

## Extended Stay

While you're in the planning phase, think about how many pediatric patients you might keep for extended periods for observation. These observation rooms should have additional space for recliners or couches for parents and family members. Many hospitals that emphasize the patient experience include private toilets in each observation room. Private toilets add cost, but by adding them each of these rooms can be negative pressure and allow the patients to remain within the room for their entire observation stay. Consider amenities for these rooms such as movies on demand and other items that will help patients and family members pass the time.

## Additional Considerations

Most interior designers with health care experience know that a pediatric emergency department might receive patients as old as 18 or 21 years. Make sure to opt for decorating with interesting colors and shapes rather than cartoon-like graphics and characters and animals. Remember the age variations among your patients.

Here are some other considerations for your pediatric emergency department:

- **Play evaluation rooms** with adjacent one-way glass observation spaces for clinicians and social workers
- **Family consultation rooms** for private conversations
- **Administrative and support spaces** for your unique operations and services, including social workers, case workers, child life specialists, and pediatric/adolescent psychiatric specialists
- In addition to regular-sized facilities, additional **smaller toilets, lower sinks, lower drinking fountains**, and so on
- **Diaper changing stations** in all rest rooms

## A Good Place to Start

Excellent resources on the care of children in emergency departments are available from ACEP and accessible from the ACEP website,<sup>8</sup> in particular, the policy developed jointly with the American Academy of Pediatrics.

In summary, the flow and management of pediatric patients closely mirror those of patients in general emergency departments. The need for privacy, comfort, confidentiality, and security is just as important. To guarantee success, work hard with your design team and architect, as well as the pediatric experts in your resource group, to identify the necessary variations in service delivery, operations, and design.

## Geriatric Emergency Departments

Baby boomers began turning 65 in 2011, and that's a sign that the population of older Americans is expanding. By 2030, one in five Americans will be a senior citizen, nearly double the 12% documented in 2000, according to "The State of Aging and Health in America," a 2013 special report from the Centers for Disease Control and Prevention (CDC). This wave of older Americans is compounded by the fact that life expectancy has increased by nearly 30 years over the past century. Research shows that life expectancy in 1900 was 48 years for men and 51 years for women; by 2000, it was 74 years for both men and women; and by 2050, it's expected to be 80 years for men and 86 for women.<sup>9</sup>

In the United Kingdom, the number of people of working age in relation to retirees is

known as the dependency ratio. In 2014, there were four people of working age supporting each pensioner in Britain. By 2035, this number is expected to fall to 2.5, and by 2050 to just 2.<sup>10</sup> All of these signs point to an aging population on both sides of the pond.

Combine rising life expectancy with the increased use of emergency departments by older persons, and the nationwide impact of an aging population on emergency departments is ominous. According to the CDC, average visits to an emergency department were 420 per 1,000 population in 2010. Among older patients, the use rate was 573 visits per 1,000 population for persons 75 to 84 years old and 832 visits per 1,000 population for patients 85 years and older.<sup>11</sup> My experience with health care professionals in Canada and Europe suggests similar trends: rising populations of the elderly presenting to emergency departments with complex conditions and comorbidities. These trends have led health care organizations to focus on developing geriatric-sensitive and geriatric-specialized care services within their emergency departments.

“Geriatric Emergency Department Guidelines” was published in 2013 by the American College of Emergency Physicians, the American Geriatrics Society, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.<sup>12</sup> This document describes the impact of geriatric care in emergency departments and this patient group’s significantly higher use of resources compared to younger populations. Here are some of the findings:

- Geriatric patients make up 43% of admissions and 48% of ICU admissions.
- Their emergency department length of stay is 20% longer.
- They use 50% more laboratory and imaging studies.
- And they’re 400% more likely to use social services.

This is a patient group that uses emergency department and hospital resources differently from other groups. The focus on geriatric emergency departments has a lot more to do with a comprehensive care strategy than just sensitive facility design.

## **More Than Environmental Design**

The term “geriatric emergency department” gives great credence to developing an environment that is comfortable and suitable to older patients. But the most successful geriatric emergency departments start with a more strategic focus on the *care* of the elderly and then develop facilities to support their clinical goals. This includes a greater focus on geriatric competencies across the board, from residents to seasoned emergency physicians.

A great example of a strong strategic focus on the elderly is the GEDI WISE program at Northwestern Memorial Hospital (Chicago), St. Joseph’s Regional Medical Center (Paterson, New Jersey), and Mount Sinai Hospital (New York). GEDI WISE stands for Geriatric Emergency Department Innovations in Care through Workforce, Informatics, and Structural Enhancements. It’s defined as:

“an integrated multidisciplinary approach that incorporates workforce education, training, and expansion; evidence-based geriatric-specific clinical protocols; informatics support for patient monitoring and clinical decision support; and structural enhancements to improve patient safety and satisfaction.”

