

Do patients labelled as ‘failure to cope at home’ have acute medical needs? A multicentre retrospective study in two French emergency departments

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Research Article

Keywords: Failure to cope at home, Acopia, Emergency Department, Older People, Neurocognitive Disorders: Care Coordination

Posted Date: October 5th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-10806567/v1>

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Additional Declarations: No competing interests reported.

Abstract

Background

“Failure to cope at home” (FTC) is a non-specific label without a specific definition. Its French equivalent, “maintien à domicile difficile”, is frequently used in emergency departments (ED), but the clinical meaning and outcomes associated with this label remain poorly described in this context. This term is sometimes used as the main diagnosis of care and could mask a medical condition. This study aims to assess the clinical and social characteristics of patients presenting with FTC term in EDs.

Methods

A retrospective study was conducted at Tours and Orléans University Hospitals Center from January 1 to December 31, 2022. Patients aged 18 or older with a documented FTC label were included. We described demographics, comorbidities, frailty burden, ED characteristics, acute medical conditions, hospitalisations, post-discharge outcomes and mortality.

Results

A total of 667 emergency admissions (EA) involving 614 patients were analysed. The population was predominantly older, with a mean age of 80.9 ± 11.2 years, and 348 patients (57.2%) were female. Neurocognitive disorders, psychiatric illness, and stroke were the most frequent medical histories. Over half of the patients lived alone (55.8%), and 91.7% resided in their own homes. Hospitalisation occurred after 485 emergency admission (71.0%). Only 6.4% ($n = 40$) of ED admissions had no medical problems other than the FTC label. Overall, 348 EA (54.5%) resulted in return home at hospital discharge, and the weighted mean hospital length of stay was 16.7 ± 16.6 days. In-hospital mortality rate at discharge was 8.8% ($n = 60$), while 30-day and 90-day mortality were 10.9% ($n = 71$) and 18.6% ($n = 119$), respectively.

Conclusions

The FTC label identifies a complex and vulnerable population. Notably, acute medical conditions predominated, and cases with only social or functional presentations were rare. This suggests that the FTC label should not be interpreted as indicative of purely social admission. Instead, a syndromic approach integrating acute medical assessment, functional evaluation, caregiver burden, and discharge feasibility may better address the needs of these specific population.

Trial registration

This study was conducted following the French regulation and was approved by a local ethics committee (reference number: CERO 2603-03). Study was registered on <https://health-data-hub.fr> with reference F20230606113524 (6 June 2023).

BACKGROUND

Home care is increasingly recognized as a global priority, with many countries, including France, focusing on enabling dependent individuals to remain in their own homes. This trend, supported by European projections, underscore challenges posed by an aging population and the associated economic and healthcare burden [1, 2]. In France, national policies provide financial aid, caregiver support, and home adaptations to facilitate this goal [3].

At the same time, recent years have seen unprecedented overcrowding in emergency departments (ED), exacerbated by the rising number of older patients with chronic conditions. Studies report that overcrowding not only worsens patient outcomes but also places significant stress on healthcare providers [4] [5]. EDs are often become the front door to the healthcare system, even when the primary issue is described as social, functional, or related to home-care failure rather than as a clearly defined acute medical condition. This is especially relevant in the context of ED crowding, where the growing number of patients with chronic conditions, frailty, and complex needs may contribute to longer stays, hospitalisation, and difficulties in discharge planning [6–8]. This situation is often referred as "failure to cope at home" (FTC) [9], "acopia" [10] or "social admission" [11]. However, these terms do not correspond to a standardised medical diagnosis, complicate the clinical picture and may overshadow acutes medicals conditions [12].

A better understanding of the population labelled as FTC could be the first step toward improving ED care pathways and avoiding premature interpretation of these visits as purely social presentations. Numerous studies have examined the role of frailty and functional decline among older adults frequently admitted to EDs, emphasizing the need for tailored interventions that address both medical and non-medical needs [13]. Comprehensive geriatric assessment has also shown promise in improving outcomes for frail older people at the interface between hospital and community care [14]. Nevertheless, the clinical meaning, acute medical burden, care pathways, and outcomes associated with the FTC label in ED patients remain poorly described.

The combination of medical frailty and social instability presents complex care needs that cannot be adequately addressed within the ED setting alone. Identifying FTC-labelled patients early and understanding their clinical and social profiles could help clarify whether this label reflects isolated social difficulty or, more often, complex medical situations requiring emergency assessment.

Therefore, the aim of this study is to describe the clinical and social profiles of patients presenting to the ED with FTC status, assess the presence of acute medical conditions, quantify their length of stay, analyse their post-ED care pathways and mortality and identifying local specificities depending on the establishment to explore differences in the use of the label FTC.

