

Older adults experiences of rehabilitation in acute health care

Background:

Discharging patients from hospital is a key component of nursing and allied health care professionals roles in health and social care settings. It is noteworthy that despite government legislation and research that stretches back over twenty years in both Europe and North America, discharge planning remains problematic. Discharge planning entails bridging the gap between hospital and home and is regarded as a process that can enable resources to be used more effectively and efficiently. The challenge for health care professionals is to ensure that older adults who are hospitalised continue participating fully within society once discharged from hospital.

Objectives: This paper reports on stage two of an action research project to ascertain older adult's perceptions of the rehabilitation process.

Design: Semi-structured post discharge interviews.

Setting: A large acute teaching hospital in London serving a diverse social, economical and cultural population.

Participants: All older adults discharged from an acute older acute rehabilitation ward to their own homes in the community were eligible to participate. The only exclusion criteria was older adults who were thought to be unable to give consent to participate by the nurse in charge and the researcher. Whilst 92 older adults were eligible to participate in this research study only 20 agreed to be interviewed.

Method: 20 post discharge semi-structured telephones interviews .The interview transcripts were analysed using thematic content analysis.

Results: The findings from this study suggest that nursing and the professions allied to medicine play a limited role in restoring occupations of daily living. In addition older adults expressed dissatisfaction with their current level of function once discharged back into the community. Older adults valued interaction with health professionals but were aware of time constraints that hindered communication.

Conclusion: This study suggests that both nurses and allied health care professional are not actively providing rehabilitative services to promote health and wellbeing, which contradicts the focus of active ageing. Furthermore, there was evidence of unmet needs on discharge, weak communication and older adults unable to recall the professions that were involved and the rationale for therapy input. It is suggested that further research is needed to explore the effectiveness of allied health rehabilitation in the acute setting. Furthermore there is evidence of health care professionals failing to evaluate the effectiveness of the discharge once the patient was at home which suggests that professionals are not regarding discharge planning as a linear process.

Key words: active ageing, acute care, allied health profession, nursing, rehabilitation, discharge

What is already known about the subject?

Older adults often require a longer period of rehabilitation to improve or maintain the same level of function as a younger individual with a similar level of disability.

Multidisciplinary rehabilitation is an essential part of older adults' services.

Older adults that are hospitalised are at risk of losing previous functional skills required for independent living.

What this study adds:

Within acute care hospitals there is a need to carefully examine what professionals, service users and providers understand by the term older adult rehabilitation.

Further work is needed regarding the effectiveness of team care versus an individual skilled professional carrying out effective rehabilitation programs with older adults.

Nurses and allied health professionals within acute care are failing to regard discharge planning as a linear process hence the unmet needs on discharge. Post-discharge surveys should become an integral part of ensuring quality discharge planning.

INTRODUCTION

Discharge planning is a process that can enable resources to be used more effectively and efficiently and entails bridging the gap between hospital and home. It is an activity that is at the centre of health and social care legislation and policy making both in Europe, Australia and North America (Shepperd et al 2005). It is essential to take into account that the discharge process is not a single isolated event but a linear process. For example it involves the procedure of admission and the documentation of the expected problem(s) and outcome, the referral process, multidisciplinary assessment, the setting of goals, the planning of interventions, the implementation of the plan, evaluation, discharge and finally the evaluation of the discharge. Rehabilitation is an important component of discharge planning. Within the international community there is a growing recognition of the importance of rehabilitation to enable all persons with a disability to reach and sustain their optimum level of function (WHO 2005). Both the Association of Rehabilitation Nurses and American Geriatrics Society emphasize that the aim of older adult rehabilitation is to enable older adults to achieve their optimal level of physical, mental, and psychosocial health and well-being (American Geriatrics Society 1999, Association of Rehabilitation Nurses 2005).

