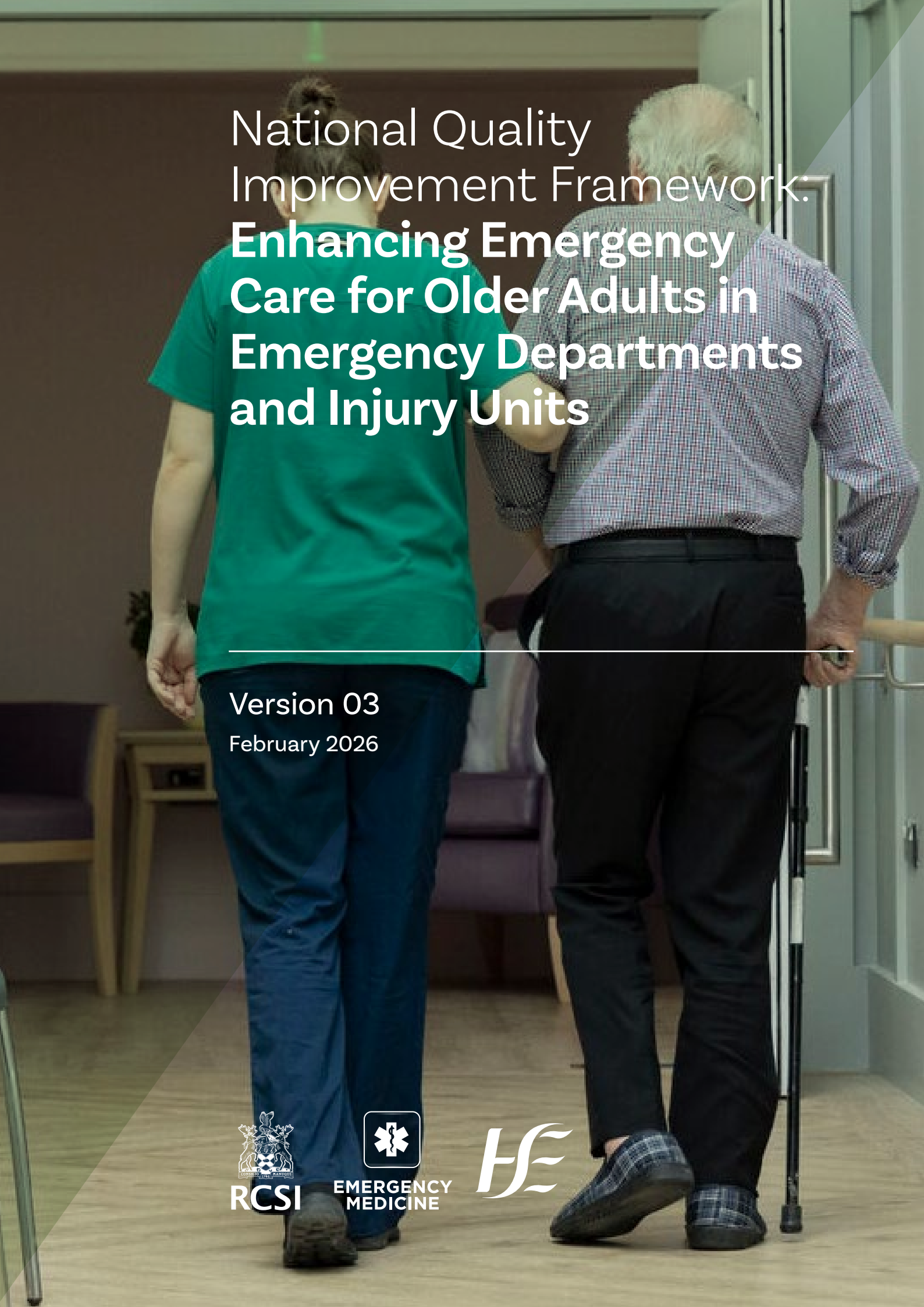

National Quality Improvement Framework: **Enhancing Emergency Care for Older Adults in Emergency Departments and Injury Units**

