

Service Use and Prevention of Emergency Hospital Admissions: a Comparison of the Views of Older People and Health and Social Care Professionals

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Abstract

This paper presents a comparison of the perceptions of health and social care professionals and older people on the prevention of emergency hospital admissions and the use of care services. Whereas older people viewed emergency admission as an inevitable part of ageing, professionals attributed many emergency admissions to the social isolation of older people. Professionals reported that the majority of services were not designed to minimise isolation in older age. Older people listed quality of life, boosted by socialising and support during periods of good health, as their first priority. Older people and professionals presented differing arguments why some health and social care services were underutilised. Older people explained that they deliberately avoided using some services because they believed these would undermine their independence and level of activity. Professionals reasoned that low uptake of services was associated with service providers' lack of knowledge and trust as well as problems with the accessibility of services. This shows that service users and providers differ in their assessment of need and service delivery. Hence, it is argued that both professional and patient perspectives are required to inform service development that meets the needs of older people and health and social care staff

Key words

Older people, user involvement, service delivery, service use; interviews, qualitative research.

Introduction

Older people have diverse and varied needs. They are frequent users of health and social care services (Audit Commission, 2000; Hellstrom & Hallberg, 2001; Keene *et al.*, 2001) and they constitute the majority of emergency hospital admissions in the UK (Audit Commission, 1997). This poses a considerable challenge for care services (Byles, 2000), especially as this age group as a proportion of the population is set to rise. Additionally, uncertainty surrounds effective strategies to manage unscheduled care (that is, urgent or emergency care) for older people (Iliffe *et al.*, 2005). This

uncertainty is accentuated as they are particularly likely to experience a complex mixture of health and social care needs necessitating a series of service responses (Glendinning & Rummery, 2000). It is for these reasons that there has been considerable attention paid by policy-makers, service planners and developers and by researchers to the unscheduled care of older people.

Previous research suggests that admissions and readmissions to hospital are a consequence of the interplay of social and medical factors in that they are associated with increasing age, frailty and an inability to cope (Fethke *et*

al., 1986). The accumulation and sequence of factors leading to medical episodes of older people, including mental health, marital status, comorbidity, chronic health problems, and medications (Chan *et al.*, 2002; Coast *et al.*, 1996; Fethke *et al.*, 1986), make it difficult to provide a straightforward treatment or care plan (Cambell *et al.*, 2004; Parker *et al.*, 1997). These challenges include recognising the support required and being aware of the range of local services and agencies that can be utilised (Littlechild & Glasby, 2000; Manthorpe *et al.*, 2005; Poncia *et al.*, 2000). Evidence suggest that chance also appears to be a decisive factor in determining whether health and social care providers offer older people adequate assistance (MacDonald, 1999). Consequently, any meaningful discussion of issues around emergency hospital admissions is advised to include the perceptions and experiences of older people (Themessl-Huber *et al.*, 2007).

Research confirms that the deterioration of their health status does not stop older people from aspiring to live an active and fulfilling life (Audit Commission, 2004a; 2004b; Older people's steering group, 2004). Whether they are able to fulfil their aspirations depends on factors including independence, confidence, safety, security, dignity, familiarity of place and people, and the capacity to make choices and exercise control over their life (Audit Commission, 2004a; 2004b; Gignac *et al.*, 2000; Tanner, 2001; Woolhead *et al.*, 2004). Most of these factors require the ability to exercise control over the type and form of service received (Andrews *et al.*, 2004; Audit Commission, 2004b).

Previous research aiming to develop understandings of issues relating to emergency hospital admissions has explored frequencies and reasons of emergency admissions (Damiani &

Dixon, 2002; Kendrick & Conway, 2003; Parker *et al.*, 1997), service evaluations (Bowes & McColgan, 2003), service development (Bridges *et al.*, 2003), and perceptions and experiences of professionals or older people (Parker *et al.*, 1997). The purpose of this paper is to enhance understanding of the latter approach, which is an area often neglected in research about emergency admissions (Glasby & Littlechild, 2000; Parker *et al.*, 1997). This paper compares the views of health and social care professionals and older people on the reasons for emergency hospital admissions and the role health and social care services are playing.