Access to skilled rehabilitation professionals and facilities are imperative if hospitalised older adults are to live well in later life. By not investing in rehabilitation facilities can result in disabled adults being excluded from society (WHO 2005(a)). One study found that the mean physiotherapy time available to older adult per day ranged from 17 minutes 41 seconds in acute settings to 26 minutes 24 seconds in rehabilitation wards (Hubbard et al 2004). Observational

studies carried out in hospitals in the United Kingdom (UK) looking at activity levels of older patients show that therapeutic activities only occupy a minimal proportion of their time, and that most of the day is unoccupied (Nolan et al 1995, Birchall & Waters 1996, Perrin 1997, Clissett 2001). However, more research needs to be conducted into the cost effectiveness of older adult rehabilitation, and sustainability of outcomes (Wells et al 2003). There is however insufficient evidence to compare the effects of care home environments, hospital environments and own home environments on older persons rehabilitation outcomes (Ward et al 2004).

Older adults are particularly vulnerable to problems, which can arise during a hospital stay and are at high risk of poor functional outcomes during hospitalisation (Covinsky et al 2003). Functional decline is significantly associated with subsequent mortality, re-hospitalisation and institutionalisation (Sager et al 1996). Two of the factors that contribute to functional decline in the older person in hospital have been identified as excessive bed rest and immobility (Creditor et al 1993). Good management of the older person in hospital will involve attention to their rehabilitation potential. The most effective rehabilitation programmes are those, which promote interdisciplinary teamwork, target patients, provide comprehensive assessments and intensive and patient-targeted rehabilitation (Jonsson et al 2003, Wells 2003).

Patient perceptions and evaluations can give health and social care professionals a deeper understanding of how older adults experience and evaluate the care and rehabilitation process. Indeed, consumer satisfaction is a key way in which health care quality can be measured and as a basis for reforming or improving services (Bauld et al 2000). But obtaining the opinions of older people can be problematic, as researchers must overcome two major obstacles. The first obstacle is related to methodological problems associated with the ageing process (Bowsher et al 1999). The second obstacle being the fact that older people, when compared with younger consumers, repeatedly report positive outcomes regarding health and social care services (Bremhaar et al 1990, Khayat & Salter 1994). For one of the main problems associated with measuring satisfaction is that the concept is elusive and subjective (Ford & Walsh 1994). Indeed, a study by Krevers et al (2002) found that patients' expectations of the care and rehabilitation process in older adult medicine was based on a comparison of their wishes, experiences and overall knowledge of health care.

THE STUDY

This study is part of an action research project, located in a large NHS trust in the United Kingdom. The project aimed to explore whether health care professionals are actively engaging older adults in rehabilitation programmes. The first stage of the action research project, aimed to ascertain the perceptions of nurses, health care assistants, doctors and therapists' of rehabilitation on a rehabilitation ward for older

adults. The findings suggest that therapists relied on nurses and health care assistants for therapy carry over. Health care assistants were perceived as the professional group who could deliver therapy carry. There was evidence of role hierarchy since health care assistants perceived that they were not actively involved in decision-making or discharge planning.

The second stage of the action research project, which is reported in this paper, aimed to:

- Ascertain older adults' perceptions and experiences of rehabilitation in acute health care

DESIGN OF THE STUDY

Post-discharge semi-structured telephone interviews

Post-discharge semi-structured interviews were considered to be the most cost effective and efficient way of ascertaining the views of older adults and they have been used successfully in previous studies (Worth & Tierney 1993, Wilson & Roe 1998). However, Minnick & Young (1999) suggest that pre-discharge personal interviews are equally as expensive. Nevertheless they were considered to be a more effective means of capturing older adults' experience of hospital care due to the acute nature of the hospital environment. Indeed Berkman et al (2001) experiences of conducting interviews with hospitalised older people have been problematic. They found that interviews were often interrupted and timely access to inpatients was a major difficulty, consequently 29% of their interviews occurred over the telephone.

Data Collection

The interviews occurred in two phases. The first phase during the months of June and August 2004, and the second phase occurred between December 2004 and February 2005. The questions focused on older adults' perceptions of the rehabilitation process and whether they perceived that they had been given opportunities to enhance, restore or maintain occupations they perceived were of importance to them. During the telephone interviews the researcher wrote down the older persons responses as they were spoken. This allowed the researcher the opportunity to read back to the respondent their responses

Ward staff informed a member of the research team of all impending discharges. The researcher then met older adults and invited them to participate in the study. An agreed time was then made for the discharge telephone interviews. The semi-structured telephone interviews lasted between 20 and 30 minutes and were conducted from a consulting room in the therapy centre 3 days after discharge from hospital.