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CONTENTS

Executive Summary 5

Introduction 6

Context 7

Objective 1: Adopt and Implement Minimum Care Standards for Older Adults in EDs and IUs 9

Objective 2: Strengthen Post-Triage Assessment Pathways for Older Adults 11

Objective 3: Education and Workforce Development 14

Special Considerations for Injury Units 15

Toolbox of Resources 16

Audit & Measurement Tools 18

Conclusion 19

References 20

ABBREVIATIONS

ACPs	Advanced Care Plans
ANP	Advanced Nurse Practitioner
CFS	Clinical Frailty Scale
CGA	Comprehensive Geriatric Assessment
CPD	Continuing Professional Development
CNS	Clinical Nurse Specialist
ED	Emergency Department
EDITH	Emergency Department in the Home
EMP	Emergency Medicine Programme
EHR	Electronic Health Record
FITT	Frail Intervention Therapy Team
GEM	Geriatric Emergency Medicine
GEMU	Geriatric Emergency Medicine Unit
HSCP	Health and Social Care Professional
ICPOP	Integrated Care Programme for Older Persons
IFEM	International Federation for Emergency Medicine
IU	Injury Unit
LOS	Length of Stay
MDT	Multidisciplinary Team
MTS	Manchester Triage System
OT	Occupational Therapist / Therapy
PET	Patient Experience Time
PDSA	Plan-Do-Study-Act (Cycle)
QIF	Quality Improvement Framework
RCF	Residential Care Facility
RCSI	Royal College of Surgeons in Ireland
SDEC	Same Day Emergency Care
SLT	Speech and Language Therapist
SVUH	St. Vincent's University Hospital
4AT	4 'A's Test (for Delirium Screening)

Executive Summary

Ireland's Emergency Departments (EDs) and Injury Units (IUs) are seeing a steady increase in attendances by older adults, with over 560 people aged 75 and over presenting each day in 2025. This national Quality Improvement Framework (QIF) aims to ensure that every older person receives safe, timely and respectful care, regardless of when or where they attend.

The QIF builds on the Emergency Medicine Programme Model of Care (HSE, 2025) and aligns Delivering an Age-Friendly Health System (DoH and HSE, 2025) as well as with international standards from the International Federation for Emergency Medicine (IFEM). It focuses on three key areas: implementing minimum care standards, improving post-triage assessments and strengthening education and workforce development.

Minimum care standards ensure all older adults have access to essentials such as hydration, seating and timely assessment and that discharge and follow-up are clearly documented. Post-triage bundles, including frailty and delirium screening, allow teams to act early and avoid deterioration. The education component promotes GEM-focused training for all ED staff, with dedicated leads and simulation-based learning.

Examples from across Ireland, including FITT teams, UHL's GEM Unit and SVUH's EDITH service demonstrate what is already possible, even in constrained environments.

With practical tools, local flexibility and a clear evidence base, this QIF provides a path to consistently excellent emergency care for older people across Ireland.

Introduction

Ireland, like many countries, is facing a demographic transition characterised by a growing population of older adults. As of 2025, over 560 people aged ≥75 years present to Emergency Departments (EDs) in Ireland daily and this number is rising steadily. With this demographic shift comes a corresponding change in the patterns and presentations of illness and injury—changes that Emergency Medicine must adapt to in order to provide appropriate and effective care.

This QIF endorses and aligns with the International Federation for Emergency Medicine (IFEM) Minimum Standards for the Care of Older Persons in Emergency Departments and Delivering an Age-Friendly Health System (DoH and HSE, 2025). It also builds on national policy and strategy, including the Emergency Medicine Programme Model of Care (HSE, 2025), existing publications on management of older people in the ED and IU (EMP, 2022) and the Triage Quality Improvement Framework 2025. The goal is to deliver a consistent, high-quality, age-attuned, evidence-informed emergency care experience for all older adults, irrespective of where in the country they present.