A great deal of the GEDI WISE program is focused first on the geriatric-centered workforce that will provide a comprehensive approach to emergency care for the elderly patient, such as the one at Mount Sinai that includes:<sup>13</sup>

- Geriatric emergency physician
- Geriatric emergency department nurse coordinator

- GEDI WISE nurse practitioner (care transitions)
- Geriatric emergency department social worker (care transitions)
- Emergency department-savvy geriatrician (geriatric liaison)
- Geriatric emergency department pharmacist
- Geriatric emergency department physical therapist
- CARE (Care And Respect for Elders) volunteers

Similar efforts to define comprehensive emergency care in the United Kingdom include the “Silver Book” developed by lead authors Jay Banerjee (College of Emergency Medicine, University Hospitals of Leicester NHS Trust) and Dr. Simon Conroy (British Geriatrics Society, University of Leicester), with special advisers Matthew Cooke (National Clinical Director for Urgent and Emergency Care), David Oliver (National Clinical Director for Older People), and Alistair Burns (National Clinical Director for Dementia).

The Silver Book is “a set of quality standards for the emergency care of older people” and recommends “ways in which emergency admissions can be reduced and the experience of those admitted improved.” The document considers all the clinical contacts a patient might experience and defines the skills and competencies needed by health care staff to ensure they are better able to assess and manage frail older people. It addresses the “appropriate communication skills—both with patients and other health and social care professionals; clinical reasoning and assessment skills in respect of complex co-morbidities, poly-pharmacy and altered physiological response to trauma and illness; and risk management skills surrounding discharge planning with knowledge of community services.”<sup>14</sup> The Silver Book was developed by a multidisciplinary group of stakeholders, including:

- Age UK
- Association of Directors of Adult Social Services
- British Geriatrics Society
- Chartered Society of Physiotherapy
- College of Emergency Medicine
- College of Occupational Therapists
- Community Hospitals Association
- National Ambulance Services Medical Directors
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Physicians
- Royal College of Psychiatrists
- Society for Acute Medicine

So, without getting too far into the details of delivering geriatric emergency services (especially since I’m an architect and not a physician), let me summarize by saying that the development of a geriatric emergency department should start with your commitment to, and depth of, geriatric services within your future emergency department. As noted by the expanded teams above for Mount Sinai and the input into the United Kingdom’s Silver Book, the development of your geriatric emergency department might include the input of numerous participants who will each have a unique point of view for what a geriatric emergency department of the future might, or should, be.

## ***A Good Place to Start***

Just as it provides excellent resources for pediatric considerations, the ACEP website provides terrific information on geriatric care in the emergency department.<sup>12</sup>

In particular, I recommend “Geriatric Emergency Department Guidelines” as a great starting point if you’re considering a geriatric emergency department. Its purpose is “to provide a standardized set of guidelines that can effectively improve the care of the geriatric population and which is feasible to implement in the emergency department.” The document covers the larger view of how the emergency department, inpatient, and outpatient resources can be pooled for comprehensive assessment and treatment of the geriatric patient. It also covers recommendations for administration, staffing, follow-up/transition of care, education, policies, procedures, and protocols. Specific to the geriatric emergency department environment, it also summarizes recommendations for equipment, supplies, and a few physical design attributes. It’s a great reference.

## **The Patient Experience**

If you’ve read this book from the beginning, you already know that I emphasize analysis and improvement of the operational flow of a facility *before* you design the environment, including your vision of the patient experience. Well, nothing drives the design of the physical environment in a geriatric emergency department more than a clear focus on the patient experience, which should be expanded to include the patient and family experience. With a clearly defined focus on the care, diagnosis, treatment, and follow-up care for the elderly, an organization can then concentrate on how it wants elderly patients and their friends and families to experience the delivery of the specialized geriatric emergency services. My recommendation is to document your goals for patient experience before you start listing special rooms to design into the emergency department. I’ll use the next few sections to describe some considerations for your goals.

## **Levels of Geriatric Separation**

If you jumped to this section because of your special interest in this specific design solution, please go back to the beginning of this chapter and read the section on pediatric emergency departments, specifically “Levels of Pediatric Separation.” When considering a geriatric emergency department as part of a specialized area within a general emergency department, the level of separation and options for splitting general emergency department patients from specialty populations will apply to your focus on geriatrics. The section on pediatrics goes into much more detail than the following summary.

### **Geriatric Separation Level 1: No Separation**

No special pathways, protocols, or amenities for a geriatric population.

