

Acute care and older people: challenges and ways forward

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KEY WORDS

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ABSTRACT

Objective

This article aims to (a) suggest ways in which acute hospital environments might be modified to better meet the needs of the older person and (b) question whether options other than acute care should be canvassed for older people.

Setting

Acute hospital settings.

Subjects

Older people and people with cognitive impairment

Primary argument

Older people are large consumers of acute hospital care, and acute hospitals are known to pose significant risks for this vulnerable population. Such risks include delirium, falls, restraints, drug side effects, and general de-conditioning entailing loss of function and independence. Eight dimensions of person-centred care are presented to promote assessing and meeting the needs of older people in acute care. Alternatives to acute hospital admission are also suggested, such as developing 'older people centres' to which older people could be admitted for triage in older-friendly environments staffed by geriatric experts, places in which their multidimensional care needs could be better met.

Conclusions

As an alternative to acute hospital admission, 'older people centres' could be developed to which older people could be admitted for triage in older-friendly environments staffed by experts in care of older people. In the mean time, why not provide a balanced approach that provides some environmental adjustments for older people, core knowledge and skills for all staff, and access to gerontic expertise in the acute hospital care of older people.

INTRODUCTION

This paper draws on contemporary evidence regarding the challenges for older people in acute care hospitals and the concept of person-centred care to (a) suggest ways in which acute hospital environments might be modified to better meet the needs of the older person and (b) question whether options other than acute care should be canvassed for older people.

BACKGROUND

Older people are admitted to acute hospitals more commonly and have longer lengths of stay than younger persons (Nay and Garratt 2004). While people aged over 65 constituted 12.1% of the Australian population, they accounted for 48% of all hospital days in 2001. During the same year, the mean length of stay for a female patient between 40-45 years was 2.8 days, as compared with 10.9 days for a female patient above 85 years (AIHW 2002). Not only are older people larger consumers of health care, there is also ample evidence that older people admitted to general acute hospital care face considerable physical and psychological stressors, and are at an increased risk of adverse events, psychological and behavioural symptoms, general deconditioning, falls, loss of mobility and functional decline (Nay and Garratt 2004; Cassidy 2001). In addition, as many as 33-66% of older people receiving hospital care are estimated to suffer from cognitive impairment (Dewing 2001; Tolson et al 1999) and this poses additional challenges for hospitals as people with dementia have increased needs to experience safety, calmness and familiarity in their environments (Zingmark et al 2002).

The hospitalisation of older people can often exacerbate distress and dysfunctional behaviours (Miller 1999). Stressors that negatively affect older people and persons with cognitive impairment include changes in routine, environment or caregiver, but also facing demands that exceed functional capacity through multiple and competing stimuli, and/or having pain or negative reactions to medications. It has also been shown that older people

have an increased risk of post-surgery complications, episodes of acute confusion during hospitalisation, and so called 'challenging behaviours', which are manifested through expressions of anxiety, hallucinations and delusions, aggression and agitation, wandering, restlessness, rummaging and other socially deviant behaviors (Miller 1999; Finkel et al 1996). In acute care hospital settings, behavioural changes can emerge from a combined stress of illness and being in an unfamiliar and confusing environment, and are not necessarily symptoms of dementia. These 'behaviours' are unfortunately too often managed through the provision of psychotropic medication, the use of physical restraint, and/or the engagement of specially assigned patient attendants (Werner et al 2002). Besides the obvious personal suffering for the person and family afflicted by such behaviours, these are also associated with poor outcomes during hospitalisation, with increased length of stay, mortality, post-hospital institutionalisation, and escalating health care costs (Schofield and Dewing 2002).

In light of knowledge that the overall wellbeing of older people is often adversely affected by experiencing the hospital environment, we argue there is a need to increasingly apply person-centred perspectives in acute hospitals. Person-centred care has emerged as a contemporary gold-standard model receiving much attention within sub-acute and residential aged care for older people (McCormack 2004; Kitwood 1997). Person-centred care was developed as a response to the bio-medical view of disease which was said to downgrade the person to being merely a carrier of disease or a malfunctioning organ (McCormack 2004). Even though the concept person-centred care lacks a clear consensus definition (Edvardsson et al 2008), it is generally described as collecting and using personal information in care, taking a bio-psychosocial perspective and seeing the patient as a person (Edvardsson et al 2008; Slater 2006). Furthermore, offering and respecting patient choices, using the person's past life and history in care, and focusing on what the person can do rather than the abilities that have been lost due to the disease is

central to a person-centred care approach (Brooker 2007; McCormack 2003). However, the concept has been criticised for being a political slogan or evangelical ideal (Packer 2000), often quoted but ill-defined (Nolan et al 2004) and used synonymously with good quality care even though this remains to be supported by evidence (McCormack 2004).

A fictitious but not unusual event of a busy acute hospital ward is described below from three perspectives to illuminate how the same series of events can be interpreted very differently by the nurse, the older patient, and a family member, and is also presented to provoke reflection on how person-centred care can be used to address some of the issues emerging in the event.

