In many Western countries including Sweden, length of stay in hospitals has decreased during the past years, leaving patients in poorer health at discharge as compared to if they had received longer hospital stays.1–5 At the same time, the number of beds in institutional care has decreased, resulting in a higher number of older people living in ordinary housing and receiving home help services and home health care.6 Old people receiving home health care are often frail and susceptible to diseases. Hence, these individuals should only be transferred to hospitals when necessary as the hospital setting may pose a risk of being exposed to nosocomial infections.7

Still, hospitalizations are rather common among older people receiving home health care, despite frequent contacts with outpatient care, physicians in primary care and specialized medical care.8 For example, in the United States (U.S.), almost one third of people receiving home health care become hospitalized over the course of one year9 and in Sweden more than half of the people receiving home health care are hospitalized over the course of a year.8

Although frequent hospitalizations and readmissions have received increased attention in the literature recently, little is known about older people’s experiences and perceptions of decision to seek hospital care. Quantitative studies have focused on factors related to the hospital setting10–12 as well as on risk factors related to measurable patient characteristics and health outcomes to reduce avoidable hospitalization and rehospitalization.13,14 It has been shown that the risk for hospitalization among home health care patients increases with decreased functional ability,14 lacking informal care, and incidence of chronic conditions as congestive heart failures (CHF), respiratory problems, wound problems and diabetes.15 However, reasons for seeking hospital care seem to be more complex than can be captured by quantitative data. By using qualitative study design it is possible to gain an inside perspective and obtain aspects like the patient’s own perceptions, both individual and collective, and the consequences of a hospital stay.16

The extant research on hospitalization decisions among home health care patients is scarce. Prior research has found that older people tend to experience health care transitions as difficult, and the decision to seek hospital care is often made hastily because of acute illness.16 Further, the majority of community dwelling older persons as well as home health care patient seem to prefer treatment at the hospital as compared to treatment at home.17,18

The purpose of this study was to explore how older people experience and perceive decisions to seek hospital care while receiving home health care. Twenty-two Swedish older persons were interviewed about their experiences of decision to seek hospital while receiving home health care. The interviews were analyzed using qualitative content analysis. The findings consist of one interpretative theme describing an overall confidence in hospital staff to deliver both medical and psychosocial health care, In Hospital We Trust, with three underlying categories: Superior Health Care, People’s Worries, and Biomedical Needs. Findings indicate a need for establishing confidence and ensuring sufficient qualifications, both medical and psychological, in home health care staff to meet the needs of older people. Understanding older peoples’ arguments for seeking hospital care may have implications for how home care staff address individuals’ perceived needs. Fulfillment of perceived health needs may reduce avoidable hospitalizations and consequently improve quality of life.
Another study including older people receiving home health care due to CHF or chronic obstructive pulmonary disease, found that these older adults viewed home care as a service with limited health care resources, not capable of treating acute illnesses.19

Knowledge about older people’s own decisions of seeking hospital care can form a substantial knowledge base in understanding health utilization patterns among the elderly. Therefore, the purpose of this study was to explore how older people with a variety of health problems experience and perceive decision to seek hospital care while receiving home health care.

Methods

Design and participants

A qualitative interview study was conducted in southern Sweden. Participants were recruited from eleven municipalities in a county with one county hospital and two local hospitals. The inclusion criteria were: adults aged 65 years or older; receiving home health care for a minimum of 6 months; and being hospitalized while receiving home health care. A need assessor in charge of each municipality identified participants. The need assessors mailed written information letters to prospective participants about the purpose of the study. After a week or two, the need assessors contacted prospective participants by phone and asked if they wanted to participate in the study. The need assessors gave the first author’s name and telephone number to the 24 people who were interested in participation. The first author contacted these people by phone and gave them detailed information about the study.

Twenty-two persons agreed to participate in the study. Written informed consent was obtained at the interview sessions from all participants. Fifteen of the participants were women (7 men), and their ages ranged from 66 to 93 years (median 84.0). Fourteen participants lived in urban areas and six in rural areas. Fifteen participants lived alone and seven lived with a partner. The participants received a wide variety of home health care. Some received help with medication or dressing of wounds, whereas others had advanced home health care with intravenous infusion treatments.

Procedure

The interviews were conducted in the participants’ homes by the first author over a period of 8 months. The interviews lasted between 25 and 80 min (median 50 min) and were recorded and transcribed verbatim by the first author. Participants were asked to reflect upon their decision to seek hospital care. The interview opened with the question: “Could you tell me about your experiences of hospitalization while having home health care?” Follow-up questions depended on the nature of the participants’ stories.

