UNIVERSITY OF SOUTHAMPTON

FACULTY OF MEDICINE, HEALTH AND BIOLOGICAL SCIENCES

School of Nursing and Midwifery

An exploration of the factors influencing emergency admission to hospital, and the impact of these factors on the delivery of care and the patient's hospital experience

by

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Corrections sheet

Amendments to text:

Bullet point lists x 2

Pages 37 - 38 - summary of main points arising from the literature review

Pages 159 - summary of key recommendations for practice

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ABSTRACT

FACULTY OF MEDICINE, HEALTH AND BIOLOGICAL SCIENCES

Doctor of Philosophy

AN EXPLORATION OF THE FACTORS INFLUENCING EMERGENCY ADMISSION TO HOSPITAL, AND THE IMPACT OF THESE FACTORS ON THE DELIVERY OF CARE AND THE PATIENT'S HOSPITAL EXPERIENCE

By Jennifer Leigh Beattie

Rising emergency admissions rates are a recognised problem within the NHS and lead to pressure on acute medical beds. Many well researched factors have been shown to add to this rise, and include decreasing numbers of acute beds, inappropriate acute admissions, increasing numbers of frail elderly patients and limited access to acute care alternatives. Despite the research into each of these areas, the problems with acute bed crises remain. It was proposed then, that there were other less well researched factors that also influenced the patient's emergency admission to hospital. This study was designed to explore these latter influences in greater detail from the unique perspective of the patient.

A case study approach was used. Eight patients (who were admitted to the accident and emergency department of a large acute hospital) were recruited into the study over the course of one year. Data were collected using three data collection methods: interviews with patients and health professionals; observations of ward rounds and nurse handovers; and documentary analysis of nursing and medical notes. The data collection period for each case ranged from between 24 hours to three weeks. Results from the study demonstrated that there are many less well defined factors that influence emergency admission to hospital and delivery of care. These factors fell into one of three categories: individual patient characteristics and needs, delivery of care issues and the context and politics of care delivery.

It can be concluded that, the needs of patients with chronic conditions and /or symptoms are not being addressed in a timely fashion. This is due in part, to the poor responsiveness of healthcare services in the community and the patient's lack of awareness of these services. Care within hospital is still delivered in a routine and ritualistic fashion with little regard given to the patient's individual requirements and knowledge of their condition. Health professional decision-making is influenced as much by their own perceptions, experience, uncertainty and access to diagnostic tests as the patient's clinical signs. There is currently no single person responsible for keeping the process of care moving within the hospital, with the result that care stalls and patients are detained in hospital longer than necessary. In addition, capacity and resource issues within the hospital are not clearly understood and finally, there is a wide gulf between the patient's hospital experiences and perspectives and current healthcare policy. This indicates that policy is not being translated effectively into practice.

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Key to Codes

A number of codes have been used throughout the chapters of this thesis. These codes relate to specific data sources; interviews, observations and documentary analysis. The following is a guide to these codes.

Study Codes

There were eight patient cases in this study, each had a name. However, each also had a number which helped to identify specific cases and specific data sources within each case.

Susan -	Case 4	**Lillian** -	Case 5
Mark -	Case 6	**Betty** -	Case 7
Gail -	Case 8	**Nigel** -	Case 9
Norman -	Case 10	**Vera** -	Case 11

For example, each interview, observation or documentary analysis has an identifiable code:

4/PInt/ad

Refers to Case **4** (Susan). **PInt** -patient interview. **ad** - admission day.

7/Obs/d2

Refers to Case **7** (Betty). **Obs** - observation period. **d2** - day two

Other codes used:

HPInt -	Health professional interview
Doc -	Documentary analysis
G/HPInt/Obs -	General health professional interview or observation not related to a specific case
HPInt/0706/2006/ 2406/1309/1610 -	all refer to interviews with senior health professional managers.

A further breakdown of the data sources can be found in **Table 3.2**

List of Abbreviations

A number of common abbreviations were used throughout this thesis. A list of these abbreviations and their definitions are detailed below.

