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Comprehensive Geriatric Assessment on an acute medical unit: A qualitative study of older people's and informal carer's perspectives of the care and treatment received

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Abstract:	Objective: This qualitative study was imbedded in a randomised controlled trial evaluating the addition of geriatricians to usual care to enable the comprehensive geriatric assessment process with older patients on acute medical units. The qualitative study explored the perspectives of intervention participants on their care and treatment. Design: A constructivist study incorporating semi-structured interviews which were conducted in patients' homes within six weeks of discharge from the acute medical unit. These interviews were recorded, transcribed, and analysed using thematic analysis. Setting: An acute medical unit in the United Kingdom. Participants: Older patients (n=18) and their informal carers (n=6) discharged directly home from an acute medical unit, who had been in the intervention group of the randomised controlled trial. Results: Three core themes were constructed: 1) perceived lack of treatment on the acute medical unit; 2) nebulous grasp of the role of the geriatrician; and 3) on-going health and activities of daily living (ADLs) needs post discharge. These needs impacted upon the informal carers, who either took over, or helped the patients to complete their ADLs. Despite the help received with ADLs, a lot of the patients voiced a desire to complete these activities themselves. Conclusions: The participants perceived they were just monitored and observed on the acute medical unit, rather than receiving active treatment, and spoke of on-going unresolved health and activity of daily living needs following discharge, despite receiving the additional intervention of a geriatrician.

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Introduction

Acute medical units in UK hospitals receive patients presenting with an acute illness from either the emergency department or directly from general practitioners. Patients on these units are assessed and treated over a short designated period (typically under 72 hours), and are then either discharged directly home or transferred to a specialist ward [1]. A survey in England, Wales and Northern Ireland revealed that as many as 98% of hospitals have an acute medical unit [2], and their use is becoming increasingly widespread in Australia and New Zealand [3].

To date, research conducted on acute medical units has been predominantly quantitative in nature, and has revealed positive outcomes, including reduced waiting times for hospital beds [1, 4], reduced length of hospital stay [1, ,4, 5], increased direct discharge rates [1, 5] and reduced mortality rates [1]. However one concern is that at least half of older patients discharged home from acute medical units are readmitted in the near future [6, 7].

One model of care found to be effective in reducing readmission rates for older patients is comprehensive geriatric assessment (CGA) [8, 9]. This is a process in which a comprehensive assessment of health domains specific to the problems facing older people is used to derive a multidimensional care plan, which is

methodically implemented but a systematic review evaluating the comprehensive geriatric assessment found no trials on acute medical units [10].

Subsequent to the above review, a randomised controlled trial was conducted to evaluate the delivery of the comprehensive geriatric assessment process on acute medical units. In this study five geriatricians provided the comprehensive geriatric assessment in patients due to be discharged in addition to the treatment routinely provided by the units' consultant physicians and medical team. Plus they usually visited them at home shortly after discharge from hospital. The geriatricians liaised with hospital and community health professionals with the aim of enabling the comprehensive geriatric assessment process to be delivered across the interface between the acute medical unit and the community. However the trial showed no benefits in terms of resource use or health outcomes for this intervention [7].

We conducted a qualitative study as part of the above randomised controlled trial, with the purpose of gaining an in-depth understanding of the older patient and informal carer experience of an acute medical unit stay and their experience of receiving the additional intervention from geriatricians. Ultimately the study sought to provide explanations behind the trial outcomes, and to guide further development of interventions for this group of patients. It is this qualitative study that is reported on here.

Method

The study was guided by a constructivist epistemology. A belief that realities exist in the form of multiple mental constructions. The aim of constructivism is to draw together the variety of constructions that exist and to search for consensus amongst these constructions. The way to access these constructions is through subjective

interaction [11]. This epistemology was therefore considered the most appropriate to guide the design of the study. To ensure a range of constructions were represented a strategy of maximum variation sampling was adopted (see below).