This QIF is structured around three priority areas:

- **Priority Area 1: Minimum Care Standards for Older Adults in EDs and Injury Units**
- **Priority Area 2: Post-Triage Assessment and Bundles of Care**
- **Priority Area 3: Education and Workforce Development**

The QIF is organised using a "Must/Should/Could" framework and is designed for use at site level, with accompanying tools, audit indicators and appendices to support implementation and local adaptation.

Context

In 2023 the EMP produced guidance on the need to adapt the approach to care of older adults using our EDs. In that document a review of ED attendance patterns and triage data among patients aged ≥75 years found that:

- 60% of patients aged ≥75 years were assigned to MTS Categories 3, 4 or 5, with a high volume in Category 4.
- Patients aged ≥75 in Categories 4 and 5 often had extended ED lengths of stay (>9 hours), reflecting systemic inefficiencies rather than clinical appropriateness.
- There was substantial variability in triage categorisation across sites, suggesting the need for more age-attuned triage practice.
- Many older adults with significant clinical need (e.g., frailty, cognitive impairment, falls, or delirium) were being under-triaged, leading to care delays, unmet needs and avoidable admissions.

The paper recommended a suite of changes to triage practice to better reflect the complex presentations of older adults and to prompt earlier identification and intervention.

Key recommendations included:

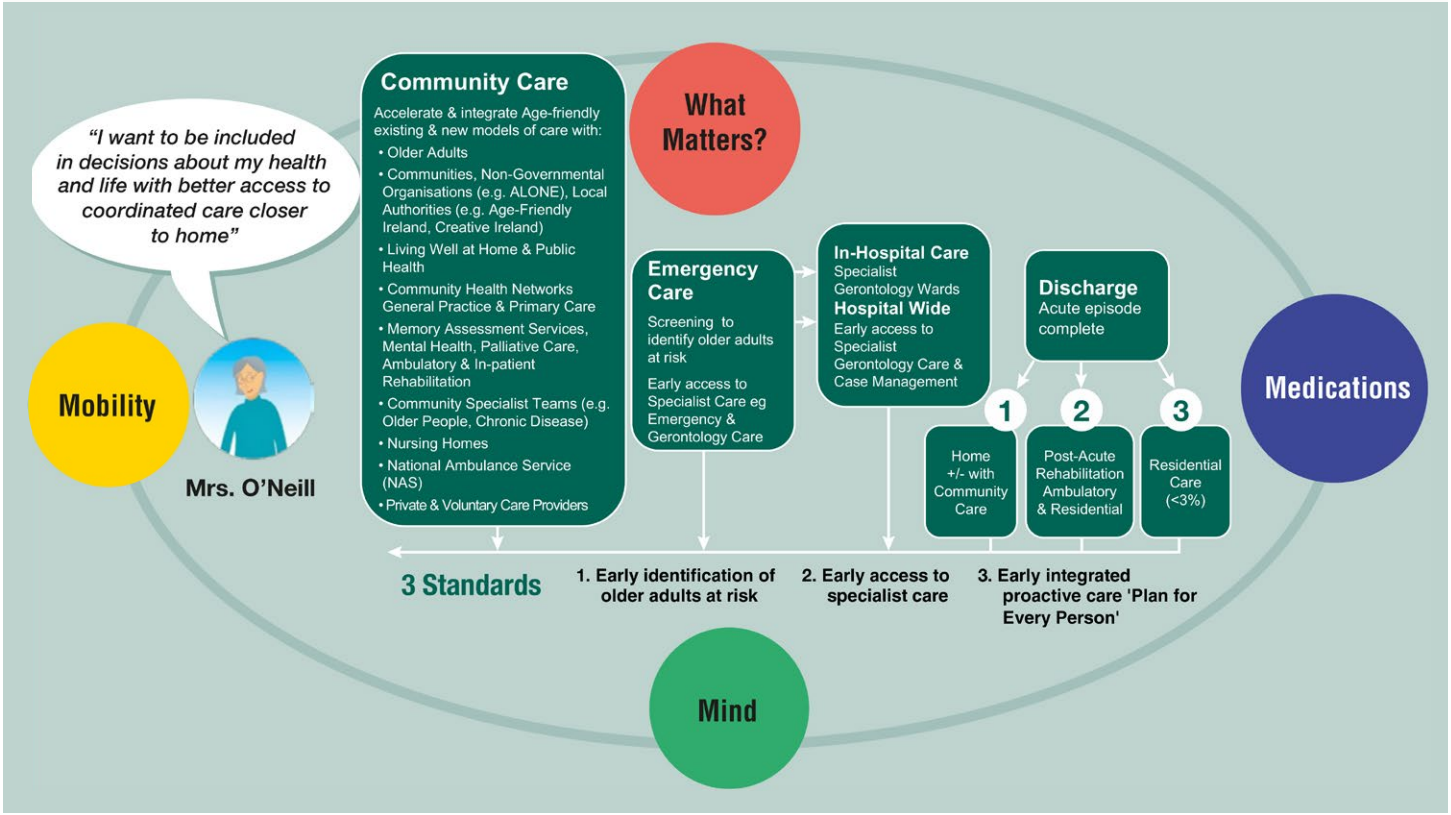
- Avoid categorising patients aged ≥75 years as MTS Category 5 unless clinical acuity is clearly minimal and explicitly documented.
- Encourage review of Category 4 designations in this age group and promote additional post-triage assessments where uncertainty exists.
- Introduce a post-triage assessment bundle for all patients aged ≥75 years, including tools such as:
  - 4AT Delirium Screening
  - Clinical Frailty Scale (CFS)
  - Falls Risk Assessment
  - Trauma Safety Net Checklist
  - A “What Matters to You” prompt