Data analysis

Transcribed data were subjected to content analysis, which can be used to systematically analyze written or verbal communication, such as gathered by interviews.20 The analysis was performed in several steps, according to Graneheim and Lundman.21 First, each transcribed interview as a whole was read several times by the first author to understand the meaning and to capture the essential message. Second, the first author identified and marked text that was relevant to the study objectives. These text sections were further divided into meaning units, each consisting of one or more continuous sentences. Third, the meaning units were condensed and labeled with codes (Table 1). Fourth, the codes (41 in total) were sorted into categories through a back-and-forth process among all co-authors until agreement was reached. Fifth, all authors identified in agreement an interpretative and solid theme that captured the latent underlying meaning of the content.

Trustworthiness of the study was established using the framework developed by Lincoln and Guba (1985).22 To establish credibility, two of the authors [JH, IJ] independently coded three of the transcripts, and further compared the codes according to differences and similarities until agreement was reached. Further, dependability of the study was enhanced because three of the authors have several years of professional experience in home health care and hospital care.

The final analyses were presented and discussed with other researchers with expertise in qualitative research to strengthen confirmability. The analysis was conducted in Swedish and translated into English after it was completed, according to recommendations.23

Ethical considerations

This study was conducted in accordance with the Declaration of Helsinki, and was approved by the Regional Research Ethics Board in Linköping, Sweden (dnr 2012-22-31). Participants were informed that their participation was voluntary and could be withdrawn at any time and without any negative repercussions. All material was treated as confidential, and only the first author knew participants’ personal data.

Results

The findings consist of one theme with three underlying categories. The theme In Hospital We Trust points out an overall confidence in hospital staff to deliver both medical and psychosocial health care. Three categories describe this in more detail: Superior Health Care, which concerned health care quality; People’s Worries, which deals with, for example, feelings related to insecurity; and Biomedical Needs, which concerned specific health conditions. The categories were divided in seven subcategories. Representative quotes were selected to illustrate the views of the participant in each subcategory.

Superior Health Care

The category Superior Health Care consists of three subcategories. Health care availability involved experiences and perceptions of differences in health care availability at the hospital and in the participants’ homes. Staff competence included participants’ comparisons of staff competency at the hospital with that of the home health care. Quality of care described participants’ perceptions of the kind and quality of health care that could be delivered by home health care and at hospitals.

Health care availability

Access to health care seemed to be important regarding the decision to seek hospital care. Participants felt that entering a hospital was easy, by either seeking care at the emergency room or alerting an ambulance. Home health care, in contrast, was perceived as being less available. For instance, home health care was not available 24 h a day and not for acute needs. Participants discussed the availability of home health care by talking about the difference in staffing between day and evening shifts. With fewer staff in the evening and at night, it becomes more difficult to get help when needed.

Another explanation offered by participants was that registered nurses often delivered home health care in large areas with high patient loads, especially in the evenings and on weekends. When
Participants talked about feelings of insecurity in their home situation and that the hospital environment felt more secure. One participant described:

If I am at the hospital and have a wound dressing, they will come with their little table that is stainless and everything is perfect and the nurse puts on her gloves, though the home health care does that too. But … it’s so much more sterile [at the hospital]. Because here [in my home] there are of course lots of germs in the kitchen, or in the bedroom. So I think that it is very bad. That they handle it that way—I’m not a nurse and I’m not a doctor but I understand that it’s not really good.

**People’s Worries**

This category involves the worry of being at home when one is ill, including having feelings of insecurity and dealing with the fact that others might worry for a participant’s own wellbeing. **Other worries** were not experienced by the participants themselves. Participants expressed that they felt their relatives and the home help staff were worried and that these people influenced the decision to seek hospital care. **Insecurity at home** involved the participants’ experiences and perceptions of receiving health care at home and of the their own feelings of being at home when one is ill—factors which all affected the propensity to seek hospital care.

**Others’ worry**

Participants spoke of events when the registered nurses in the home health care staff delegated duties to the nurse assistant in the home help services. This was mostly a normal procedure, but when something extraordinary occurred the home help staff worried about being responsible for the patient. For example, one day when one of the participants could not move his or her leg, the home help staff member said, “No, I do not dare to be responsible for you anymore.” On such occasions the staff made the decision of seeking hospital care because of their own worries.

Participants expressed that they perceived the staff to not feel confident enough to be responsible for the patient at home, and therefore decided to send them to the hospital as a way of handling extraordinary situations.