Methods

For the purposes of this study, an emergency (or unscheduled) admission was defined as any unplanned admission to an inpatient facility. For more detailed information about the clinical codes used to identify emergency admissions see CRAG report of 2000 (Clinical Resource and Audit Group, 2000). Multiple emergency admissions refer to an older person having more than one unplanned admission to an inpatient facility within a pre-defined timescale.

The study was carried out in six Primary Care Trust regions in Scotland. Primary Care Trusts (PCTS) were responsible for primary, community, and mental health services within the geographical boundaries of individual Health Boards. In 2003, these Trusts were abolished and Community Health Partnerships and NHS Boards took over their responsibilities. Ethical as well as Trust approval was granted. The interviews with older people, primary health care and social care professionals were semi-structured in that the researchers combined a guided interview and conversational approach (Patton, 2002).

The interviews focused on professionals' and older people's perceptions and experiences of emergency hospital admissions and the use of health and social care services. A sample of 34 primary care and social care professionals were interviewed to capture their views and experiences of older people's emergency hospital admissions (see Table 1). From each Primary Care Trust area between five and seven professionals were recruited

who were either managerial or frontline staff. The professionals were recruited purposefully on the basis of their knowledge and experience of local services for older people. We have reported on the interviews with professionals elsewhere (Hubbard & Themessl-Huber, 2005). This article focuses on the views of both professionals and older people.

Table 1: Characteristics of participants

Professionals		Older people	
Health care staff	19	Women	12
Social care staff	14	Men	6
Managerial staff	23	Age range: 80-92	
Frontline staff	11	Emergency admissions: 3-12	
Totals	67		18

Table 2: Inclusion criteria for the recruitment of older people

Age	80 years old and over	✓
Hospital admissions	Admission to hospital as an emergency between October and December 2003	✓
	More than two emergency admissions in the previous five years	✓
Consent	Able to give informed consent	✓
	Agreement of geriatric consultant to include the patient in the study	✓
Diagnosis	Patients with a diagnosed dementia were excluded from the study	×

The recruitment of 18 older people was conducted with particular sensitivity. Potential participants fitting pre-defined inclusion criteria (see Table 2) were purposefully selected by geriatric consultants working in the study areas. The inclusion criteria were based on evidence suggesting that people fitting these criteria were particularly at risk of emergency admissions (Kendrick & Conway, 2003).

Older people who agreed to be approached were given an information sheet and consent form. Additionally, on-going consent was monitored throughout the interview.

Older people's perceptions and experiences were elicited with respect to their:

- living arrangements;

- social life;
- emergency admissions;
- use of health and social care services prior to admission; and
- whether or not they thought that their admissions could have been prevented.

The interviews were conducted either on the hospital ward or in the visitor room, depending on the older person's preference.

Interviews with primary care and social care professionals were guided by the following four questions:

1. What main health and social problems do older people have in this locality?
2. What local care services are available for older people designed to prevent hospital admission?
3. How, if at all, do services link up to care for older people in the locality?
4. How are services for older people in your locality developed?

Interviewed professionals were asked to explicitly distinguish between mainstream health and social care services and speciality services as well as between primary care, secondary care, social care, and voluntary/charity services. Older people were not asked to distinguish between different service providers but were asked whether they were referring to a health (for example, a nurse or doctor) or social care professional (for example, a social worker or home carer).

All interviews were audiotaped and transcribed verbatim. A framework approach for analysis (Ritchie & Spencer, 1994) was adopted whereby each interview was compared using an

iterative process. This allowed for identification of patterns in the data. Literature provided additional key themes that together with data-derived themes formed an initial framework for analysis. Coding categories were revisited, expanded, and refined throughout the period of analysis.

