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Atwal, Anita, Tattershall, Kirsty, Murphy, Susanna, Davenport, Neil, Craik, Christine, McIntyre, Anne and Caldwell, Kay (2007) Older adults' experiences of the rehabilitation process in acute health care. *Scandinavian Journal of Caring Sciences*, 21 . pp. 371-378. ISSN 0283-9318  
[Article]

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# Older adults experiences of rehabilitation in acute health care

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*Scand J Caring Sci; 2007; 21; 371–378*

## Older adults experiences of rehabilitation in acute health care

Rehabilitation is a key component of nursing and allied healthcare professionals' roles in most health and social care settings. This paper reports on stage 2 of an action research project to ascertain older adult's experience of rehabilitation. Twenty postdischarge interviews were conducted and the interview transcripts were analysed using thematic content analysis. 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 criterion 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 were interviewed. The findings from this study suggest that older adults valued communication with health profes-

sionals but were aware of their time constraints that hindered communication. This study suggests that both nurses and allied health professionals are not actively providing rehabilitative services to promote health and well-being, which contradicts the focus of active ageing. Furthermore, there was evidence of unmet needs on discharge, and older adults unable to recall the professions that were involved in their interventions 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. This study highlights the need for further research into older adults' perceptions of the rehabilitation process in the acute setting.

**Keywords:** Acute care, rehabilitation, older adult, active ageing, discharge.

*Submitted 30 November 2005, Accepted 9 May 2006*

## Introduction

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 (1). Both the Association of Rehabilitation Nurses and American Geriatrics Society emphasise 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 (2, 3). Hence the ultimate aim of the rehabilitation is to promote re-integration into the family, home, work, leisure, social and community occupations. Consequently, team working is an essential part of the rehabilitation process. The first stage of the rehabilitation process is to

assess the older adult and to identify and analyse their problems and strengths.

Based on these, the second phase involves analysing the older adult's problems and strengths and agreeing goals that have been identified by professionals, other members of the multidisciplinary team and the older adult. The third phase is the management stage that aims to restore lost abilities as much as possible, prevent further complication and to enhance or maintain the older adults' quality of life and chosen occupations. The fourth phase is to evaluate the effectiveness of the interventions and the final stage involves tertiary, secondary and primary interventions although these health-promoting interventions may occur at any time in the rehabilitation process (4, 5).

Access to skilled rehabilitation professionals and facilities are imperative if hospitalised older adults are to live well in later life. Not investing in rehabilitation facilities can result in disabled adults being excluded from society (1). 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

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wards (6). Observational studies carried out in hospitals in the 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 (7–9). However, more research needs to be conducted into the cost effectiveness of older adult rehabilitation and sustainability of outcomes (10). There is, however, insufficient evidence to compare with the effects of care in home environments, hospital environments and own home environments on older persons rehabilitation outcomes (11).

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 (12). Functional decline is significantly associated with subsequent mortality, re-hospitalisation and institutionalisation (13). Two of the factors that contribute to functional decline in the older person in hospital have been identified as excessive bed rest and immobility (14). 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 (10, 15).

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 healthcare quality can be measured and as a basis for reforming or improving services (16). Davidson et al. (17) conducted a literature review of the perceptions and experiences of older women with heart disease and were able to identify that they presented with symptoms that were different from older men. Research has been conducted ascertaining that older adults' perceptions of cardiac rehabilitation programmes has informed clinicians about how services can be improved (18). Whilst research has been conducted exploring the experiences of hospitalised elderly patients in acute care settings (19, 20), little research has been conducted in the area of rehabilitation that the older adults receive during hospitalisation in acute care. A study by Lui and Mackenzie (21) examining Chinese older adults perceptions of rehabilitation following a stroke found that older adults were critical about the type and amount of information they received, particularly information about the reasons for stroke and about the activities that promote recovery. A database search of the literature from 1996 to 2005 (Medline, AMED, Cinahl) could not identify any other research that has explored older adults experience of rehabilitation in acute care environment.

