EMPirical research - mixed methods

Fundamental nursing actions for frail older people in the emergency department: A national cross-sectional survey and a qualitative analysis of practice guidelines

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Abstract

Aims: To map how frailty among older people is assessed at Swedish emergency departments and to describe fundamental nursing care actions for these patients.

Design: Descriptive national survey and a qualitative analysis of text.

Methods: A majority (82%, n = 54) of the Swedish hospital-based emergency departments for adults were included, representing all six healthcare regions. An online survey was used to collect data, together with submitted local practice guidelines for older people at the emergency departments. Data were collected during February–October 2021. Descriptive and comparative statistics were performed together with a deductive content analysis framed by the Fundamentals of Care framework.

Results: Sixty-five per cent (35 of 54) of the emergency departments identified frailty, with less than half of them using an established assessment instrument. Twenty-eight (52%) of the emergency departments have practice guidelines containing fundamental nursing actions for the care of frail older people. The majority of nursing actions in the practice guidelines were related to patients' physical care needs (91%), followed by psychosocial care needs (9%). No actions could be identified as relational actions (0%) according to the Fundamentals of Care framework.

Conclusion: Many Swedish emergency departments identify frail older people, but they use a range of different assessment instruments. While practice guidelines directing fundamental nursing actions for frail older people are often in place, a holistic, person-centred view addressing the patient's physical, psychosocial and relational care needs is missing.

Impact: The population is growing older, and more people are needing more complex hospital care. Frail older people have an increased risk of negative outcomes. The use of a variety of assessment instruments for frailty may pose a challenge to equal care. To ensure a holistic, person-centred view of frail older people, the Fundamentals of Care framework can be used in developing and reviewing practice guidelines.
1 | INTRODUCTION

The proportion of older people at emergency departments is increasing (United Nations (UN), 2019), and frailty may lead to more care needs. Together with a crowded emergency department, this situation could pose a challenge to patient outcomes and cause patients to feel exposed. Identifying frailty is challenging, but necessary and appropriate care actions are warranted. However, there are a limited number of practice guidelines regarding identifying, managing and preventing frailty (Zheng et al., 2022) and research on frail older people and the provision of adequate nursing care at the emergency department is lacking.

1.1 | Background

Life expectancy around the world is increasing yearly (World Health Organization (WHO), 2018). Older people (those >65 years of age) make up more than 40% of all emergency department visits in Sweden (Swedish Council on Health Technology Assessment, 2013). Furthermore, international research shows that annual emergency visits among the older people are increasing (Pines et al., 2013).

Visiting the emergency department might be a challenge for older people for many reasons, such as long waiting times (Perdahl et al., 2017) and crowding (Morley et al., 2018). Crowding relates to imbalances in input, throughput and output processes, which can have a higher risk of negative outcomes (Lewis et al., 2019), highlighting nurses’ responsibilities to provide safe and high-quality health care to meet frail older peoples´ fundamental care needs. As such, it has been interpreted and adapted to Swedish health care (Muntlin & Jangland, 2022) and is applicable in emergency care (Muntlin & Jangland, 2020), see Figure 1. The framework contributes to our topic, as it addresses the following dimensions: establishing a relationship; integrating the patient’s physical, psychosocial and relational needs/actions; and outlining the care context where the care takes place. The care relationship is the core, the most central part that is indispensable to satisfy the rest of the patient’s fundamental needs. The integration of care (middle dimension) addresses the need for a more holistic and person-centred view of the care, where the patient should be invited in their care. The care context focuses on prerequisites to be able to deliver fundamental care (Kitson, Conroy, et al., 2013; Muntlin & Jangland, 2022). The importance of this holistic approach to patients is supported by research showing that older patients report feelings of neglect, loneliness and being exposed in the emergency department (Eriksson-Liebon et al., 2021). Also, meeting patients’ fundamental care needs in the emergency department might be challenging (Cetin-Sahin et al., 2020), as there is a lack of communication with patients at the emergency department (van Oppen et al., 2019). An established relationship, where nurses care for and meet the older patient’s different needs makes the older patient calmer and less anxious. This has been highlighted, as older patients often do not want to be an inconvenience (Kihlgren et al., 2004; Parke et al., 2014). Ensuring person-centred fundamental care in a chaotic emergency department environment might be even more challenging regarding frail older people.