METHODS

Study Design

This retrospective study was conducted at the University Hospital of Orléans (UHO) and the University Hospital of Tours (UHT) from January 1, 2022, to December 31, 2022. Tours and Orléans are metropolitan areas with respective populations of 292,001 and 297,273 as of 2021. In 2022, the UHO recorded a total of 45,929 emergency admissions (EAs)[15], while the UHT recorded 49,111 EAs [16]. This study aims to analyse the clinical and social characteristics of patients with documented FTC label at ED admission.

Study Population

All patients aged 18 years or older were eligible. The French term "*maintien à domicile difficile*" corresponding to the French formulation of a 'failure to cope' was used to identify relevant medical records through verbatim analysis. All ED visits with this label documented in nurse triage notes, medical records, or discharge diagnoses were considered FTC-labelled ED visits.

This study was conducted across two centres. In the first centre (UHO), all eligible FTC-labelled EA admitted during the study period were included. In the second centre (UHT), a stratified random sampling design was implemented due to the large number of patients eligible. UHT patients were allocated to 32 strata defined by the combination of sex (male/female), age group (4 classes based on quartiles of age distribution: <74.2, 74.2–83.0, 83.0–89.4, ≥ 89.4 years), and season of admission (the 4 quarters of the year were considered). Within each stratum, 50% of patients were randomly selected. Patients who opposed the use of their data were not included from the final analysis.

Two emergency physician and one geriatrician, reviewed all extracted medical records to ensure inclusion criteria.

Data Collection

Data were extracted from electronic health records and included the following variables: demographics (age, sex, living conditions), clinical characteristics (comorbidities assessed using the Charlson comorbidity index (excluding age points) [17], Hospital-coded frailty risk was additionally assessed using the Hospital Frailty Risk Score (HFRS) [18], ED-related data (admission reasons, time of presentation, discharge outcomes and FRENCH triage category [19]), social factors (details about home assistance, legal protection, and post-ED care pathways), hospitalisation details, post-discharge outcomes. Mortality was assessed at hospital discharge, 30 days, and 90 days after the index FTC-labelled EA. Data were obtained from linkage through the open access French national death registry. A full list of variables and methods for data extraction were provided in the **Appendixes: Text S1**.

Ethical Considerations

This study was conducted following the French réglementation and was approved by a local ethics committee (reference number: CERO 2603-03). Study was register on <https://health-data-hub.fr> with reference F20230606113524 (6 June 2023). Participants were informed of the use of their data for research purposes through posted notices in both EDs. Written consent was not required, as this study involved retrospective, anonymized data collection, but patients had the option to withdraw their data at any time.

Statistical Analysis

To account for the complex sampling design, each selected UHT record was assigned an inverse-probability weight equal to the reciprocal of its stratum-specific sampling fraction. The resulting weights ranged from 1.61 to 2.14. UHO records were assigned a weight of 1 because all eligible records were included. The combined dataset was analysed using a stratified-weighted design, using the *svydesign* function from the survey package in R. Prevalence estimates and their 95% confidence intervals were computed using the *svyciprop* function; for continuous variables, weighted means and standard deviations were estimated using the *svymean* and *svyvar* functions, 95% confidence intervals for standardized mean differences (SMD) were estimated using a stratified bootstrap with 100 replicates, with resampling performed within the UHT sampling strata.

Continuous variables were presented as weighted means $\pm$ weighted standard deviations, or weighted medians with weighted interquartile ranges where appropriate. Categorical variables were presented as unweighted counts with weighted percentages. Weighting was used to account for the stratified sampling design at UHT; UHO patients and EA were assigned a weight of one because all eligible records were included.

In addition to the primary analysis, an exploratory analysis was conducted to further investigate differences between the populations of the UHT and the UHO to explore differences in the use of the label FTC. This analysis aimed to identify any differences in clinical, social, and ED-related factors between two populations. Exploratory between-centre differences were described using absolute standardized mean differences (SMD) with their 95% confidence intervals rather than hypothesis testing, because no formal between-centre superiority hypothesis was prespecified and multiple variables were compared. Absolute SMD values below 0.10 were considered negligible, 0.10–0.20 small, 0.20–0.50 moderate, and above 0.50 large. All analyses were performed using R software version 4.1.3 [20].

RESULTS

A total of 1,306 EAs met the inclusion criteria, with 924 (70.7%) were from the UHT and 382 (29.3%) from the UHO. After stratified sampling at UHT, exclusion of non-included records, and exclusion of patients who opposed the use of their data, the final analysis included 667 EA involving 614 unique patients (Fig. 1).