Obtaining the opinions of older people can be problematic, as researchers must overcome three major obstacles. The first obstacle is related to methodological

problems associated with the ageing process (22) whilst the second obstacle being the fact that older people, when compared with younger consumers, repeatedly report positive outcomes regarding health and social care services (23, 24). The third obstacle being that older adults are often reluctant to discuss their experiences for fear of reprisals from professionals (25). One of the main problems associated with measuring satisfaction is that the concept is elusive and subjective (26). Indeed, a study by Krevers et al. (27) 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 UK. This study is part of an action research project, located in a large NHS trust in the UK. The research occurred on an acute older adult rehabilitation ward. Older adults are admitted to this ward with mixed pathologies. However, older adults with fractured neck of femurs and or neurological conditions as their primary presenting condition.

The project aimed to explore whether healthcare professionals are actively engaging older adults in rehabilitation programmes. The first stage of the action research project, aimed to ascertain the perceptions of nurses, healthcare assistants, doctors and therapists' of rehabilitation on a rehabilitation ward for older adults. The findings suggest that therapists relied on nurses and healthcare assistants for therapy carry over. Healthcare assistants were perceived as the professional group who could deliver therapy carry over. There was evidence of role hierarchy as healthcare 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

An interpretative approach was used to elicit understanding of older adults' perception of the rehabilitation process in acute health care. The primary aim of qualitative research in user studies is to interpret the fundamental motives of individual user behaviours by taking into account the whole picture in quest for seeking information and to understand users behaviour (28). Postdischarge semistructured 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 (29, 30), even though Minnick and Young (31) suggest that pre-discharge in-person interviews and

postdischarge telephone interviews were equally costly. 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. reported (32) their experiences of conducting interviews with hospitalised older people as having 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 data were collected in two phases. It was important to ascertain whether older adult's opinions changed over a period of time as satisfaction could be dependent upon the time intervals at which satisfaction is measured (33).

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 older adults 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 semistructured 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. Consent had been obtained from a further seven patients but three were readmitted to hospital before the interview could take place, two were too confused to answer questions on the phone and two declined when phoned.

#### *Phase 1*

During phase 1, 43 older adults were eligible for inclusion in the study, 25 were female (mean age 78.5 years) whilst

18 were male (mean age 81.4 years). In total 11 older adults consented to participate in the interviews. Ten of these were interviewed over the phone, one was to be interviewed on the ward but later refused.

#### *Phase 2*

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

#### *Data analysis*

Thematic content analysis was used to analyse the data from the interviews (34). 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. 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. 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 2 years after the study was completed.

### **Findings**

Data analysis produced three themes, which were related to specific stages of the rehabilitation process. The first theme was in relation to identifying and analysing problems and strengths. The second theme that emerged was the failure to value the importance of social interaction to restore lost abilities in older adults. The third theme was the evaluation and effectiveness of interventions in relation not only to the type and amount of therapy that was received but also the need for specific rehabilitation programmes tailored to individual needs.

### *Identifying and analysing problems and strengths*

Older adults perceived that their needs were not being met. One older adult commented that he/she would have liked to have seen someone about his/her 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.

One 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.

The ultimate aim of the rehabilitation is to promote re-integration into the family, home, work, leisure, social and community occupations. The failure to clearly identify the older adults problems and strengths resulted in older adults having unmet occupational goals on discharge from the acute care setting. On discharge older adults reported that they were dependent upon family members and or health and social care services to perform occupations of daily living. Many of the older adults reported having assistance to carry out 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 was waiting for an outpatients appointment from physiotherapy due to swelling around the ankle. Another older adult perceived her level of mobility had deteriorated as 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 well-being.

'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'.

### *Restoring lost abilities in older adults*

Psychosocial factors were not evident as being an integral part of the rehabilitative process. Older adults expressed concern regarding communication with health care professionals. However, they were also 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 but they 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.

One also expressed some distress regarding the support, which he/she obtained from the nurses and other patients. This in turn impacted upon his/her emotional well-being:

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.

Older adults had to ring call bells to get nurses' attention and even then the call could be ignored and or the older adult had to wait. Indeed, two participants 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 1/4 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 commented not only on the fact that nurses were busy but also that 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 over-worked. 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 of the participants 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.

#### *Evaluation and effectiveness of interventions*

Successful rehabilitation is dependent upon older adults receiving skilled rehabilitation from health and social care professionals. 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 commented that he/she '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.