### **Geriatric Separation Level 2: Minimal Separation**

A few rooms in the emergency department are designated for geriatric patients, but for the most part, geriatric patients are just part of the general emergency department population.

### **Geriatric Separation Level 3: Clinical Separation**

One entry point at the main walk-in entrance, one triage area, and then geriatric patients are diverted to a geriatric care zone. This includes internal waiting, designed specifically for geriatric patients and supportive of specialized “geri-ED” services. The department might still flex general adult patients into the geriatric emergency department,

but the intent is to keep geriatric patients separated from the general adult and pediatric patients as much as possible.

## **Geriatric Separation Level 4: Maximum Separation in one Emergency Department Location**

Level 4 separation means you further split the geriatric and general emergency department populations by defining a separate entrance to the geriatric emergency department. You might still have a centralized triage area that allows staff to flex back and forth between geriatric and general emergency department patients, but geriatric patients are separated from the general emergency department population by use of specialized geriatric triage rooms. Geriatric patients remain separated in a special subwaiting area or are escorted immediately to the geriatric care area. Again, the space might be flexible for the general emergency department population based on your capacity needs and intention to designate the area for only geriatric patients.

## **Geriatric Separation Level 5: Completely Separate Geriatric Emergency Department**

If you opt for Level 5 separation, you'll be developing a completely separate geriatric emergency department. This level of separation usually occurs when an organization splits the geriatric emergency department away from the general emergency department and puts it in a different location, sometimes on a different floor. St. Joseph's Regional Medical Center in New Jersey, for example, has placed its geriatric emergency department two floors above the main emergency department and adjacent to a geriatric care unit.<sup>15</sup>

## ***Geriatric Emergency Department Access***

Once you decide how you'll assign geriatric patients to care areas, you should consider the patient and family experience from the time the patient first accesses your hospital campus. First, let's discuss automobile access. Driveways and entry points must be clearly marked. This is even more important with the development of a geriatric emergency department. Keep driveways simple and straightforward, and make sure visibility to your "front door" is clear for people approaching your building via automobile.

Give careful consideration to offering valet services, for two reasons. First is the obvious support for parking cars for family members or aging spouses or significant others. Second is that there should always be someone at the front door outside of the facility to meet and greet patients. The attendants can assist elderly patients out of the car and immediately alert clinical staff inside if their assistance is necessary.

Earlier discussions about security and being able to see the walk-in entry point from the reception area apply to the geriatric emergency department as well, perhaps even more so. Staff members in the reception area should be able to maintain visibility for arriving older patients and make sure they can help as needed.

## **EMS Access**

Emergency departments that purport to have specialized geriatric emergency care capabilities must plan carefully what to do with ambulance patients. Having an elderly patient lie on a stretcher in a cold, busy entry vestibule or corridor while EMS personnel and emergency department personnel complete a handoff is a problem that can be avoided.

Perhaps you can have a separate and immediate pathway from the EMS entrance to an area within the geriatric emergency department. You don't want to bring every arriving geriatric patient into the center of the geriatric emergency department, but you should have a designated area adjacent to, but removed from, the EMS entry and away from other stretchers entering the emergency department. It should be out of the way of traffic, climate controlled, and away from the general EMS entry vestibule. If possible, make sure the area is visible from the central control area of the geriatric emergency department module so staff can see the crew and the patient when they come in.

## Geriatric Intake

Whether you have one care initiation area for the whole emergency department or a separate one for the geriatric emergency department, you should ask for private rooms for the intake process. Private rooms support privacy and reduce noise and confusion. The use of comfortable recliners in this area allows geriatric patients to remain vertical and comfortable if they don't need to lie down. Make sure the intake rooms are large enough for accompanying family members.

### If the unit is at capacity ...

Even when your geriatric clinical area is at capacity, you should do your best to not mix geriatric patients with other patient populations. Develop a separate geriatric inner patient lounge (inner subwaiting room) to keep geriatric patients moving forward in the process within the geriatric care zone. This should not be the same inner waiting room for your general emergency department patients. One option for flexibility is to develop multiple subwaiting areas next to each other that allow you to flex back and forth and use the various spaces as needed if different populations (general versus geriatric) need more or less subwaiting space.

Although visual control by an emergency department staff member (clinical, if possible) is important for any inner waiting room, it's imperative for a geriatric subwaiting area. Make sure you can keep an eye on these patients and that the configuration doesn't create blind spots (as would happen with an L-shaped room). As with any subwaiting area, make sure your geriatric emergency department inner patient lounge has immediate access to a toilet and an adjoining consultation room for private conversations.