On other occasions, relatives found home health care to be insufficient and felt worried about their loved ones being alone at home. This was especially true in situations where a wound seemed to be infected and the wound dressing no longer helped. One participant described:

I cried at times and I was just, it aches so that I ooh. And this smell, and the girl [the daughter] … she came sometimes, and “ooh” she said, so it smelled. Then my daughter-in-law who lives nearby said “now you are going in to the hospital. You cannot bet left at home with this anymore.” So she drove me.

**Insecurity at home**

Participants talked about feelings of insecurity in their home situation and that the hospital environment felt more secure. One
infections. One participant described how a serious condition led to hospital care. Such needs involved heart attack, stroke, or severe complications. These complications often resulted in severe wounds and/or fractures. How such fall accidents may appear is described:

Yes, there was a stop so I could not pee ... so it was ... so blasted throughout the body so it was as pretty close to death as one could be. They [the staff] never thought that I was going through it.

When speaking about hospitalizations because of biomedical needs the focus of the stories was not of the decision to seek hospital care or the hospital environment, but rather the conditions that required inpatient care. The planned treatments were not decided by the participants or their relatives but rather by the hospital staff and sometimes arranged in collaboration with the home health care staff.

And then of course I am in contact with the hospital because I've been hospitalized a couple of times, because of this with the blood cells. So they take samples and then send in how much cortisone I should have and stuff. But now I had to go to a specialist, and then he said that it did not help now, so now let's see what this [cortisone treatment] does.

Discussion

The purpose of this study was to explore how older people experience and perceive decision to seek hospital care while receiving home health care. The findings reveal a trust in hospitals by older people using home health care, regardless of whether the type of problem concerned biomedical or psychosocial aspects of their care. The trust in hospitals seems to be associated with hospitals’ high availability, more competent staff, and better quality of care compared with home health care.

Participants described hospital care as the only level of care to seek when affected by severe conditions. This could be one explanation for the finding that older people's worries and feelings of insecurity seemed to play an important role in their considerations to seek hospital care. The view of hospital care as superior to home health care was shared by participants’ relatives as well as by the home health care staff themselves, according to the participants. The findings is consistent with previous research showing that home health care patients prefer to be treated at the hospital instead of at home, mainly because of a sense of greater safety at the hospital.17

It was illuminated in this study that worries, in terms of insecurity at home while waiting for home health care staff to arrive, influenced the participants’ decisions to seek hospital care. This might have to do with the home situation in general, but also to perceptions of that registered nurses come too seldom. Constant presence of staff to help with tasks has been shown to be a major reason for the decision to choose hospital care instead of home health care even if the home care can offer equivalent therapies.17

Several studies have focused on reducing home health care patients’ hospitalization and readmissions through intervention programs including prediction models of hospitalization, follow up phone calls by pharmacist and frontloading of skilled nursing visits24–27 with more or less successful results. Older persons’ own experiences and perceptions of decision to seek hospital care should also be taken into account when developing interventions aiming at reducing hospitalization.

The findings indicate that the competence levels of hospital staff are perceived to be more highly valued than that of home health care staff. This is similar with findings from a U.S. study showing that home health care patients think of home health care to only consist of low-intensity services with limited resources.17 Another study has shown that home health care patients emphasize that the staff competence, both practical and social, is an important contributor to good care.28 However, registered nurses in municipal elderly care prioritize specialty care and drug administration, but give less attention to care interventions and informing patients about their treatment.29 It is possible that older people's psycho-social worries could be taken care of at home if nurses allocated time to inform the patients and build trust through dialog.

The lack of trust in the competence levels of home health care staff could also be a result of the Swedish home health care organization. The main portion of the overall nursing time in elderly

Biomedical Needs

Participants spoke of how biomedical needs mattered for seeking hospital care, such as for serious conditions or planned treatment. These were illness-related events participants considered to be most appropriately dealt with at the hospital. When spoken about decision to seek hospital care in terms of biomedical needs, the condition itself was the focus.

Serious conditions

Some of the biomedical needs participants described were serious conditions, which the participants felt ought to be handled in hospitals. Such needs involved heart attack, stroke, or severe infections. One participant described how a serious condition led to significant consequences:

I believe my hospitalization could have been avoided, I'm sure of it by the way. Yeah ... I'm sure. And they told me all the time at the hospital, "You have to eat so that the leg heals. You have to eat so the leg heals." It is so important what you eat. But at home I threw food away every day.

