The Elderly Patient's Return Home from Hospital: Enabling Families to Support Relatives During Periods of Convalescence

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Abstract

This a reflective account of the impact of three days in hospital on my aunt. She had fallen while trying to get to her feet. Once hospitalised, it would appear due to her age of 99, she would be classified as a frail elderly person; the family objected to this classification. She lived at home and managed successfully, with occasional help. Returning from hospital made her dependent, and it took a while for her to regain her normal lifestyle. During this period I searched for articles or research which could help the family with my aunt's convalescence; she had made it clear that she did not want to go into care. But there were very few suggestions to help the person's relatives know if what they are doing is right or wrong. Our solution was to offer my aunt something liked if she would do what we asked, and it worked; but were we treating my Aunt as a child initially?

This paper will use reflection as described by Burns and Bulman (2000, p.5): "Reflection on action is the retrospective contemplation of practice to uncover the knowledge used in a particular situation, by analysing and interpreting the information recalled. The reflective practitioner may speculate how the situation might have been handled differently and what other knowledge would have been helpful." Their work is based on the work of Donald Schön (1987), an American philosopher and industrial consultant who developed critical reflection as a strategy for learning from practice to solve complex situations that require problem solving skills and a degree of creativity. This paper is written in the first person, from the point of view of the lead author.

Introduction and Preparation

My aunt slipped on her bedroom floor in August, while walking around in her socks. My sister and I arrived in a short time after she fell; we called an ambulance and waited eight hours for it to arrive. Once in hospital the process was very slow, however the registrar who saw her talked to her as an adult and not a child. He got her up and she walked on her own with her walking stick, so we knew there was not a problem, but because of her age the doctor said she had to be admitted. Despite being admitted just after three in the afternoon, she was not warded until two in the morning. After three days she was allowed home. However, that was the first problem, as she told the medical staff she did not want to leave. Did she feel more secure in hospital?

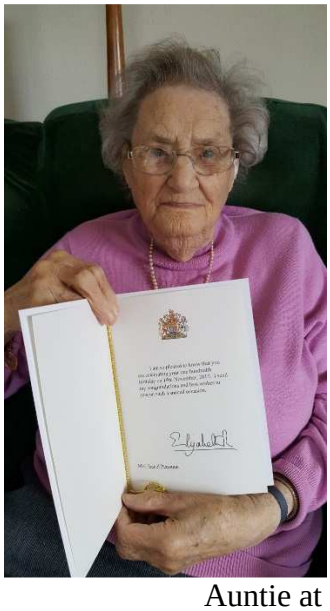
A different registrar told us not to worry if my aunt forgot to take her new medication, which was an interesting attitude to take with relatives. We were told that during the next two weeks her General Practitioner and the Community Nurse would visit. Because it had been a short stay, we presumed that my aunt would resume her previous normal lifestyle.

My aunt's bed was moved downstairs, as she has other facilities there. She is well known in the village, having lived there since 1948, and had remained active by playing whist on Tuesdays, knit-and-nattering on Wednesdays, having coffee on Thursdays and the hairdresser and bowls on a Friday, for example. For these activities people from the various clubs would fetch her and take her home. In addition, two ladies from the village would help her through each day by seeing that she was up and helping her with meals. My aunt had lived on her own since her husband died in 1987.

Initial Problems

Our problems started immediately. My aunt wanted to know where her maid was, as she could do nothing without her maid. (At home, she did not have a maid, of which more below.) She would not get up, dress or eat her meals and washing up was a thing of the past. The next problem was that the physiotherapist said she should use her frame and not the walking stick that they had given her. In the end we moved all the rugs and she stuck to the stick, but it was a concern as she seemed to drag one foot. The removal of the rugs caused a great deal of upset, where sleeping downstairs received no comment. However, we were to learn that she had broken two ribs; it was easy to understand why she would not use the frame. At her discharge it would have been nice to know this fact, and that they also thought she had a urinary tract infection.