Sample

Whilst 92 older adults were eligible to participate in the study only 20 agreed to be interviewed. Reasons for not wanting to participate ranged from, simply not wanting to participate, not feeling well enough to participate, being discharged

early, short admissions (1-3 days) and or not wanting to make a decision without consulting friends or family.

Phase one

During phase one, 43 older adults were eligible for inclusion in the study, 25 were female (mean aged 78. 5 years) whilst 18 were male (mean age 81. 4 years). In total 11 older adults consented to participate in the interviews. 10 of these were interviewed over the phone, one was to be interviewed on the ward but later refused.

Phase two

During this 49 older adults were eligible for inclusion in the study, 27 were female and 22 men. In total 9 older adults consented to participate in the interviews. Consent had been obtained from a further 7 patients but 3 were readmitted to hospital before the interview could take place, 2 were too confused to answer questions on the phone and 2 declined when phoned.

Data Analysis

Thematic content analysis was used to analyse the data from the interviews (Neuendorf 2001). In order to become familiar with the data the interviews were read three or four times. Comments and notes were made in the margins. A number of codes emerged and these were then grouped together by grouping the data into units of meaning and considering how the codes might be meaningfully clustered together.

In order to enhance the credibility of the research three researchers independently coded the data. A high degree of consensus was found. Once a relationship between the cluster themes had been determined the themes were established. Data analysis produced 3 themes, which were unmet occupational needs on discharge, limited communication between health care professionals and older adults, dissatisfaction with the type and amount of therapy. The participants were asked if they wished to receive a copy of the interview transcript however none of the participants felt this was necessary.

ETHICAL CONSIDERATIONS

Ethics approval for the study was obtained from Local Ethics Research Committee in March 2004 following NHS REC application procedures. Participants were informed that the interviews were confidential and information provided would subsequently be anonymous and would be stored securely and destroyed two years after the study was completed.

FINDINGS

Communication

There was evidence of limited interaction occurring between older adults and health care professionals. However, older adults were willing to ‘forgive’ nurses for not listening to them because they were perceived to be so busy, “they did their best for me, everyone’s doing their best, everyone’s so busy to keep listening”. Another older adult stated, “ the nurses are so busy, they just ignored me”. Another older adult seemed to defend the physiotherapist who did not keep an appointment because she was busy. “I was supposed to be seen by a physiotherapist to give me exercises but she didn’t turn up. She did come and explain why, that she was busy”.

Older adults appeared to value interaction with health professionals. Older adults perceived that their hospital stay could have been enhanced if they could have had more interactions with nurses and allied health care professions:

“I think we could do with more people like you talking to us and asking questions. Someone that you could talk to...you can’t always talk to nurses, they’re busy ‘in a minute, in a minute’ and then it’s in an hours time. They have a job to do”.

Another older adult expressed some distress regarding the support, which he/she obtained from the nurses and other patients. This in turn impacted upon his/her emotional wellbeing:

“It was horrible... I was miserable and unhappy... partly my fault... I’m quiet. I couldn’t speak to others across the ward. The nurses didn’t speak too much either”.

Likewise another older adult commented on not only social isolation but also the lack of activity on the ward:

“There was nothing to do... just sit in your chair or on your bed all day... pity they can’t find some occupational therapy for people to pass their time away”.
Something to keep you busythere were times when you’d think you’d like more attention from the nursing staff...but they are so busy... but it would be nice to be asked “How’re you doing?”. In the evening after evening meal you hardly see anybody at all”.

There was evidence that older adults had to ring call bells to get nurses attention and even then the call could be ignored and or the older adult having to wait. Indeed, two older adults expressed dissatisfaction with the practice of having to call out to nurses to gain their attention:

“The experience was not very good.... They are very short staffed... there are not enough people to look after everybody... this is causing danger to patients due to being short-staffed ... people had to shout before they came”.

“It’s concerning that every patient has a call bell placed in their hand and told to ring if they need anything. I found the response poor, up to ¼ hour, which is not acceptable. If you press the bell for assistance to go to the toilet you need to go to the toilet then”.

Another older adult commented not only on the fact that nurses were busy but those nurses would often leave tasks uncompleted which in turn impacted upon the older persons well-being.