These recommendations align with the broader shift in Irish emergency care policy toward more age-attuned, needs-based triage and assessment and person-centered, value-based care, as outlined in the Emergency Medicine Model of Care 2025 and Delivering an Age-Friendly Health System (DoH and HSE, 2025) .

This QIF adopts these insights and aspirations, translating them into practical, structured improvements that can be implemented at ED and IU level nationwide.

Figure 1

Age-Friendly Health System: 4Ms across the care pathways for older adults



Source: https://assets.gov.ie/static/documents/c3f509d8/Delivering_an_Age-Friendly_Health_System_-_A_Blueprint_to_Transform_Health_and_Healthcare_for_Older_Adults.pdf

Objective 1: Adopt and Implement Minimum Care Standards for Older Adults in EDs and IUs

Why This Matters: Older adults are disproportionately affected by functional decline, delayed assessments and adverse outcomes in the ED. Implementing minimum care standards improves safety, dignity and care outcomes. Standards ensure a consistent, equitable approach across sites.

Must Do
Minimum Standard for All EDs and IUs

ID	Description
M1	Provide people living with frailty with appropriate seating, hydration, nutrition and access to toileting.
M2	Integrate HSCPs into the ED/IU care pathway for early parallel gerontologically -attuned assessment and discharge planning.
M3	Ensure that any patients discharged from the ED/IU to RCFs are accompanied by a standardised discharge summary. All patients should have a letter sent to their GP.
M4	Include older adult care metrics in routine ED/IU performance reports, including PET >75s, conversion rates

Should Do
Best Practice in EDs Ready to Advance

S1	Adopt IFEM Minimum Standards for Older Person Care in EDs.
S2	Implement older person-friendly signage, access to mobility aids and environment standards.
S3	Include care of older persons in monthly ED quality audits.
S4	Use MDT safety huddles to identify and escalate older adults at risk of deterioration or delayed care.
S5	Map out-of-hospital urgent care options for older adults (e.g. FFD, Pathfinder, virtual wards, OPAT, Same Day Emergency Care) and create access flowcharts.
S6	Ensure a working process for daily review of older patients remaining in ED >9 hrs.
S7	Contribute anonymised case studies to EMP shared learning events.

