

# Managing “socially admitted” patients in hospital: a qualitative study of health care providers’ perceptions

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## Abstract

**Background:** Emergency departments are a last resort for some socially vulnerable patients without an acute medical illness (colloquially known as “socially admitted” patients), resulting in their occupation of hospital beds typically designated for patients requiring acute medical care. In this study, we aimed to explore the perceptions of health care providers regarding patients admitted as “social admissions.”

**Methods:** This qualitative study was informed by grounded theory and involved semistructured interviews at a Nova Scotia tertiary care centre. From October 2022 to July 2023, we interviewed eligible participants, including any health care clinician or administrator

who worked directly with “socially admitted” patients. Virtual or in-person individual interviews were audio-recorded and transcribed, then independently and iteratively coded. We mapped themes on the 5 domains of the Quintuple Aim conceptual framework.

**Results:** We interviewed 20 nurses, physicians, administrators, and social workers. Most identified as female ( $n = 11$ ) and White ( $n = 13$ ), and were in their mid to late career ( $n = 13$ ). We categorized 9 themes into 5 domains: patient experience (patient description, provision of care); care team well-being (moral distress, hierarchy of care); health equity (stigma and missed opportunities, prejudices); cost of care (wait-lists and scar-

city of alternatives); and population health (factors leading to vulnerability, system changes). Participants described experiences caring for “socially admitted” patients, perceptions and assumptions underlying “social” presentations, system barriers to care delivery, and suggestions of potential solutions.

**Interpretation:** Health care providers viewed “socially admitted” patients as needing enhanced care but identified individual, institutional, and system challenges that impeded its realization. Examining perceptions of the people who care for “socially admitted” patients offers insights to guide clinicians and policy-makers in caring for socially vulnerable patients.

Emergency departments have become a destination of last resort for some patients who are made vulnerable by social circumstances, resulting in their occupying hospital beds typically designated for people with acute medical issues.<sup>1</sup> “Social admission” is a colloquial, nondiagnostic label used to describe a person for whom no acute medical issues are recognized to be contributing to their seeking health care. However, many health care providers understand that patients who are admitted for social reasons face challenges such as a breakdown of care supports or an inability of the patient or family to cope with the demands of living at home.<sup>2</sup> These patients often have lengthy stays in emergency departments or hospital wards, and frequently encounter barriers (e.g., housing or home support) delaying safe discharge

from hospital. The colloquial terms “failure to cope,” “acopia,” “orphan patient,” or “home care impossible,” among others, are sometimes used to refer to these patients.<sup>3-5</sup> Such terminology can be stigmatizing because it indicates a value judgment that patients require admission solely on “social” grounds, sometimes failing to account for underlying medical complexity.<sup>6</sup>

The “social admission” phenomenon is an under-researched area in health care. These patients, often categorized by health care providers as not being acutely ill, experience in-hospital death rates as high as 22.2%–34.9%.<sup>7,8</sup> Explanations may include under-triaging in the emergency department owing to poor recognition of atypical clinical presentations and delays in timely assessments.<sup>5</sup> Patients may be misdiagnosed or develop acute

illness during their hospital stay. In 2 international studies, by the end of hospitalization, an admission diagnosis of “acopia” was no longer the discharge diagnosis in 88%–92.5% of cases.<sup>7,9</sup> Diagnoses of falls, delirium, and mobility problems were common, but sepsis was initially undiagnosed in almost one-third of these patients.<sup>7</sup> This raises questions about health care providers’ awareness of atypical presentations and decision-making for “social” presentations, which often require a nuanced understanding of both medical and social care needs.

Health care providers face challenges providing high-quality care to this patient population across Canada<sup>1,10</sup> and internationally.<sup>1,4,10–13</sup> “Social admissions” may account for as many as 1 in 10 patients (0.57%–9.3%) presenting to the emergency department and 1 in 25 admissions to hospital, with increasing prevalence with age.<sup>14</sup> A survey from Wales showed that 51.8% of hospital physicians consider that they frequently care for these patients, encountering them several times per week.<sup>15</sup>

Since “social admission” is a nondiagnostic label, its definition varies across regions and health care systems, meaning no guidelines exist to standardize approaches to meet medical or social care needs. Qualitative data evaluating how health care providers perceive and care for these patients are lacking. Therefore, we aimed to explore the perceptions of health care providers regarding patients admitted as “social admissions.”

## Methods

### Study design

This qualitative study was informed by constructivist grounded theory, which uses inductive analysis of data collected from participants to generate new theories.<sup>16,17</sup> We conducted semistructured interviews with clinicians and health care administrators between October 2022 and July 2023. Given that little is known about “social admissions,” grounded theory was best suited to our objective to generate an explanatory theory about this phenomenon.<sup>17</sup>

The research team included qualitative methods experts, geriatric medicine specialists, clinician scientists, primary care and emergency department clinicians, and members with administrative leadership roles. We also included nursing students, medical students, and internal medicine residents of diverse backgrounds.

We reported this study using the Consolidated Criteria for Reporting Qualitative Research Checklist (Appendix 1, available at [www.cmaj.ca/lookup/doi/10.1503/cmaj.231430/tab-related-content](http://www.cmaj.ca/lookup/doi/10.1503/cmaj.231430/tab-related-content)).<sup>18</sup>

### Setting and participants

Studying “social admissions” can be challenging because of the variability in terminology and admission policies across different jurisdictions.<sup>19</sup> The Orphan Patient Policy is a standardized “social admission” pathway used at the Queen Elizabeth II Health Sciences Centre, a tertiary care centre in Halifax, Nova Scotia. Halifax is the provincial capital and the largest city in the Atlantic region of Canada. In Nova Scotia, health care is provided through a publicly funded health care system.

Since March 2012, any patient, regardless of age or living situation, can be admitted to the Queen Elizabeth II Health Sciences

Centre under the Orphan Patient Policy if they have undergone a medical assessment by a physician in the emergency department, are determined to have no acute or new medical conditions, and have been seen by a social worker or discharge planning nurse to exhaust all home care options. Inability to return home includes situations of homelessness, unavailable community supports, or waiting for transitions to long-term care. These patients are admitted to the first available inpatient bed, based on a rotating roster of all hospital admission services (e.g., medicine, psychiatry, surgery, subspecialty medicine or surgery, and hospitalist). The admitting service and its allied health care team become responsible for the patient’s care and disposition, with the expectation that discharge planning is the primary issue. Although these patients are locally called “orphan patients,” we use the terminology “social admission” throughout this paper.