Another 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 busy ...there 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.

Education and advice are an integral part of the rehabilitation process; however two older adults were disappointed with the advice and education that was given by professionals. Another older adult expressed concern about whether his/her family had been informed about the discharge.

#### **Discussion**

To date very few researchers have investigated patients' perspectives of hospitalised older adults (19). By accumulating the experiences and perceptions of patients currently receiving acute inpatient rehabilitation it was anticipated that rehabilitation professionals could address any issues which arose. The findings from this study highlight the importance older adults' place upon social interaction as well as the restoration of lost abilities. Similar findings are reported by Huckstadt (19) and Jacelon (20) who highlighted older adult's perceptions that independence was lost once admitted into hospital. A study in the UK asked adults what they want from services as they age. Older adults highlighted the importance of services that promote independence as well as social and leisure activities (35). Acute care environments need to ensure that social rehabilitation forms an integral part of rehabilitation programmes. Indeed, successful ageing is dependent upon both biomedical and psychosocial approaches (36, 37). Furthermore success ageing in the oldest old (85 and over) value well-being and social functioning higher than physical or psychosocial functioning (38).

When beginning the rehabilitation process (identifying problems and strengths) is it essential that therapists and nurses design rehabilitation programme tailored to individual needs that value the importance of psychosocial factors. 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 (7, 9, 39, 40). However, older persons who are the most interesting and socially skilled receive most attention from nurses (7). 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 (40).

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 well-being of older adults (41–43). Indeed, Scarmeas et al. (44) suggest 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 their unmet needs were not a result of the nurses' not caring but a direct consequence of heavy work loads and lack of time. One study which 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 (45). Attree (46) 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 (47).

Examining older adults' perception of acute care has highlighted concerns regarding the quality of rehabilitation in acute care. Therefore, professional practice can be guided and improvements in quality of care made in order to improve both the patient experience and outcomes.

The findings from this research suggest that older adults were dissatisfied with the specialist support and rehabilitation from healthcare professionals. Hence important occupations could not be restored. Older adults were often unsure whether that had been assessed or treated by an occupational therapist although there was evidence that some older adults recognised and valued 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 healthcare professions. One possible reason for this could have been to role confusion or the fact that numerous therapists assess older adults. Tyson and Turner (48) found that the greatest cause of dissatisfaction amongst stroke patients was the limited amount of therapy that they received.

There was evidence of interventions not being effective as 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 of time spent by therapists and nurses interacting with older adults. Parry (49) examined communication during goal-setting in physiotherapy sessions and concluded that various interactional difficulties were factors that prevented therapists from ascertaining the patients' opinions and incorporating them into agreed goals.

### Study limitation

Cooper & Buckner (50) reinforce the importance of researchers collating the opinions of older adults. However they suggest that it is often difficult to obtain because older adults perceive that it will impact upon their stay whilst hospitalised and the possibility that they will revisit the hospital when it becomes necessary in the future. Consequently, this may explain why older adults were reluctant to participate in the research study. The researchers found that older adults appeared reluctant to discuss aspects of their care on the telephone and they were reluctant to elaborate on opinions and perceptions. Furthermore the interviews were not tape-recorded. With 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.

### Conclusions

To enhance practice, healthcare professionals need to understand the concerns and experiences of older adults. There is a lack of research that has explored older adults' perceptions of the rehabilitation process in the acute setting. Whilst the study does have methodological limitations it does highlight the need for further research in this area. Acute care settings are failing older adults for a number of reasons. The first reason is the failure of nurses and allied healthcare 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 in their intervention and the rationale for therapy input. The third reason is related to communication with older adults as 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. In addition, it is essential that professionals understand that to achieve the goals of rehabilitation it is essential to listen to the opinions and views of older adults.

## Author contribution

Anita Atwal designed the study and wrote the paper. Data was collected by Kirsty Tattersall, Susana Murphy and Neil Davenport. Data analysis was performed by Anita Atwal, Kirsty Tattersall and Neil Davenport. The manuscript was prepared by Christine Craik, Kay Caldwell and Anne McIntyre.

## Funding

Funding was received for this study from Challenge Fund, North West London Workforce Development Committee.

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