Sample selection

Participants were recruited from one of the two randomised controlled sites. The criteria for participating in the trial have been described in detail elsewhere [7, 12]. Briefly, participants were aged 70 or over and identified at being at risk of future health problems, using the Identification of Seniors at Risk (ISAR) screening tool (predictive tool of high acute care hospital utilization and adverse health outcomes) [13] and had a short stay of up to 72 hours in the acute medical unit.

Participants assessed by the trial research assistants as having cognitive impairment, which meant they would not be able to be interviewed, were excluded from the qualitative study.

All participants who received the geriatrician intervention in the randomised controlled trial were asked if they would be interested in taking part in an interview about their experience of the care on and associated with the acute medical unit. A purposive sample of patients, and their informal carers (where present), were selected by the lead author (JD) from those participants that expressed an interest. Informal carers were defined as family, neighbours and friends who provide care and support on a regular basis as opposed to employed care workers. A strategy of maximum variation sampling was adopted to ensure the selection of a range of participants who had different characteristics [14], such as different ages, and a range of Barthel (level of independence/dependence performing activities of daily living) and ISAR scores.

Data collection

The selected participants were contacted by telephone by the lead author and provided with information about the interviews. At this point, those with a carer in the trial, were also asked if their carer might be interested in taking part in an interview. Those participants expressing an interest were sent a study information sheet (and carer information sheet where applicable). Individual or paired (patient and informal carer) interviews were conducted by the lead author in the patient participant homes. The lead author is an occupational therapist by background but has never practiced in acute medical care, and did not work on the AMU. Written consent to take part in the study was given by participants on the day of the interview.

An interview guide (see Appendix), developed from the relevant literature and informed by concerns of the randomised controlled trial team [15] was used, covering participant perceptions of the acute medical unit stay, the intervention by a geriatrician, discharge arrangements, resettlement at home, any on-going problems with health, and any impact of their illness on everyday activities. Data on participant characteristics and functional status measured by the Barthel Index [16] were taken from the trial data base. All the interviews were audio recorded and transcribed verbatim.

Data analysis

Data were analysed by the lead author using thematic analysis, a method which identifies patterns and themes across interviews. The lead author was trained in this method of analysis, and it is compatible with a constructivist epistemology [17]. The data was analysed using a manual method to enable the author to remain close to the data [18]. Six phases of analysis were used to guide the process [17]. These

involved a systematic process of coding data, collating these codes into potential themes, reviewing the themes, and finally refining and naming the definitive themes. Recruitment of participants continued until saturation of data occurred and no new themes arose. Trustworthiness was enhanced by the use of reflexivity and peer debriefing with the second author (TW). This author is a nurse by background with different assumptions and personal interests to the lead author.

Results

One hundred and thirty six patient participants were recruited to the intervention group. Forty of these participants were purposively selected to take part in an interview, 22 (55%) accepted the invitation to be interviewed. However two participants were readmitted before the interview could take place, and two participants could not be interviewed within six weeks of discharge, leaving a total of 18 patient participants for interview. The participants had a mean age of 82 years, 10 were women and all were of white ethnicity. Participants had a Barthel score ranging from 3-20 (mean 17) (Table 1 shows patient participant characteristics).

Of the 18 patient participants, eight identified that they had an informal carer, and these were invited for interview. This achieved a final sample of six carer participants. The carers that declined to take part stated that they did not provide any direct care for the participant. This was in direct contrast to the carers interviewed who stated that they provided care on a daily basis for the participant. There was an even mix of demographic factors amongst the informal carer participant sample (Table 2).

All the patient participants requested that their informal carers were interviewed alongside themselves, so a total of 18 interviews were completed. These ranged in length from 15 minutes to 100 minutes, with an average length of 38 minutes.

Themes

Three substantive themes resulted from the coding process: perceived lack of treatment on the acute medical unit; nebulous grasp of the role of the geriatrician; and perception of on-going needs post discharge. Each is discussed below. All names used throughout the paper are pseudonyms.