Perspective one: Karen, 33 years old, registered nurse at Ward X:

We have been extremely busy; the registrar has been up all night; the phones have not stopped ringing; two nurses have rung in sick; and the ward is crowded. One of the older patients, Emmy, started to wander about, became aggressive, verbally abusive, impossible to shower and was constantly trying to get out of bed all night. We simply had no option but to restrain her to stop her hurting herself. However, she nearly strangled herself in the rails so we sedated her and removed the restraints. When she woke up, she fell over the end of the bed and now has a major bump on her head. The family is furious and said we should have called them earlier but we just didn't have time. Person-centred care... who has time for that?

Perspective two: Emmy, 86 years old, patient in Ward X:

My name is Emmy. I am a holocaust survivor and I have awful pain; I don't recognise anything or anyone in this dreadful place. Everyone is on the run and there are loud noises everywhere. I do know that if you go to the shower you don't come back. I need to pass water but they have tied me down and I can't get to the lavatory. They say the doctor is coming but I've heard they do awful experiments so I must try to escape.

Perspective three: Ronnie, 52 years old, Emmy's son:

My name is Ronnie, I am Emmy's son - I have told them and told them to call me if Mum has a problem - now I get here and find her all bruised and bleeding. She is never angry at home but they rush her and don't listen. She is very dignified and would be mortified to wet the bed but they don't seem to care. Is this what quality care is all about?

DISCUSSION

Applying person-centred care in acute care settings – eight dimensions for discussion.

Adopting person-centred approach to care for older people in acute settings begins with trying to establish a philosophy of care that puts the older person's experiences at centre stage. This can then be merged with gold standard clinical guidelines and best practice approaches to the assessment and maintenance of health among older people in acute hospital settings (Nay and Garratt 2004). The following aspects have been extracted from the literature as making up the cornerstones of person-centred care for older people, and are presented to illustrate how acute hospitals can better meet the needs of older people and family members.

1. Establishing a philosophy of care that is person-centred and holistic

The establishment and use of a philosophy of care that states the fundamental assumptions, goals and care strategies of the institution has been shown to assist health care staff in making care decisions and communicating to patients, and patients have described how they appreciated explicit care philosophies as they appeared to unite staff towards a shared goal (Edvardsson et al 2005). A holistic person-centred care philosophy means placing the patient with his/her needs and wishes in the centre of care, collecting and respecting patient choices and giving relationships and tasks equal importance (McCormack and McCance 2006). As emerging in the example of the nurse at ward x, the concept of person-centred care needs to be operationalised and integrated

into daily practice so that it does not feel like another burden adding to staff stress.

2. Developing care systems that support person-centred care

Care needs to be organised in a way that promotes shared interdisciplinary assessment, communication and treatment in a teamwork fashion. Developing systems to secure valid, reliable and comprehensive data collection about symptoms as well as life histories for development of individualised intervention strategies and systematic outcome measurements are important. Such would preferably include all relevant aspects that might influence the person's well-being, which obviously involves drawing on the expertise of family.

3. Collecting personal history of patients

Collecting and disseminating information regarding who the person is can inform appropriate person-centred care by supporting staff to see the person 'behind the disease'. Knowledge of significant life events, interests, likes and dislikes can help to maintain and enhance a sense of self in older people whose world has been altered by the sudden onset of disease (Penrod et al 2007; Brooker 2004). In the case of Emmy, collecting such a personal history could have contributed to interpreting her behaviours as adequate reactions in light of her history as a holocaust survivor, and thus other care strategies aside of sedating her might have been chosen.

4. Establishing a trusting relationship

Person-centred care also entails giving attention and value to establishing relationships in addition to completing tasks. Establishing a relationship facilitates feelings of being seen and cared for, or in the case of task orientation, neglected and treated like an object. In acute care, patients and family have generally no competence to evaluate the medical procedures, but they can all evaluate the way in which they are encountered. Also, making space for meaningful activities can be of immense value. This can include basic activities such as

reading the paper or helping out with serving lunch. Those are small but important things that can be provided even in a busy acute care environment, and can help to maintain a sense of self in the older patient (Edvardsson et al 2005).

5. Adapting environments to assist comprehension rather than confusion

The acute hospital environment can also be adapted to promote independence in finding different places such as the bathroom, the bed space, the dining space or other place. The environment should enhance rather than obstruct patient independence. Consider keeping corridors free from institutional clutter; symbols indicating the function of rooms, clear signage and other landmarks such as changes in colours, paintings, or other symbols have been shown beneficial for orientation (Day et al 2000). Conscientious use of colour and creating effective colour contrast in the environment can together with good lighting aid the older person to move about more confidently (Wijk 2001). If Emmy's personal history and needs had been known, the environment could then have been adapted to better fit her needs of calmness, staff presence and consolation.

6. Developing care plans with emphasis on strengths rather than problems

Care plans need to be developed directly with the older person, by the interdisciplinary team and in cooperation with family. The care plan should emphasise the older person's strengths and remaining abilities rather than focus on deficits and problems. The concept of informed flexibility, defined as facilitating decision making through sharing of information and integrating new information into care practices and perspectives, is one central constituent of person-centred care (Edvardsson et al 2008). In the case of Ronnie, he could share valuable information about Emmy with staff to integrate in daily practice. Also, taking part in planning for Emmy's stay might have facilitated a mutual understanding between him and the staff in addition to benefiting Emmy's care.