Eligible participants included any clinical provider or administrator who worked directly with “socially admitted” patients. To identify potential participants for our study, we held initial interviews with hospital nursing bed flow managers who are responsible for administering the Orphan Patient Policy.

To recruit participants, we used snowball sampling: we emailed each health care provider or department that had been recommended by the initial interviewees (i.e., the nursing bed flow managers), and those suggested by study participants during their interviews or by key knowledge users with whom we shared preliminary findings (see Data analysis). Preliminary analyses also informed recruitment, and we used purposive and theoretical sampling<sup>20,21</sup> to ensure that the perspectives of multiple health care professionals within the “social admission” care pathway were included, with the aim of data saturation. We approached several departments and individuals who declined to participate or did not respond to our requests for interviews. These included recreation therapy, physiotherapy, occupational therapy, some administrative positions, and several subspecialty medicine divisions.

### Data collection

The interview guide (Appendix 2a, available at [www.cmaj.ca/lookup/doi/10.1503/cmaj.231430/tab-related-content](http://www.cmaj.ca/lookup/doi/10.1503/cmaj.231430/tab-related-content)) was based on our literature review of “social admissions”<sup>14</sup> and informed by our chart reviews of more than 350 “social admissions” in Nova Scotia (unpublished data, 2021). The entire research team gave input on the interview guide through several iterative processes: multiple meetings to develop the guide, a pilot test with non-author colleagues, and a meeting after all interviewers had conducted at least 1 interview to discuss whether the guide was robust enough to elicit the information we were seeking. We revised the interview guide wording for clarity and understanding, and we added 2 major questions (interview guide questions 7 and 8) and several prompting questions.

Experienced qualitative researchers (C.S. and E.G.M.) provided training. We held 2 group and 1 individual interactive training and practice sessions, which provided methodological context, and practical approaches and techniques in qualitative interviewing. One research team member (J.C.M., L.E., G.A., or M.K.) administered individual interviews. Interviews occurred virtually (via Microsoft Teams) or in person in quiet rooms on hospital wards or

participants' offices. After interviews were completed, we contacted participants by email to provide self-identified demographic data. The survey was voluntary and anonymous, and participants selected from predefined categories or supplied free text for sex, gender, ethnicity, role, and profession (Appendix 2b).

Interviews were audio-recorded and transcribed verbatim. For additional rigour and contextualization during analysis, interviewers kept detailed field notes of their reflections during the interviews.

### Data analysis

Data collection and analysis occurred simultaneously. All participants were invited to review their transcripts before analysis (1 participant opted to). We used Dedoose software for data coding and organization.

Two team members independently coded interview transcripts using an inductive approach.<sup>16,17</sup> Throughout the initial coding process, the coders (J.C.M., C.S., G.A., and M.K.) met regularly to refine, merge and expand codes, come to consensus about any disagreements and interpretations, add context to certain transcripts with their field notes from the interviews, and identify additional participants suggested by the participants. Using constant comparative and selective coding processes,<sup>16,17</sup> we generated categories and subcategories to form themes to reflect participants' perspectives on "social admissions."

We used several strategies to ensure rigour and trustworthiness throughout the research process. As per the grounded theory approach, we incorporated reflexivity into our analytic process and acknowledged our dual roles as researchers and health care providers delivering care. Most members of the research team were affiliated with the research site and possessed an in-depth understanding of the local context and providers involved in "social admission" care. This intimate understanding enabled us to add context to the findings. However, we also challenged our preconceptions and biases by recruiting participants with diverse experiences and perspectives, and scheduling regular meetings among research team members to triangulate findings with our internal chart review, knowledge user feedback, and data analysis.<sup>22</sup>

We put participant narratives at the forefront by presenting the data (from preliminary interviews and after completion of interviews) to engaged key knowledge users within our hospital and university network (e.g., experienced researchers, clinicians, social workers, and administrators) in a variety of settings (e.g., individual communications, small group sessions, or internal department presentations). The knowledge users provided feedback and suggested further participants. The data were also triangulated with findings from our recent literature review.<sup>14</sup>

After data saturation was achieved, we mapped our findings on the Quintuple Aim conceptual framework at the suggestion of a knowledge user and as per consensus with the research group.<sup>23,24</sup> This framework adequately organized and contextualized our findings and is a well-known approach to optimizing health system performance and defines 5 fundamental domains (definitions in Appendix 1) for transforming health care: enhance patient experience, better population health, optimize cost of care, improve care team well-being, and advance health equity.<sup>23,24</sup>

### Ethics approval

Nova Scotia Health granted institutional research ethics approval (REB no. 1027628).

### Results

We conducted 20 interviews (9 in person and 11 virtual) among hospital administrators and clinicians (Table 1). Clinicians were nurses

**Table 1: Demographic information of hospital administrators and clinicians who were interviewed**

Characteristic*	No. of participants n = 20
Age group, yr	
30–49	9
50–69	7
Missing†	4
Sex	
Male	5
Female	11
Missing†	4
Race and ethnicity‡	
White	13
Missing†	4
Stage of career	
Early	3
Mid	7
Late	6
Missing†	4
Role	
Clinical	8
Leadership or administrative	6
Both	2
Missing†	4
Professional designation	
Registered nurse	10
Medical doctor	6
Social worker	2
Other§	2
Department	
Medicine	8
Surgery	5
Emergency medicine	5
Other¶	2

\*Sex, ethnicity, role, and profession were self-identified by participants, using an anonymous survey with the options of prespecified categories or free-text boxes (Appendix 2b, available at [www.cmaj.ca/lookup/doi/10.1503/cmaj.231430/tab-related-content](http://www.cmaj.ca/lookup/doi/10.1503/cmaj.231430/tab-related-content)).

†As described in the Data collection subsection of the Methods, the participants self-described their demographic information in a postinterview survey; not all participants responded to the survey.

‡Other races and ethnicities were suppressed for participant confidentiality.

§Other degrees included Bachelor of Arts and Master of Science.

¶Other departments included long-term care and psychiatry.