“A nurse removes bottles from a patient during the night and then doesn’t return any, this could be quite worrying for a patient. How easy is it to remove two and bring two back? I think the staff are so overworked. You ask them for something, they go outside your room and talk to someone else, they completely forget. Too much intense going on day and night. I also noticed the behaviour of some patients took up the nurses’ time”.

In contrast three older adults were highly pleased with the attention that they received.

“If I called for anything they came. If I needed help to the toilet they would come”.

Two older adults reported that the attitude of staff reflected greatly on the care they received:

“In my opinion what makes a good nurse is 70% training and 30% attitude to patients. They all have training but in terms of attitude some have it and some don't. Some have a very cold attitude to patients and some are very caring”.

Perceptions of therapy to restore and promote independence

Seven older adults were unable to identify health professionals that encouraged them to be independent with occupations of daily living, “No I can't remember any particular person.” Another older adult stated, “they haven't got time to stand and watch over you.” Six of the participants were aware why they had been assessed by a physiotherapist but were not specific about receiving input from occupational therapists.

One older adult commented that they, “Saw the OT for general stuff, Nothing special”. Whilst another older adult stated that he “Saw two girls...one of them helping me going upstairs and going downstairs... can't remember... they weren't nurses.”

For one older adult who did remember specific therapy involvement he/she did not value this:

“Can I comment on the business of discharge? A lady came to look at what I needed at home to access in and out, recommended bars. I came home and took a look at it and all we need are 2 rails each side of the door...they also

brought me a shower seat but it is too big for the cabinet. I don't know why they didn't assess it properly. Now we are planning to do it ourselves.”

In addition two older adults were disappointed with the advice and education that was given by professionals, whilst another uttered concern whether his/her family had been informed about the discharge. Another older adult commented that he/she would have like to have seen someone about their eating. One older adult expressed particular dissatisfaction with aspects of self-care particularly in relation to the type and amount of input, which he/she received for this activity. One older adult used the word ‘service’ which suggests a misunderstanding as to why the participant may have been left to continue with aspects of the self care occupation:

“The service was not good.... they took a long time to do things... Not up to standard... more help with dressing in the morning”.

Another older adult expressed disappointment about the care that she received for her leg ulcers and was surprised that she would “have to ask for my dressing to be changed”. Likewise, there was evidence that older adults were having to take responsibility for own rehabilitation as two older adults stated that nurses allowed them to perform self care activities without offering any assistance.

Occupations of daily living on discharge

Many of the older adults reported having assistance to carry our daily occupations now at home; “My wife is helping me with everything, getting up and down the stairs, out of the bath”. Although some reported difficulties they were ‘coping’, “my

breathing's not good, anything I do is quite hard. I had to walk to the paper shop this morning slowly. I'm doing breathing exercises". Another older adult stated, "We've made adaptations at home with the help of my sons, I'm coping". One older adult suggested that he had been discharged home too soon saying, "Had they said stay in for a couple of days, I would have".

Four older adults voiced concerns about their level of mobility, whilst another commented that he/she were waiting for an out patients appointment from physiotherapy due to swelling around the ankle. One older adult perceived her level of mobility had deteriorated since her admission into hospital

"In the hospital you lie around and your legs... muscles I suppose really. . become weak, so I'm walking around slowly... I'm not as good as I was before.... I'm just sitting around at home".

Another older adult described in depth her account of her ability to perform daily occupations and how it was impacting upon her health and wellbeing

"Can't wash myself properly at home... I do get help from Help the Aged... some difficulty in doing things.... they brought me a stool for the kitchen".
"My sister lives next door... she's very old and confused". "I live in sheltered accommodation ... need to be self-sufficient... I'm worried about not managing things as well as I might". "Age Concern to be with me for 6 weeks... they will contact social services when they're finished". "I can't do any cooking... I get meals on wheels". "My niece does the shopping".

DISCUSSION

The findings from this research suggest that there was evidence of older adults not receiving specialist support and rehabilitation. Older adults were often unsure whether that had been assessed or treated by an occupational therapist although there was evidence that some older adults did value the input of physiotherapists. Whilst rehabilitation is considered to be a multidisciplinary process there was evidence that older adults were unsure of the roles of the allied health care professions. One possible reason for this could have been to role confusion or the fact that numerous therapists assess older adults. In addition, some cares were dissatisfied with the level of input. Tyson & Turner (1999) found that the greatest cause of dissatisfaction amongst stroke patients was the limited amount of therapy that they received.

