



Full Length Article

Inpatient geriatric care in Sweden—Important factors from an inter-disciplinary team perspective

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ABSTRACT

The purpose of this study was to describe factors of importance for the quality of inpatient geriatric care from an inter-disciplinary team perspective, an area that has not been previously studied to our knowledge. The study design was qualitative descriptive with data being collected from focus-group interviews with members of geriatric care teams. The data collection was conducted at a Swedish university hospital with 69 beds for geriatric care. It comprised five group interviews with a total of 32 staff members, including representatives of all the seven professions working with geriatric care. Data was analysed using qualitative content analysis and a thematic framework approach. Three main themes were identified as being perceived as characterising important factors essential for quality geriatric care: Interactive assessment processes, A holistic care approach, and Proactive non-hierarchical interaction. Aspects of Time and Goal-Orientation were additionally running like common threads through these themes and informed them. Accessibility, open communication, and staff continuity were experienced as prerequisites for well-functioning teamwork. Including patients and relatives in care planning and implementation was seen as essential for good care, but was at risk due to budget cuts that imposed shortened hospital stays. To meet the care demands of the growing population of older frail people, more specialised team-based care according to the concept of Comprehensive Geriatric Assessment – which is possibly best provided by older-friendly hospitals – appears as a constructive solution for reaching high degrees of both staff and patient satisfaction in geriatric care. More research is needed in this area.

Introduction

Due to many of the world's populations aging, the demand for adequate health care for older people is rapidly increasing. Flaws in the care management of older people in hospital settings have been reported in a number of studies from various countries (Gill, Allore, Gahbauer, & Murphy, 2010; Haines et al., 2015). Common shortcomings include fragmented care due to a high level of specialization, and poor continuity of care (Clarfield, Bergman, & Kane, 2001). Despite the increasing number of older patients, care organizations and the competence of health care professionals have not changed to the degree required to be able to accommodate their needs. It has also been found that geriatric specialized care is not a priority in many countries, despite the demographic changes seen in their populations. In Sweden, the number of hospital beds for geriatric patients has decreased considerably in the last two decades.

Many older patients have complex health care needs based on comorbidity or frail health. There is no global consensus on how to define

frailty, however, common features of frail health in older people include decreased capacity in bodily functions leading to increased vulnerability in the event of acute illness or psychosocial trauma (Clegg, Young, Iliffe, Rikkert, & Rockwood, 2013). One perspective on frail health includes the presence of general weakness, fatigue, decreased endurance, weight loss, low physical activity, poor balance, decreased mental function, and low stress tolerance (Fried, Ferrucci, Darer, Williamson, & Anderson, 2004), whereas another perspective is based on the presence of co-morbidity, loss of functional capacity, and specific health problems (Gobbens, Luijckx, Wijnen-Sponselee, & Schols, 2010). Even if definitions of frail health vary, it is agreed that frailty is a stronger predictor for health care needs and mortality than age alone (Clegg et al., 2013). Older patients with frail health are also at risk of losing functional capacity during hospital stays, which may result in a higher level of dependency after discharge (Ellis, Whitehead, Robinson, O'Neill, & Langhorne, 2011; SBU, 2013) (Ellis, Whitehead, Robinson, O'Neill, & Langhorne, 2011; SBU, 2013). It has been shown that 3–5% of deaths in older adults could be delayed if frailty had been prevented

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based on comprehensive assessment (Shamliyan, Talley, Ramakrishnan, & Kane 2013).

Acknowledging the problems described above calls for hospital care of older people that does not only focus on the patients' specific diseases or conditions, but rather on a more holistic perspective that takes into account the specific needs of each individual.

Internationally, the most commonly used method for holistic acute care of older people is Comprehensive Geriatric Assessment (CGA) (Matthews, 1984). CGA has no standardized method of execution so specific assessment instruments vary between institutions and countries. In general, however, CGA includes the assessment of a patient's health history, current diseases and medication, functional status, psychosocial function, and cognitive, mental, and nutritional status (Ellis, Whitehead, O'Neill et al., 2011; Rubenstein, Wieland, & Bernabei, 1995). In addition, the experiences and perspectives of the patient and his/her family should be taken into account.

A central aspect of CGA is the role played by the care team, both in assessing and planning for the care of the patient (Headrick, Wilcock, & Batalden, 1998; Young et al., 2011). A review of the literature shows that CGA-based interventions performed by inter-professional teams who take on the primary responsibility for patient care is the most effective method to maintain the health and independence of older people (SBU, 2013).