In recent years, more attention has been paid to the identification and assessment of frailty among older people at the emergency department to provide more adequate emergency care to this subgroup of older people (Carpenter & Mooijaart, 2020). The concept of frailty is complex, and there is a wide range in the definition criteria; also, there is no international consensus on how the concept of frailty should be defined (Junius-Walker et al., 2018; Markle-Reid & Browne, 2003). In the present study, the definition specified by the WHO (2016) is used: Frailty is defined as a progressive age-associated deterioration of various body functions, which results in reduced physiological reserves and leads to great vulnerability to various strains and therefore increases the risk of different types of negative health outcomes.

The degree of frailty is a good predictor of adverse health effects in the older people, for example, regarding impaired quality of life, the risk of revisits to the emergency department, increased mortality and increased need for help at home (Lewis et al., 2019). More specific nursing care needs include activities such as moving, feeding, using the bathroom and dressing (Sánchez-García et al., 2017). However, the variety of definitions of frailty gives a vast number of assessment scales for identifying frailty of varying quality and
clinical usefulness (Lewis et al., 2019). A review (Zheng et al., 2022) has identified that there is a lack of practice guidelines regarding management of frailty. Also, frail older people need extra support with, for example, nutrition, physical function and activities in daily life. However, there is no enough evidence regarding how this should be done or which actions are the most effective (Dent et al., 2019). Using the Fundamentals of Care framework might facilitate a more holistic approach to these patients. Therefore, research is needed to illuminate fundamental nursing actions for frail older people in emergency departments.

2 | THE STUDY

2.1 | Aim

The aim of this study was to map how frailty among older people is assessed at Swedish emergency departments, and to describe fundamental nursing actions for these patients. The aim was guided by the following research questions: (1) Is frailty assessed at Swedish emergency departments? If so, in what way, and does it occur differences between type of hospitals?; (2) Do they have practice guidelines available regarding nursing actions for frail older people?; and (3) What fundamental nursing actions are described in these guidelines for frail older people, and how do they correspond with the Fundamentals of Care framework?

2.2 | Design

A descriptive national survey about older people and frailty together with a qualitative analysis of practice guidelines was conducted.

2.3 | Sample

A total sample approach was used. Of emergency departments open 24/7, 66 were identified (National Board of Health and
Welfare, 2020); of these, 54 (82%) responded to the survey. The inclusion criterion was: hospital-based emergency department for adults. If a hospital had emergency departments at multiple sites, each site was included and addressed as an individual emergency department. Emergency departments for specific care, such as psychiatric care or care for infectious diseases, were excluded.

Based on the inclusion criteria, nurse managers or persons in an equivalent position were approached by email. They received an information letter with information on how to log in to the online survey using a weblink and a request to submit available practice guidelines. The information letter clarified the concept of frailty (WHO, 2016) and the definition of older people, that is, patients >65 years (UN, 2019).

The included emergency departments were divided into type of hospital (i.e. university hospital, mid-sized hospital or small hospital) in line with the annual national quality benchmarking by Dagens Medicin (DM) (2020). University hospitals have teaching and research assignments, manage trauma patients to a broader extent and are located in the largest cities. Mid-sized hospitals have emergency departments open 24/7, including maternity and obstetric care. Small hospitals have emergency departments (some with limited opening hours) without maternity and obstetric care. The national survey covered all six healthcare regions in Sweden.

2.4 | Data collection and process

The present study includes data from the survey along with text comments and the electronically submitted practice guidelines. The content of the electronic survey was based on the literature and background information regarding Swedish emergency departments listed by the National Board of Health and Welfare (2020). The survey consisted of demographic, open- and closed-ended questions and included three parts: (1) submission of local practice guidelines; (2) six questions regarding identification of frail older people at the emergency department (yes/no), use of assessment tools (yes/no and type of tool); and (3) six questions concerning background information regarding the emergency department. To confirm face and content validity, the survey was tested by a number of clinicians and non-health professionals, which generated some revisions. The survey was electronically provided using the software program Webropol (version 3.0). The response time was set to 4 weeks, in spring 2021. Up to three reminders were sent by email and phone.