(charge, discharge planning, and inpatient), physicians (residents and staff physicians), and social workers, representing the following services: emergency department, internal medicine, medical subspecialties (cardiology, neurology, and geriatric medicine), psychiatry, hospitalist, and surgical specialties (orthopedics, general surgery, cardiovascular surgery, and vascular surgery). Administrators included nursing bed managers and directors of hospital divisions and long-term care. The mean interview length was 38 (range 16–76) minutes.

We categorized 9 themes into each of the 5 domains of the Quintuple Aim framework as shown in Figure 1: patient experience (patient description, provision of care); care team well-being (moral distress, hierarchy of care); health equity (stigma and missed opportunities, prejudices); cost of care (wait-lists and scarcity of alternatives); and population health (factors leading to vulnerability, system changes).

### Patient experience

#### Participants' description of patients

Participants provided diverse descriptions of these patients (Table 2). One cited financial precarity as a key problem faced by

these patients. Another highlighted recurrent health care system interactions as being important. Some mentioned these patients had a mix of medical, mental health, and social problems. Most equated “social admissions” with older patients or those who were cognitively impaired. Some deemed them the most frail, vulnerable, or complex cases. Few considered that “socially admitted” patients had no medical conditions involved (Appendix 3) or that the medical conditions could wholly be managed at a primary care level.

#### Provision of care

Participants described “socially admitted” patients as receiving passive and hands-off care, contrasting this with active approaches for medical and surgical cases. Participants reported that patients, especially those who were older or confused, often received limited attention and workup, leaving their needs unaddressed (Table 2). The approach to care was characterized by patients being left in their beds, being the last person rounded on by the care team, and not being chosen to participate in rehabilitative programs or exercises. In short, these patients' care needs were the last in the queue of nursing and physician priorities. Beyond direct provision of care, participants identified that hospital programs (e.g., recreation therapy) benefitting these patients had been discontinued or under-resourced (Appendix 3). Almost all clinical participants considered their ward was not the place to care for these patients.

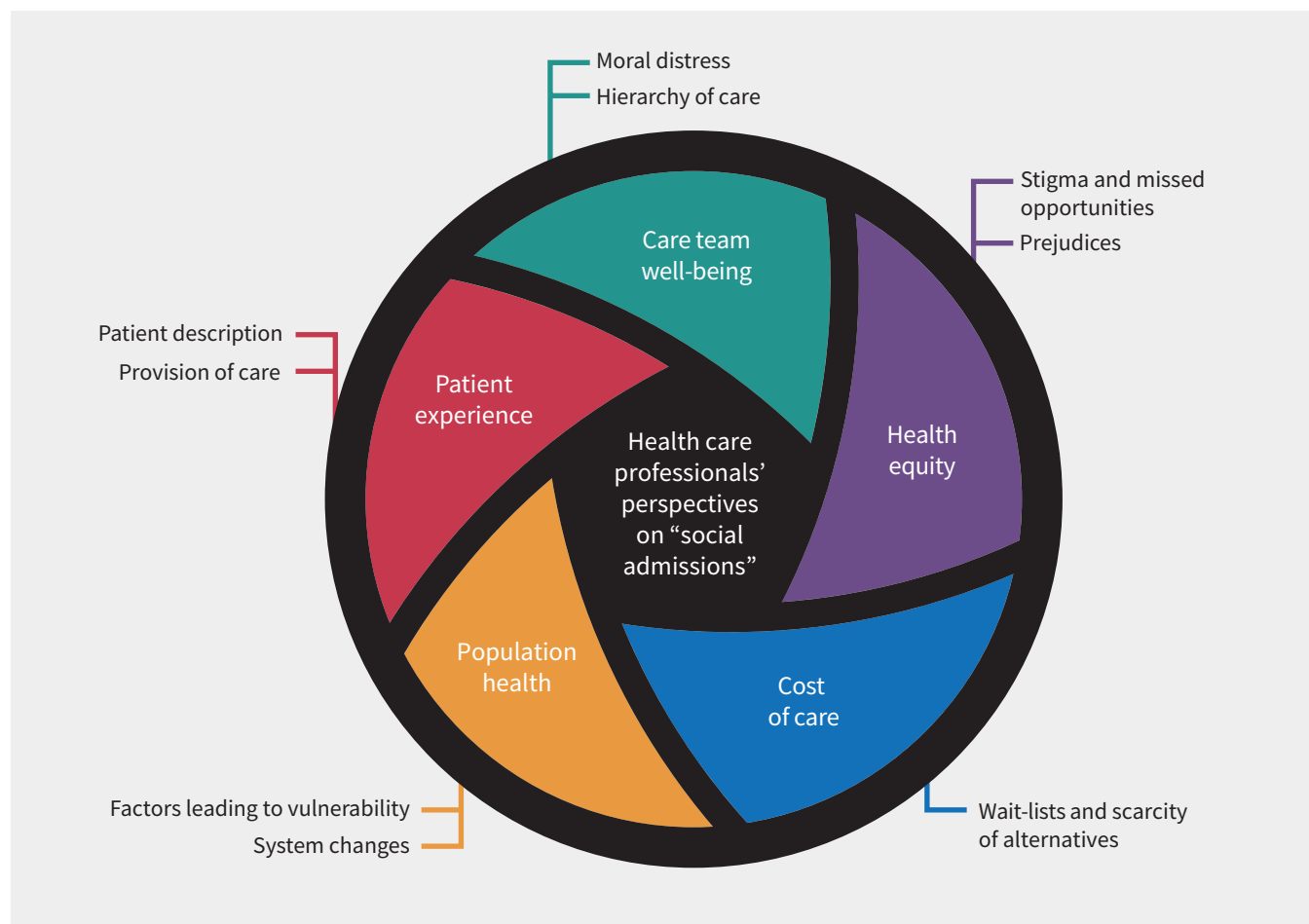


Figure 1: Domains (in the circle) and themes (outside the circle) using the Quintuple Aim framework.<sup>23,24</sup>

Care team well-being

Moral distress

Health care providers described their roles as acute care or sub-specialized experts but said they felt helpless when they were unable to provide care for “socially admitted” patients, who often had complex, unrecognized, or chronic health issues. They often stated that better care should be offered yet described challenges when caring for “socially admitted” patients. These included a lack of appropriate training, struggles to arrange suitable care, and resistance when attempting to involve other services, allied health care, or social work, leading to delays in appropriate management (Table 3). As articulated by 1 participant (HC605): “I think that’s a lot to ask of different providers who may not have that skill set. So, sometimes I think it does cause, you know, moral distress and challenge for people sometimes, which then gets perhaps articulated as being ‘they

shouldn’t be here.’” Many reported feeling negative toward the policy and labelling of these patients, and acknowledged it was used primarily to communicate with other health care providers. One participant suggested the policy prevented blame on clinicians for “admitting this [patient]” (HC840).

