

Where is the Research Enabling Families to Understand What Happens to Their Elderly Relatives Returning Home on Discharge from Hospital after a Short Stay? A Reflective Account

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Abstract

This a reflective account of the impact of three days in hospital on my Aunt. She had slipped/fallen getting up. Once hospitalised it would appear due to her age of 99 she would be classified as a frail elderly person which she was not, she lived at home, on her own and with a little bit of extra help and managed successfully. Returning from hospital made her dependent and it took a while to her to regain her normal life style. During this period I searched to see if there was any articles Or research which could help us solve the situation as we were aware she did not want ever to go into care. There were many papers about the physical needed on returning home but not how to overcome the mental challenges. This was an unexpected finding since the number of people being discharged in a day at an equivalent age must run into the hundreds. Is research in this area not able to be considered as most people do not go home? Whatever theory explains this phenomena it is easy to see that older patients appear to be planted by their bedside a bit like a nursery with no ordinary interaction so it is not difficult to see why such a problem occurs. If there was some answers would help the person's relatives to know what they are doing is right or wrong. Nobody wish to do harm but how persuasive can the carers become? Our solution was to offer something she liked if she would do what we asked, it worked, but were we treating my Aunt as a child?. However in April Professor Stephen Powis and the work proposed by Michelle Johnson may begin a new strategy for the older person hospital care.

Introduction

This paper will use reflection as described by Burns and Bulman (2000, p.5) "Reflection on action is the retrospective contemplation of practice in order 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." There 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.

My Aunt slipped on her bedroom floor in August as she will walk around in her socks. My sister and I arrived in a short time after she fell, because we could not lift her up we had to call an ambulance. We did not expect to wait 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 not a child which some doctors do. 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 admit just after three in the afternoon she was not warded until two in the morning. During the next three days she was checked over and was allowed home. However, that was the first problem, as she told the medical staff she did not want to go,

when we arrived she was ready to go home, so was this a mistake or did she feel more secure in hospital? Before discharge I spoke to the registrar who was different from the one we met originally and asked if there was anything we need to do and was she going home on the medication, since they had started her on new medication. He said yes but if she forgets to take do not worry. So that I felt was an interesting attitude to take with relatives. We were told during the next two weeks her General Practitioner and the Community nurse would visit. Because this was a short stay we presumed she would resume her normal life style

Preparation

Her bed was moved downstairs as she has the other facilities there. She is well known in the village as she has lived there since 1948, now being the oldest resident having reached 100 in November. She is still active going to club or whist on Tuesday, knit and nattering on a Wednesday, coffee on Thursday and hairdresser and bowls on a Friday and once a month there is a film night and a luncheon. For these activities people from the various clubs fetch and bring her back. In February she won the whist.

Two ladies from the Village who help her through each day by seeing she is up, her lunch arrives and getting her tea are already known to my Aunt so there was no stranger coming to upset her regime. She has lived on her own since her husband died in 1987 so that aspect does not worry her nor the fact that her house is on its own as there are houses above and below on the road. The family do the rest.

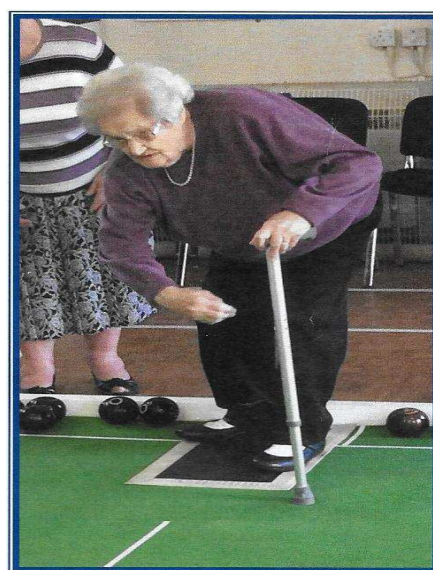
Initial Problems

Our problems started immediately she wanted to know where her maid was, as she could do nothing without her maid. If it was not such a problem one could smile. Since there was no maid 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 a walking stick that they had given to her to ensure stability. No she was not going to use the frame as she said it hurt her we did try but 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 at her return visit from the Locum Consultant she had broken two ribs it was easy then 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 infection as her count was four times the normal range, this was one result I felt was incorrect as she did not appear to have any infections no urinary tract infection which is common in elderly due to dehydration.