2.5 | Ethical considerations

International and national ethical guidelines were followed (Codex, 2022; World Medical Association, 2013). According to Swedish regulations, no formal ethical approval is needed if one is not studying people or including sensitive personal information. Participation in the present study consisted of submitting clinical guidelines and responding to questions about the organization of the emergency department. Participants were informed that participation was voluntary, and written consent was obtained from all nurse managers, or equivalent, who responded to the questions and submitted their written guidelines. The submitted surveys were coded 1-54, and no personal information regarding the responding person was retrieved.

Data were handled in a confidential manner, and only the research team had access to them. The data were stored on a password-protected computer. Findings are presented at group level to ensure that no individual identification can be made.

2.6 | Data analysis

Statistical analyses were performed using Excel (version 16.6.7) and GraphPad Prism (version 9.1.2). For quantitative data, descriptive statistics were presented as numbers and percentages. Chi-square tests for independence with Yates continuity correction were performed to examine the relationship between the type of hospital, on the one hand, and (a) the occurrence of the identification of frailty and (b) the prevalence of practice guidelines regarding nursing actions at the emergency departments, on the other. Due to the small sample size, a two-tailed Fisher’s exact test was used to examine the associations between regional location and (a) and (b). A confidence level of 95% and an alpha level of ≤.05 were used in all calculations to indicate statistical significance.

The included practice guidelines involved the care of older people, identified as ‘frail older people’ or as patients with an increased risk of negative health outcomes during their stay at the emergency department. Content varied from brief texts to more comprehensive guidelines. As this study’s focus was on nursing actions provided bedside at the emergency department, texts about patient flow processes, specific diagnosis groups, medical examinations and treatments, collaboration with home care services, documentation and assessments not describing nursing actions were excluded.

Text from the submitted practice guidelines and free-text responses of the survey—‘What nursing actions are taken for frail older people?’—were analysed using manifest content analysis with a deductive approach (Graneheim et al., 2017). As the theoretical lens for the deductive analysis, the central parts showing integration of care (i.e. the fundamental care needs and the relational nursing actions) in the Swedish version of the Fundamentals of Care framework were used (Muntlin & Jangland, 2020, 2022). To ensure a structured and similar data analysis process, two of the practice guidelines were analysed by the two first authors together. After this, reviews of the practice guidelines were performed individually. The last author reviewed the analysis and confirmed the findings. The process and analysis were discussed continuously within the whole research team until consensus was reached (Polit & Beck, 2017).

A number of meaning units were identified and interpreted as nursing actions related to frail older people, condensed into codes and applied as subcategories, that is, the predetermined elements of patients’ needs according to the Fundamentals of Care framework.
The subcategories represented the categories of physical care needs, psychosocial care needs and relational actions. Following this, the nursing actions were mirrored against the framework to appraise which nursing actions met the frail patient care needs according to the framework. Some of the text consisted of single words, that is, not grammatically formulated as an action, but was still interpreted as a nursing action if it fell within the registered nurse’s scope of practice. Data that could not fit into the elements of the framework were merged into a category labelled not applicable. Moreover, a quantitative content analysis was conducted to further illuminate the strength, or lack, of identified fundamental care needs and nursing actions within the practice guidelines, displayed as frequencies and proportions.

### 2.7 Rigour

A number of strategies were used to achieve trustworthiness (Lincoln & Guba, 1985). All authors have experience of clinical practice from emergency departments or emergency care, and the last author has extensive experience of research within the emergency care field. This experience supported the data collection process and the interpretation of the study’s qualitative part. However, our preunderstanding was acknowledged and reflected on both before the study started and during the analysis process as an attempt to limit blind spots, which may negatively affect study quality (Patton, 2015).

### 3 Findings

The findings are based on information from 54 of the 66 eligible emergency departments in Sweden. The characteristics of the emergency departments’ hospitals appeared as follows; 10 university hospitals, 29 mid-sized hospitals and 15 small hospitals.