Hierarchy of care

Participants highlighted a hierarchy in health care, prioritizing acute care patients over “social admissions.” One participant reflected on how hospitals rely on pathways with these patients not fitting into a clear “slot,” representing individuals not well differentiated, individuals with complexity, or individuals with issues that are not specialty specific. Consequently, “social admissions” were passed down the hierarchy, from physicians to residents, and sometimes to nursing assistants, implying they were less worthy of routine medical attention (Table 3).

**Table 2: Descriptions and illustrative quotations of the patient description and provision of care themes in the patient experience domain**

Domain	Theme and key findings	Illustrative quotations
Patient experience	<b>Patient description</b> Participants’ descriptions of “social admissions” were inconsistent and included a wide range of health and social indicators from the patients experiencing financial troubles, unstable housing, or psychological issues, to the patients having medical complexity. In few cases, participants expressed that they (or their colleagues) believed that “socially admitted” patients had no immediate medical needs.	<p>“... finances is, like, one of the biggest contributing factors for a lot of them. Because we see ..., like, people don’t have the finances to find adequate housing. Like, a lot of people come in, they’re, like, homeless or where they’re living, like, the conditions are poor.” — HC803</p> <p>“They’re obviously the ones that have accessed the health care system multiple times for the same types of presentations.” — HC840</p> <p>“Usually these patients are the most frail. They’re the most vulnerable. They’re the most complex.” — HC569</p> <p>“And, so, I do think they are [a] really heterogeneous group in many ways in terms of what elements go into their sort of bucket of comorbidities. And again, you know, a combination of, like, medical, sometimes some mental health issues, some psychological issues, and then the social issues.” — HC300</p> <p>“So, typically, the patients are elderly. They typically have multiple comorbidities. They typically have polypharmacy. As well as they may or may not have family members who are caregivers.” — HC156</p> <p>“As far as orphan patients, I would say it’s, they oftentimes have a medical condition that I guess most people would say would be managed at the primary care level.” — HC307</p>
	<b>Provision of care</b> Participants described the care provided to patients. The approach to care was passive, and “social admissions” were generally deprioritized in a tertiary care setting. Further, participants shared that the hospital environment often does not meet the basic needs of patients and is not the ideal setting for anyone unless they are needing acute care. Others commented on the lack of dedicated allied health services available to these patients (e.g., physiotherapy, recreation therapy, or occupational therapy) after admission.	<p>“The approach to caring for the patient is passive. Which is in huge contrast to our approach to caring for medical and surgical acuity — which is very active.” — HC375</p> <p>“... someone older or confused, or can’t give a history, they kind of stop the workup there, and say, like, oh, they either have nothing going on with them or they have, like, an infection that they actually don’t have, and kind of leave it like that. So, I think there are shortcuts taken on some of these patients at times.” — HC840</p> <p>“Nursing is built on the foundation of caring for patients holistically. And you don’t see a lot of that. And I think it’s very easy for nurses, especially on a unit like ours, to look at these patients and go, “Well, they don’t need an IV change, and they don’t need a dressing, and they don’t need this. So, there’s nothing for me to do.” Meanwhile, this poor guy is there ... unwashed, isn’t dressed. You know, like there is a lot of care that can be provided, but it’s not the care that they think is the ‘important’ stuff ...” — HC413</p> <p>“I’ve heard this from allied health as an example over the years, is we only have so much physiotherapy. We’re going to focus on those who are participating in rehab right now and we’re going to be able to get them home. We don’t have the resources to continue working with people who plateaued.” — HC375</p>

Note: IV = intravenous.



**Table 3: Descriptions and illustrative quotations of the moral distress and hierarchy of care themes in the care team well-being domain**

Domain	Theme and key findings	Illustrative quotations
Care team well-being	<p><b>Moral distress</b></p> <p>Participants described the distress and tensions from competing priorities and values experienced by many staff when providing care to “socially admitted” patients. This is a result of these patients having complex social and chronic health issues that they feel are outside of their clinical scope. Participants caring for these patients feel better care could be provided elsewhere and they themselves do not have the right training to care for them, which can cause further distress.</p>	<p>“The trouble is, you know, a lot of us here in the hospital, we’re sub-sub-subspecialists. And if you happen to have a disease in that subspecialty, there’s somebody here that might be a world expert on it. But these people don’t need that. They just need, kind of, like, you know, humane general care. And this is the worst place to get that.” — HC549</p> <p>“I think that’s a lot to ask of different providers who may not have that skill set. So, sometimes I think it does cause, you know, moral distress and challenge for people sometimes, which then gets perhaps articulated as being ‘they shouldn’t be here.’” — HC605</p> <p>“We really had a fight to get continuing care involved. And once they got involved, he was placed rather quickly because he was perfect for them. But it’s just that initial hesitation.” — HC075</p> <p>“And, you know, are there any advantages to calling them an orphan patient? I’m not sure there really is, other than just trying to come up with some term for everyone to understand that, you know, this patient isn’t ... you know, not to blame, I guess, blame someone per se for admitting this [patient], ... I think would be the only benefit really to it. So that at least the trainees aren’t getting yelled at, and things like that, right.” — HC840</p> <p>“So, as per the — and I hate this word — Orphan Patient Policy, I think that has a huge connotation to it, and I don’t use that word at the bedside. I think it removes all therapeutic rapport with someone when you say that word. I use that [term] medical facing, talking with other practitioners when I’m outside the room just to, kind of, name the policy, bring a thought to this is what exists.” — HC236</p>
	<p><b>Hierarchy of care</b></p> <p>Participants described a perceived order of importance of patients and their reasons for hospital admission. Participants described the hierarchy in acute care with “social admissions” being at the bottom of that hierarchy. Participants also described the “bed blocking” that exists and how these “social admissions” can make it much more difficult to provide the appropriate care to other patients.</p>	<p>“... admissions to hospital require that you fit into a slot. And these patients frequently don’t.” — HC156</p> <p>“I would say most of their medical issues, if they do arise, between the nursing, they wouldn’t necessarily actually arise to the level [of] the attending. Most of it’s managed by the residents.” — HC307</p> <p>“You don’t need an RN looking after them. You could have an LPN and a CTA or something. Resources that are not as expensive.” — HC151</p> <p>“The patients who are a ‘placement problem,’ who are waiting for a nursing home or a group home, or are homeless, this is actually increasingly something we’re seeing with orphan patients — who are just people who are homeless — and sit on our unit, sometimes for months, while the social workers try in vain to find a place for people to go. So, all of these things make it much harder to deliver care to acutely sick [specialty] patients who are coming in every day through the emergency department. You know, our ward is full of these people. And we can’t get the really sick people up to our unit because the beds are all full of people waiting to go somewhere.” — HC549</p>

Note: CTA = care team assistant, LPN = licensed practical nurse, RN = registered nurse.