1) Perceived lack of treatment on the acute medical unit

Patient and carer participants spoke about a lack of treatment on the acute medical unit. Participants perceived that they were just monitored and observed during their acute medical unit stay with no active treatment. They spoke about being checked on regularly, and being 'kept an eye on', rather than being actually treated. One participant, Albert, who was admitted with chest pain, stated the following when asked specifically about his treatment:

> *"Well, nothing really. Just monitoring. Just had observations every hour or so, blood pressure, being diabetic they come and took my erm sugar level every now and again, examined me two or three times, but, never had any medication other than my tablets which I took in with me"* (Patient participant, age 78).

Albert spoke about the acute medical unit staff observing him, but did not consider this to be formal monitoring as part of his treatment. He associated treatment with medication, specifically tablets. Similarly, Keith, one of the carer participants,

perceived that the emphasis on the acute medical unit was upon observation rather than treatment. His mother was admitted as a result of vomiting. He stated:

> *"I don't think its* [acute medical unit admission] *had a positive or detrimental effect on her. Because all they did, took her in there for obs, and that's it. They just saw how she was, yer she's ok, she's stable, send her home. No extra or different treatments like. That's it"* (Carer participant, son).

Keith stated that no new diagnosis had been provided, and that his mother had returned home with no change to her condition. He perceived that nothing new had been done for his mother during her acute medical unit stay.

Patients and carers perceived treatment as such things as medication, oxygen, intravenous drips, and injections.

Likewise most of the participants did not perceive they were treated by the geriatrician, as outlined in the theme below.

2) Nebulous grasp of the role of the geriatrician

Most of the patient and carer participants could recall seeing the geriatrician. The participants were keen to point out how pleasant they found him/her. They talked about the geriatrician spending time with them, talking to them, examining them and asking questions. Participants reported favourably about the geriatrician saying that he/she was very good, pleasant, or indeed charming. However the majority of participants had difficulty articulating what the geriatrician actually did for them. Edna, who was admitted onto the acute medical unit following a fall, provides an example:

> *"I don't know what he's* [geriatrician] *done really. Just to talk to me that's all, yer he was quite nice really, he come, and the nurse said it's very rare that he ever visits patients outside"* (Patient participant, age 89).

When asked to expand on her comment Edna added:

> *"Oh he only, he sat there* [indicating sofa] *just talked to me that's all. Asked me what, how I was and was I going on alright and that kind of thing. You know. He was quite nice actually. Nice person".*

Like many of the participants Edna was vague about the actual geriatrician intervention. Only two of the patient participants could verbalise details about the geriatrician intervention. This is not to say that the geriatrician did nothing, but rather that participants were unaware of the details of their intervention. This can result in participants perceiving that nothing has been done to resolve their reason for admission, and this concern is reflected in the theme below.

3) On-going needs

This theme described how the patient participants perceived their health and activities of daily living following discharge from the acute medical unit.

On-going health needs

The patient participants perceived they had on-going health problems despite their recent hospital admission and treatment by the geriatricians. They expressed concerns about on-going symptoms which had been directly attributed to the cause of their acute medical unit admission and they had unanswered questions about their health. Norman, who was admitted onto the acute medical unit with severe back

pain, explained how this pain remained throughout his admission and continued post discharge:

> *"Well I was more or less stationary, I mean I couldn't move, with me back, I know I keep on about me back but I couldn't move… I was, was, I couldn't even go to the toilet"* (Patient participant, age 76).

Norman raised concern about his unresolved symptoms on ten separate occasions during the course of his interview. He had been admitted into hospital for the same symptoms only months before, and spoke of his concern that he had been discharged prematurely from the acute medical unit. He left the unit with the very symptoms that took him into hospital, and because his symptoms persisted he called out both his general practitioner and the out of hour's emergency service.

Some of the carer participants similarly reported no change in the health of the patient participant as a result of the acute medical unit stay. One of the carers, Jane, stated that her mother had been 'very up and down' since discharge from the acute medical unit, and perceived her mother's health had deteriorated since the stay on the unit.