#### 3.1 Identification of frailty

Results show that 65% (35 of 54) of the emergency departments stated that they identified frailty. Of these emergency departments, 15 (43%) used an established assessment instrument, 10 (29%) used another instrument and 10 (29%) did not use any assessment instruments. Of those emergency departments (n = 15) with established instruments, most used the Clinical Frailty Scale (n = 6, 40%) or the Frail Elderly Support Research Group (FRESH) screening instrument (n = 5, 33%). Some emergency departments used the Geriatric Risk Profile (n = 3, 20%) or the Frail Scale (n = 1, 7%). The emergency departments reporting that they did not use any established tool but still identified frailty used the Care Assessment Scale (CAS) or locally developed criteria. Concerning the number of emergency departments identifying frailty, no statistically significant differences could be noted among the group divisions, with proportions varying between 60% and 71% for type of hospital, and between 50% and 88% among the healthcare regions (Table 2).

#### 3.2 Practice guidelines for care of frail older people

Of all 54 emergency departments participating in this study, 28 (52%) have practice guidelines for the care of frail older people. The type of guideline varied from short checklists, specific pathways for frail older people to practice guidelines. A great variation could be seen between the healthcare regions and the prevalence of practice guidelines, from the Northern Region having the lowest percentage of emergency departments with practice guidelines describing nursing actions for frail older people (2 of 8, 25%) to the Western Region having the highest percentage (7 of 8, 88%). However, there was no statistically significant difference among the type of hospital and the occurrence of practice guidelines (p = .951), see Table 3.

#### 3.3 Nursing actions related to the fundamentals of care framework

The review of the practice guidelines and the free-text responses revealed a variety of nursing actions that addressed the frail patient’s fundamental care needs. In total, 31 types of nursing actions were identified 337 times, and were categorized to elements within the Swedish version of the Fundamentals of Care theoretical framework; see Table 4.

**Table 1** Examples from the data analysis process.

<table>
<thead>
<tr>
<th>Meaning unit</th>
<th>Condensed unit</th>
<th>Code</th>
<th>Subcategory ( ^a )</th>
<th>Category ( ^a )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular turning and alleviating</td>
<td>Regular turning and alleviating</td>
<td>Pressure ulcer prevention</td>
<td>Physical well-being</td>
<td>Physical care needs</td>
</tr>
<tr>
<td>Offer food or drink if patient is not fasting</td>
<td>Offer food and drink</td>
<td>Food and drink</td>
<td>Food and drink</td>
<td>Physical care needs</td>
</tr>
<tr>
<td>Give regular and frequent information to patient and family members</td>
<td>Frequent information</td>
<td>Information</td>
<td>Being involved and informed</td>
<td>Psychosocial care needs</td>
</tr>
</tbody>
</table>

\( ^a \) Subcategories and categories were predetermined according to the Swedish version of the Fundamentals of Care framework (Muntlin & Jangland, 2020, 2022).
In the category physical care needs, preventive actions—for instance, pressure ulcer prevention, malnutrition prevention, and fall prevention—were the most commonly identified nursing actions. The most dominant nursing action was pressure ulcer prevention (n = 78, 23%), which mainly included actions such as repositioning, or offering a bed or support surface for pressure ulcer treatment. A few nursing actions also included skin care or pressure ulcer dressing, for example, ‘If the patient has dry skin—offer body lotion/oil for skin care’ (Emergency Department 53, practice guidelines).

Fall prevention constituted almost the entire mobilization subcategory. The most frequently occurring fall-preventive action was environmental adaptation, for example, ‘Prevent fall injuries, e.g. the safety rails can be lowered and the trolley can be lowered to the minimum height’ (Emergency Department 10, practice guidelines).

Another fall-preventive action involved placing the frail patient close to the healthcare professionals at the emergency department so that they could keep an eye on him or her. Remaining preventative actions included patient transfer assistance and encouraging relatives to stay with the patient, with one guideline also mentioning patient education: ‘Instructing the patient to rise slowly and pay attention to any dizziness...’ (Emergency Department 2, practice guidelines).

Nursing actions to meet the frail patient’s need to be clothed were not mentioned in any practice guidelines, but were included in free-text answers, e.g. ‘Attention to... clothing before we send [the patient] on to the ward or home’ (Emergency Department 24, free text).

Nursing actions were identified in three of the six subcategories within psychosocial care needs. Most actions were categorized...
### TABLE 4
Nursing actions identified in practice guidelines for older people in emergency departments, according to the fundamentals of care framework.