The helpers had a difficult first week! However, having known my aunt before, they hoped that this would be a short-lived episode. This was not to be the case. It took over eight weeks before she began to resume most of her normal functions. By the end of this period, she was dressing herself and getting her breakfast; washing up was still a bit hit and miss. She had begun to make her bed and be interested in her clubs.



Auntie at 100 and playing bowls.

Research Beginnings

The reason for writing this paper was to find out if there were any articles or research items available that would have helped us understand how we should have best approached enabling my Auntie to resume the life that she had been used to. This difficulty must be happening daily in millions of homes. Were there ways we could have helped my aunt return to her previous understanding of her life? After all, she had only been in hospital three days.

My initial step was to review the current literature. There were more than 180 associated articles and research papers written between 2003 to 2018. They mainly covered transfer home after surgery or short stays. Although interesting, the pitch of the papers was on making the environment safe; adding the necessary structures, such as rails and raised seats. There was mention of psychological needs and the patient's spiritual needs. Nothing, however, was found that offered *the family* pertinent advice.

Dependency

What might I find of use in the theories of dependency? Dependency can be defined as a tendency of an individual or individuals to rely on others for advice, guidance or support. Should we consider that hospitalisation of an older person leads to a dependency situation, because the patient is always being told what can be done and when? This appears to cover the first two characteristics of the definition of dependency, in that the person finds it difficult to make everyday decisions once they leave hospital; she has lost control of her life during the stay.

The patient is told when she can wash, rather than being asked if she would like to go now or later. If she takes too long in choosing from the menu for the following day, the staff suggest that they would like X or Y: it is considered too time consuming to leave a pencil with the patient. This meant that my aunt did not eat many of the meals, because she does not like gravy or custard. Furthermore, the patient is told not to get out of bed or out of the chair without ringing for the nurse or healthcare assistant. A visitor would form the impression that patients were planted by their bed like flowers in a nursery, with nothing to do until the next interaction.

Once a patient reaches nearly one hundred years of age, hospital staff tend to consider the person incapable. However, staff might improve the patient's experience by finding out about the *person* and what sort of life she lived and is living. Perhaps it is all too easy to stereotype patients; and perhaps this is a fault of education, as we tend to build a persona for the elderly in general. However, if you work in this area of care, would part of ongoing professional development not cover this aspect of dependency? In talking to staff, it would appear it is downgraded in relation to the need to ensure a patient's safety. I was told that if you allow "them" to take part in their care they may fall or hurt themselves… and we cannot have this as there would be problems with the managers.

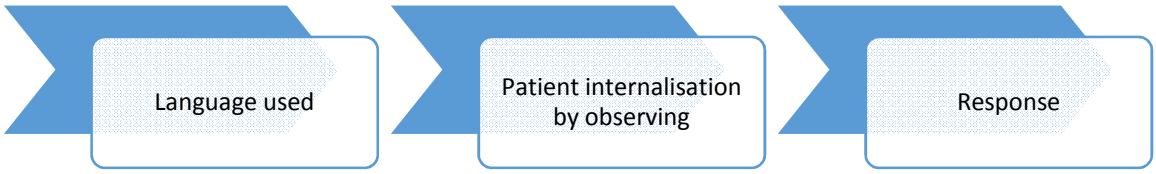
While visiting my aunt in hospital, I had noticed that one of the young health care workers would tell her patients that she was "your maid", and was to be asked or called before they did anything. (My aunt's use of the phrase had stemmed from here.) While on the ward, the patients were told they could not do anything without ringing the bell for assistance. This was understandable: staff would not want to risk more falls, but why did it take so long for my aunt to regain her normal style of life on returning home? Equally, why did the staff not find out how capable my aunt was? Knowing that she was 99 years of age, assumptions had been made that she had lost her faculties. My aunt was constantly addressed as though she was a child and hard of hearing and unable to do anything for herself. Could

she have become become dependent so quickly or can a person be conditioned in such a short time?