## Health equity

### Stigma and missed opportunities

The term “social admission” led to incorrect assumptions about medical needs and cognitive abilities. Beliefs about behaviours were noted by several participants. These assumptions were propagated as early as handovers from paramedics to emergency nursing teams (Table 4). Participants highlighted instances where these patients were not medically stable and emphasized that social stressors did not exempt patients from becoming medically ill during the admission. The label was reported to be an impediment to opportunities to look for underlying treatable medical issues, compounded by the need to make timely decisions because of pressures to free up beds.

### Prejudices

Ageist beliefs underpinned assumptions about capacity, especially for older “socially admitted” patients. Some participants recognized that these patients could not effectively advocate for themselves,

and others pointed out that older patients were often assumed to be cognitively or functionally impaired, and decisions were made without them. Participants provided examples of premature capacity determinations made without proper medical evaluation or consultation (Table 4). One participant described the invisibility of these patients, especially for women and minorities, and another noted how the care of “socially admitted” patients is undermined by negative attitudes similar to those encountered by individuals with substance use disorders (Appendix 3).

### Cost of care

#### Wait-lists and scarcity of alternatives

Inadequate community support often resulted in emergency department visits and hospital admissions, with the perception that hospitals are the safest place. Participants noted lengthy wait-lists for community services like home care, physiotherapy, or occupational therapy, which led to deconditioning (Table 5). The transition to long-term care was described as

**Table 4: Descriptions and illustrative quotations of the stigma and missed opportunities, and prejudices themes in the health equity domain**

Domain	Theme and key findings	Illustrative quotations
Health equity	<p><b>Stigma and missed opportunities</b></p> <p>The label comes with assumptions about the admitted patients' medical needs, cognitive abilities, and behaviours, which in turn affects the underlying assumptions held by health care providers and subsequently the care patients receive. Participants described how patients being labelled as a "social admission" early in the care chain led to an belief that they were medically stable when, in fact, they were not always.</p>	<p>"... often they would come to the door and the paramedic would say to the charge nurse and myself ... I was sitting beside the charge nurse ... They'd say, "Okay, this patient's definitely going to be orphan." So, of course, once they're tagged with that label, it stuck, you know." — HC236</p> <p>"You know, from nursing's perspective, it's like, "Oh, an orphan patient. So, they're going to be difficult behaviour, difficult discharge, and long stay." — HC151</p> <p>"An orphan patient's usually a demented patient." — HC075</p> <p>"And they're supposed to be categorized as, like, medically stable. Unfortunately, we've had several experiences where patients have been labelled as 'orphans' and they've not been medically stable." — HC803</p> <p>"So, you may miss a diagnosis of delirium and an opportunity to treat. And I think ... and if the services aren't as familiar with those issues then, you know, you miss things, I guess, and people can get worse." — HC605</p>
	<p><b>Prejudices</b></p> <p>Participants described underlying group assumptions about "social admissions." In particular, ageism that occurs when patients access acute care services for social issues was noted, for example, assuming all older patients have cognitive decline or lack capacity, or assuming certain health services would not benefit older patients. Participants reflected on how race and gender implicitly affect care.</p>	<p>"I just had a patient that came over from a [redacted] unit. And that patient was placed on the long-term care list ... They somehow removed their capacity but didn't get their family members to sign ... But their family is adamant they go home. The patient is adamant [they go] home. So, how in the world did [they] lose [their] capacity? ... A physician removed capacity, while this patient most likely is experiencing a delirium, and made a permanent future decision for them without consulting the family." — HC676</p> <p>"We take for granted what we feel and what we value is dignified aging, then we just don't include them. So, you know, there's these whole conversations occurring outside of the patient. And oftentimes myself and the other social worker on our unit will go, 'Well, did anybody talk to the patient?' 'No.'" — HC231</p> <p>"I think there's just a general lack of respect for the aging process and aging with dignity ... You know, there's so many levels of invisibility that can be added to a person. So, you know, if you're a woman in comparison to a man, you're made a little less visible. If you're a minority in comparison to a White person, you're made a little less visible. If you have the history of mental health in comparison to somebody who might not have had those challenges, you're a little less visible." — HC676</p> <p>"You know, not understanding frailty, what it means to be frail, how it impacts patients who are vulnerable. And I think of my mom, who is quite frail, and I think any incident could take her over that edge. But if she were to show up in emerg, I don't know that that would be so recognized. I don't. So, I do believe ageism plays a big role." — HC236</p>

**Table 5: Description and illustrative quotations of the wait-list and scarcity of alternatives theme in the cost of care domain**

Domain	Theme and key findings	Illustrative quotations
Cost of care	<p><b>Wait-lists and scarcity of alternatives</b></p> <p>Participants commented on the inadequate supports available in the community, which frequently lead to "social admissions." They described a system that is inefficient and ineffective at caring for this population because of severe resource constraints. Some of these patients have advocates or family caregivers who simply cannot do it anymore.</p>	<p>"If someone needs PT, OT at home, the wait-list is like 6+ months ... They're waiting 6 months for anyone to come help them. They'll be so deconditioned by that time, they'll be 'bed-sored' into the bed. So, there's the realities of the barriers of what's out there. It's out there. Can I get it? There's wait-lists for everything." — HC569</p> <p>"... there's a person that I have right now that should be in a nursing home, but she is at home with twice-a-week care. Has been waiting for a month to get an increase on that twice-a-week care. And she's scared, and she's struggling, and she's confused and went to somebody else's apartment. And she knows she's getting confused. And I chatted with the care coordinator, and they say, 'Well, she should be in a nursing home. But even if we assess her for a nursing home, she might likely not get in there for 3 years.'" — HC737</p> <p>"There are a lot of patients that have done, and their families have done, everything that they're supposed to do. And whether it's they've maxed out their care, or they're on the list, and this is their last resort." — HC791</p> <p>"It's wrong. It's not the right... It's a real misunderstanding that that's the right place for the patients to be. The last place in the world anyone should want their patient or loved one is in the hospital. And, then, what do we do as a system to help reinforce that? Because we can't tell people that and expect them to believe it if we're not able to put supports and services in place to keep them out of the hospital." — HC375</p>

Note: OT = occupational therapy, PT = physiotherapy.