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory (numerically descending order)</th>
<th>Identified nursing action (numerically descending order)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical care needs (n = 306, 91%)</td>
<td>Physical well-being (n = 98, 29%)</td>
<td>Pressure ulcer prevention (n = 78, 23%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pain management (n = 10, 3%)</td>
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<tr>
<td></td>
<td></td>
<td>Skin and wound care (n = 8, 2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Keep patient warm (n = 2, 1%)</td>
</tr>
<tr>
<td></td>
<td>Food and drink (n = 94, 28%)</td>
<td>Drink (n = 31, 9%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Food (n = 31, 9%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Infusion (n = 15, 4%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nutritional drink (n = 10, 3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nutrition (n = 6, 2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Include dietician (n = 1, 0.3%)</td>
</tr>
<tr>
<td>Toilet needs (n = 63, 19%)</td>
<td>Help with toilet visits (n = 21, 6%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Perform bladder scan (n = 14, 4%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incontinence protection (n = 14, 4%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care for urinary catheter (n = 9, 3%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Micturition (n = 3, 1%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elimination (n = 2, 1%)</td>
<td></td>
</tr>
<tr>
<td>Mobilization (n = 42, 12%)</td>
<td>Fall prevention (n = 40, 12%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ambulation (n = 2, 1%)</td>
<td></td>
</tr>
<tr>
<td>Personal hygiene and getting dressed (n = 5, 1%)</td>
<td>Mouth care (n = 2, 1%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clothes (n = 2, 1%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal hygiene (n = 1, 0.3%)</td>
<td></td>
</tr>
<tr>
<td>Rest and sleep (n = 4, 1%)</td>
<td>Comfortable positioning (n = 2, 1%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Offer bed (n = 2, 1%)</td>
<td></td>
</tr>
<tr>
<td>Psychosocial care needs (n = 31, 9%)</td>
<td>Being involved and informed (n = 20, 6%)</td>
<td>Information (n = 17, 5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Involve relatives (n = 2, 1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Involve patient (n = 1, 0.3%)</td>
</tr>
<tr>
<td></td>
<td>Communication (n = 8, 2%)</td>
<td>Provide call bell (n = 6, 2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication aids (n = 1, 0.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use interpreter (n = 1, 0.3%)</td>
</tr>
<tr>
<td>Emotional well-being (n = 3, 1%)</td>
<td>Anxiety&lt;sup&gt;a&lt;/sup&gt; (n = 2, 1%)</td>
<td>Confusion&lt;sup&gt;b&lt;/sup&gt; (n = 1, 0.3%)</td>
</tr>
<tr>
<td>Privacy (n = 0, 0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dignity (n = 0, 0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respect (n = 0, 0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relational actions (n = 0, 0%)</td>
<td>Active listening (n = 0, 0%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Be empathetic and show compassion (n = 0, 0%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Be engaged in the patient (n = 0, 0%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Be present and offer support (n = 0, 0%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensure that goals are set (n = 0, 0%)</td>
<td></td>
</tr>
</tbody>
</table>

Note: In parentheses: number of identified nursing actions meeting patient's need, and percentage of all nursing actions (total n = 337). Category and subcategory according to the Fundamentals of Care framework, Swedish version (Muntlin & Jangland, 2020, 2022).

<sup>a</sup>Address patient’s anxiety.

<sup>b</sup>Address patient’s confusion.
under the subcategory being involved and informed (n = 20, 6%), the involvement mostly entailing providing information; for instance, ‘Information—e.g. about waiting time, what to expect, how we work’ (Emergency Department 37, practice guidelines). The few nursing actions within the subcategory communication (n = 8) focused mainly on accessibility: ‘Make sure the call bell works and that the patient can use it’ (Emergency Department 20, practice guidelines).

Nursing actions related to frail patients’ emotional well-being were identified three times, but were not described in depth. In general, many emergency departments stated only in general terms that they looked after the patient’s needs, sometimes in only a few words, or even just one, such as ‘anxiety’. No nursing actions related to the category relational actions were identified. Aside from the 337 included nursing actions, 51 actions could not be categorized in line with the framework and were therefore merged into the category not applicable, consisting of briefly described general actions—nursing round (n = 43) and caring (n = 8), described as: ‘All frail patients should regularly have a nursing round during their visit to the emergency department’ (Emergency Department 34, practice guidelines).