Over the next 8 weeks

The helpers had a difficult first week! However knowing her before they hoped this was 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 abilities. So by the end of this period she was dressing herself and getting her breakfast washing up was still a bit of hit and miss. She began to make her bed and be interested in her clubs.

My Auntie at 100 and playing bowls.



Where to start?

The reason for this paper was to find out if there were any articles or research undertaken that would have helped us understand this phenomenon and how should we approach enabling my Auntie to resume the life she had been used too. This difficulty must be happening daily in millions of homes. Were there ways in which we could have helped my Aunt return to her previous understanding of her life after all she was *only* in hospital three days.

My initial step was to review the current literature and work up what and how we could have managed her care more successfully. There were more than 183 articles and research papers written since 2003 to 2018. They mainly covered transfer home after surgery or short stays. Although interesting the pitch of the papers were on making the environment safe, added the necessary structures such as rails and raised seats. There was mention on psychological need and highlight occasional was the person's spiritual needs. Nothing offered to the family in the way of advice.

How should I classify my Aunt's condition over the first 8 weeks.

With no published research on the subject and plenty of time to observe her progress, what should I look at first to see if her state could be defined. Should I look at dependency, conditioning or learned helplessness and how my Aunt viewed her locus of control?

Dependency

What would I find in considering the theories of dependency what would it offer me in the way of practical help? Dependency can be defined as a tendency of an individual or individuals to rely on others for advice, guidance or support. So, should we consider hospitalisation among the older person leads to a dependency situation, because they are always being told what they can do and when it can be done. This appears to cover the first two characteristics of the accepted definition of dependency in that the person finds it difficult to make every day decisions once they leave hospital as they have lost the control of their life during their stay.

They are told when they can wash rather than asked if they would like to go now or later. It was easy to observe lack of involvement it appeared they take so long in choosing their menu for the following day so the staff suggest that they would like x or y, as it is considered too time-consuming to leave a pencil with the person, which meant that my Aunt did not eat many of the meals as she does not like gravy or custard. Likewise, they are told do not get moved out of

bed or out the chair without ringing for the nurse/healthcare assistant. The ward life gave a visitor the impression that they were up and planted by their bed like flowers in a nursery until the next interaction with nothing to do until the next interaction. Once you get to nearly a 100 they staff tend to consider the person frail elderly and not capable. The second feature described is a need for other people to assume responsibility of deciding what they should do. This last area acquaints with everyday life in hospital due to the possibly the staff being busy and the person seeing their situation as having changed their life so challenging the things they would normally do which would mean they could see even small tasks presenting themselves an insurmountable problem.

However, the staff do not appear to find out about the person and what sort of life they lived or are living, it is all too easy to stereotype their patients perhaps this is a fault of education as we tend to build up a type of persona for the elderly. However, if you are working 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 downgrade in relation to the need to ensure patient's safety. I was told 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 the managers. So, is there no half way?

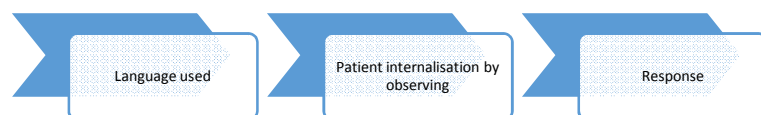
It was interesting whilst visit my Aunt in hospital you were able to observe the practices of the staff. I was to notice that one of the young health care workers used to tell her patients she was her maid and was to be asked or called before they did anything. This sorted out where the phrase had come from as we knew she did not have a maid growing up and lived on a farm where everybody had a job to do and in her teenage years she was responsible for taking the milk round the village using a horse and cart and villagers would come out with their jugs. A worker's life, not leisure. Whilst on the ward they were told they could not do anything without ring the bell and they would come. That was understandable since staff would not want to risk more fall, but why did it take so long for her to regain her normal style life. Equally why did they not find out how capable my Aunt was, it would appear knowing she was 99 they consider she had lost her faculties. So continually addresses her as if 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.

Repeative conditoning

Next I looked a conditioning as repeative conditioning because the words the staff used they used 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. Repeative conditioning is derived from social leaning theory which combines both a person 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. This would be possible absorbed easily by my Aunt as she would have no problem since she is a master at the card game whist and used in her eariler days to play brdge and was either the winner or very near to it. Now she plays whist so well she would win too often that they now announce the second person will be the winner. So it could be considered that what had happened in this brief period of time could be put down to conditioning.