“abysmal,” leaving patients in challenging situations for extended periods. Admissions were a “last resort” after all other options were exhausted, with patients and families struggling to access necessary care. The lack of alternatives contributed to participants’ distress when caring for “socially admitted” patients (Appendix 3).

## Population health

### Factors leading to vulnerability

Participants identified many issues that were associated with the “social admission” label, particularly for patients with cognitive impairment (Table 6). These included physical barriers (e.g.,

**Table 6: Descriptions and illustrative quotations of factors leading to vulnerability and system changes for addressing “social admission” themes in the population health domain**

Domain	Theme and key findings	Illustrative quotation
Population health	<p><b>Factors leading to vulnerability</b> Participants commented on the multitude of social issues that increase the risk of a community-dwelling adult becoming a “socially admitted” patient, such as poverty, homelessness, social isolation, lack of primary care, and substance use disorders. The inability to advocate for oneself was also a common observation.</p>	<p>“And I find, like, for the most part, for us, like, a lot of it comes down to, like, finances is, like, one of the biggest contributing factors for a lot of them. Because we see, especially lately in today’s society, like, people don’t have the finances to find adequate housing. Like, a lot of people come in, they’re, like, homeless or where they’re living, like, the conditions are poor. So, like, we had a patient not that long ago who he had literally was living in a shop that he once owned because he couldn’t afford his apartment anymore . . . . During COVID, it closed because he couldn’t keep up with the, like, financial pressures and everything with COVID. There’s no bathroom in the place. There was no running water. And he was, like, using the garage next door to use the bathroom. So, like, we see a lot of patients that, like, homelessness is huge. And then a lot of our patient[s] are vulnerable as well in the sense of, like, their educational levels because they don’t understand. And I find, too, like, sometimes they’re taking. . . . Like, they’re going outside for smokes, whatever. They’re going socializing, and they’re, like, being taken advantage of by other patients in the hospital. Like even if it’s as little as, like, “Can I have a smoke?” or “Can I have \$5?” Like, I find our patients literally, like, fall under this category of, like, they just don’t know better so they get taken advantage of by other people.” — HC803</p> <p>“One of the challenges with community supports is that, as we all know, there’s lack of sufficient community support for the aging population in our community. The second part is, is that sometimes there are physical issues. So, sometimes these patients are living alone in a home that is multilevel, and they don’t have a washroom on the main floor, for example, and they need to ambulate with a walker. And, so, there are physical barriers that may impair their ability to even exist in the community even with added community supports. So, those are things that have to be taken into consideration that we often as health care providers don’t think about.” — HC156</p> <p>“... sometimes it’s the home situation has gone for so long not being looked into or sort of being overlooked. We sometimes get couples or who are living alone, managing. Sort of managing the best that they can at home. But if they don’t have a lot of social support or don’t have a lot of family checking in on them often.” — HC638</p> <p>“And I think the absence of having . . . of that subset of people, having an advocate for them, both in the community and when they interact with the acute care system, makes them particularly vulnerable.” — HC300</p>
	<p><b>System changes for addressing “social admissions”</b> Participants shared their visions for improvement to the current system to provide appropriate care to those accessing acute care with social needs.</p>	<p>“The acute care system is becoming the community system. We’re becoming nursing homes . . . this [inter]mediate pathway between community and long-term care. Because long term care is failing at admitting people in a timely fashion.” — HC506</p> <p>“I would like to see more geriatrics in the hospital. I think we need to [be] more prevention-based rather than reaction-based . . . which is what we are.” — HC236</p> <p>“In an ideal world, if someone presented to the emergency department where their presentation was considered to be a social admission or a ‘can’t go home’ situation, that there would be a multidisciplinary team that would look at that patient’s situation from a holistic perspective. So, taking into account their medical history and their presentation, making sure that, you know, they’ve had a full workup, making sure that we understand the social factors and the kinds of resources that they’ve accessed, and what could be accessed.” — HC300</p> <p>“How do you put the patient back at the centre of the table? . . . . Even if you look at how our services are delivered, they’re organized from a provider lens, not from a patient-need lens.” — HC605</p> <p>“So, there’s some longstanding [type] disease or the sequela of something [type] that happened 20 years ago. We would never be involved in their care if they were in the community because there’s no need.” — HC549</p>



inaccessible homes), homelessness, and financial challenges. Social isolation left individuals unsupported, managing alone until emergencies, such as falls, catalyzed hospital admission. The inability to advocate for oneself was also a common observation.

### System changes for addressing “social admissions”

Participants identified systemic barriers that they considered disadvantaged “socially admitted” patients. Participants were concerned that the health care system is currently in crisis (e.g., with a lack of primary care and home support), and emergency departments cannot function as intended, causing the acute care system to become the community system or “the [inter]mediate pathway between community and long-term care” (Table 6). Some called for specialized seniors’ care teams to address the unique needs of older adults. Participants emphasized the importance of understanding these patients’ situations holistically, with a multidisciplinary approach to assess medical history, social factors, and available resources; several examples of ideal approaches were shared. The system’s focus on individuals with higher functioning left “socially admitted” patients underserved, with emphases on services that are “organized from a provider lens, not from a patient-need lens” (HC605).

## Interpretation

We sought to understand how health care providers perceive patients labelled as “socially admitted” in hospital, and we identified 9 key themes across the Quintuple Aim framework.<sup>23,24</sup> The themes in the patient experience domain highlighted inconsistent definitions and passive care approaches for these patients, who are often seen as low priority in hospital. Under the care team well-being domain, themes of moral distress and hierarchy of care showed the challenges and dilemmas faced by health care providers. Issues of stigma (e.g., “they have dementia”), prejudices (e.g., ageism), wait-lists, and scarcity of alternatives underscored systemic challenges under the health equity and cost of care domains. Finally, factors leading to vulnerability and potential system changes were described by participants as ways to better the health of this population.