## Location of the Geriatric Care Zone

Most geriatric emergency departments are developed within the larger context of a multizoned emergency department at separation Level 3 (separate care zone) or Level 4 (separate entrance and care zone). If that's the case for your future department, you'll have a separate geriatric care zone within your emergency department that will be designed to support the special functions associated with your unique strategy for delivering emergency care to the elderly. First, you'll need to identify the most appropriate location for this zone. Although the most obvious location is close to triage, here are some other considerations that will affect patients:

- First, the obvious: can you develop the unit **close to triage** to limit the number of steps to the unit?
- Does the position of the unit allow **rapid access from the EMS entrance**?
- Can you position the unit for **rapid access to imaging facilities** without crossing the traffic of trauma patients, pediatric patients, or general emergency department patients?

- Anticipating that some elderly patients will stay in the unit for an extended time, is there a **clear path for visiting family members** from the public entry and waiting area?
- Is the unit in **an area that can be locked down and secured**? Can you position the unit in a location where staff won't use it as a pass-through to the main emergency department clinical area and the hospital?
- What's the **path from an emergency department resuscitation room** to the geriatric emergency department?
- If patients are admitted to the hospital from the geriatric emergency department, **will they have to be transported through the main emergency department**, or will they have a more direct route?

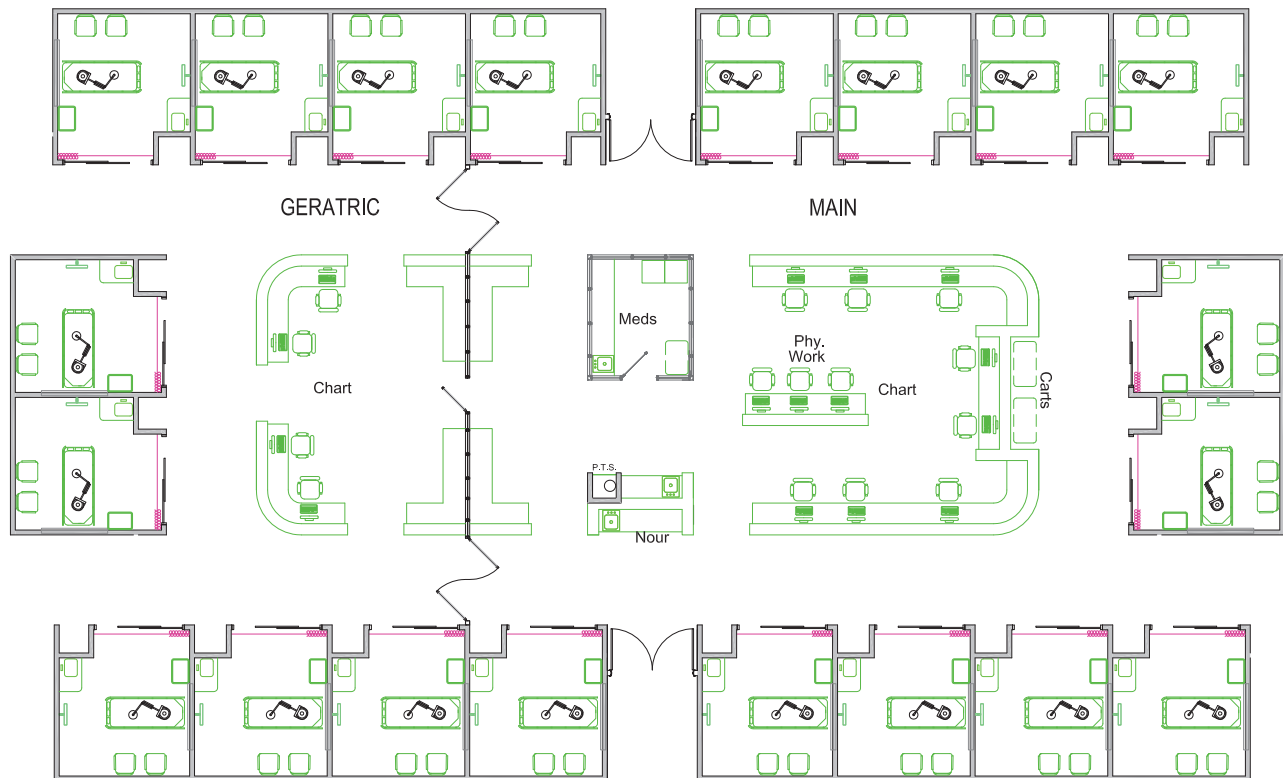
With large emergency departments, not all zones have access to exterior walls and, thus, the opportunity for windows. If only selected areas of your department will have exterior windows allowing daylight in, you might choose to allow the geriatric emergency department to take advantage of such a benefit.