Primary objective: population characteristics

The study population included 614 unique patients and had a weighted mean age of 80.9 ± 11.2 years (Table 1). The majority were female ($n = 348$, 57.2%) and came from their own homes ($n = 564$, 91.8%), where they lived alone in 56.1% ($n = 341$ out of 564) of cases. The medical comorbidities most frequently observed were neurocognitive disorders ($n = 218$; 35.3%), psychiatric disorders ($n = 152$; 24.7%) and stroke ($n = 120$; 19.3%) (Fig. 2). The weighted mean HFRS was 6.6 ± 8.2 . Most patients were classified as having a low frailty risk (316, 54.5%), followed by intermediate risk (213, 31.5%) and high risk (85, 14.0%).

Table 1
Baseline characteristics participants

Age (years), mean $\pm$ SD	n = 614
	80.9 $\pm$ 11.2
Female, n(%)	348 (57.2)
Charlson comorbidity index, mean $\pm$ SD	2.4 $\pm$ 2.4
Polymedication, n(%)	329 (53.1)
Lifestyle, n(%)	
<i>Living alone</i>	341 (56.1)
<i>Home help</i>	320 (50.0)
<i>Walking aids</i>	269 (43.8)
<i>Legal protection</i>	53 (8.4)
Living space, n(%)	
<i>House/ Apartment</i>	564 (91.8)
<i>Residence / Care Facility</i>	47 (7.7)
<i>Homeless</i>	2 (0.4)
<i>Nursing Home</i>	1 (0.1)
HFRS score, mean $\pm$ SD	6.6 $\pm$ 8.2
HFRS risk category, n (%)	
<i>Low risk</i>	316 (54.5)
<i>Intermediate risk</i>	213 (31.5)
<i>High risk</i>	85 (14.0)
ED visit per participant in 2022	2.1 $\pm$ 1.5
Participants who were admitted in ED before inclusion date	239 (37.8)
<i>HFRS: Hospital Frailty Risk Score. SD: Standard deviation. ED=Emergency Department. Results are presented as unweighted counts with weighted percentages for categorical variables, and weighted means $\pm$ weighted standard deviations for continuous variables. Percentages and continuous estimates were weighted to account for the stratified sampling design at UHT.</i>	

Characteristics of EAs

Among the 667 EA, patients were most often referred by their close circle (n = 256, 38.1%). Most admissions were triaged as Category 3 (n = 354, 48.5%) or category 4 (237, 39.8%). The weighted mean of length of stay in the ED was 20.4 ± 15.5 hours. Hospitalisation occurred after 485 EA (71.0%) (Table 2).

Table 2
Characteristics of emergency admissions and follow-up

Send By	n = 667 (weighted %)
<i>Close circle (family, friend)</i>	256 (38.1)
<i>Third person</i>	178 (26.0)
<i>Doctor</i>	172 (25.7)
<i>The patient</i>	61 (10.2)
ED Triage	
<i>1</i>	3 (0.3)
<i>2</i>	16 (1.6)
<i>3</i>	354 (48.5)
<i>4</i>	237 (39.8)
<i>5</i>	53 (9.0)
<i>ND</i>	4 (0.8)
Medical ground at admission (nurse diagnosis)	
<i>Fall</i>	121 (18.8)
<i>Confusion</i>	91 (13.5)
<i>Failure to cope at home</i>	90 (14.5)
<i>Orthopedic / Traumatologic</i>	60 (8.8)
<i>Infectious</i>	54 (8.1)
<i>Neurological</i>	53 (7.5)
<i>Digestive</i>	48 (7.0)
<i>Cardiological</i>	43 (6.0)
<i>Pulmonary</i>	37 (5.4)
<i>This table sets out all the characteristics of the various visits to emergency department (ED). Some patients may have made several visits which explains why the number of visits (n = 667) is higher than the number of patients (n = 614). EA = Emergency Admission; GP = General Practitioner; EP = Emergency Physician; FTC = Failure to cope at home. SD: Standard deviation. Results are presented as unweighted counts with weighted percentages for categorical variables, and weighted means $\pm$ weighted standard deviations for continuous variables. Percentages and continuous estimates were weighted to account for the stratified sampling design at UHT.</i>	