Our findings highlight the potential adverse effects on care when patients are labelled as “socially admitted” (or as “orphan patients” in the study hospital), such as incorrect assumptions about medical needs and cognitive abilities, which impedes opportunities to look for treatable medical issues. Despite a “social admission” pathway ostensibly designed to ensure there are no acute or new medical issues, patients were still perceived as having “multiple comorbidities” or being “the most frail ... the most complex” (Table 2). This finding is in keeping with the results of a case-control study (in London, Ontario), in which medical comorbidity played a minimal role in the label of a “failure to cope” admission among adults aged 70 years or older. Instead, recent failed discharge from hospital was significantly associated with a “social admission” label, leading the authors to suggest blame was an important part of the use of this label in a system that prizes efficiency.<sup>3</sup> This supports the viewpoint that it is more a system’s failure to cope than the patient’s.<sup>10</sup>

Our findings also demonstrate possible negative impacts on health care providers not addressed in previous research. Although similar patient populations (“failure to thrive” or “failure to cope”) in British Columbia<sup>25</sup> and Ontario,<sup>3</sup> and “acopia” admissions in the United Kingdom and Australia,<sup>7,9</sup> have been researched, these studies did not consider the insights of providers directly caring for these patients. We highlight some structures (e.g., propagation of the label early in care) or cultures (e.g., ageism) in our health care systems, leading to system and individual tensions caring for “socially admitted” patients, especially in the context of few readily available alternatives. We observed that participants frequently reported feeling conflicted defining, prioritizing, and managing this patient population, yet unequivocally considered these patients deserved care — albeit care delivered by someone else. This latter finding contrasts with a survey of physicians in Wales in which two-thirds (62.7%) considered patients labelled as “social admissions/acopia” were a burden on national health resources, with 44.8% of physicians admitted to feeling that these patients were a burden on their time.<sup>15</sup>

Despite considering that “socially admitted” patients were deserving of care, our participants recounted how care was passed down to less-senior members of the health care team. This pattern of downgrading care can lead to situations in which “socially admitted” patients are looked after by team members who possess minimal experience recognizing evolving medical presentations or lack the authority to advocate strongly for clinical reassessments when needed. The implication that the care of “social admissions” should be delegated to others reflects an implicit attitude of hierarchy and detachment from the needs associated with this patient population. Not being able to provide the care that is warranted while at the same time believing that the needed care is beneath the care they provide is in keeping with cognitive dissonance literature in medicine (i.e., holding 2 or more inconsistent beliefs or behaving in a way that is inconsistent with core beliefs).<sup>26</sup> Cognitive dissonance can trigger negative emotions and subsequent defensive reactions resulting in fault finding in others (e.g., blaming “social admissions”), reinforced commitment to wrong actions (e.g., propagating labels), and overlooked medical errors,<sup>26,27</sup> offering some explanations for understanding how stigma and hierarchies of care can lead to missed acute medical illnesses (e.g., sepsis, malignancy, and strokes) in previous “social admission” populations.<sup>5,7,9</sup>

Existing literature indicates that “social admission” labelling may harm patients.<sup>14</sup> Our findings suggest that the use of this label appears to have little benefit for the health care providers who care for this patient population. Moreover, no evidence exists to date that “social admissions” labelling or pathways help the health care system. Therefore, re-evaluating an approach to caring for “socially admitted” patients is imperative, and this may include abandoning the nondiagnostic label.

Better support for this patient population may be achieved through enhanced policies that propose feasible solutions to support these patients. To achieve this, further steps are required to define “social admissions,” and to highlight the importance and scope of the issues surrounding the patient population captured under this label.<sup>28</sup> However, we found inconsistencies in how “social admissions” are described, which adds to

the challenge in developing effective policies for these patients, and in comparing similar presentations across Canada.<sup>29</sup> Developing a consistent definition for “social admissions” may also prompt clinical specialties to claim responsibility for this population, as challenges are key to raising issues for prioritization in health care.<sup>30</sup>

“Social admissions” can be considered a “wicked problem” with no single easy solution.<sup>31</sup> A previously proposed ecological approach can guide clinicians in managing “social” presentations.<sup>2,32</sup> Participants in our study made suggestions about community- and institutional-level solutions such as home care and primary care teams that support social integration, more multidisciplinary care teams in and out of the hospital, and “geriatrizing” acute care. These suggestions reflect many of the same calls for action made by previous scholars and advocates,<sup>33,34</sup> and are similar to solutions proposed by the National Institute on Ageing’s “Ageing in the Right Place” report.<sup>35</sup> Scholars in France have proposed a societal-level solution involving the procedural and financial restructuring of ultraspecialized medicine, coupled with a revival of historic values combining medicine and social work to address the needs of an increasingly frail and socially complex population.<sup>36</sup>

## Limitations

Our study was conducted in a single tertiary health centre in Nova Scotia, where “socially admitted” patients are admitted under an institution-specific Orphan Patient Policy, which likely limits the generalizability of our findings. Our participants were mainly White and female, which also limits the generalizability to other settings across the country and internationally. Furthermore, the participant sample did not include recreational therapists, volunteers, physiotherapists, or occupational therapists. In the study centre, recreation and volunteer programs had been discontinued or reduced following the COVID-19 pandemic, and there were no occupational or physiotherapists specifically assigned to this patient population. Another limitation of our study is that some interviewers had prior acquaintance with the participants they interviewed. This familiarity may introduce bias in the data collection and interpretation, although this should be balanced with constructivist grounded theory’s emphasis on researchers as co-participants in the research process.

## Conclusion

Our research draws attention to health care providers’ challenges in managing care for “socially admitted” patients, and to perceptions regarding “social” presentations, perceived system barriers and resource shortages, and some potential solutions for better patient care. Overall, no consensus emerged as to what constitutes a “social admission” (who are the patients labelled as “socially admitted”?) or ownership for “social admissions” (who cares for these patients?), and participants reported inconsistencies in care delivered for such patients (how to care for “socially admitted” patients). To improve the patient experience and alleviate the moral distress of staff who care for “socially admitted” patients in hospital, the inherent structures of our health care system, such as hierarchies and stigmatization, should be reformed to better address the needs of patients with increasingly complex social problems who present to hospitals.