On-going activity of daily living needs

The patient participants also spoke about experiencing problems with their activities of daily living. An example is provided by Beryl, who was admitted onto the acute medical unit with chest pains, which followed on from an earlier heart attack. Beryl spoke about how her recent poor health had affected her confidence to go out shopping:

> *"I think it's just a bit scary when you er you know you wonder, erm when you go out you know am I going to be alright? And I can't, I can't walk like I used to, I soon get tired walking, and erm, I mean like if I go into town, going to Marks and Spencer's, well I'm probably alright going down there, but coming back up, you know, erm I have to come up, erm [name of street] now, catch the bus, and it's, oh it's such an effort to get back up there again"* (Patient participant, age 80).

The carer participants also spoke about the difficulties that patient participants were experiencing with their activities of daily living. Yet despite these difficulties, few participants were referred for an occupational therapy or physiotherapy assessment, and none were referred for rehabilitation. These claims were verified by examination of the geriatrician documentation.

Impact of on-going needs on carers

The difficulties that the patient participants experienced completing their activities of daily living (ADL) impacted on their informal carers. The patient participants spoke of carers either taking over, or helping them to complete their ADLs. David, who was experiencing a lack of energy and shortness of breath, spoke about how his health problems were impacting on his elderly wife:

> *"... But it's hard work for my good lady there. It makes it hard work for her, it wears her out a bit, but it is, it is hard work. But she's struggling, she's getting by aren't you"* (Patient participant, age 80).

David later went onto describe how his 77 year old wife was physically helping him to climb into and out of the bath due to his fear of falling. One of the carer participants,

Diane, whose mother was admitted to the acute medical unit with heart concerns, also provided an example of how difficulty completing activities of daily living had ultimately impacted on the informal carers:

> *"It's getting quite tiring for us. We've got to be honest, erm you know we would rather be coming and taking mum out somewhere, whereas it can get tiring when you get here and realise that she needs some shopping doing or you know the bed needs changing, that sort of thing"* (Carer participant, daughter).

Desire for independence

Although the term rehabilitation was not specifically mentioned, the participants did express a desire to be independent with their activities of daily living, rather than being dependent on their carers. Barry, who was admitted onto the acute medical unit with chest pain, expressed a strong desire to maintain his independence:

> *"I like to do most things for myself. I just have a cleaner to come and clean up once a week. And for me shopping and that I like to do it myself"* (Patient participant, age 77).

As part of the geriatrician intervention, Barry's family was contacted, and they requested home care support. However this service was declined by the participant, who preferred to maintain his independence. He stated:

> *"Well er I've been fine* [since returning home]. *And I've still keep going if I've got to drop dead* [laughs]".

The patient participants perceived that completing activities of daily living provided a role and purpose in life, met their values, took their mind of anxieties, made them

feel better, and provided a range of emotional responses such as enjoyment and pleasure.

Discussion

Older higher risk patients admitted to and discharged from an acute medical unit perceived that they were largely monitored and observed during their hospital stay, which did not meet with their view of what constituted treatment. This was equated with the provision of medication, oxygen, intravenous drips or injections. Patients felt that the reasons they originally presented at the acute medical unit were not simply an expected extension of an existing condition, but a treatable exacerbation of an existing condition or a new health need warranting investigation and treatment. They expressed that these needs were not fully addressed through observation and monitoring. The participants perceived that they were discharged home with on-going health and needs related to the performance of activities of daily living that, should have been resolved and were not, despite the additional input from a geriatrician. Although the term rehabilitation was not explicitly stated the participants spoke of a desire to regain their independence.

A strength of this study was that the interviews and analyses were conducted independently of the trialists in the randomised controlled trial and the staff providing the clinical interventions, enabling a separate and objective way to consider the effect of the clinical care and trial intervention. A limitation is that it was conducted in one centre (although there were five geriatricians who provided the trial intervention). The sample was also fairly homogeneous, being entirely of white ethnicity with most participants scoring high on the Barthel Index. However as the sample was drawn from the randomised controlled trial it largely reflects the attributes of this trial. One

important variation between the study reported here and the randomised controlled trial relates to participants with cognitive impairment. These patients may benefit most from the intervention, and were included in the randomised controlled trial. Their exclusion from the qualitative sample means that their views, and those of their carers, were not represented. Similarly, as all the interviews were conducted jointly with patients and carers, there may have been a reluctance on the part of both parties to be open about difficulties.