Send By	n = 667 (weighted %)
<i>Psychiatric</i>	29 (4.3)
<i>Caregiver Burnout</i>	15 (2.4)
<i>Renal / Urinary</i>	15 (2.0)
<i>Endocrinological</i>	8 (1.3)
<i>Gynecological</i>	2 (0.3)
Failure to cope at home by nurse	356 (56.1)
Medical ground at discharge (EP diagnosis)	
<i>Failure to cope at home</i>	180 (25.5)
<i>Infectious</i>	153 (22.1)
<i>Neurological</i>	70 (11.1)
<i>Cardiological</i>	56 (8.3)
<i>Orthopedic / Traumatologic</i>	54 (8.8)
<i>Renal / Urinary</i>	53 (7.9)
<i>Digestive</i>	36 (6.1)
<i>Caregiver Burnout</i>	19 (2.8)
<i>Psychiatric</i>	19 (3.0)
<i>Endocrinological</i>	18 (2.9)
<i>Gynecological</i>	6 (0.9)
<i>Pulmonary</i>	3 (0.5)
Failure to cope at home by emergency physician	512 (74.5)
Time spent in ED (hours), mean $\pm$ SD	20.4 $\pm$ 15.5
Hospitalisation	485 (71.0)
Length of stay in hospitalisation (days), mean $\pm$ SD	16.7 $\pm$ 16.6
<i>This table sets out all the characteristics of the various visits to emergency department (ED). Some patients may have made several visits which explains why the number of visits (n = 667) is higher than the number of patients (n = 614). EA = Emergency Admission; GP = General Practitioner; EP = Emergency Physician; FTC = Failure to cope at home. SD: Standard deviation. Results are presented as unweighted counts with weighted percentages for categorical variables, and weighted means $\pm$ weighted standard deviations for continuous variables. Percentages and continuous estimates were weighted to account for the stratified sampling design at UHT.</i>	

Send By	n = 667 (weighted %)
Consultation with a social worker during the hospital stay	376 (53.8)
Participant's Status at Hospital Discharge	
<i>Returning home with a change</i>	175 (27.0)
<i>Returning home</i>	173 (27.5)
<i>Continuing care and rehabilitation</i>	118 (16.2)
<i>Nursing Home</i>	86 (12.6)
<i>Death</i>	60 (8.8)
<i>Change of living place</i>	5 (0.9)
<i>Palliative Care</i>	5 (1.0)
<i>Runaway</i>	4 (0.8)
<i>Psychiatric Centre</i>	2 (0.3)
<i>Hospitalisation department in another hospital centre</i>	2 (0.4)
<i>Drunk tank</i>	1 (0.2)
<i>Data missing</i>	37 (4.4)
Participant's future at 3 months from EA inclusion date	
<i>Lost to follow up</i>	197 (39.5)
<i>No living place change</i>	162 (25.0)
<i>Death</i>	119 (18.6)
<i>Nursing Home</i>	93 (12.7)
<i>Still in Continuing care and rehabilitation</i>	15 (2.0)
<i>Change of living place</i>	11 (1.7)
<i>Still hospitalised</i>	3 (0.5)
<i>This table sets out all the characteristics of the various visits to emergency department (ED). Some patients may have made several visits which explains why the number of visits (n = 667) is higher than the number of patients (n = 614). EA = Emergency Admission; GP = General Practitioner; EP = Emergency Physician; FTC = Failure to cope at home. SD: Standard deviation. Results are presented as unweighted counts with weighted percentages for categorical variables, and weighted means $\pm$ weighted standard deviations for continuous variables. Percentages and continuous estimates were weighted to account for the stratified sampling design at UHT.</i>	

FTC label used and acute medical conditions at EA

Among the 667 EAs, the FTC label was documented by nurse triage (NT) in 356 cases (56.1%) and by EPs classified in 512 (74.5%). At NT, FTC was the first diagnosis in 90 EAs (14.5%), after fall ($n = 121$; 18.8%) and before confusion ($n = 91$; 13.5%). At ED discharge, FTC was the first EP diagnosis in 180 cases (25.5%), followed by infectious diseases ($n = 153$; 22.1%) and neurological condition ($n = 70$; 11.1%) (Table 2). Considering NT diagnoses, EP discharge diagnoses, and hospitalisation diagnoses, 627 EA (93.6%) had at least one documented concurrent acute medical condition requiring medical assessment. Only 40 EA (6.4%) had FTC without any documented concurrent acute medical condition.

Hospitalisation and Discharge from ED

Hospitalisations occurred after 485 EA (71.0%). A few EA (60, 8.8%) ended in death during hospitalisation or at hospital discharge. At hospital discharge, 52.3% ($n = 352$) of EA resulted in return home, of whom 173 out of 352 (49.1%) with changes to home care. Additionally, 13.8% ($n = 86$) of patients were admitted to nursing homes. At 3 months from EA, 162 (25.0%) had no living place changing following hospital discharge. National death registry data showed that 71 patients (10.9%) died within 30 days and 119 patients (18.6%) within 90 days after the index FTC-labelled EA. Ninety-day survival according to FTC is shown in Appendix Figure S1.

Exploratory analysis: Differences in the use of the label FTC

In the exploratory between-centre comparison, most patient-level characteristics were broadly similar between UHO and UHT (Table 3). The weighted mean HFRS was higher at UHO than at UHT (7.9 ± 7.2 versus 6.1 ± 8.5 ; absolute SMD 0.22, 95% CI (0.07–0.39)). Low-risk HFRS classification was more frequent at UHT, whereas intermediate-risk classification was more frequent at UHO. Home help was more frequent at UHO (60.3% versus 45.3%; absolute SMD = 0.30 [0.15–0.46]). Other baseline medical and social characteristics showed negligible or small differences. At the EA level, the FTC label was more frequently documented by nurses at UHT (61.6% versus 43.6%; absolute SMD = 0.366), whereas it was more frequently documented by EP at UHO (84.7% versus 70.0%; absolute SMD = 0.356).