Could Do
Innovative Practice for EDs with Capacity

C1	Establish an Older Adult Care Improvement Group at site level with service user input.
C2	Conduct bi-annual simulation training focused on common presentations in older adults (e.g. delirium, falls, polypharmacy).
C3	For high volume sites consider developing a dedicated Older Adult Assessment Area within ED/IU footprint.
C4	Use visual prompts (stickers/ electronic alerts) to flag people living with frailty or dementia in ED systems.
C5	Introduce 'What Matters to You' boards or cards as part of routine ED assessments.
C6	Participate in cross-site peer review or benchmarking activities.

Spotlight: **GEMU UHL**

Geriatric Emergency Medicine Unit (GEMU) Team

The Geriatric Emergency Medicine Unit (GEMU) was established in 2023 as a dedicated space to assess older adults—specifically those aged ≥75, or frail individuals aged ≥65—during weekday daytime hours. From the outset, the impact was clear: patients received care in a calmer, age-friendly space, supported by a multidisciplinary team with a focus on what matters to older people. This led to improved patient satisfaction and faster patient experience times (PETs) for those seen in GEMU.

Like many initiatives in a busy hospital environment, GEMU has had to adapt. As the site moved toward 24/7 ED coverage and came under greater pressure for inpatient beds, the GEMU space was often repurposed for boarding patients awaiting admission. This reduced the number of older adults who could be assessed in the original unit.

Despite these challenges, the team didn't step back, they stepped sideways. They identified space elsewhere in the ED where "fit to sit" patients could still receive age-attuned, team-based care. They continued to uphold the principles of GEMU, even when the original footprint was unavailable. This flexibility ensured that many older adults continued to benefit from holistic, multidisciplinary assessment in a supportive setting. Most recently, the team has built on this approach by launching a “Frailty at the Front Door” service, further extending the reach of specialist assessment earlier in the patient journey.

The lesson from GEMU is clear: even in the face of space and staffing pressures, it is possible to carve out protected time, people, and processes that prioritise older adult care. Every ED can start by asking:

- Is there a space that could be used differently?
- Do we have existing staff who could come together as a focused team?
- Can we create a calmer, safer area—even for part of the day?

GEMU shows that with leadership, creativity, and teamwork, real improvements for older people are within reach—no matter the size or setup of your ED.

Stephen McNamara, GEM Candidate ANP

Denys Shchetkovskyy, Consultant in Emergency Medicine

Objective 2: Strengthen Post-Triage Assessment Pathways for Older Adults

Why This Matters: Many key risks for older people such as delirium, frailty, falls are not identified in standard triage. Post-triage assessment bundles ensure that care is tailored and risks are mitigated early, improving outcomes and reducing avoidable admissions.

Figure 2

4Ms Framework of an Age-Friendly Health System

Source: https://assets.gov.ie/static/documents/c3f509d8/Delivering_an_Age-Friendly_Health_System_-_A_Blueprint_to_Transform_Health_and_Healthcare_for_Older_Adults.pdf

Must Do
Minimum Standard for All EDs and IUs

ID	Description
M5	Implement a Post-Triage Assessment Bundle for patients aged ≥75 years, including: • 4AT Delirium Screen • Screen for frailty e.g. Clinical Frailty Scale (CFS) • Falls Risk Assessment Tool- Kinder • Trauma Safety Net Toolo • 'What Matters' Conversation Prompt
M6	Additional items such as bed rails assessment, time-critical medication, skin bundles or other local pathways can also be introduced in the post-triage space.
M7	Amend local triage policy to review use of Category 4/5 in patients ≥75 years, ensure specifically justified and documented. Avoid assigning MTS 4 or 5 categories unless clinical acuity is clearly minimal.
M8	Provide training for all triage staff in atypical older adult presentations, including low-velocity trauma, altered mental state and non-specific complaints.

Should Do

Best Practice in EDs Ready to Advance

ID	Description
S8	Develop or designate space for post-triage assessments separate from the resus or majors area.
S9	Bundled assessments should be completed within 30 minutes of triage. This should be audited annually.
S10	Integrate post-triage assessments into electronic records, with mandatory completion prompts.
S11	Review post-triage bundle compliance monthly at clinical governance meetings.
S12	Provide frailty screening data to inpatient teams to support early decision-making.