## References

- Luther RA, Richardson L, Detsky AS. Failure to cope. *CMAJ* 2018;190:E523-4.
- Andrew MK, Powell C. An approach to ‘the social admission.’ *Can J Gen Intern Med* 2015;10:20-2.
- Burrell A, Chahine S, Diachun LL. Factors associated with a label of failure to cope in older medical inpatients: a case-control study. *Can Geriatr J* 2021;24:118-24.
- King D. Acopia is a town in Peru, not a medical term to describe people. *Nurs Stand* 2004;18:31.
- Rutschmann OT, Chevalley T, Zumwald C, et al. Pitfalls in the emergency department triage of frail elderly patients without specific complaint. *Swiss Med Wkly* 2005;135:145-50.
- Gonski PN. Acopia: A new DRG? *Med J Aust* 1997;167:421-2.
- Kee Y-Y, Rippingale C. The prevalence and characteristic of patients with ‘acopia.’ *Age Ageing* 2009;38:103-5.
- Rai GS, Bielawska C, Murphy PJ, et al. Hazards for elderly people admitted for respite (“holiday admissions”) and social care (“social admissions”). *Br Med J (Clin Res Ed)* 1986;292:240.
- Obeid JL, Ogle SJ. ‘Acopia’: A useful term or not? *Australas J Ageing* 2000;19:195-8.
- Campbell SG. It is the system that is “failing to cope,” not the emergency department. *CMAJ* 2019;191:E401.
- Davis ID, Zajac JD. Can’t cope with ‘acopia.’ *Intern Med J* 2005;35:574; author reply 574-5.
- McKee K. ‘Granny dumping’ troubles Ontario doctor who sees it most over the holidays. *CBC News* 2021 Dec. 24. Available: <https://www.cbc.ca/news/canada/london/elderly-relatives-granny-dumping-holidays-1.6295864> (accessed 2023 Mar. 10).
- Smellie S. Newfoundland hospitals grapple with patients admitted because they have nowhere to go. *CBC News* 2023 Aug. 16. Available: <https://www.cbc.ca/news/canada/newfoundland-labrador/newfoundland-hospitals-grapple-with-patients-admitted-because-they-have-nowhere-to-go-1.6937697> (accessed 2024 Jan. 2).
- Mah JC, Searle SD, Koller K, et al. Admissions for presumed social reasons: epidemiology, risk factors, and hospital outcomes. *Can J Gen Intern Med* 2023;18(4):16-26.
- Curran D, Chattopadhyay I. Survey on the attitudes of hospital doctors towards the terms ‘acopia’ and ‘social admission’ in clinical practice. *Clin Med (Lond)* 2015;15:312.
- Charmaz K. Grounded theory as an emergent method. In: Hesse-Biber SN, Leavy P, editors. *Handbook of Emergent Methods*. New York: The Guilford Press; 2008:155-72.
- Charmaz K. *Constructing grounded theory*. 2nd ed. Thousand Oaks (CA): SAGE Publications Ltd.; 2014:1-416.
- Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;19:349-57.
- Furlong KR, O’Donnell K, Farrell A, et al. Older adults, the “social admission,” and nonspecific complaints in the emergency department: protocol for a scoping review. *JMIR Res Protoc* 2023;12:e38246. doi: 10.2196/38246.
- Morse JM, Field PA. *Qualitative research methods for health professionals*. 2nd ed. Thousand Oaks (CA): SAGE Publications; 1995.
- Strauss A, Corbin J. *Basics of qualitative research: techniques and procedures for developing grounded theory*. 2nd ed. Thousand Oaks (CA): SAGE Publications; 1998.
- Holloway I. *Basic concepts for qualitative research*. Wiley-Blackwell: Wiley-Blackwell; 1997:1-208.
- Nundy S, Cooper LA, Mate KS. The quintuple aim for health care improvement: a new imperative to advance health equity. *JAMA* 2022;327:521-2.
- Itchhaporia D. The evolution of the quintuple aim: health equity, health outcomes, and the economy. *J Am Coll Cardiol* 2021;78:2262-4.
- Tsui C, Kim K, Spencer M. The diagnosis “failure to thrive” and its impact on the care of hospitalized older adults: a matched case-control study. *BMC Geriatr* 2020;20:62.
- Klein J, McColl G. Cognitive dissonance: how self-protective distortions can undermine clinical judgement. *Med Educ* 2019;53:1178-86.
- Harmon-Jones E, Mills J, eds. An introduction to cognitive dissonance theory and an overview of current perspectives on the theory. In: *Cognitive Dissonance: Progress on a Pivotal Theory in Social Psychology*. Washington (DC): American Psychological Association; 1999:3-21.
- Shiffman J. A social explanation for the rise and fall of global health issues. *Bull World Health Organ* 2009;87:608-13.
- Curry K. The importance of defining and refining words. *J Am Assoc Nurse Pract* 2022;34:611-2.
- Shiffman J, Smith S. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. *Lancet* 2007;370:1370-9.
- Sinskey JL, Margolis RD, Vinson AE. The wicked problem of physician well-being. *Anesthesiol Clin* 2022;40:213-23.

32. Bronfenbrenner U. Ecological models of human development. In: *International Encyclopedia of Education*. 2nd ed. Vol. 3. Oxford (UK): Elsevier Sciences, Ltd.; 1994:1643-7.
33. Fulmer T, Reuben DB, Auerbach J, et al. Actualizing better health and health care for older adults. *Health Aff (Millwood)* 2021;40:219-25.
34. Rowe JW, Fulmer T, Fried L. Preparing for better health and health care for an aging population. *JAMA* 2016;316:1643-4.
35. *Ageing in the right place: supporting older Canadians to live where they want*. Toronto: National Institute on Ageing, Toronto Metropolitan University 2022:1-148. Available: <https://static1.squarespace.com/static/5c2fa7b03917eed9b5a436d8/t/638e0857c959d1546d9f6f3a/1670252637242/AIRP+Report+Final2022-.pdf> (accessed 2023 Dec. 18).
36. Gansel Y, Danet F, Rauscher C. Long-stay inpatients in short-term emergency units in France: a case study. *Soc Sci Med* 2010;70:501-8.

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