It would fit with the understanding of the behaviourist's who look at the way reflect observation and the enviornment play on ones mind. We can say from the research undertaken by behaviourist who looked at the work of Pavlova, Skinner and Watson(McLeod, 2007, Oliver & Ellerby-Jones 2008) consider the most import aspect of their principles is

observable behaviour rather than any stress on the internalisation of thinking. So constant stimulus should enlist a behavioural response which is desired. Would it be correct to say that observations result in consequence leading to a simple response feature? So, are we going down the path of conditioning? Could it happen in such a short period? Could it be said that elderly care staff use conditioning to gain the result they want, because it could lead to safety care environment. Does the use of their repetitive language achieve the elderly person responding in the way wish? So is it as simple as the diagram would suggest.



So, after hearing the same phrase many times in a day spoken not only directed to the person but heard by all the persons in the ward. My Aunt's ward had six beds, so you could we guess how often she would have heard it. On one afternoon while visiting my Aunt, I found no difficulty in listening to staff communications as they speak quite loudly so in the space of thirty minutes I had heard the phrase being said to one person or another "Must use your bell if you want help: not get out of your chair you may fall" over twenty times. How long would it take before the person who was 'normally able' to understand they must not do anything before asking. However for it to be useful and used there would need to be a cognitive element so if action were to occur some sort of cognitive function will have to had taken place. I recognise the importance attached played by the environment and reinforcement in the learning process however this must depend on the cognitive process of the person.

My concern was in listening to the conversations 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? No papers which is normal as it is not expected that people read papers nowadays. However, my Aunt read the Telegraph every day she listens to the news and Sport as she was an Arsnell fan, she mixed with younger people on all her outings. One of the careers would bring her grandchild of 2 and this interaction she enjoyed. In her club she so kept up with the gossip that is rive in a village. Although they classified her very old she still had an intellect. Unfortunately there was no stimulus for her in her three day stay, but she was quickly reduced to a sick roll to the fact when she was asked what she would like for the evening meal while she was thinking the person said I know you would like x and y, only I knew she would not eat y as she hates custard and this was to be apple crumble with custard. It also answered a question for me as it would appear she did not eat many meals as she dislikes any food with a sauce or gravy and was asking what we had bought her to eat. At each visit my Aunt was still wearing a hospital gown not her nightie, the staffed helped or dressed her in the morning without asking which night 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 a learned helplessness could this be possible occur in three days. How is learned helplessness categorised Seligman in 1967 (Oliver & Ellerby-Jones 2008) who was an American psychologist referred to it when he was looking at the responses of animals as a way of achieving a response to a specific action. Latter 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 true of my Aunt even at her age she likes to think she is in charge whereas it must have been a shock to find herself being 'done to'. My Aunt had usually the locus of control and now it was reversed as she would perceive it.

Johnson et al. (2004) cite the work compiled by Gatz and Karel in which they imply the up until middle age the locus of control is with the person after this period the locus of control decreases until the control in later life becomes more external these findings are supported by Schultz and Schultz (2005). So, is it the locus of control that differs or is it our self-esteem? I do not think for my Aunt it is self-esteem as she will speak her mind, whereas she felt 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 she did not need their care!

How did we resolve our dilemma?

The approach we used was to gently persuade her by offering something in return. For example, to encourage my Aunt to get up the careers would say 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 she would refuse, and we let her be as to harass would not be something we would want to do as it was important to maintain a good relationship with the careers and the family. On reflection it was a slow way, but harmony was maintained throughout.

While I have been writing this paper, I read the interview by Professor Stephen Powis NHS's medical director said pensioners stuck in hospital can age a decade in ten days. He said 'trapping' vulnerable patients in unsuitable settings has a debilitating effect on long-term mobility and muscle mass. He called for drastic health reforms. Professor Stephen Powis said the biggest task facing the health service was to prevent unnecessary stays in hospital for pensioners by building community services. He has called for reforms and wants to prevent unnecessary stays in hospitals. (By Daily Mail Reporter. Published: 21:02 EDT, 10 April 2018 | Updated: 01:59 EDT, 11 April 2018). At last people are looking at care in the Times (21-4-18) Michelle Johnson the Chief nurse at the Whittington Hospital in London told the Camden News Journal 18 April 2018 — By Tom Foot). "It isn't normal for people to spend all day in pyjamas at home why should they do this in hospital? Getting dressed makes it more likely that our patients will get out of bed and move around, meaning that will regain strength and go home sooner. Studies suggest that three in five older patients do not need to be in bed all day and that doubling their walking can make their stay shorter. The Royal College of Nursing supports this drive". At last there is some movement in one out of our UK. Trusts.