### Separation of Clinical Area

In Chapter 7, I described how the behavioral health care zone should be sound isolated and visually isolated to patients but still remain visually connected to other zones. The basic goal is to allow for clinical (and auditory) separation of that specialty population while still allowing a visual connection to the staff in that area from the general clinical area. This is a challenge, but push your design team to make sure the geriatric emergency

**FIGURE 8.7.**

Visual connection to geriatric care zone. *Courtesy of Huddy HealthCare Solutions.*



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department is a physically (and acoustically) separated zone that still has a visual connection to other care teams in the main emergency department. **Figure 8.7** shows the concept of a separate geriatric zone that still has a visual connection to the main emergency department.

## Design Considerations

When I do presentations on the fundamentals of geriatric emergency department design, I always end by saying that great geriatric emergency department design is great emergency department design overall. What I mean by that is every geriatric emergency department design consideration that supports safety, comfort, confidentiality, and sound clinical care is also applicable to a general emergency department. But, where the following design considerations are appropriate for all emergency department care zones, I believe they're mandatory for a truly great geriatric-specialized emergency department or care zone.

### Private Rooms

It seems obvious, and it's a must in a geriatric emergency department care zone. The emphasis on privacy and confidentiality and the ability to control the environment for sound and lighting are extremely important. Nearly every geriatric emergency department emphasizes the importance of thicker, more comfortable mattresses on the examination room stretchers, and some geriatric emergency department exam rooms are large enough (at approximately 150 to 160 sf) for actual hospital beds. That might sound like a great idea, but remember that selecting larger rooms might mean that you're selecting *fewer* rooms because of a fixed amount of area to design within. Each examination space should be large enough for a stretcher (with extra padding!) or a bed, but you might consider outfitting some rooms with a recliner for patients who don't need to be kept horizontal. Or, have the ability to switch a stretcher out for a recliner.

Room for side chairs is also a must for a geriatric emergency department examination room. Family members and spouses are nearly always present for an elderly patient, and their role in the patient's care and comfort is important. Look back to the section on multifunctional treatment rooms for pediatric patients, and review the discussion of configurations that allow family members to be present without impeding the staff.

### Should you ask for all private toilets?

One decision that will have a significant impact on space and your construction budget is whether to provide a private toilet for each geriatric treatment room. This is a great patient and family satisfier, but the cost of the extra toilets and the potential reduction of the number of treatment rooms mean that you have to make this decision carefully. Are eight examination rooms with all private toilets going to deliver your objectives better than 10 examination rooms with two common/shared toilets in the unit? If you're not going to have private toilets for every examination room, ask your designer to try to limit travel distances from each examination room to an available toilet.

If your design does include private toilets, ask the architect to position them so that the patient can hang on to a handrail from the bed or stretcher to the toilet room. In **Figure 8.8**, the patient has to travel across the room to gain access to the toilet without the support of a handrail. **Figure 8.9** shows a handrail along the wall between the bed and the toilet.



## How many rooms should you ask for?

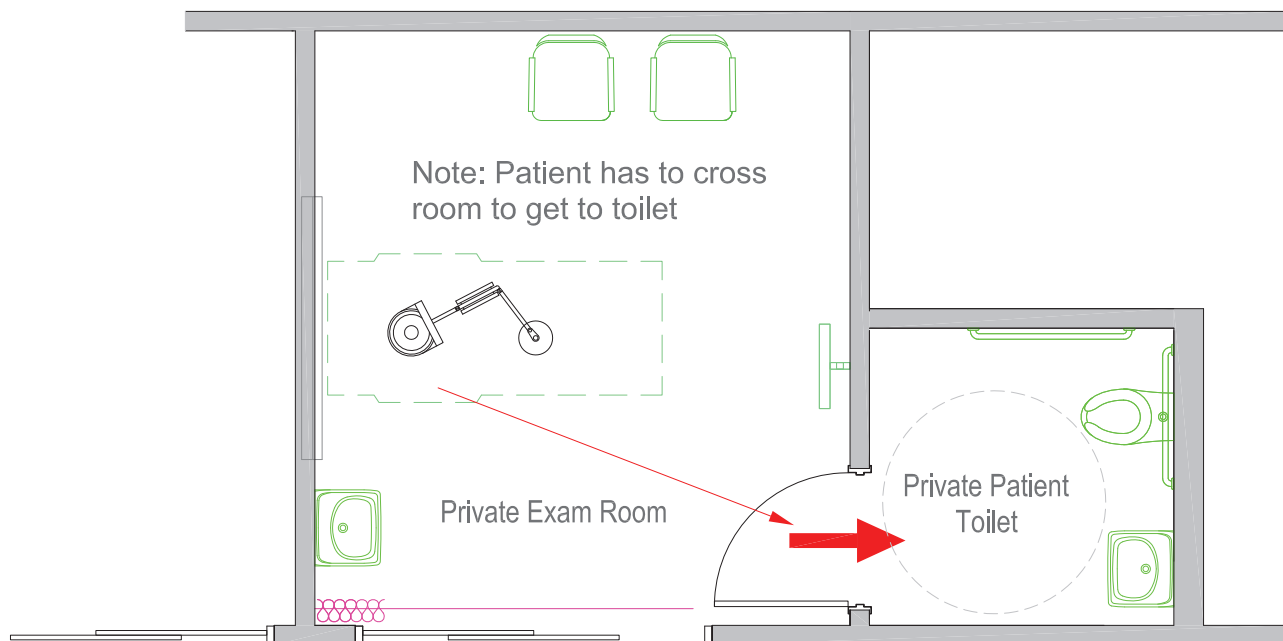
To maximize visibility to each treatment room, ask your architect for ICU-like glass doors and a design that allows visibility from a central control location to the head of the patient. Yes, bedside nursing care is the goal, but visual control of all patients is also a must.