Repetitive Conditioning

The words that staff used on the ward all day long were very similar. I felt on one visit I could have made a tape so they would only need to press a button. Repetitive conditioning derives from social learning theory, which combines both a person's cognitive ability and their behavioural changes through repetition. Albert Bandura (1976) wrote that when considering these two elements we must look at four components that he said would be present if this type of learning were to take place. These were observation, retention, reproduction, and motivation/stimulus. Such learning would easily be absorbed by my aunt since she was a master at the card game whist and used to win at bridge regularly.

Behaviourists explore the way that observation and the environment play on one's mind. McLeod (2007) and Oliver &Ellerby-Jones (2008) consider the most important aspect of their principles is observable behaviour, rather than the internalisation of thinking. Constant stimulus should enlist a behavioural response. Would it be correct to say that observations result in consequences leading to a simple response feature? Is this conditioning? And could it happen in such a short period? Do elderly care staff use conditioning to gain the result they want, because it could lead to a safer care environment? Does the use of their repetitive language lead to the elderly person responding in the manner wished for? A simple diagram would suggest:



On one afternoon, while visiting my aunt in her six-bed ward, I listened to staff communications; in the space of thirty minutes, I had heard the following phrase more than twenty times: "You must use your bell if you want help: not get out of your chair, you may fall." How long would it take before a person understood that they must not do anything before asking? However, for it to be useful and used there would need to be a cognitive element; if action were to occur, some sort of cognitive function will have to have taken place.

My concern was that it would not be long before the person did not bother and took on the "sick" role. After all, they were expected to rely on the staff for every task they undertook. During each day, what activities were undertaken so that the person was actively stimulated? There were no newspapers available; however, my aunt would read *The Telegraph* every day, not to mention listening to the news and sport (as an Arsenal Football Club fan). She would mix with younger people on outings. She would keep up with the gossip that is rife in any village. Although the hospital staff classified her as very old, my aunt had an intellect. Unfortunately, there was no stimulus for her in her three-day stay. Instead, she was quickly reduced to a sick role. Each time I visited, my aunt was still wearing a hospital gown and not her nightie. The staff helped to dress her in the morning without asking what she would like to wear. They said it was easier to use a gown. Not once in the three days did she wear her own nightwear, which was degrading.

Helplessness

Finally, I looked at learned helplessness. Could this possible occur in three days? In 1967, an American psychologist named Seligman (cf. Oliver &Ellerby-Jones, 2008) referred to this idea while looking at the responses of animals to specific actions. Later it was extended to be a possible reaction to human situations such as depression, death or other personal circumstance which were out of the usual pattern of life.

That would be valid in the case of my aunt: even at her age, she liked to believe that she was in charge; indeed, it must have been a shock to find herself being 'done to' (Benjamin, 2018). My aunt had usually enjoyed the locus of control and now the situation had been compromised. To what effect to her self-esteem, we must ask. Certainly, she felt that she was being controlled while she was in hospital. This was evident when at her last outpatients visit, she told the doctor to discharge her, because she did not need their care!

A Dilemma's Resolution

The approach that the family used was to persuade my aunt to do something by offering something in return (as in, a favour for a favour, or *quid pro quo*). For example, to encourage her to get up, the carers would say that if she did not get up, she would be too late for her coffee morning. This calm way produced results, but it did take a long time before normality was established. Sometimes it did not work, and my aunt would refuse; we would let the situation be, in order to maintain a good relationship. Harmony was maintained throughout.

Conclusion

It is my contention that the gap in relevant literature is a deficit and should be addressed, so that other families can be helped to enable their relative to re-establish their life on discharge. Caregivers would be aware of how firm or gentle they needed to be when using persuasion.

My aunt went on to live to over 100 years of age, attending her activities until her final months. She had a happy and long life which she said was due to her upbring as a child of a farming family, to marrying a farmer, and to belonging to a large family.

My aunt died following a stoke. After her admission, her care was excellent, made so because the Consultant, who discussed my aunt's future in realistic terms; we were allowed to let her die with dignity once we knew that she would not recover.

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