Abbreviation	Definition
A&E	Accident and Emergency
AEP	Appropriateness Evaluation Protocol
CDU	Clinical Decision Unit
COAD	Chronic Obstructive Airway Disease
COPD	Chronic Obstructive Pulmonary Disease
DVT	Deep Vein Thrombosis
ECG	Electrocardiogram
Echo	Echocardiogram
EEG	Electroencephalogram
EEAU	Elderly Emergency Admissions Unit
EMAU	Emergency Medical Admissions Unit
GP	General Practitioner
ISD-A	Intensive Severity Discharge - Adult
ITU	Intensive Care/Therapy Unit
MAU	Medical Admissions Unit
MCAP	Managed Care Appropriateness Protocol
MI	Myocardial Infarction
NHS	National Health Service
OT	Occupational Therapy
PCT	Primary Care Trust
PE	Pulmonary Emboli
Physio	Physiotherapist
PMH	Past Medical History
SOB	Shortness of Breath
SHO	Senior House Officer

Chapter One - Introduction

1.1 Introduction

I was first introduced to the idea of conducting this research study following the publication of the National Beds Inquiry (Department of Health 2000b). There were certainly concerns raised within this report relating to the availability of beds in UK National Health Service (NHS) hospitals, and the rising number of elderly emergency admissions. Various strategies were proposed, although, it became clear that there was considerable uncertainty regarding the projected number of beds needed for the future, and the possible impact of new approaches and techniques on bed needs and emergency admissions. At the same time, the NHS was experiencing an extremely pressurised winter in terms of beds and staff, as the country was in the midst of a serious outbreak of influenza. As a result, the need to improve the use of acute hospital beds was even more pressing than usual.

1.2 Exploring alternative approaches

There were several possible ways of developing this study further, as the general remit was to look at issues pertaining to acute emergency medical admissions. At the time, the hospital hosting the study had considerable problems with bed capacity, delayed discharges and long delays in the accident and emergency department (A&E). There was some interest in trying to understand why this was happening and what changes, if any, could be made to alleviate the pressures. The first possibility explored was to collect retrospective data on 10% of the hospital's acute medical admissions. This data could then be used to simulate the impact of hospital and community changes on admission and discharge rates and trends in bed utilisation. This has been shown to be useful in some settings (Bagust and Place *et al.* 1990), although, even these modelling exercises are not without their problems. However, this was rapidly discounted as work of a similar kind had already been conducted within the hospital. Therefore, it was felt that conducting another almost identical study was not justifiable, as it would only confirm what was already known. Also, there were many documented methodological limitations associated with using simulation models.

The next possibility examined emerged during initial exploratory work. I arranged several informal meetings with health professionals working within the areas related to acute emergency medical admissions. During these meetings, I discovered that there were many issues that appeared to have an influence on admission to hospital that were largely not understood, and certainly under-researched. In effect these were the influences that could not be easily accounted for in a simulation model, or randomised controlled trial. However they were very important in relation to the organisation of acute emergency admissions. One of the main issues seemed to be the lack of agreement concerning the nature of the problems, and how they could be tackled. I began to examine the literature and noticed that there was considerable confusion and ambiguity in relation to the factors that increased, or even decreased emergency medical admission rates. Undoubtedly, some of these factors could be attributed to the way in which care was organised and delivered within individual hospitals, besides the influence of the patients themselves. Designing a research study to satisfactorily address these issues and determining the best research strategy would be challenging. Research conducted by Dempsey (2000) assisted in determining the direction of this study. Dempsey's study used a triangulated approach to examine the appropriateness of admission to hospital, the potential causes and delays within this admission, and the potential usefulness of alternative forms of care for the patients. In addition, physician interviews were conducted to complement the study and looked at the factors influencing their decision to admit a patient. It was however, what this study did not include and take account of that particularly interested me; for example the patient's perspective. A further search of the literature revealed that, at the time, there was very little research that examined emergency admission to hospital from anything other than a simulation, or an appropriateness of admission perspective. Clearly very few looked at other perspectives or influences such as physician decision making or patient experience. In this respect, Dempsey's study at the time was unusual.

Additionally, following the National Beds Inquiry, the NHS Plan (Department of Health 2000a) was published and widely circulated, and it emphasised the need to improve standards in NHS care, in particular making the NHS more patient centred and focussed.

1.3 Shaping the research strategy.

Deciding on the direction of this study was only the first challenge; the next challenge was choosing the best research strategy to examine the various influences on emergency admission to hospital from the patient's perspective. I liked for example, the fact that Dempsey's (2000) study had utilised a triangulated approach to look at the influences on admission. However, the approach that Dempsey used (e.g. appropriateness review protocols - see Chapter Two) would not, it was felt, be a suitable approach for exploring the influences on admission from the patient's perspective. More beneficial within this context was the use of interviews with patients and staff, observations and examination of relevant clinical documents. This strongly indicated a qualitative study, but more specifically a case study approach.

1.4 Research aim and theoretical considerations

Taking into consideration the various personal, professional and organisational issues that influenced the design of this study, the following aim was devised:

> *To explore the factors that influence the emergency admission of patients to hospital, and the impact of these factors on the patients' hospital experience and the delivery and organisation of patient care*

The nature of this aim indicated that this study required an open, exploratory and eclectic approach. Therefore, I was particularly careful during this study not to rush into making assumptions from the data, nor to attempt to apply a theoretical perspective prematurely. This study did not lend itself easily to one particular theoretical perspective; rather it was informed by several.