4 | DISCUSSION

The survey showed that the majority of Swedish emergency departments state that they identify frailty, but that how this is done varies considerably. Our findings also showed that a variety of assessment instruments were in use, which may negatively affect the appropriate identification of frailty and confirm the findings by Lewis et al. (2019). The reason for this likely lies in the complexity of the concept of frailty (Junius-Walker et al., 2018). If there is room for interpretation of the concept, it is reasonable that identification strategies also differ. Hence, there is need for consensus on how the concept should be defined to be able to benchmark between different healthcare organizations. Also, as no statistically significant differences were identified, further investigations are needed to explore the reasons for the great variation. A third of the emergency departments in this study did not identify frailty at all. As frailty increases the risk of various types of adverse health outcomes (Lewis et al., 2019; WHO, 2016), it is of clinical relevance that emergency departments begin to identify frail patients to a greater extent than is done today. Screening and prioritizing older people, to ensure that they receive the nursing care they need, are warranted. Also, older people are positive regarding frailty screening to detect risks; they believe this could contribute to more holistic care (Blommaard et al., 2021). Furthermore, the findings show that frailty is often assessed based on local routines and non-established instruments, indicating a lack of evidence-based care, which has been identified as having a negative impact on patient outcome, patient participation and cost-effectiveness (Spruce, 2015), and may also pose a challenge to equal care.

Knowledge-based practice guidelines are contextual resources that support and guide healthcare professionals in providing safe and good care on equal grounds (Woolf et al., 1999). Thus, it is remarkable that not all of the emergency departments claiming to identify frailty have practice guidelines for their older people. Together with a clear variation in content in the submitted practice guidelines in general, this indicates that frail older people may receive unequal care. Moreover, previous research shows that the evidence for practice guidelines regarding frailty is insufficient (Zheng et al., 2022). To further address this, a systematic quality assessment of existing practice guidelines for the care of frail older people would be desirable, along with an observational study to examine how well submitted practice guidelines are actually implemented in daily practice.

As the Fundamentals of Care framework is a model for explaining and supporting person-centred fundamental care, it was deemed feasible to study how nursing actions described in the practice guidelines corresponded to the framework. Nursing actions aimed at meeting the frail patient’s physical care needs accounted for the largest part of identified nursing actions by far. This is important, of course, but patients’ care needs should be integrated in a holistic way (Muntlin & Jangland, 2020, 2022). Traditionally, in emergency care, it is common to focus on a patient’s physical care needs and medical interventions (Muntlin Athlin et al., 2017). However, studies indicate the importance of addressing psychosocial care needs as, for example, loneliness and lack of involvement increase the risk of developing physical frailty (Gale et al., 2018). However, nursing actions related to the frail patient’s psychosocial care needs were underrepresented in the current study, with involve patient, for example, mentioned only once. It may be that emergency departments do involve frail older people, but did not state this as a nursing action in their practice guidelines or in the survey. Nevertheless, patient involvement should be emphasized more, as patients have a fundamental need for participation (Muntlin & Jangland, 2022). The results from this study can raise awareness of this shortcoming and contribute to increasing the participation and autonomy of older people at emergency departments. Respecting the patient’s autonomy to a greater extent strengthens the ethics of care, as autonomy is a fundamental ethical concept (Taylor, 2013).

Even more remarkably, no nursing actions could be found that met the frail patient’s need for privacy, dignity or respect. This might be related to the fact that it is more complicated to describe actions taken to meet patients’ psychosocial needs than to describe physical actions. Since the estimated quality of practice guidelines is based on the possibility to measure and evaluate them (Agree, 2017), it may be hard to motivate the inclusion of psychosocial-focused nursing actions. At the same time, both healthcare professionals and patients feel that older people at the emergency department are treated with a lack of dignity (Tauber-Gilmore et al., 2018), and frail older people are afraid of being alone at the emergency department and want the healthcare professionals to engage with them (van Oppen et al., 2019).