Table 3
Comparison of patient profile and emergency department profile characteristics
between UHO and UHT.

(A) Patient comparison			
	UHO (n = 287)	UHT (n = 327)	Absolute SMD [IC95%]
Age (years)	81.7 ± 10.4	80.5 ± 11.5	0.11 [0.00–0.22]
Female	168 (58.5)	180 (56.6)	0.03 [0.00–0.15]
Charlson comorbidity index	2.44 ± 2.38	2.35 ± 2.34	0.04 [0.00–0.19]
Medical history			
Neurocognitive disorders	104 (36.2)	114 (34.8)	0.03 [0.00–0.18]
Psychiatric illness	63 (22.0)	88 (26.6)	0.11 [0.00–0.26]
Stroke	60 (20.9)	60 (18.3)	0.07 [0.00–0.22]
Polymedication	158 (55.1)	171 (52.2)	0.06 [0.00–0.21]
Lifestyle			
<i>Living alone</i>	156 (54.4)	185 (56.9)	0.05 [0.00–0.21]
<i>Home help</i>	173 (60.3)	147 (45.3)	0.30 [0.15–0.46]
<i>Walking aids</i>	128 (44.6)	141 (43.4)	0.02 [0.00–0.17]
<i>Legal protection</i>	26 (9.1)	27 (8.1)	0.04 [0.00–0.19]
Living space			
<i>House/ Apartment</i>	265 (92.3)	299 (91.5)	0.03 [0.00–0.19]
<i>Residence / Care Facility</i>	21 (7.3)	26 (7.8)	0.02 [0.00–0.18]
<i>Homeless</i>	0 (0.0)	2 (0.6)	0.11 [0.00–0.18]
<i>Nursing Home</i>	1 (0.3)	0 (0.0)	0.08 [0.00–0.15]
HFRS score, mean(SD)	7.9 ± 7.2	6.1 ± 8,5	0.22 [0,07–0,39]
HFRS risk category			
<i>Low risk, n(%)</i>	118 (41.1)	198 (60.6)	0.40 [0.24–0. 57]
<i>Intermediate risk, n(%)</i>	130 (45.3)	83 (25.2)	0.43 [0.27–0.59]
<i>High risk, n(%)</i>	39 (13.6)	46 (14.2)	0.02 [0.00–0.17]

(B) Emergency admission comparison			
	UHO (n = 307)	UHT (n = 360)	Absolute SMD [IC95%]
Send by			
<i>Close circle (family, friend)</i>	119 (38.8)	137 (37.8)	0.02 [0.00–0.17]
<i>Third person</i>	90 (29.3)	88 (24.5)	0.11 [0.01–0.26]
<i>Doctor</i>	80 (26.1)	92 (25.5)	0.01 [0.00–0.17]
<i>The patient</i>	18 (5.9)	43 (12.1)	0.22 [0.08–0.36]
Mean of ED' visit in 2022 per EA	1.99 ± 1.30	2.12 ± 1.63	0.09 [0.01–0.25]
ED Triage (median [IQR])	3 [3–4]	4 [3–4]	0.75 [0.60–0.90]
FTC used by nurses			
<i>In medical record</i>	134 (43.6)	222 (61.6)	0.37 [0.22–0.52]
<i>At first admission diagnosis</i>	32 (10.4)	58 (16.2)	0.17 [0.03–0.32]
FTC used by emergency physician			
<i>In medical record</i>	260 (84.7)	252 (70.0)	0.36 [0.20–0.51]
<i>At first discharge diagnosis</i>	98 (31.9)	82 (22.7)	0.21 [0.06–0.36]
<i>UHO: University hospital centre of Orleans. UHT: University hospital centre of Tours. ED: Emergency department. EA: Emergency admission. FTC: Failure to cope at home. HFRS: Hospital Frailty Risk Score. SMD: standardized mean difference. Absolute SMD values below 0.10 were considered negligible, 0.10–0.20 small, 0.20–0.50 moderate, and above 0.50 large.</i>			

DISCUSSION

This observational, retrospective, multicentric study provides a unique insight into the population described with FTC status in the ED. The study population was predominantly older adults and majority of female, with cognitive impairments being the most common medical history among older adults and psychiatric disorders predominating in younger individuals. Many of these patients lived alone, received home assistance, and required mobility aids due to their limited physical autonomy.