There was evidence of unmet needs in occupations of daily living on discharge, which in turn can impact upon the quality of hospital discharges. Possible reasons for this could be the failure of nurses, occupational therapists and physiotherapist to take into account the need and aspirations of patients when planning discharge and or interventions. Hence it is essential that all professionals are familiar with rehabilitation principles and are able to perform rehabilitation intervention. Another reason could be due to the limited amount to time spent by therapists and nurses interacting with older adults. Parry (2004) examined communication during goal- setting in physiotherapy

treatment sessions and concluded that various interactional difficulties was a factor that prevented therapists from ascertaining the patients opinions and incorporating them into agreed goals. In a study examining the involvement of adult rehabilitation patients in settings, occupational therapy factors that impacted upon the subjects participation were not only related to a specific theory or technique, but to time constraints, patient's age and assumptions about the patients' cognitive status (Northen et al 1995).

This study has highlighted the value that older adults place upon interaction with nurses and allied health care professionals as well as participating in social activities. One of the barriers preventing this from occurring was perceived to be lack of time. Indeed there is evidence that nurses social interactions with older persons are often brief and limited (Armstron- Esther et al 1994, Nolan et al 1995, Clissett 2001, Lyytinen et al 2003). However, older persons who are the most interesting and social skilled receive most attention from nurses (Nolan et al 1995). Nurses who placed a higher importance of talking to older persons held a more positive attitude towards older adults than those nurses who place a higher importance on nursing tasks such as self care and bathing (Armstrong-Esther et al 1989).

Despite the acute nature of rehabilitation wards it is essential that older adults have access to a wide range of facilities that include social and leisure occupations. Some studies have been able to demonstrate that the continued engagements in meaningful occupations such as the promotion of social engagement and leisure occupations are important for the health and wellbeing of older adults (Everard et al 2000, Lennartsson & Silverstein 2001, Menec 2003). Indeed, Scarmeas et al (2001)

suggests that engagement in leisure activities may reduce the risk of incident dementia, possibly by providing a reserve that delays the onset of clinical manifestations of the disease. Furthermore, older adults perceived that unmet needs was not a result of nurses not caring but a direct consequence of heavy work loads and lack of time. One study investigated complaints from older adults found that 73% of complaints were made by advocates rather than by older adults themselves and 96% related to communication or treatment issues (Anderson et al 2000). Attree (2001) suggests that good quality care is characterised by patients and relatives as individualised, patient focused and related to need, provided by professionals who demonstrate a caring relationship by involvement, commitment and concern. In contrast not so good quality care was routine, unrelated to need and delivered in an impersonal manner by professionals, who they did not know, engage with or involve the patient. Furthermore, higher satisfaction is associated with patient compliance and better outcomes (Keith 1998).

STUDY LIMITATION

The researchers found that older adults appeared reluctant to discuss aspects of their care on the telephone and were reluctant to elaborate on opinions and perceptions. Furthermore the interviews were not tape-recorded. In regards to establishing rapport the researchers felt this was not a problem as they had established a relationship with the older adult via face to face prior to their discharge. Herzog et al (1983) found that older adults who experienced ill health were more likely to refuse a telephone interview than a face to face interview.

CONCLUSION

In order to enhance practice, health care professionals need to understand the concerns and experiences of older adults. Acute care settings are failing older adults for a number of reasons. The first reason is the failure of nurses and allied health care professionals to restore and maintain occupations of daily living. The second reason is related to the allied health professionals, as older adults were often unable to recall the professions that were involved and the rationale for therapy input. The third reason is related to communication with older adults since time constraints impacted upon the type and amount of patient/therapist and or nurse communication. It is suggested that further research is needed to explore the effectiveness of allied health rehabilitation in the acute setting. More international dialogue is needed regarding the effectiveness of acute older adult rehabilitation and international professional bodies need to agree professional competencies. Furthermore it is essential that professionals understand that in order to achieve the goals of rehabilitation in acute care discharge planning must be regarded as a linear process.

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