No relational nursing actions were identified in the practice guidelines in our study, although engaging, being present and offering support may increase patients’ confidence and make them calmer (Parke et al., 2014). Relational actions are crucial for patient care and for the patient’s ability to meet his or her basic needs.
(Kitson, Conroy, et al., 2013; Muntlin & Jangland, 2022). As older people hesitate to disturb the healthcare professionals (Eriksson-Liebon et al., 2021), it is even more important that healthcare professionals initiate relational nursing actions.

The nursing actions that could not be related to the Fundamentals of Care framework consisted of two general terms: nursing round and caring, without further specification. General terms only present a guide for action if nurses have a preunderstanding of them; otherwise, there is a risk that the practice guidelines become subjective and difficult to interpret. If general terms are used, their meaning should be clear. Throughout the collected practice guidelines, many nursing actions are only mentioned as a checklist with single words such as anxiety, elimination or nutrition, without further guiding the nurse to appropriate actions. If these are not clarified, there is an imminent risk that they may contribute to a neglect to care for the frail patient's multidimensional needs. The use of a framework in clinical practice, such as the Fundamentals of Care framework, may facilitate the articulation of frail patients' fundamental care needs and ensure the provision of a person-centred fundamental care to frail patients visiting the emergency department.

Appropriate nursing actions are one important aspect of the care of frail older people at the emergency department. Nevertheless, it is crucial to also further investigate how organizational interventions might add support to shorten waiting times and increase the quality of care for frail older people. This will be the topic of our next study.

### 4.1 Limitations

This study approached all Swedish hospital-based emergency departments and had a high response rate (82%) with representation from all healthcare regions, which strengthens the findings. However, some limitations need to be discussed. The survey was developed specifically for this study, and despite tests for face validity, some unclear free-text responses were received. This, despite the fact that explanations of the concept of frailty and the definition of older people were included with the information letter. However, as participants had also submitted their practice guidelines, the data were still possible to interpret. Also, to avoid the risk of relevant guidelines not being attached, we requested practice guidelines for care of the older people in general, rather than specifying guidelines regarding frailty.

The deductive use of Fundamentals of Care, an evidence-based theoretical framework, strengthened the analysis. However, some data did not fit into the theoretical lens. To avoid the subjective exclusion of data, criteria for what was intended to be included in the analysis were created beforehand, and the leftover data are presented in a transparent way. All authors have a preunderstanding of the subject, as they all work as registered nurses in emergency care. This preunderstanding may have affected the interpretation of responses, as the authors may have sensed unwritten underlying information/meanings. However, the analysis process is described in a transparent and clear way, and the authors had continuous discussions about every step throughout the study, which increases its confirmability (Lincoln & Guba, 1985). Meaning units were analysed both individually and among the whole team until consensus was reached, to increase the study’s reliability. Nevertheless, it needs to be highlighted that, for example, the subcategory physical well-being is a broad concept and open to interpretation, which can threaten the reliability. In this study, it was interpreted that everything from pressure ulcer prevention and pain management to skin and wound care and keeping patients warm could be included in the subcategory of physical well-being. Our findings could be considered in further development of the framework. The study may have limited transferability to other healthcare units, as it is aimed specifically at emergency department contexts. On the other hand, there should be good transferability and generalizability to emergency departments worldwide with a healthcare structure similar to that in Sweden.

### 5 Conclusion

While the majority of Swedish hospital-based emergency departments identify frailty, the use of a systematic approach to assess frailty in older people differs. Improvements are needed before frailty in older people is assessed in an equal and evidence-based way. As practice guidelines directing nursing actions for frail older people often focus on patients' physical needs, seldom on psychosocial needs, and never on relational needs, a holistic, person-centred fundamental care was missing. This study demonstrates a new way to review practice guidelines to ensure the provision of holistic, person-centred nursing using the theoretical framework Fundamentals of Care.

### Author Contributions

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE*): (i) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (ii) drafting the article or revising it critically for important intellectual content. *http://www.icmje.org/recommendations/. David Ekermo: Conceptualization, data collection, data analysis, writing-original draft preparation. Matilda Ronnäus: Conceptualization, data collection, data analysis, writing-original draft preparation. Åsa Muntlin: Supervision, conceptualization, data analysis, writing-reviewing and editing.

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**SUPPORTING INFORMATION**

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