Planned treatment

Participants also spoke about biomedical needs in terms of planned, specific treatments carried out occasionally or in a treatment series. These planned treatments were often initiated by the hospital and could involve testing or adjusting new drugs, dosage adjustments, or cancer treatments. Hospitalizations caused by planned treatments were described by the participants as severe conditions that required inpatient care. The planned treatments were not decided by the participants or their relatives but rather by the hospital staff and sometimes arranged in collaboration with the home health care staff.

And then of course I am in contact with the hospital because I've been hospitalized a couple of times, because of this with the blood cells. So they take samples and then send in how much cortisone I should have and stuff. But now I had to go to a specialist, and then he said that it did not help now, so now let's see what this [cortisone treatment] does.
care in Sweden is not performed by registered nurses, but delegated to other health care professionals. It is estimated that about 60% of the tasks are delegated mainly to assistant nurses, and the registered nurses perform about 40% of the tasks. In the U.S., registered nurses comprise about 55% of the health care staff. Since the Swedish home health care is highly dependent on delegations to different health care professions, the home health care organizations need to develop and secure transfer of knowledge and information. This is particularly important as it has been suggested that home health care nurses in U.S. have the competence to identify patients with higher risk of readmission.

According to the participants in the present study, good health care involves quality as well as availability of health care. These results indicate that the participants had perceptions about what health care quality they wanted for one self. Further, this indicates that a patient’s and his or her relative’s own capacity for decision making should not be underestimated. Instead, the findings open up for a dialog about what services and care that home health care can provide. In line with our findings, earlier research has shown that one third of readmitted patients made their decision to seek hospital care without prior medical input. If the accessibility to nurses were higher in home health care, patients may have greater opportunity to make their decisions to seek hospital or to be continued to be treated in the home, in consultation with nurses. Such dialog would support care at right level.

The participants in this study reported that it was easier to go to the hospital than to contact home health care staff, and home health care staff themselves have reported experience difficulties when being forced to prioritize different patients’ needs and expectations. This is especially true during nights with fewer personnel. It is important to provide information to patients regarding when and how to reach home health care staff, as well as what type of services home health care can provide.

The decisions to seek hospital care were sometimes initiated by the participants’ relatives. This family influence in hospitalization decisions can be confirmed by a recent study. Although, it has been found that older persons who preferred to be treated at home instead of the hospital found greater comfort at home and presence of family to be important factors for this decision. Involvement and collaboration with relatives should be encouraged to better support older people in need of social, psychological, or medical care.

Participants’ reasoning about the importance of biomedical needs in their decision to seek hospital care seems to be less problematic. Most severe conditions must be dealt with in the hospital setting, whereas some less severe conditions could be cared for by home health care staff. The trend during the last 10 years has shifted towards readmitted home health care patients being older, sicker, and having more complex needs. With regards to lowering hospitalization rates, the competence levels and availability to the home health care staff need to meet both new professional demands and the expectations of older people.

Limitations

This study is limited to the participants’ experiences and perceptions about their decisions to seek hospital care. It would have been valuable to combine these stories with details of their specific hospital admissions and whether those were considered as necessary or avoidable, although this was beyond the scope of the study.

A limitation of our study is the lack of knowledge about the number of people received the information letter and the characteristics of those people, since the need assessors gave the first author names and telephone number only to those interested in participation. Although, transferability was taken into account by carefully considering the selection of participants through the inclusion criteria which included both genders, a wide age range and from both urban and rural areas.

Further, the participants reported a wide variety of both somatic and psychological symptoms as well as many different aspects of the care they received. Given that we captured many different aspects, the results can probably be transferred to other elderly with home health care. The wide geographical area and the age range among the participants contribute to the transferability to similar Swedish contexts.

Conclusion

The study concludes that home health care patients, their relatives and home health care staff, according to the participants, share a trust in hospital care. This suggest a need for establishing confidence in home care staff, thus ensuring that home health care staff possess sufficient qualifications, both medical and psychological, to meet the needs of older people. In order to reduce avoidable hospitalizations, we recommend organizational efforts to improve availability to the home health care, and to ensure that every patient know where and how to reach their home health care in order to feel safe at home. Knowledge of what skills and resources to expect from the home health care should also be clearly relayed to both patients as well as their relatives. The clinical implications from our findings suggest that health care staff should consider older peoples own perceptions, arguments and ability to seek hospital care and incorporate into implementation programs targeting reducing unnecessary hospitalization. How knowledge of home health care patients arguments for seeking hospital care could guide nurses in implementation programs need to be further studied.

References


