code_Plus_Physical_Design_Components_Elder_Friendly_Hospital_2nd_Edition.pdf