The discussion of visibility into each geriatric treatment space brings us to the discussion of the overall size of a geriatric emergency department zone. In Chapter 7, I said that once an emergency department exceeds 12 or 14 rooms, it's difficult to support visual control of each room with only one centralized nurses' station. Consider this same sizing formula for your geriatric care unit. Once you exceed 12 or 14 treatment rooms, your choices are to compromise visibility into the care rooms, to expand the central work area (nurses' station) larger than it needs to be, or to split the geriatric area into multiple care zones.

The standard utilization of a general emergency department examination space is in the range of 1,300 to 1,500 patients annually for every examination room. But, remember that this is a blended rate for general emergency departments that includes nonurgent, urgent, and much sicker patients. As you can imagine, a geriatric care zone will accommodate sicker older patients with potential comorbidities. When estimating the average number of patients per room for a geriatric emergency department, I would skew programming to the lower end of 1,300 patients per room over 1 year. That means a 12-bed geriatric emergency department with one centralized nurses' station (with a view to all patients) would accommodate in the range of 15,600 elderly patients per year (12 rooms x 1,300 patients/room). Obviously, this is a general range, but it gives you a feel for the potential capacity of your unit and when you might need to expand.

### FIGURE 8.8.

No handrail to private toilet. *Courtesy of Huddy HealthCare Solutions.*



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## Additional Considerations

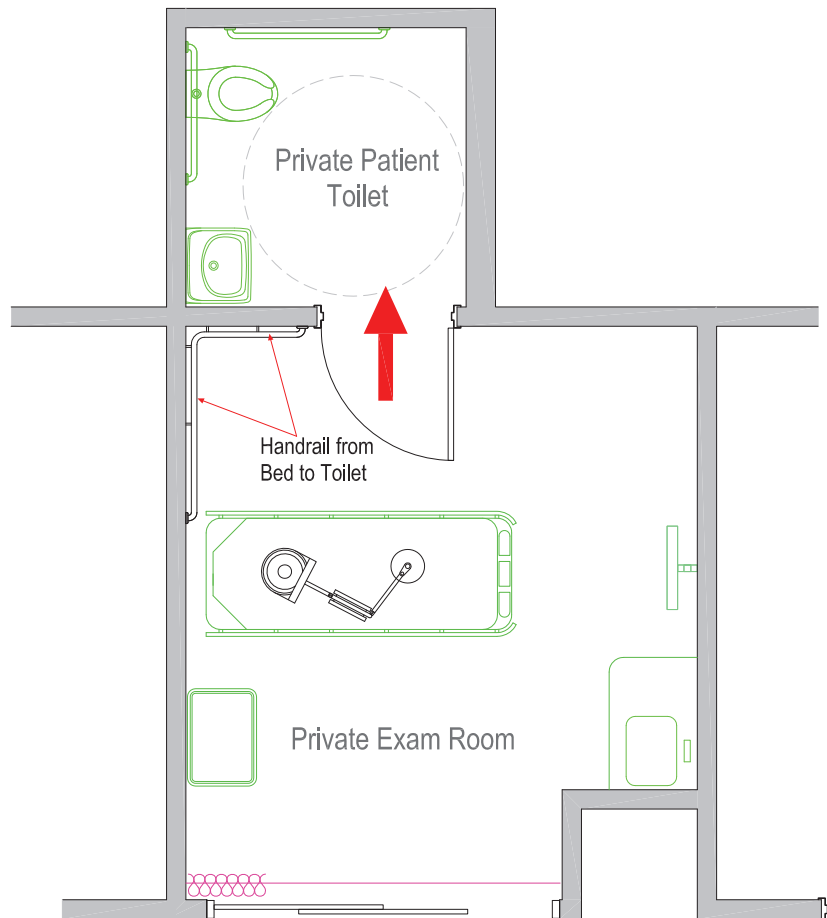
The geriatric care unit will have the typical support needs—clean supply rooms, soiled utility rooms, equipment storage, medication rooms, charting areas, and so on. But you should also consider additional administrative/clinical support spaces: work space or offices, for case managers, social workers, nutritionists, physical therapists, pharmacists, psychiatrists, and volunteers. You don't have to duplicate lots of office space beyond your budget, but you can develop universal work spaces that the various specialists can share while they're in the unit. Work with your internal design team to determine who will need a consistent space every day versus a shared work area. A full-time employee will likely be in the unit around the clock, but specialists will be called to the unit only as needed. Identify which staff members really need to be in the nurses' station versus on the periphery of the geriatric care zone.

