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Feature Article

In Hospital We Trust: Experiences of older peoples' decision to seek hospital care

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ABSTRACT

The purpose of this study was to explore how older people experience and perceive decisions to seek hospital care while receiving home health care. Twenty-two Swedish older persons were interviewed about their experiences of decision to seek hospital while receiving home health care. The interviews were analyzed using qualitative content analysis. The findings consist of one interpretative theme describing an overall confidence in hospital staff to deliver both medical and psychosocial health care, *In Hospital We Trust,* with three underlying categories: *Superior Health Care*, *People's Worries*, and *Biomedical Needs*. Findings indicate a need for establishing confidence and ensuring sufficient qualifications, both medical and psychological, in home health care staff to meet the needs of older people. Understanding older peoples' arguments for seeking hospital care may have implications for how home care staff address individuals' perceived needs. Fulfillment of perceived health needs may reduce avoidable hospitalizations and consequently improve quality of life.

In many Western countries including Sweden, length of stay in hospitals has decreased during the past years, leaving patients in poorer health at discharge as compared to if they had received longer hospital stays.[1–5] At the same time, the number of beds in institutional care has decreased, resulting in a higher number of older people living in ordinary housing and receiving home help services and home health care.[6] Old people receiving home health care are often frail and susceptible to diseases. Hence, these individuals should only be transferred to hospitals when necessary as the hospital setting may pose a risk of being exposed to nosocomial infections.[7]

Still, hospitalizations are rather common among older people receiving home health care, despite frequent contacts with outpatient care, physicians in primary care and specialized medical care.[8] For example, in the United States (U.S.), almost one third of people receiving home health care become hospitalized over the course of one year[9] and in Sweden more than half of the people receiving home health care are hospitalized over the course of a year.[8]

Although frequent hospitalizations and readmissions have received increased attention in the literature recently, little is known about older people's experiences and perceptions of decision to seek hospital care. Quantitative studies have focused on factors related to the hospital setting[10–12] as well as on risk factors related to measurable patient characteristics and health outcomes to reduce avoidable hospitalization and rehospitalization.[1,13,14] It has been shown that the risk for hospitalization among home health care patients increases with decreased functional ability,[14] lacking informal care, and incidence of chronic conditions as congestive heart failures (CHF), respiratory problems, wound problems and diabetes.[14,15] However, reasons for seeking hospital care seem to be more complex than can be captured by quantitative data. By using qualitative study design it is possible to gain an inside perspective and obtain aspects like the patient's own perceptions and experiences of hospitalization.

The extant research on hospitalization decisions among home health care patients is scarce. Prior research has found that older people tend to experience health care transitions as difficult, and the decision to seek hospital care is often made hastily because of acute illness.[16] Further, the majority of community dwelling older persons as well as home health care patient seem to prefer treatment at the hospital as compared to treatment at home.[17,18]

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Another study including older people receiving home health care due to CHF or chronic obstructive pulmonary disease, found that these older adults viewed home care as a service with limited health care resources, not capable of treating acute illnesses.[19]

Knowledge about older people's own decisions of seeking hospital care can form a substantial knowledge base in understanding health utilization patterns among the elderly. Therefore, the purpose of this study was to explore how older people with a variety of health problems experience and perceive decision to seek hospital care while receiving home health care.

Methods

Design and participants

A qualitative interview study was conducted in southern Sweden. Participants were recruited from eleven municipalities in a county with one county hospital and two local hospitals. The inclusion criteria were: adults aged 65 years or older; receiving home health care for a minimum of 6 months; and being hospitalized while receiving home health care. A need assessor in charge of each municipality identified participants. The need assessors mailed written information letters to prospective participants about the purpose of the study. After a week or two, the need assessors contacted prospective participants by phone and asked if they wanted to participate in the study. The need assessors gave the first author's name and telephone number to the 24 people who were interested in participation. The first author contacted these people by phone and gave them detailed information about the study.

Twenty-two persons agreed to participate in the study. Written informed consent was obtained at the interview sessions from all participants. Fifteen of the participants were women (7 men), and their ages ranged from 66 to 93 years (median 84.0). Fourteen participants lived in urban areas and six in rural areas. Fifteen participants lived alone and seven lived with a partner. The participants received a wide variety of home health care. Some received help with medication or dressing of wounds, whereas others had advanced home health care with intravenous infusion treatments.

Procedure

The interviews were conducted in the participants' homes by the first author over a period of 8 months. The interviews lasted between 25 and 80 min (median 50 min) and were recorded and transcribed verbatim by the first author. Participants were asked to reflect upon their decision to seek hospital care. The interview opened with the question: "Could you tell me about your experiences of hospitalization while having home health care?" Follow-up questions depended on the nature of the participants' stories.

Data analysis

Transcribed data were subjected to content analysis, which can be used to systematically analyze written or verbal communication, such as gathered by interviews.[20] The analysis was performed in several steps, according to Graneheim and Lundman.[21] First, each transcribed interview as a whole was read several times by the first author to understand the meaning and to capture the essential message. Second, the first author identified and marked text that was relevant to the study objectives. These text sections were further divided into meaning units, each consisting of one or more continuous sentences. Third, the meaning units were condensed and labeled with codes (Table 1). Fourth, the codes (41 in total) were sorted into categories through a back-and-forth process among all co-authors until agreement was reached. Fifth, all authors identified in agreement an interpretative and solid theme that captured the latent underlying meaning of the content.

Trustworthiness of the study was established using the framework developed by Lincoln and Guba (1985).[22] To establish credibility, two of the authors [JH, IJ] independently coded three of the transcripts, and further compared the codes according to differences and similarities until agreement was reached. Further, dependability of the study was enhanced because three of the authors have several years of professional experience in home health care and hospital care.

The final analyses were presented and discussed with other researchers with expertise in qualitative research to strengthen confirmability. The analysis was conducted in Swedish and translated into English after it was completed, according to recommendations.[23]

Ethical considerations

This study was conducted in accordance with the Declaration of Helsinki, and was approved by the Regional Research Ethics Board in Linkoping, Sweden (dnr 2012-22-31). Participants were informed that their participation was voluntary and could be withdrawn at any time and without any negative repercussions. All material was treated as confidential, and only the first author knew participants' personal data.

Results

The findings consist of one theme with three underlying categories. The theme *In Hospital We Trust* points out an overall confidence in hospital staff to deliver both medical and psychosocial health care. Three categories describe this in more detail: *Superior Health Care*, which concerned health care quality; *People's Worries*, which deals with, for example, feelings related to insecurity; and *Biomedical Needs*, which concerned specific health conditions. The categories were divided in seven subcategories. Representative quotes were selected to illustrate the views of the participant in each subcategory.

Superior Health Care

The category *Superior Health Care* consists of three subcategories. *Health care availability* involved experiences and perceptions of differences in health care availability at the hospital and in the participants' homes. *Staff competence* included participants' comparisons of staff competency at the hospital with that of the home health care. *Quality of care* described participants' perceptions of the kind and quality of health care that could be delivered by home health care and at hospitals.

Health care availability

Access to health care seemed to be important regarding the decision to seek hospital care. Participants felt that entering a hospital was easy, by either seeking care at the emergency room or alerting an ambulance. Home health care, in contrast, was perceived as being less available. For instance, home health care was not available 24 h a day and not for acute needs. Participants discussed the availability of home health care by talking about the difference in staffing between day and evening shifts. With fewer staff in the evening and at night, it becomes more difficult to get help when needed.

Another explanation offered by participants was that registered nurses often delivered home health care in large areas with high patient loads, especially in the evenings and on weekends. When