Throughout the inclusion period, the term FTC and its equivalents were almost systematically associated with a wide range of medical situations, such as falls, infections, and confusion such as previous studies [21, 22]. This is consistent with previous work in older ED patients hospitalised for delirium, showing that apparently nonspecific cognitive presentations may reveal complex medical and therapeutic issues requiring structured multidisciplinary assessment [23]. Although these manifestations are not strictly social problem, the use of the term FTC to categorise these patients highlights the difficulty of applying a term that encompasses both social and medical challenges in ED [24]. In our

study, the hospitalisation rate following an EA higher than the national average after an EA (19.9% in 2021) across all age groups [25]. This observation is also found for specific populations over 80 years old, which more closely resemble our study population, with a national average hospitalisation rate of 46.6% in 2021 compared to 71.0% in our study. Thus, the term FTC appears to be used when there is difficulty in patients returning home. However, if the term FTC were used strictly in cases of actual difficulty returning home, then one would expect all patients requiring hospitalisation after an EA to be defined as FTC. Yet, the age distribution in our population does not seem representative of hospitalisations following EA. Indeed, a 25-year-old patient hospitalised via ED for peritonitis should, just like an older patient, be classified as FTC. These analyses suggest a potential cognitive bias in the use of the term FTC.

Our exploratory analyses support this assertion. Indeed, there is a difference in the use of the term FTC between our two hospital centres. Firstly, there is a significant disparity in the use of the term FTC, with nearly twice as many patients classified as FTC at UHT compared to UHO, despite the two facilities having a similar number of EA during the period. The term FTC appears to be used at UHO for more frail patients according to the HFRS score but not in terms of social, medical and comorbidities profiles. This could be explained by differences in the methods used to code medical procedures. This could also possibly explain the differences in how the term FTC is used across hospital, as this term can be entered as the primary diagnosis either by the nurse triage or by the physician [26]. These differences may be explained by the absence, to date, of a standardised definition of the term FTC, which does not correspond to any precise medical or social diagnosis. Conducting a qualitative study using focus groups would make it possible to explore these differences in the use of the term and provide a more precise definition.

With regard to the patient care pathway, a large number of them returned to their home, with a half proportion of their care plans being adjusted. This suggests that earlier recognition of issues related to loss of functional independence and autonomy by community care providers could reduce the number of FTC term used in emergency room. We also observed a higher mortality rate than in the general population, suggesting that the FTC-labelled population may be at greater risk of pejorative evolution. By comparison, the in-hospital mortality rate among FTC patients in our study is similar to that seen in elderly patients with NSTEMI (9.8%) [27]. A comparative study with a non-FTC control group would provide a clearer answer to this question.

The strength of this study lies in the large sample size and the inclusion of data from two hospital centres, thereby providing a comprehensive overview of the hospitalised population in France. However, this study has some limitations. Its retrospective nature and the inclusion of repeated admissions may have introduced biases. Nevertheless, we chose to include all relevant EA in order to avoid selection bias in the use of the term FTC by considering only the first visit for each patient. Due to difficulties in data collection, we had to select only a subset of patients from the UHT population. Nevertheless, we performed a random selection by sex and age to ensure that the sample was representative. The use of the FTC term would therefore seem to reflect a sense of difficulty in returning home. Since our study did

not include a qualitative analysis based on semi-structured interviews, we cannot explain the cognitive biases that might lead to the use of the term FTC. The lack of a standardised definition of hospitalisation in France complicates the interpretation of our results. In order to establish a precise definition, we intend to explore the cognitive processes involved in the use of the term FTC by conducting a qualitative study involving interviews with EP from various institutions. Moreover, given the prominent use of the term FTC in ED for patients who almost systematically present with an acute medical issue, it seems relevant to assess whether the use of this term leads to a change in patient management, primarily among older patients. We are currently conducting a comparative study of our FTC-labelled population with a population of patients not labelled FTC across our two establishments.

CONCLUSION

The "Failure to cope at home" label represents a critical intersection of medical and social challenges that seems to require early, comprehensive intervention. These findings argue against interpreting FTC as a purely social admission. While EDs and hospitals serve as safety nets for such patients, our findings divergent uses of the term FTC due to a lack of consensual definition of this term.

To better address the needs of this vulnerable population, FTC status should trigger a syndromic approach integrating both medical and social care. Identifying the true drivers of ED visits and strengthening pre-hospital support systems including appropriate social and administrative assistance—could reduce reliance on EDs for issues manageable in alternative settings. A targeted, multidisciplinary approach is essential to improving outcomes for patients and alleviating pressures on emergency services.