Make sure you program additional family consultation rooms in the geriatric care module. Many times, private conversations with family members or spouses need to occur outside the room, so these consultation rooms should be readily accessible from within the unit. Consider separate family inner waiting areas that provide a place for a patient's family members or spouse to spend some time outside of the examination room, especially in the case of extended-stay visits in the unit. Consider family nutrition areas for snacks or coffee or access to research and educational materials with regards to geriatrics.

## Where will you care for geriatric patients with nonurgent conditions?

In the design planning phase, decide whether you'll provide care to all of your older patients in the geriatric emergency department or care zone, or accommodate nonurgent geriatric patients in the general emergency department nonurgent area such as in the general population rapid care, or vertical, area of your main emergency department. Most of my clients have decided that, if an older patient is a candidate for rapid treatment, he or she is usually accommodated within the general population where the processes, staffing,

**FIGURE 8.9.** Handrail to private toilet. *Courtesy of Huddy HealthCare Solutions.*



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and facilities are designed for rapid “treat and release.” But some of my clients have considered creating a “mini fast track” area in their geriatric care zones where specialized geriatrics-trained staff and clinicians can interact with older patients regardless of acuity.

I believe you should consider the alternatives and determine, based on your specific geriatric emergency department program, the best location for nonurgent geriatric emergency department patients to receive care. This decision might also have an impact on where you put the whole geriatric care zone: can it be adjacent to the rapid care area so the geriatric specialists in the geriatric emergency department can have quick access to elderly patients in the general population rapid care area?

## Geriatric Care Zone Configuration

In Chapter 7, I covered the linear emergency department concept and presented what I see as the associated pros and cons. In the linear emergency department configuration, patients enter examination rooms through doors on an outer loop corridor, and staff and clinicians enter examination rooms from the interior central work core. The drawback of this configuration is the lack of visual supervision (except by cameras) of the outer loop corridor from the interior central work core. This is why I advise against the linear approach for a geriatric emergency department care zone. Maintaining visual control of your elderly patients while they circulate through your emergency department should be a major consideration in your design: it’s a key to the continuous evaluation of your patients and their conditions and safety.

Even with a centralized control area and visibility to each treatment room, you still should try to eliminate blind spots at the ends of corridors. Work with your designer to determine where the blind spots are, where a corridor might turn a corner, and where visual supervision is compromised from your central control point. The ability to maintain full control of your geriatric emergency department from a centralized area will make the department safer and more secure, especially with the potential fall risks with elderly patients.

## Facility Impacts

The overriding design drivers for a geriatric emergency care unit are safety, comfort, and mobility support. The design should allow for safe movement around the unit, clear visibility to patients in care areas (examination rooms), and limited travel distances to imaging and toilets. Wayfinding should be supported by large images or murals along the walls that allow patients to make a visual connection with their locations within the unit. Signs might be created with larger-than-usual text, which might mean deviating from the hospital’s usual wayfinding sign standards. Many geriatric units also use large-faced clocks in the corridors and examination rooms.

## Lighting

Here’s another opportunity to incorporate patient-centered design: instead of going with the typical large 2x4-foot fluorescent lights down the corridor ceiling, consider nonglare lighting, canned down lights, wall sconces, and other styles that brighten the way with less glare.

In the examination rooms, you’ll still want lights on the ceiling, but these lights can be small, and they can have dimmers. Canned down lights and some new LED lights allow examination rooms to be bright for examinations and dimmed for resting.