In England, concern has been raised that early hospital discharges of older patients has resulted in growing readmission rates [20]. In a recent national inquiry, older patients themselves reported that they had been readmitted for the same problems for which they were discharged [21]. Patients on acute medical units typically experience a short hospital stay, and in keeping with the current study, previous studies conducted on acute medical units have found that patients often require subsequent medical care for the same problem after their discharge [3, 21, 22]. It has also been noted previously that patients experiencing a short length of stay are less likely to receive multidisciplinary input on discharge than patients experiencing a longer length of hospital stay [23], and that these patients should be targeted for formal rehabilitative services [24], such as intermediate care [25] - uptake of which, from emergency departments, remains low (6%) [26].

The participants in the current study also received intervention from a geriatrician in addition to the usual care provided on the acute medical unit. Despite this additional intervention, the findings of this study are consistent with those of the randomised controlled study [7] which also showed that the geriatrician had little impact on the participant perspective of their overall health and functional status. One explanation is that the geriatricians either did not adequately assess the health and rehabilitation

needs, or were unable to facilitate services to respond to the needs. This may have been because they were working in addition to the routine service and not part of the integrated multidisciplinary team. In studies that demonstrated the effectiveness of the comprehensive geriatric assessment process in patients in acute care [8, 9, 10, 11, 28, 29, 30], geriatricians were part of a multidisciplinary team. One study, like the current study, found that when geriatrician intervention was provided without a multidisciplinary team, it was not effective [27].

The finding that acute illness leads to increased dependency in activities of daily living, that are mainly met by an informal carer accords with other studies [30- 37], and such increased dependency is often pertinent to the decision for older patients to return to hospital [3].

The implications of this study are that although acute medical units may be successful in identifying medical emergencies in need of immediate intervention, for many older people they do not adequately identify or effectively respond to on-going or increased dependency in patient's activities of daily living, which may lead to increased demands upon informal carers and increased likelihood of re-presentation to hospital. The provision of additional input from a geriatrician alone, was insufficient to address these needs. The on-going needs in patients discharged from acute medical units require an intervention that is capable of identifying them, and responding to them in the community. Further research should consider the development of an integrated team linking comprehensive assessment in the acute medical unit to community services such as intermediate care.

Clinical messages

- Older people had perceived on-going unresolved health and daily living needs after discharge from an acute medical unit despite having additional geriatrician input.
- Informal carers assisted patients with their new and unresolved daily living needs, but patients wished to regain their independence with these activities.

Competing interests

The authors declare that they have no competing interests.

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. **Ethical approval**

Ethical approval was obtained from Nottingham 1 Research Ethics Committee, and University of Salford College of Health and Social Care Ethics Committee.

Table 1: Patient Participant Sample

Name:	Age	Gender	Ethnicity	Residency status	Barthel score	ISAR score	Admission reason
Annie	78	F	W	Lives with partner	19	3	Collapse
Beryl	80	F	W	Lives alone	19	4	Chest pain
Albert	78	M	W	Lives with wife	16	3	Chest pain
Doris	81	F	W	Lives alone	20	2	Exhaustion
Barry	77	M	W	Lives alone	20	2	Chest pain
Edna	89	F	W	Lives alone	18	2	Dizziness/fall
Charles	74	M	W	Lives with wife	12	3	Swollen leg
David	80	M	W	Lives with wife	20	3	Diarrhoea
Ida	88	F	W	Lives alone	17	3	Fall
Jake	87	M	W	Lives with wife	17	3	Shortness of breath
Freda	81	F	W	Lives with son	3	5	Vomiting
Leonard	87	M	W	Lives with wife	20	2	Abdominal pain
Malcolm	89	M	W	Lives in care home	16	4	Fall
Norma	80	F	W	Lives alone	18	2	Chest pain
Grace	79	F	W	Lives with husband	18	3	Haematemesis
Norman	76	M	W	Lives alone	12	3	Back pain
Jean	83	F	W	Lives alone	18	5	Heart racing
Kath	88	F	W	Lives alone	20	4	Shortness of breath

All names are pseudonyms

Barthel score : 10 item screening tool with a maximum score of 20. The higher the score the less dependent the patient is with self care activities [16].