Abbreviations

- **AIDS**

Acquired Immuno Deficiency Syndrome

- **CNIL**

Commission Nationale de l'Informatique et des Libertés

- **EA**

Emergency Admission

- **ED**

Emergency Department

- **EP**

Emergency Physician

- **GP**

General Practitioner

- **FTC**

Failure to cope at home

- **MADD**

Maintien à Domicile Difficile

• **NT**

Nurse Triage

• **SD**

Standard Deviation

• **TIA**

Transient Ischemic Attack

• **UHO**

University Hospital of Orléans

• **UHT**

University Hospital of Tours

Declarations

Ethics approval and consent to participate

This study falls within the scope of the French Reference Methodology MR-004 (declaration 2205437 v0 2018 August 22, subscribed by the Orléans University Hospital), which requires which requires providing the patient with individual information and confirming that the patient has no objections to used data. This study has been approved by the local ethics committee of UHO (CERO 2603-03).

Consent for publication: Not applicable

Competing interests

The authors declare that they have no competing interests.

Funding

The authors declare that no funding grants or other support was received during the study or manuscript writing.

Author contributions:

All the authors contributed to the study conception and design. Material preparation and data collection were performed by LV, GM and AM. VG and MC performed the statistical analysis. The first draft of the manuscript was written by VG and MC, and all the authors commented on previous versions of the manuscript. All the authors have read and approved the final manuscript.

Acknowledgements: We would like to thank all participants in the study, as well as the clinicians involved in recruiting and managing the patients.

Clinical trial number: F20230606113524 (<https://health-data-hub.fr>)

Availability of data and materials:

The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

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Figures

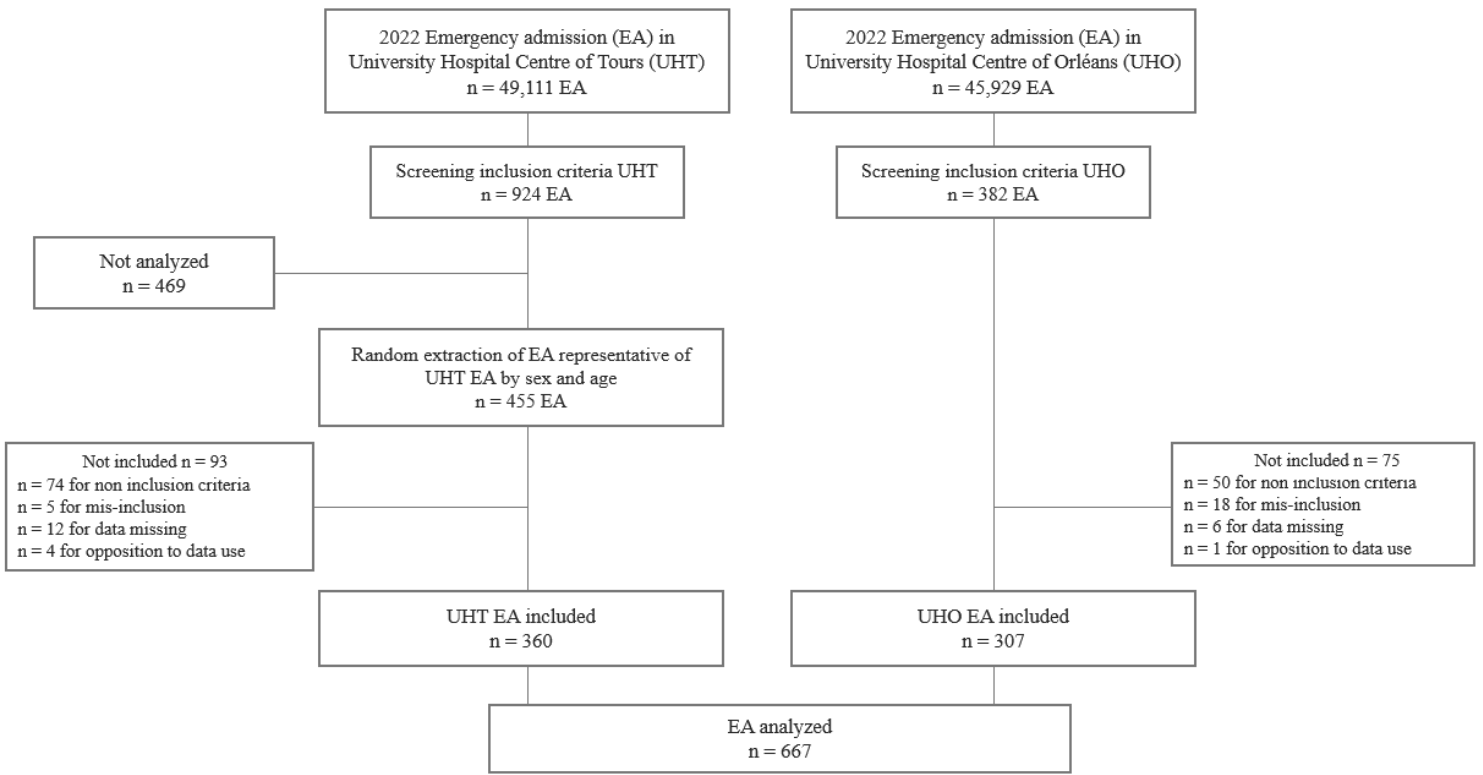


Figure 1

Flowchart of the selection process of emergency admissions (EAs) and participants included in the study. UHT = University Hospital of Tours; UHO = University Hospital Orléans.