Quotations in the text are referenced as follows: Patient quotations are followed by two capital letters referring to the patient interview in our files (e.g. AB). Professional quotations are followed by two lower case letters referring to the professional interview in our files and a short description of their roles (e.g. ab, frontline clinician). Thus, the initials do not refer to a person's first or family names.

Findings

Similarities and differences between the perceptions of older people and primary care and social care professionals are summarised and presented in Table 3 and are explained below in more detail.

Can emergency hospital admissions be prevented?

Health and social care professionals recommended directly addressing symptoms and consequences of social isolation among older people as the most promising way of preventing unscheduled admissions. Social isolation was perceived as leading to loneliness, mental and physical ill-health which in turn, perpetuated further reliance on services by this group of the population. One professional described the relationship between social isolation and ill-health as follows:

It can be a continuum from the impact of social isolation and therefore a kind of deterioration in mental health, depression to more serious depression, which GPs tell me, it tends to bring on perhaps more physical ailments.

(en, social care manager)

Table 3: Key differences in perceptions between professionals and older people about the context of emergency hospital admissions (EHA)

	Older people	Health and social care professionals
Prevention of EHAs	EHAs are inevitable at this stage in life.	EHAs are mainly a function of social isolation.
Services or care needed versus services provided	Socialising, being mobile, and ability to get out and about.	Most services are not designed to facilitate socialising and getting out and about.
Service (under) utilisation	Older people often deliberately do not use health and social care services.	Older people under-utilise health and social care services due to access problems and lack of knowledge or trust in a service.

They also thought that better coordination of existing health and social care services would have an impact on the number of emergency admissions.

However, the older people argued that emergency hospital admissions could not be prevented. The main trigger behind unscheduled admissions was from becoming old and frail and this, they said, could not be halted. More specifically, older people did not believe that their admission could have been prevented because the episode of ill health that led to their admission happened rapidly and unexpectedly. One woman said, *'These things come on so quickly, there's nothing you can do about it'* (MR). Similarly, another person said, *'This happens out of the blue no matter how careful you are, your leg just goes...If you got some warning but you don't'* (IR). Others were resigned to inevitable accidents and bouts of illness. For example, one person said, *'If you are going to fall you're going to fall,'* (GC) and another

said, *'It's just one of those things that happen'* (MT).

Many of them were reconciled with the fact that as they got older they would experience increasing periods of feeling unwell. Thus, most believed that at this stage in their life it was almost inevitable that they would end up in hospital at some point. When asked specifically why they were admitted to hospital the majority of older people said that they had either *'fallen'* (GC) *'took a turn'* (AM, AR, ID, MR, RB) *'took not well'* (AL, ID), *'blacked out'* (RB) or had *'felt dizzy'* (MT). Older people did not mention social isolation as an important factor in causing their admissions. Indeed, only one participant mentioned being lonely or isolated at all.

Are health and social care services providing appropriate care?

Health and social care professionals considered social isolation to be a key contributor to older people's health and social care needs. However, according to the same professionals, the overwhelming majority of health and

social care services were not designed to mitigate the effects of social isolation. Those services that did, such as befriending services, day care, community alarm services, and home care were thought to play a valuable role in providing companionship and assurance. One professional for example, explained how home carers played an important role in mitigating the effects of social isolation:

I think the biggest social care issue is isolation. A lot of these older people ...rely upon their carers for part of their social life ...You're going in for something that's a routine matter but they've obviously not seen anybody all day and they want to sit and chat to you...they don't have major health issues it's just security and confidence.

(mm, social care frontline staff)

Many older people were adjusting to playing a less active role in social life for a number of reasons. Yet, all of them considered the availability of opportunities to adequately socialise as one of their key priorities. One woman explained that she did not go out much because:

I've nobody to go out with, on my own ...friends have all left me.