1.5 Thesis structure

The structure of the thesis is as follows:

Chapter Two examines in detail the literature relating to the process of emergency admission to hospital. It looks at the issues emerging at a national level, with respect to the processes occurring at the hospital level. It also examines the issues pertinent to individual patients and health professionals. The first section (**section 2.2**) examines the healthcare policy documents and research of influence at a national level. The next section (**section 2.3**), examines the influences on admission from a local hospital level, again concentrating on some of the key healthcare policy documents, but also examining the literature pertaining to the organisation of hospital care. The final section (**section 2.4**), explores literature relating specifically to the patient and the health professional. It examines the influence of perspective, both the health professionals' and the patients' on the emergency admission experience and *vice versa*. In accord with the other sections, the final section also examines relevant healthcare policy.

Chapter Three provides a detailed description of the research design and the rationale for choosing a case study approach. It justifies why certain data collection methods were used and explores the various critiques of each. Later sections of this chapter also provide a discussion of the ethical considerations important in the conduct of this study. The final section (**section 3.12**) of Chapter Three provides a description of the data analysis strategy used.

Chapter Four is a large chapter and has therefore been divided into four sections. The first section briefly provides a description of the eight patient cases that were central to the study. **Table 4.1** presents some of the key contextual data relating to each patient's admission. The next section (**section 4.3**) provides a description of the themes emerging in relation to the patients' pre-admission lives and experiences, and explores thematically the factors influencing the lead up to the patient's ultimate admission to hospital. The following section (**section 4.4**) concentrates on the themes emerging in the post-admission period; the period of time commencing upon arrival at the A&E department. The final section (**section 4.5**) draws predominantly upon data from health professional interviews, and particularly details the themes related to the management and organisation of the hospital and how these appeared to influence the delivery of patient care.

Chapter Five provides an exploration of the themes emerging in Chapter Four, in relation to the literature and current healthcare policy, and looks again at the aim and research questions that guided this study. The discussion is structured under three main headings: the influence of the patient's living arrangements and way of life on admission; the delivery of acute hospital care; and the context and politics of care delivery. Although distinct, these sections are inter-connected with one another, the research literature and with healthcare policy.

Chapter Six presents the conclusions from the study by drawing on the data and literature detailed in the previous five chapters. In addition, it provides an insight into the potential impact of this study on future healthcare practice and further research. The final sections of this chapter provide a critique of the research strategy utilised during this study.

The data and discussions contained within the six chapters of this thesis provide not only a rich description of the patient's experience of emergency admission to hospital, but also help to clarify some of the key factors influencing this process. It is anticipated that this study will add to the understanding of this area and help to improve the patients' experience of emergency admission to hospital.

Chapter Two - A Review of the Literature

2.1 Introduction

This chapter explores the literature that has informed the area of emergency admission to hospital, organisation of care and the patient's hospital experience. In particular this review has two main aims: to gauge the current level of knowledge about emergency admission to hospital and the patient's experience; and to help clarify the focus of the research study and chosen research design.

In order to achieve this, this chapter has been divided into three main sections. It is important to note at this point that these sub divisions are to aid clarity as there are considerable connections between the sections and the literature within them. The three main sections are as follows: **Section 2.2**- National level influences. This section examines the broader context of emergency admission to hospital. Emphasis is placed on exploring empirical research and national government policy related to healthcare, particularly reports published since the NHS Plan (Department of Health 2000a). **Section 2.3** - Local level influences. This section examines some of the issues that are important at the hospital level, particularly in relation to the delivery and organisation of care. **Section 2.4** - Patient and health professional level influences. This section examines more closely the literature pertaining to the individual, both patient and professional and their contribution to the area of emergency admission to hospital and the patients' hospital experience.

2.2 National level influences

The subject of emergency admissions to hospital has received considerable attention within the literature, particularly in the last ten years. Some of the available literature has taken the form of professional comment and opinion (Blatchford and Capewell 1997; Capewell 1996; Edwards 1996; Elwyn and Scott 1994; Hobbs 1995). In addition, a range of empirical studies also exist, including surveys and questionnaires of health professionals for example, Jankowski and Mandalia (1993). This area is also informed by a number of key government reports, such as the National Beds Inquiry (Department of Health 2000b), The Emergency Services Action Team

(Department of Health 1998 and 1999), The NHS Plan (Department of Health 2000a), Audit Commission review of accident and emergency services (Audit Commission 2001), Reforming Emergency Care (Department of Health 2001e) and National Service Frameworks (Department of Health 2001c). The literature is prolific although much of it relies on subjective comment and opinion and the empirical work existing in this subject area utilises a variety of methodological approaches, and there is therefore considerable variability within results.