This research paper looked at patient improvement. "One way to improve patients' experience would be to encourage them to wear their own clothing, Krummholz and his colleague Dr. Allan Detsky, of the University of Toronto, suggested in a recent commentary published in JAMA in June. "This would help patients maintain their self-esteem and orientation and remind their care professionals to recognize them as people," the doctors wrote (<https://www.livescience.com/47947-hospital-patients-should-wear-own-cloths.html>).

Conclusion

Having read the interview Professor Stephen Powis and the work proposed by Michelle Johnson this should begin a new strategy for the older person hospital care. On his reckoning my Aunt should be considered as 103 I am not sure she would appreciate it. The gap in literature is a major deficit and now needs to be addressed, so that other families like mine can be helped to enable their relative on discharge to re-establish their life. So, they would be aware of how firm or gentle they need to be when using persuasion. Hopefully this situation will be resolved in the next five years.

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Appendix 1

Stephen Powis:

As the NHS approaches its 70th birthday, cracks must be fixed rather than simply papered over

- The Daily Telegraph
- 11 Apr 2018
- STEPHEN POWIS



The creation of the NHS 70 years ago was one of the greatest social advances of the last century. For the first time in our history, it replaced public fears about the affordability of healthcare with a service based on equity. Theresa May, the Prime Minister, was right to commit to increased long-term funding.

The NHS'S biggest task this century must be to adapt to profound shifts in patterns of ill health. When founded in 1948, it was principally dealing with working-age populations requiring one-off treatments. Today, people are living 10 years longer on average. There are half a million more-people aged over 75 than in 2010 – and there will be two million more in 10 years' time. They are also spending more years in ill health. Between 2015 and 2035, the number of older people with four or more diseases will double and a third of these will have mental ill health.

Incurable long-term conditions now account for half of all GP appointments, almost two thirds of outpatient appointments, and seven out of 10 inpatient bed days. Tackling multiple and long-term conditions is overwhelmingly the main business of the NHS, not the exception.

In response, we need a system that supports an individual's complete needs, rather than treating each body part, illness, or care problem in isolation. As we each seek to prevent, cure and manage illness, we need support from professionals who act as one team and work for organisations that behave as one system.

This has been made difficult by historic administrative and cultural fractures. Opportunities to limit ill health are missed, patients get pushed from pillar to post, staff are frustrated when trying to “do the right thing”, hospitals pick up the pieces – and pressures build. Those pressures, which loomed particularly large this winter, are symptomatic not only of constrained funding but also of a system designed for a different era.

As the NHS'S 70th anniversary approaches, it is time to fix the cracks rather than paper over them. The good news is that it is starting to happen.

Over the next few weeks, the first parts of the country formally begin to work as integrated care systems, as England makes the biggest national move to integrate care of any major Western country. They are comprised of all local health and care organisations – including local government with social care – working in partnership and pooling resources, and their task is to show how to build the care systems that can better serve the needs of the public.

In the Frimley system, in Surrey, joined-up care is well under way. Single multi-disciplinary care teams – GPs, nurses, mental health, social care, therapists – are being created to help people avoid crises and stem rising emergency hospital admissions for the first time in years. They ensure that all care is delivered smoothly, and that people tell their story once.

Where people do arrive at A&E, doctors there get help to find solutions that prevent unnecessary hospital stays. If admitted, care teams work proactively to help people get home

and avoid them getting trapped: a person over 80 who spends 10 days in hospital loses 10 per cent of muscle mass, equivalent to 10 years of ageing. Not only is this better for patients, but hospital staff have said they have “more time to care” and their jobs feel less stressful and more rewarding.

The NHS of the future also needs to be proactive on prevention and empowering rather than paternalistic in helping people look after themselves. For example, by joining forces with local government to keep houses warm, safe and dry, the NHS can reduce lung and heart disease, saving £70 for every £1 spent.

In Wakefield, mental health navigators now take referrals from housing associations, so they can identify problems early, helping to reduce ill health and prevent homelessness. If you have a lifelong condition you are an expert needing support, not a passive recipient of care. In Dorset 1,000 patients with diabetes, lung disease and heart disease have had free phone apps to help them manage their own health.

Initiatives such as these are breaking out across the country. The innovations that will help to tackle the issues facing the health and care system will be found on the front line. We need to nurture them, bottle the best ones, and spread them to create the NHS of the future.

Professor Stephen Powis is NHS England National Medical Director