Medical history by age group

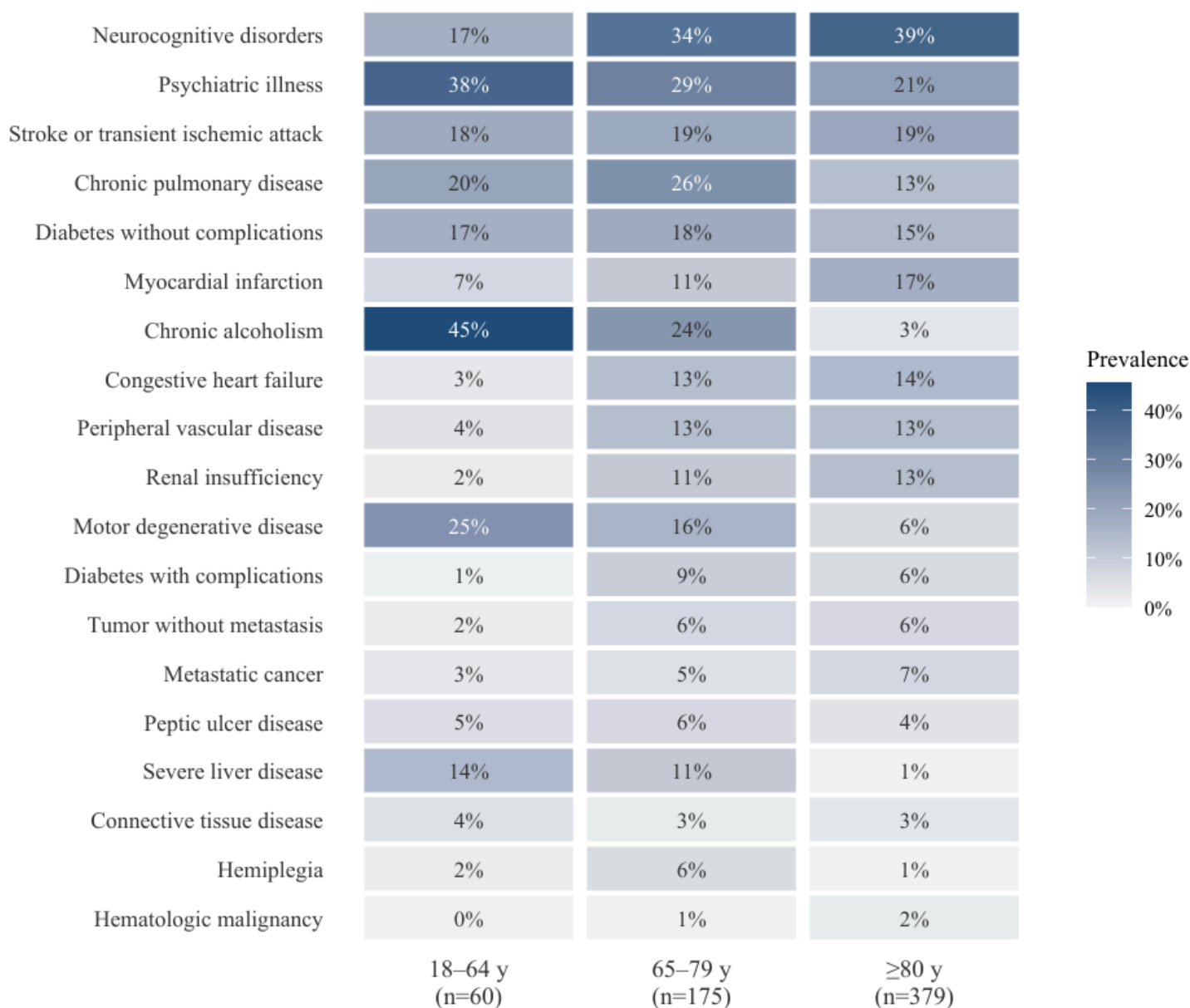


Figure 2

Medical history distribution by age range for patients presenting to the Emergency Department (ED).

Cells represent the weighted prevalence of each condition within the corresponding age bracket. Age-group sample sizes shown in brackets are unweighted. AIDS and mild liver disease were not displayed because of very small counts; lymphoma and leukemia were grouped as hematologic malignancy.

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