Could Do

Innovative Practice for EDs with Capacity

C7	Trial electronic alerts for frailty screening completion.
C8	Use digital whiteboards or dashboards to track completion of screening tools in real time.
C9	Share monthly data on bundle completion with the multidisciplinary team.
C10	Develop local decision aids to support shared decision-making post-assessment.
C11	Embed clinical pharmacist review within the post-triage zone.
C12	Trial a post-ED review clinic.

Spotlight: **Frail Intervention Therapy Teams (FITT): A Model for Holistic Emergency Care**

Frail Intervention Therapy Teams (FITT)

(back row l-r): Faiza Sefroun (Senior Pharmacist), Emer Byrne (Clerical Officer), Dr Abhilasha Thapa (Registrar), Carol Lyons (Advanced Nurse Practitioner, Gráinne Maher (Clinical Specialist Occupational Therapist), Megan Keane (Senior Speech and Language Therapist), Phil Williams (Senior Physiotherapist), Conor McDermott (Senior Occupational Therapist), Tara Fay (Senior Physiotherapist)

(front row) Pedro Puertas Broggi (Geriatrician)
Team members not in photo: Sarah Collier (Senior Medical Social Worker), Ronan Kelly (Dietitian)

Frail Intervention Therapy Teams (FITT) are a practical and achievable way for Emergency Departments to improve care for older adults living with frailty. These teams are already in place in many Irish EDs and have proven to be highly effective—even when working with limited resources.

A FITT typically brings together existing staff—such as occupational therapists, physiotherapists, advanced nurse or clinical nurse specialists and medical social workers—to assess and support older adults early in their ED journey. Some teams also include pharmacists, speech and language therapists, dietitians, or have input from geriatricians. The makeup varies by site, but the goal is consistent: deliver holistic, person-centred care that supports safe decisions and avoids unnecessary admissions. The original team at Beaumont Hospital showed significant impact in both quality of care delivered and access to CGA while showing minimal disruption to time spent in the ED.

What makes FITTs work is:

- Teamwork over titles: disciplines upskill each other and share tasks where appropriate
- Simple referral triggers: e.g. frailty flags, falls, confusion, or repeat attenders
- Fast communication: huddles, shared notes and trusted relationships
- Focus on what matters: supporting safe discharge, or where needed, admission planning

Many sites started small—one or two disciplines working together—and expanded over time. FITTs are also a valuable education resource within the ED, supporting wider staff in recognising frailty, managing complex care needs and linking with community services like ICPOP and reablement teams.

In short, FITTs are not about building new services from scratch. They are about using the skills you already have, more effectively, to make a real difference for older people in the ED.

Kara McLoughlin, Clinical Specialist Occupational Therapist, Beaumont Hospital

Objective 3: Education and Workforce Development

Why This Matters: Age-attuned care relies on confident, competent staff. Emergency training initiatives must embed GEM principles into onboarding, ongoing education and professional development at local, regional and national level.

Must Do
Minimum Standard for All EDs and IUs

ID	Description
M9	Ensure all ED/IU clinical staff have access to training.
M10	Integrate older adult care principles into all ED/IU induction training (clinical and non-clinical).
M11	Nominate an educational lead for GEM topics in each ED/IU.
M12	Deliver an annual older adult simulation or scenario-based training session.
M13	Promote shared decision-making skills including use of advanced care plans and documentation of care goals.

Should Do
Best Practice in EDs Ready to Advance

S13	Support staff to enroll in formal frailty education – National frailty Programme.
S14	Ensure at least one ED nurse per shift trained in frailty and delirium care
S15	Identify one GEM lead in each site that see older adults
S16	Facilitate interprofessional education (nurses, HSCPs, doctors) on frailty, dementia and delirium.
S17	Include GEM topics in morbidity and mortality and clinical governance reviews.