ISAR score : 6 item screening tool. Score 2+ predictive of high acute care hospitalisation [13].

Table 2: Informal Carer Participant Sample

Patient name	Relationship of informal carer	Lives with patient	Level of informal carer support	Home care assistance
Beryl	Daughter	No	Domestic tasks	No
Charles	Wife	Yes	Personal & domestic tasks	Yes
Jake	Wife	Yes	Personal & domestic tasks	No
Freda	Son	Yes	Domestic tasks	Yes
Jean	Daughter	No	Domestic tasks	Yes
Kath	Daughter	No	Personal & domestic tasks	No

All names are pseudonyms.

Appendix

Interview Guide

Before the admission

Thinking back to the day you went into hospital, can you tell me what happened on that day, what led up to you going into hospital?

Prompts:

- Tell me what was it like coming into hospital?
- How did you end up being admitted to the ward?

During the admission

Please can you tell me about your stay on the ward?

Prompts:

- Have you got anything that stands out as particularly memorable during your stay on the ward?
- Tell me about the care you received?
- Tell me about the treatment you received?
- How happy were you with the care and treatment received?
- Did you have any expectations around your care and treatment? Were they met?

Can you recall being seen by the specialist doctor, for people aged over 70 years, on the day you left the ward? Tell me what happened?

Have you seen this doctor since returning home? Tell me about that?

Discharge

Please tell me about any arrangements that were made for you to go home?

Prompts:

- Can you tell me how you found out that you were going home?
- Looking back at the time of the discharge, what impression do you have of it?
- How could the discharge have been any better?

Returning home

Finally, can you talk through how things have been since you returned home?

Prompts:

- How have you have been managing on a day to day basis?
- Have you been able to do what you used to do?
- (if any difficulties mentioned by participant) -Tell me about that?

Do you think the care and treatment received from the hospital has made your life any easier, or is it the same or more difficult since returning home?

Can you suggest any improvements or better ways of doing things on the ward?

Thank you for your help. I really appreciate it. It will help the Trust to understand what people think.

Comprehensive Geriatric Assessment on an acute medical unit: A qualitative study of older people's and informal carer's perspectives of the care and treatment received

Abstract

Objective: This qualitative study was imbedded in a randomised controlled trial evaluating the addition of geriatricians to usual care to enable the comprehensive geriatric assessment process with older patients on acute medical units. The qualitative study explored the perspectives of intervention participants on their care and treatment.

Design: A constructivist study incorporating semi-structured interviews which were conducted in patients' homes within six weeks of discharge from the acute medical unit. These interviews were recorded, transcribed, and analysed using thematic analysis.

Setting: An acute medical unit in the United Kingdom.

Participants: Older patients (n=18) and their informal carers (n=6) discharged directly home from an acute medical unit, who had been in the intervention group of the randomised controlled trial.

Results: Three core themes were constructed: 1) perceived lack of treatment on the acute medical unit; 2) nebulous grasp of the role of the geriatrician; and 3) on-going health and activities of daily living (ADLs) needs post discharge. These needs impacted upon the informal carers, who either took over, or helped the patients to complete their ADLs. Despite the help received with ADLs, a lot of the patients voiced a desire to complete these activities themselves.

Conclusions: The participants perceived they were just monitored and observed on the acute medical unit, rather than receiving active treatment, and spoke of on-going unresolved health and activity of daily living needs following discharge, despite receiving the additional intervention of a geriatrician.