

What do staff perceive to be the risks to older patients in hospital, and what interventions could reduce these risks? - an interview study.

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Background

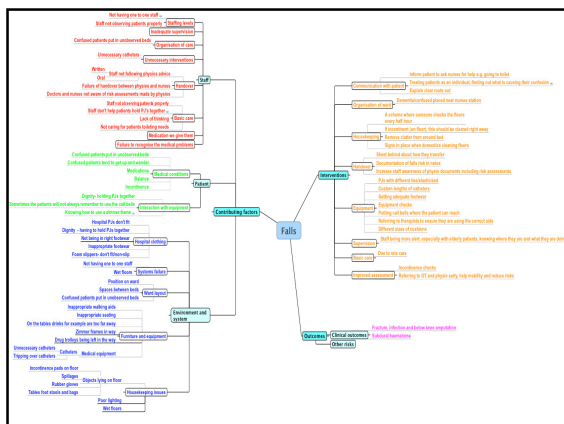
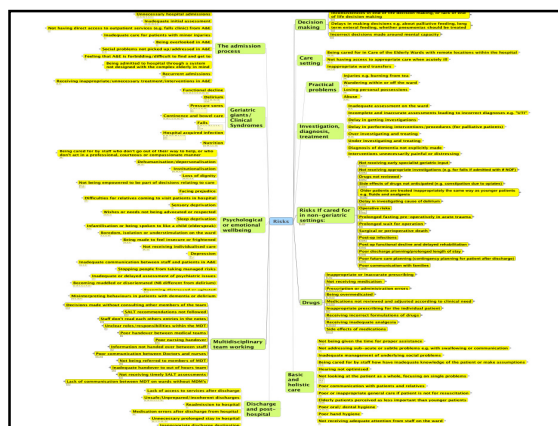
- We sought to explore risks to older people in hospital
- Literature – risks and interventions
- Case record review
- Qualitative

Aims of this study.

1. To determine what staff perceive to be risks to older patients in hospital
2. To determine what interventions they would like to see to reduce these risks

Methods

- Participants – 16 multi-professional staff members involved in the care of older people in different settings within the hospital
- Semi-structured interviews.
 - Hypothetical case vignettes given pre-interview
 - Broad open questions
 - 1) What risks might these patients encounter in hospital?
 - 2) What are the contributory factors?
 - 3) What interventions might help?
- Triangulation – Top 3 risks, Top 3 interventions
- Field notes taken and member checked
- Data analysis – grounded theory, mind mapping



"One of the things you always hear on wards in every hospital is when a patient is calling out for the loo and the nurse is saying 'Well you've got a pad on, just use your pad' when the patient is continent enough to call for help."

"Sometimes I think that people don't see caring for older people as being challenging or rewarding because they don't really know what to do. It's very much the Cinderella service..."

"Where possible they should have their own clothes definitely because it just gives them a sense of 'I'm not too bad'..."

"Delirium should be treated with the same degree of urgency as chest pain or shortness of breath"

"...thinking more about the bigger picture, where is the most appropriate place for somebody to be and what interventions might be appropriate and to me that just seems quite basic, quite simple."

"Suddenly they've become vulnerable and reliant on other people for their care so they're not getting up and making their own cup of tea, or going to the loo, so they get constipated or dehydrated. So just by nature of being in hospital I think is an adverse effect in itself. Kind of a contradiction in terms really..."

"The number of times that you go round at 12 o'clock and you see the little tubful of tablets sitting there since eight o'clock in the morning, or you crunch on something on the floor and it's a tablet"

Figure 2. "Top 3 Risks"	Risk 1	Risk 2	Risk 3
OT	Poor communication	Poor patient positioning	Incontinence
Ward Manager (1)	Loss of independence	Loss of empowerment	Incontinence
Physiotherapist (1)	Unfamiliar environment	Poor communication	Infection
A&E nurse	Unnecessary interventions	Being frightened/disorientated	Inadequate assessment
Discharge nurse	Infection	Falls	Delirium
Consultant Geriatrician	Delirium	Functional decline	Loss of dignity
Ward clerk	Poorly planned discharges	Wandering	Falls
Physiotherapist (2)	Falls	Delirium	Disruption of sleep
SpR Geriatric Medicine	Inappropriate admissions	Inappropriate medical intervention	Lack of dignity
Palliative Care CNS	Inappropriate interventions	Poor nutrition	Depression
Pharmacist	Incorrect DH on admission	Poor communication with primary care	Incorrect dosing for elderly
SALT	Loss of dignity	Poor interdisciplinary communication	Poor feeding
OASIS nurse	Poorly planned discharges	Lack of manners/respect/dignity	Poor communication with pt
Ward Manager (2)	Hospital acquired infection	Incontinence	Labelling patients, loss of respect
Ward Sister, surgical ward	Unnecessary pre-op starvation	Not being treated as individuals	Inappropriate medication

Figure 3. "Top 3 Magic Wands"	1	2	3
OT	Better equipment for positioning	A multidisciplinary continence group	Use volunteers to fill in gaps in care
Ward Manager (1)	Training to see patient as person	Changing ward environment so pt feels secure & valued	Continence Nurse Specialist
Physiotherapist (1)	Improved community services	Improved ward layout	Reduce social isolation
A&E nurse	Educating A&E staff	More elderly friendly environment	Improve links with community
Discharge nurse	Improve willingness to work with elderly	Improve cleanliness	More activities on ward for elderly patients
Consultant Geriatrician	Elderly friendly A&E dept	Improved environment	Improved links with community services
Ward clerk	Better security on wards	More staff at night	Improved ward environment
Physiotherapist (2)	More staff	Better footwear	Better continence care
SpR Geriatric Medicine	Making care of the elderly a priority	More nursing staff	Better communication with relatives
Palliative Care CNS	More thinking about the bigger picture for pts	Improved basic care eg feeding	Staff spending more time with pts
Pharmacist	Seamless primary and secondary care	Supervision of medication taking	More time for pharmacists
SALT	Improve interdisciplinary communication	More staff	More training and ensuring learning goals are achieved
OASIS nurse	Improved communication with pts	Improved attention to basics	Humanising/individualising care
Ward Manager (2)	Elderly Care Specialist Nurse	Making elderly pts a priority within the hospital	Improved education about geriatric issues
Ward Sister, surgical ward	Appropriate staffing levels and shared responsibility	Make elderly patients a priority	Improve MDT discharge planning

Conclusions

- This study highlights the broad range of risks older patients face across a variety of settings within the hospital
- The value of qualitative work such as this is that it allows us to identify problems with care that are not so easily defined by quantitative studies.
- Interviewees stressed the importance of raising the profile of older people within the hospital and of ensuring good basic care
- Staff directly involved in the care of older patients suggested several innovative interventions which could be the focus of future research.