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Feature Article

Older adults' personal routine at time of hospitalization

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ABSTRACT

This study is the first to explore whether hospitalization disrupts the daily routines of dependent and independent older adults. Data were collected as part of a prospectively designed study from 330 hospitalized older adults age 70+. Patients reported prehospitalization frequency, duration, and timing of basic activities of daily living and leisure activities at hospital admission. Hospital routine was assessed on day of discharge. Results indicated that frequency and duration of most basic activities decreased during hospitalization; the sharpest decrease was in frequency of getting dressed. Showering occurred 2 h earlier in the hospital setting, and getting dressed occurred an hour and a half later. For dependent respondents, the greatest change was in duration; for independent respondents, the greatest change was in frequency. Given the importance of routine maintenance to health and well-being, understanding the dynamics of its disruption in the hospital setting is imperative.

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Introduction

Hospitalization occurs frequently in older adults: people aged 65 and older account for 48% of inpatient hospitalization days.¹ Hospital admission rates continue to rise, particularly in those over the age of 75.² Hospitalization can be considered a negative life event that challenges the coping skills of older adults.³ In demanding situations, such as illness, individuals usually wish for their regular and familiar way of existence.⁴ If a person is used to having a cup of coffee in the morning with the daily newspaper or to taking a long, hot shower in the evening, the maintenance of these activities might create feelings of regularity in this unusual environment. In the current study, we investigated whether older adults maintain their personal daily routine in the hospital setting.

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Background

Routine

Routine is a concept pertaining to strategically designed behavioral patterns (conscious and subconscious) used to organize and coordinate activities along the axes of time, duration, social and physical contexts, sequence, and order.³ Routine can be seen as a mechanism for adjusting to one's environment, especially for those with limited resources: by streamlining activities in a semi-automatic manner, one saves energy and resources, time and effort. Maintenance of routine may be particularly adaptive in older individuals. In various studies with community-dwelling older adults, researchers have found that maintenance of daily routine facilitates functional status, quality of sleep, and well-being.^{5–8} In long-term-care settings, function-focused care (FFC) that emphasized the importance of residents' performance of regular and routine activities consistently showed functional and health benefits.^{9,10} Clark, Azen, Zemke, Jackson, Carlson, Mandel, Lipson¹¹ and Clark, Azen, Carlson, Mandel, LaBree, Hay, Lipson¹² showed improvement in functional, mental, and physical health status; life satisfaction; social functioning; body pain; and emotional problems following a routine activity-enhancement intervention in older adults.

Routine in the hospital setting

Hospitalization may disrupt older adults' daily routine. In the hospital setting, some activities (e.g., eating meals) are part of a rigid, externally created routine. The routine practices of the hospital setting are probably not synchronized with the idiosyncratic daily routine of patients. As a consequence, in domains such as eating hours, it may be challenging to maintain individuals' regular daily rhythms. Moreover, timing and duration of hospital-care-related activities (such as medical rounds, tests, and procedures) are mostly unpredictable for patients and therefore may disrupt or prevent the practice of personal routines. Qualitative research clearly demonstrates these discrepancies.¹³

The experience of hospitalization imposes additional psychological, physiological, and environmental demands that could be especially challenging for individuals with low competence.¹⁴ Whereas independent individuals have more resources to withstand such demands in order to sustain their personal routines, these additional demands might stretch the resources of dependent older adults.

Maintaining daily routine for older adults during hospitalization could be important for a number of reasons. First, routine might act as a *zeitgeber* (time-cue) contributing to human circadian entrainment.¹⁵ Synchronizing biological and physiological with personal activities is one mechanism by which individuals ensure basic physiological body regulation.¹⁶ Second, being occupied with basic routine activities shortens the passive and inactive time spent in the hospital.^{17,18} Last, a continuation of normal life and acceptance of individual needs emerged as major themes in a review of 43 qualitative studies about the experiences of older people in acute-care settings. Moreover, there is evidence that allowing inpatients to have meals tailored to their idiosyncratic timing^{19,20} increases patient satisfaction and caloric intake.

Even though routine maintenance appears to be an important issue for older adults, the literature on the subject in the hospital setting is not extensive. The aim of this study is to explore the level at which hospitalization disrupts the daily routines of community-dwelling older adults, taking into account their level of independence.

Specifically, we hypothesized the following:

Hypothesis 1. The frequency of routine activities in the hospital will be lower. This will be more prevalent in dependent respondents.

Hypothesis 2. Respondents will perform routine activities for a shorter time. This will be more prevalent in dependent respondents.

Hypothesis 3. The timing of routine activities in the hospital will be different from the timing at home.

Hypothesis 4. The total duration of routine leisure activities (i.e., watching TV and reading) will be shorter in the hospital. This will be more prevalent in dependent respondents.

We hypothesized that these associations would remain significant after controlling for severity of acute illness, age, and gender.

Method

Procedure

The described study is part of a larger prospective observational study designed to assess the effect of hospitalization-care processes on functional outcomes in older adults.²¹ It was conducted with

older patients (age 70 and older) from 2009 to 2011 in two medical centers in the northern part of Israel.

A subsample of 344 cognitively intact participants (based on their scores on the Short Portable Mental Status Questionnaire [SPMSQ],²² described in more detail in the [Method](#) section) dwelling in the community before hospitalization completed a short form of the Scale of Older Adults' Routine (SOAR²³). Of the 344, 330 had completed the SOAR questionnaire within 48 h of admission and at discharge. There were no significant differences in function and severity of illness between the current sample and participants with missing data.

Participants

The sample included 330 participants. Their mean age was 78.62 years ($SD = 5.72$), 50% were female, and 54.7% were married or living with a partner. The mean number of years of education was 10.83 ($SD = 4.69$). The basic functional status of the sample was assessed by the modified Barthel Activities of Daily Living [BADL] (described below), with a mean score of 82.55 ($SD = 25.22$). The mean cognitive-status score was 8.68 ($SD = 1.50$, Range = 5) on the SPMSQ, indicating that participants were cognitively intact (Pfeiffer, 1975; described below). The average length of hospitalization was 6.51 days ($SD = 4.50$; see [Table 1](#)).

Data collection

Demographic characteristics, as well as functional and cognitive status and prehospital routine (SOAR), were assessed through in-person interviews within the first 48 h of hospital admission. Hospital routine was assessed on the day of hospital discharge. Data regarding severity of illness were retrieved from the patients' medical records.

Ethical considerations

The study was approved by the ethics review boards of the hospital and the Ministry of Health. All participants provided informed consent, and participation was voluntary and confidential. Moreover, participants were able to withdraw at any time and had the option of omitting questions that they did not wish to answer.

Measures

Daily routine was assessed using the SOAR.²³ A modified and shortened version of the SOAR comprised four items from the basic activities in the ADL domain (oral hygiene, showering, getting dressed/undressed, and eating main meals) and two items from the leisure activities domain (watching TV and reading books). For each item, participants reported the frequency (with or without assistance) with which they performed the activity either daily or weekly (depending on the type of activity and on individual habits). The frequency of activities performed weekly was divided by 7 to obtain a score of daily frequency. In addition, participants reported the amount of time (duration) spent performing each activity (in minutes) and the timing of each activity's performance. When an activity was not performed, its duration was scored as 0, and the timing was coded as a missing score. True missing values were replaced by means, which ranged from .2% for frequency subscales to 2.2% for duration to 3.5% for timing. In a previous study, test-retest reliability indices ranged from .76 to .87 for the frequencies, timing, and duration scales; and validity tests were moderate to good with the trait of routinization.²³

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