Could Do
Innovative Practice for EDs with Capacity

C13	Host a local GEM awareness week or themed education day.
C14	Host/support undergraduate or CPD placements focused on frailty and complex care.

Special Considerations for Injury Units

Injury Units (IUs) are important access points for unscheduled care, particularly in rural or regional locations. However, these units do not employ routine triage, have staffing focused on a 2-hour care standard and may lack direct links to specialty care. Older adults presenting to IUs should be recognised as a vulnerable group.

Minimum expectations for IUs:

ID	Description
IU M1	Establish local access to falls prevention services, bone health assessments and onward referral for CGA where appropriate.
IU M2	Ensure nursing and medical staff receive regular training on identifying high-risk presentations in older adults.

Other possible enhancements:

ID	Other possible enhancements:
IU C3	Liaise with local Eds or older adults services to create safe pathways for follow-up when higher acuity or complexity is suspected.
IU C4	Create a short checklist or screening tool to flag frailty, cognitive concerns or repeat attendances.
IU C5	Document “What Matters” goals and care preferences for all patients ≥75 years.

Toolbox of Resources

Resource 1	**Geriatric Friendly ED Checklist**
Resource 2	**GeriEM Lead Terms of Reference**
Resource 3	**Useful Online Resources**
Resource 4	**Overview of the QIP and visual tool** - *PowerPoint*
Resource 5	**Minimum Standards for the Care of Older People in Emergency Departments** - *Poster*
Resource 6	**Post-Triage Assessment Bundles**
Resource 7	**Triage for Older Adults** - *PowerPoint*
Resource 8	**ICD-10-AM Coding Summary for Older Persons and Emergency Departments and Injury Units**
Resource 9	**Change Management Supports**
Resource 10	**Monitoring and Evaluation**
Resource 11	**Five Practical Tips to Improve Geriatric Care Efficiency in the Emergency Department**
Resource 12	**TOP TEN for Management of the Older Person in every Irish Emergency Department.**

All resources are available on emnow.ie

Spotlight: **EDITH – Emergency Department in the Home**

EDITH Team

(l-r): Rosa McNamara and Aidan Delany

EDITH aims to deliver emergency care to older adults in their usual place of residence, rather than requiring transport to the Emergency Department (ED). It provides a meaningful alternative for older adults who require urgent assessment and intervention but may not benefit from or need hospital-based care.

In it's first 3 years EDITH assessed 8,650 patients. Of these, 91.7% (7,930 people) were managed safely at home, avoiding ED attendance and hospital admission. With an average conveyance rate of just 8.3%, EDITH has saved an estimated 21.7 years of bed days and €6.7 million in hospital costs.

While most patients assessed were of Manchester Triage Category 4, acuity ranged from Categories 2 to 5, demonstrating EDITH's capacity to safely manage a broad spectrum of presentations. The team has also developed direct access pathways to medical assessment units, rehabilitation units, respite and community reablement services.

Audit and Measurement

The purpose of the QIF is to support staff to deliver consistent, high-quality care for older adults. Implementation of the framework should be appropriate to local demographics, with the level of implementation reflecting the number of older adults attending the ED/IU. It is anticipated that services will engage in self-monitoring against the framework, rather than formal audit and external oversight will be limited to assessment of compliance with the minimum "must-do" standards.

- Post-triage bundle completion rate (Local Audit Annually, if applicable)
- Time to post-triage assessment (Ongoing Reporting via BIU returns)
- PET and LOS metrics for ≥75s (Ongoing Reporting via BIU returns)
- Time to senior decision-maker review for ≥75s (Ongoing Reporting via BIU returns)
- Monthly conversion rates for ≥75s (Ongoing Reporting via BIU returns)

Conclusion

This national QIF represents a strategic and structured approach to raising the standard of care for older adults across Ireland's EDs and IUs. It responds to international evidence, national policy and clinical consensus.

Through clear expectations, educational investment and a robust implementation framework, this QIF aims to make Ireland a leader in age-attuned emergency care.

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