Yet, another person mentioned that she did not go out as often as she would have liked because, *'I don't like to bother people... put it this way, you can't depend on anybody... People are too wrapped up in themselves'* (AL). Others were getting used to being on their own since their spouse had died. One woman felt that she had, *'not adjusted very well'* (MB) and said, *'I really miss him. It's a lonely life.'* She enjoyed company because she could not, *'be doing just sitting here nobody to talk to'* and was contemplating moving to a residential home because she believed that she would be taken out on day trips and there would be, *'people in the evening to entertain you'* (MB). She

encapsulated her predicament when she said, *'I've got a wheelchair but I've got nobody to push it.'* Others did not socialise much because their close friends had died. Another person explained how significant it was when she met people whom she had known in the past:

You've no idea how much it lifts you because you go back and your mind goes back to the thing you're talking about... you don't feel lonely anymore.

(MF)

One woman explained that the best thing about going to the day centre was getting, *'dressed up to go, that was the most important thing...it makes you feel better'* (AL).

Opportunities to socialise were not enough, however. In order to be enjoyed, socialising needed to be adequate to a person's needs, wishes, and requirements. This could take the form of participating in everyday and familiar routines as one older person commented, *'I like going out for a wee run just to break the monotony'* (MR). Another person when asked if he enjoyed going out responded, *'Of course, everybody wants to get out...If the sun shines, I like to get out. That will do me'* (AR). One man who no longer went to the bingo because of hearing and sight impairments explained why he used to enjoy it:

It wasn't so much the bingo but to see my friends, the blether and the chat.

(RI)

Another said that:

When you get older, you don't get visitors...[At this] time of life you don't want to go out... maybe once a week go out to town.

(RW)

Several older people were reliant on others to take them out because of their

physical impairment. One woman replied, after she had been asked if she got out of her house much:

Not unless someone comes and takes me. I wouldn't go out myself because I couldn't walk right...[Members of my family and close neighbours occasionally take me out], just for a wee walk and back again.

(AM)

Another woman no longer ventured down to the communal lounge in the sheltered housing complex since her friend, who used to accompany her, became ill. One woman explained that she used to visit a friend once a week and go to the local club every Saturday evening until her 'health started to fail so that was me had it'. When asked if she would go to the club if she were taken by someone she replied:

I'm afraid of coming in later at night that's what kept me in and I wouldn't want to spoil my friend's night out... but I'm quite happy, I've enjoyed what I've had, dear.

(MM)

Are health and social care services providing care appropriately?

Professionals and older people reported that many community-based health and social care services were underutilised, both by professionals and patients. Both groups differed in explaining the reasons behind the apparent failure to appreciate existing services.

Health and social care professionals gave three reasons for why many services were not being utilised as much as had been anticipated. These were:

- a lack of knowledge among care providers about services;
- the tendency to use familiar or trusted services; and
- difficulties accessing services.

Lack of knowledge

Some professionals believed that services were not being used because health and social care providers were often not aware of existing services. Without knowledge of services, they would not be accessed and used. Others believed that although there may be an awareness of services, communication between the services was deficient. One health professional described the lack of co-ordination between health and social care service provision in his area:

What used to happen was that we [primary care] would plod along and do our work and they [social services] would plod along doing their work, and we would find we are running out of beds and all the rest of it. We would call social work and hear that they've got ten beds. And that's not very co-ordinated. We should really be doing this a bit more methodically and systematically.

(kh, clinician and manager)

Tendency to use familiar or trusted services

Traditional and familiar patterns of working also influenced which services were utilised, which meant that even if professionals knew about the full range of health and social care services they would continue to use those that they were familiar with. For example, several professionals felt that unless GPs were aware of, and had confidence in other services then they would continue to refer patients to hospital thus under-utilising community-based social services. They noted that GPs traditionally made referrals to a hospital consultant to assess a patient and, in many cases, this was the most appropriate form of action to take; however, there were instances when social care would have been able to support the older person at home. As one social care professional explained:

If somebody goes into hospital with chest pains then fair enough there's not a lot

we can do about that in social work. If somebody's going into hospital because they are dehydrated and they just need fluids pushed for 24 hours... we could certainly do something.