7. Offering a calm pace and optimal stimulation

The combination of a busy acute hospital setting and a lowered stress threshold in the older person (Hall and Buckwalter 1987) can create experiences of haste, chaos and disorganisation for the older person, as it did for Emmy. It might not be surprising to find reactions such as anxiety, agitation and restlessness in the older person as a response to sensory overload. A slower pace of care and carers, and reduced noise from telephones, buzzers and televisions can foster a relaxed and safe atmosphere (Edvardsson 2008). Optimal stimulation implies a fine balance and requires active reflection about the ambience of the ward. For Ronnie, the experience of seeing his mother in the busy acute hospital was very stressful. A small detail such as being met by staff providing a couple of minutes of calm attentive listening can contribute to beneficial family outcomes.

8. Having expert staff

The provision of person-centred care also requires staff members who are knowledgeable in the care of older people and understand the needs associated with old age and/or cognitive impairment. This includes knowledge of facts such as symptoms, disease progression, treatment regimens, outcomes, needs, and co-morbidities, but it also includes experience-based knowledge of what it means to be old, struck by illness, and being rushed to a foreign hospital environment. Staff also need knowledge of ethics, for example regarding clinical decisions such as when to abort treatment, provide treatment against someone's will and/or to use restraints. In the examples provided, it was illuminated how restraints and sedation were used to solve a stressful situation for staff even though current evidence discards such practice. However, it also highlights the difficult situation faced by staff trying to merge competing demands in midst of a high work load, and thus having care systems that support person-centred care becomes utterly important.

CONCLUSIONS AND RECOMMENDATIONS

It is not our intent to slant any blame towards physicians or nurses in the acute hospital settings, as we are well aware that most health care staff try their best to solve the equation of strict time constraints and increased work loads. However, available evidence indicates that we can do better for older people in acute care. Acute hospitals are 'fit for purpose', which is to respond to acute emergencies, road trauma and the like, undertake highly specialised and expensive tests, and conduct acute and planned surgery. However, most acute hospitals are not 'fit for purpose' in responding to the needs of the major users of their services, old, frail people with multiple co-morbidities and sometimes cognitive impairment as well. There is an inevitable culture clash between acute care where speed may be the essence in saving life and consultation with the patient is not an option, versus the slower paced, person-centred consultation and optimised stimulation that is quality elder care. The typical older patient with co-morbidities and general frailty does not present clear cut symptoms for straightforward diagnosis, efficient treatment and rapid discharge. Moreover, the acute hospital organisation into 'specialities' such as neurology and orthopaedics means that staff knowledge often lies within these specialities, something that can work against a holistic approach and quality outcome for older people. Although acute hospitals are excellent for single diagnoses, rapid treatments, and short stays, when older people end up in this setting they suffer from the consequences such visits are known to induce.

As an alternative to acute hospital admission, older people could be admitted for triage in older-friendly environments staffed by experts in care of older people, places in which their multidimensional care needs could be better met. Such 'older people centres' could be developed with similar interdisciplinary constitution, role and function as community health centres in which interdisciplinary

teams could receive and triage older people; offer comprehensive assessments, perform holistic care planning and co-ordination, and provide medical treatments, interdisciplinary rehabilitation, day care and palliation both in residential care and in the community. Current nursing homes and residential care settings could be transformed into such older people centres, and people in need of traditional residential care could receive this in their homes, supported by home health care teams. Also, developments in tele-health could provide avenues to extend the expertise of such centres into rural areas, while also offering consultancy to home care teams and acute hospitals for those older people who still do require such care. Expanding and transforming nursing homes and sub-acute care settings into becoming such 'older people centres' can also be anticipated to make aged care more attractive to health care staff.

There has been some previous work to improve acute care of older people in Australia. For example, age-friendly principles and practices were developed to facilitate health services adopting policies and procedures that address the diverse needs of older patients and their carers (AHMAC 2004a). In addition; best practice approaches have been presented to minimise functional decline in the older person in acute, sub-acute and residential aged care settings (AHMAC 2004b) and to facilitate management of delirium in older people (AHMAC 2006). Furthermore, a guide for assessing older people in hospitals exist (AHMAC 2004c), as does a national action plan for improving care outcomes for older people across the acute-aged care continuum (AHMAC 2004d). These are all important contributions, however it remains unclear to what extent such work has been adopted in clinical practice.

Although we have suggested strategies that can improve acute hospital environments, a cynic would argue that economic reality and the slow pace of change make it unlikely that these strategies will be introduced to the extent required to meet the needs of many older people. More feasible is perhaps a balanced approach that provides some

environmental adjustments for older people, core knowledge and skills for all staff, and access to gerontic expertise in care of older people. If such adaptations are accompanied by continuous development of 'older people centres', we can start to better meet the multidimensional needs of older people. Our parents and grandparents deserve better than what they currently receive.

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