## Flooring and Interior Design

For starters: nonslip flooring throughout the unit and in the examination rooms. Try to avoid the complicated colored floor patterns that can be associated with other areas of the hospital or in the main emergency department. “Wild” patterns and colors can be perceived as steps or changes in elevation by an elderly patient, so please keep the floor patterns as clean and clear as possible. When you’re considering the interior design of the rest of the emergency department, opt for soothing colors and color changes to help with navigation. Door frames and doors should be a different color than the walls for easy identification. The baseboard on a wall along the floor should be a different color than the floor and the wall so patients can more easily see where the wall meets the floor. Consider a different color, tone, or shade for nursing counters, also in support of patients being able to navigate the areas around the clinical work spaces. Different counter heights (such as 30" desk height versus 43" nurses’ station height) should be distinguished using colors and shades as well.

Ask the designer to include handrails throughout the unit, in all hallways, and in all examination rooms. The color of the handrail should be different from the color of the wall to make it easier to see. And while accessible design codes dictate handles on doors rather than knobs, you should consider using handles on all patient-accessible doors within the unit.

## Auditory Distractions

The use of all private rooms will bring down the noise level of a busy geriatric unit, but consider operational changes to eliminate other auditory distractions. For example, can you eliminate overhead paging and go to person-to-person communication devices? Work with your facilities staff to determine the best type of communication devices for the main nurses’ stations. Can you get away from high-pitched ringtones on your telephone system? Train staff on the appropriate level of verbal communication across the department. The intent is to support a calm, safe environment, and limiting auditory distractions in the unit goes a long way toward delivering a stress-free environment.

## Temperature Control

Some geriatric emergency departments are designed to allow for independent temperature control, which means the unit can be a bit warmer than the rest of the emergency department. This adds cost and complexity to the design of the HVAC (heating, venting, and air conditioning) system, as does allowing for individual temperature control within examination rooms. Work with your facilities staff and engineers to determine whether you can have an individual temperature control system in each individual room and what the impact will be on the budget.

## Equipment

Don’t forget the blanket warmers in your geriatric emergency department or other unique equipment needs such as hearing-assist devices and space for walkers, wheelchairs, respiratory equipment, and bedside commodes. Here’s another communication system to consider asking for: video-on-demand support for discharge instructions. I can’t remember the conference I was at (yes, age is catching up to me), but I remember hearing anecdotally that we remember two to three times more of what we see than what we just read. Showing short videos that reinforce the discharge instructions is an excellent way to educate patients

and family members. This extra effort could increase compliance and decrease the number of return visits.

### Before it's all said and done ...

To circle back to the beginning of this discussion, the design goals for your geriatric emergency department or geriatric care zone should include increased safety, comfort, confidentiality, and patient and family satisfaction. An appropriately designed unit also will support the expanded services that come with a comprehensive geriatric emergency department program. Work with your internal design team to determine what services you'll provide when the unit opens and the services that might be provided in the future. And, don't be surprised if younger adults who come back to your department for their own care end up asking to be placed in your geriatric emergency department because of the positive experience they had bringing their parents to your geriatric emergency department previously.

## Freestanding Emergency Departments

Based on the number of requests I've gotten over the past 5+ years for information on the design of freestanding emergency departments (FSEDs), I can tell they're gaining traction across the United States. I won't list the states that currently license freestanding emergency departments because by the time you read this, the list will be out of date. Massachusetts, Texas, Colorado, and Florida led the way, while other states are still deciding. Please be aware that your state might still prohibit FSEDs whether they're owned and operated by a hospital, by physicians, or by investors. In Texas, for example, the growth has been significant, and the facilities have been developed by both hospitals and private investors, and not just in rural areas where the population is underserved but in major metropolitan areas with multiple competing medical centers.

### A Good Place to Start

"Freestanding Emergency Departments and Urgent Care Centers: An Information Paper"<sup>16</sup> was written by members of the ACEP Emergency Medicine Practice Committee in August 2015. It covers in detail the impact of CMS, EMTALA, and other federal regulations and accreditation rules on the development, operations, and business plans for FSEDs. It covers key similarities and differences between FSEDs and urgent care centers and is an excellent resource, especially if you want to know more about the distinctions between the two types of facilities and the services they provide. It's available on the ACEP website, along with the ACEP policy<sup>17</sup> and resources developed by the ACEP Section on Freestanding Emergency Centers.<sup>18</sup>

### Types of Freestanding Emergency Departments

As described in the ACEP information paper,<sup>16</sup> there are two types of FSEDs:

- **Hospital outpatient departments** (HOPDs) and
- **Independent FSEDs**

The HOPD is owned and operated by, or licensed through, a medical center or health system. The independent FSED is owned by physicians or by a private investor group. If the hospital that owns the HOPD accepts Medicare payments, the HOPD will be governed by the same CMS rules and regulations. The FSED isn't recognized by Medicare and isn't