Teamwork can be defined as a group of people with different professional backgrounds and competence who work together. The ability to work with others has been described as one of the core competences in health professionals to ensure high quality care (IOM, 2001). The team is considered to outperform the sum of the individual contributions made by members or that of a group of professionals who each carry out their tasks independently of one another. The value of the team is therefore considered to be greater than that of a group of individuals with their own agendas. As a structure, the team is a small group consisting of staff members with various competences, who communicate with each other and integrate their efforts to ensure continuous and reliable care (IOM, 2001). At a minimum, the team should consist of competences in medicine, nursing, social work and rehabilitation therapy (Baztan, Suarez-Garcia, Lopez-Arrieta, Rodriguez-Manas, & Rodriguez-Artalejo, 2009; SBU, 2013). The team should apply an inter-disciplinary approach and work towards common goals (Headrick et al., 1998; Young et al., 2011). Such teams can create synergies that may result in better outcomes and development of the team and its members (Epstein, 2014). A recent systematic review of acute hospital care of older people with frail health shows that an integrated teamwork approach had positive effects on both the functional ability of patients and the possibility for them to remain in their own homes post-discharge (SBU, 2013).

To sum up, systematic reviews show that CGA carried out by an inter-professional team that takes responsibility for the care of older patients with frail health results in them having a higher level of functional ability and independent living than regular care. These effects have not been observed when CGA is performed by individual professionals. As the role of the team seems crucial for the success of the intervention, it is of interest to study the perceptions of health care professionals on factors that may facilitate or hinder teamwork. Therefore, this study aims to describe factors of importance for the quality of hospital-based geriatric care from an inter-disciplinary team perspective. To our knowledge, this is not an area that has been previously studied.

2. Design and method

The design of the current study is qualitative descriptive with data collected from focus-group interviews of team members working with geriatric care. The Research Ethics Committee of the University of Dalarna has approved the study. The principle of informed consent was applied and the data was treated with integrity in all the stages of

research.

2.1. Setting

The data collection was conducted at a Swedish university hospital with in total of 1100 beds, of which 69 were located in the Geriatric Clinic for specialized care, hereafter referred to as the clinic. Patients treated at the clinic were generally aged 65 years and over and had aging-associated diseases. The clinic's three geriatric wards located in the main hospital were directed towards medical disorders, orthopedic post-surgery care, and stroke. A fourth ward, located in a small rurally located community 60 km away from the main hospital, treated patients with all these health conditions as well as patients in need of palliative care.

Care episodes were usually initiated by referrals from other units of the hospital, such as the departments for orthopaedic or medical care. On occasion, patients arrived directly from the emergency department or via the geriatric home-visit team. A geriatrician at the clinic assessed all the referrals and decided who would be admitted to the clinic. The common criterion for admission was that they should be biologically aged individuals with diseases that require interventions from more than just a medical point of view, where a geriatric team was needed for the treatment.

Most patients in the clinic had complex medical disorders and functional limitations. Care was directed towards the early stages of the conditions; it was goal-oriented and limited in time. For all patients, routines according to the "Senior Alert" were applied – a Swedish quality registry for the support of standardized care and systematic preventive care processes for older adults (Qual Manag Health Care. 2015 Apr-Jun;24(2):96-101). The care was team-based with specific team-members responsible for the care of each patient, which clearly influenced the care procedures. The teams included the following professions: physician, registered nurse, assistant nurse, physiotherapist, occupational therapist, social worker plus access to a dietitian and speech therapist.

2.2. Participants

A mix of convenience and strategic sampling was used when including geriatric care team members working on the four wards of the clinic. Recruitment of participants was initiated with an information letter sent to the head of each of the clinic's wards, who gave their approval to ask the staff for participation. Staff members interested in participating were then listed and put into groups with the purpose of forming four focus groups with 5–10 members from the different wards and range of professions mentioned above (Group I–IV, Table 1). Later in the research process (see below) recruitment of only geriatricians for a fifth interview (Group V, Table 1) was carried out via the chief physicians at the clinic. The latter resulted in a sample of four senior geriatric specialists and one newly graduated geriatrician. In the other

Table 1
Overview of professionals participating in the interviews.

	Interview number					All
	I	II	III	IV	V	
Occupational therapist	1	1		1		3
Dietitian			1			1
Social worker	1	1	1			3
Physician	1		1	1	5	8
Physiotherapist	1	1	1	1		4
Registered Nurse	2	2	2	1		7
Assistant nurse		1	3	2		6
Participants/group	6	6	9	6	5	32

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