(jn, social care manager)

Difficulties accessing services

Another reason why professionals believed that the full range of services was not being used was due to problems of access. They described that some health services could not be accessed by social care professionals and vice versa. Many professionals wanted to be able to quickly access services without having to go through a health or social care gatekeeper. A social care manager explained that she would like to access health services directly without having to go through a health professional gatekeeper, which was usually the GP:

What we would like access to is the day hospital, the mental health team and to the auxiliary services. We would like to be able to say this person needs a physio because they're becoming less and less mobile and not have to go to the GP who gets a bit bothered by it anyway and he has to remember to write to the physios. Why can't we go direct?

(ja, clinician and manager)

Older people also provided three main reasons why they chose not to use certain services. They feared that services might infringe on their

- personal freedom;
- on their ability to remain active; and
- they preferred to be looked after by members of their own family.

Infringements on personal freedom

Several older people did not wish to utilise services because they believed that it would infringe on their freedom to do as they pleased. One woman wanted to remain in her own home because she

perceived that residential or sheltered housing would jeopardise her freedom since she would be:

Told what to do...I'm used to being on my own and like living on my own.

(AL)

She indicated that she would use services but only if she could remain in her own home and retain her personal autonomy.

Impact on their ability to remain active

Other participants argued that they did not want any kind of help delivered. They perceived that services would infringe on their ability to remain active. They wanted to do things for themselves as they felt this helped them to remain active, busy, and able in their eyes and, importantly, those of others. One woman said that everything took her twice as long to accomplish but '*then there's plenty of time now*'. She did not want a home carer because:

I want to do my own thing for as long as I can...I don't like people to think that I'm sick and needing help...I really want to keep going...I'd rather be on my own and fight my own battle because although I'm more disabled at least it give me something to do because there's no point in sitting down and moaning.

(MF)

This yearning to keep busy and active was expressed in other ways and was clearly important to people's sense of who they were. One man said, '*I've never been idle in my life,*' (RB) and another explained that he had always done everything for himself since he was a small boy.

Preference for being looked after by members of their own family

Other participants argued that they did not wish to receive support from health and social care services but preferred to be looked after by a member of their

own family. One man felt that being cared for by a member of his own family was preferable because they were more reassuring and reliable. He said:

I'm more sure of myself with my son because if I say something he is there to help. If I was feeling bad I phone him and he is there right away.

(GC)

Discussion

Recent policy papers have identified providing patient-centred care and involving patients in decisions about their care have been mentioned as key priorities (Department of Health, 2001; 2006; NHS Modernisation Agency, 2002). Tailoring care to patients' individual needs and responding to issues raised by them is considered good practice and a positive move towards decreasing emergency admission rates (Owen, 2001; Victor *et al.*, 2000). Consequently, a snapshot of differing and common views held by older people and health and social care professionals about key issues in relation to preventing emergency hospital admissions is bound to be of interest.

In response to the question, for example, whether emergency hospital admissions can be prevented it emerged that professionals and patients provided different answers. Professionals believed that social isolation played an important role in many emergency admissions as it was described to have a series of negative consequences on the mental and physical health of older people. Despite their emphasis on the negative effects of older people being isolated, health and social care professionals argued that most services were not designed to minimise the detrimental effects of social isolation. This missing orientation towards isolation but also the difficulties involved in assessing the effect of

interventions aimed at reducing social isolation are discussed elsewhere (Cattan *et al.*, 2005; Findlay, 2003).

None of the older people in this study related their emergency admissions to feeling isolated or lonely. Instead, many older people regarded hospital admissions as inevitable at this stage in their lives. They accepted that old age is associated with frailty and deterioration of health and believed that no service input could have prevented their admission. Indeed, hospital admissions were not foremost in the minds of older people. The priority of the interviewed older people was to enjoy their lives (Gabriel & Bowling, 2004; von Faber *et al.*, 2001). They argued that regardless of hospital admissions their quality of life would be improved if services were also able to support their ability to socialise during periods of good health.

The differences in views of professionals and older people diminished, however, with respect to the perceived suitability of health and social care services. Professionals recognised that despite the important role of social isolation in preventing emergency admissions only few services were addressing this issue. Many professionals drew attention to the need for services that focus more directly on providing older people with the opportunity to engage in social activities. Similarly, older people emphasised the need for services that assisted them in socialising. They were clear, however, that they would like to have some control over the timing and nature of activities and some say in whom they were going to meet. Many of the participating older people also mentioned that their main difficulties preventing them from socialising were deteriorating mobility and, linked with this, lack of transport options. The provision of bespoke care for individual people may indeed raise questions of

feasibility and funding but it can be argued that there is room for improvement even within the means currently available.

One such area of improvement is the utilisation of health and social care services. Professionals and older people alike raised service use as a crucial issue and provided a series of explanations for the apparent lack of service utilisation.

Professionals often raised the issue that they themselves and/or their colleagues in health and social care at times were unaware of or actively avoided using particular services. They argued that some services were simply not being used because they were not known to them or they felt they did not know enough to consider referrals. At other times, they had difficulties accessing particular services or preferred using tried and trusted services to less known ones. Other research has highlighted similar barriers to service utilisation by professionals (Abbott & Lewis, 2002; Asthana *et al.*, 2002; Glendinning *et al.*, 2002; Lewis, 2001; van Eyk & Baum, 2002). Such knowledge, trust, and accessibility issues were addressed by a series of recent policies on improving joint working among health and social care professionals. The strategies recommended usually represent a mix of organisational, structural, practical and human resource interventions (Audit Commission, 1998; Department of Health, 1998; Joint Future Group, 2000; Scottish Executive, 2004).

The views of older people on the under-utilisation of health and social care services, however, focused on an area that has not yet received much attention in the policies referred to above. Many argued that they had been taking deliberate steps to avoid using particular services. This has also been reported elsewhere (Howse *et al.*, 2004). Older

people in this study described how they disengaged with services because they believed that services would undermine their independence or infringe on their ability to remain active. Their concerns about loss of independence have been substantiated by recent research which has shown that older people receiving domiciliary care may have choice and control in everyday life restricted (Boyle, 2004; Hardy *et al.*, 1999). Others deliberately avoided using services because they preferred to be looked after by a member of their own family.

The differences observed in the opinions and arguments of health and social care professionals and older people with respect to the prevention of emergency hospital admissions and service-use raise two main questions. Firstly, to what degree are their differences impeding the prevention of admissions and service use? Secondly, how can these insights be used to inform future service delivery? For example, it was suggested that older people's use of services could be improved if care is delivered that is equally as reassuring and reliable as that given by family carers (Coleman *et al.*, 1998). Already the majority of people aged over 75, formal care appears to be complemented by the support of friends and family in addition to the formal care provided (Hellstrom & Hallberg, 2001). Evidence suggests that informal levels of care boost older people's independence, quality of life, and uptake of formal services (Poncia *et al.*, 2000).

More research is needed about how these two questions could best be answered. This small-scale study, however, was able to highlight the necessity to include the perspectives of older people and health and social care professionals in the process of developing workable strategies to provide care that meets the needs of

older people as well as supporting staff in contributing towards the prevention of emergency hospital admissions. It is important to note that this study is based exclusively on the subjective reports of health and social care professionals and older people interviewed. The perspectives of voluntary service representatives and hospital staff were not included which constitutes one of the study's limitations.

Conclusion

This study provides a snapshot of professional and older people's views with respect to the prevention of emergency hospital admissions. Findings suggest that health and social care professionals do not consider improved or more clinical interventions as the key to reducing unscheduled admissions of people aged 80 and older but advocated an increased focus on addressing social isolation. Older people with a history of multiple emergency hospital admissions, however, did not believe that their admissions could have been prevented at all. Both older people and professionals emphasised that current health and social care services are not sufficiently supportive and need to be adapted to the actual requirements of patients and staff. Given differences in perspectives, to fully understand unscheduled care and develop appropriate services it is advisable to include service user and professional perspectives.

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