2.2.1 Emergency admissions – key statistics

Aggregated statistics available from the Department of Health demonstrate that emergency admissions to hospital now account for approximately two thirds of overnight admissions. For example, provisional data obtained from the National Beds Inquiry identified that in 1998/1999, 4 million people were admitted to hospital as emergencies from either the A&E department, or as direct General Practitioner (GP) referrals (Department of Health 2000b). In fact, emergency admissions for all age groups increased by 2% between 1994 and1998, but by 2.7% for patients over the age of 65 years.

In opposition to the trend in emergency admissions, general and acute beds have decreased from around 5.2 per 1000 population in 1981 to 3 beds per 1000 population in 1998. The length of time patients spend in hospital has decreased, whilst the average bed occupancy has increased (Department of Health 2000b). It could be said that the interplay between these various factors has increased the pressure felt by the acute hospital sector, resulting in regularly reported acute bed shortages. The relationship between emergency admissions, bed availability, length of stay and bed occupancy is highly complex and has a profound influence on all aspects of care delivery and organisation. For example, the Audit Commission report published in 2001 (Audit Commission 2001) in conjunction with the Department of Health's report on Reforming Emergency Services, indicated that the majority of A&E departments were seeing and treating far more patients than they had in 1987/88. Collectively, A&E departments were treating nearly 13 million patients a year in 2000–2001 compared to nearly 11 million in 1987-1988. However, these patients were waiting longer for initial treatment, referral and transfer to hospital beds. Department of Health guidelines proposed that the time from arrival at the A&E department to transfer to a hospital bed should not exceed four hours. More recent publications have indicated that the target to reduce waiting times within the A&E department is being achieved with 19 out of 20 patients now being treated or referred within four hours of admission (Department of Health 2004c).

It could be argued that waiting for long periods for assessment still occurs and shows a real problem with the organisation of emergency care, not only at the interface between primary and secondary care, but further into the hospital system (Department of Health 2001b). The problems related to delays are not just a symptom of an inexorable rise in attendances or emergency admissions, but also the way that the provision of hospital care is organised.

2.2.2 Emergency admission to hospital - an alternative view

Even though the statistics seem to present proof of a rise in emergency admissions to hospital, other evidence suggests that this is not necessarily the case. Hobbs *et al.* (1997) caution against the accuracy and use of hospital statistics; indeed in their study many inaccuracies were discovered in routinely collected and recorded hospital data. Morgan *et al.* (1999) in their sequential analysis of health service data suggested that the rise in emergency admissions could be attributed to the internal transfer of patients between different speciality consultants. Each transfer is then recorded as a finished consultant episode and charged accordingly. However, the data in the study conducted by Morgan *et al.* were obtained from only one health authority. Watkins and Alting (2000) identified similar findings from the Stockport Annual Health Report in 1996, and suggested that information distortions, and inter-hospital transfers accounted for two thirds of the apparent rise in emergency admissions. Watkins suggests that it would be wise to be wary of the assumption that there is a constantly rising pressure. Frankel *et al.* (2000) concurred with Watkins and suggested that assumptions about health care, in particular rising pressure, need to be challenged as many of these health service assertions are not supported by strong evidence. In fact the perceived inability of the health service to meet some of the demands for health care could be as a result of many other issues other than constantly rising demand.

2.2.3 Healthcare in the community

Certainly there is a strong link between emergency admission to hospital and community based healthcare. The issue of GP decision-making is reviewed in detail in the final section of this chapter (**section 2.4**). However, this section examines the issues related to GP referral rates and healthcare provision in the community and how these influence emergency admission to hospital.

Reid *et al.* (1999) analysed cross sectional data to examine the admission rate variations between several general practices. It was identified in this study, that substantial variation existed between the practices studied, and this was partly attributed to the patient population and the deprivation index. This has been further supported by Duffield *et al.* (1997) who noted in an earlier study that, statistically, socially deprived patients (determined by applying a Social Deprivation Index (SDI) to the area in which the patient lived) were more likely to be referred to hospital as emergencies, but no more likely to be admitted. One possible reason behind this phenomenon is that GPs have their own assumptions or pre-determined ideas about the health of this particular patient group. Then, upon referral to hospital and follow up in the A&E department these pre-determined ideas regarding social deprivation are not supported. This study was based on data collected retrospectively over the course of one month, in this case November. It was also discovered that a telephone call accompanying the patient upon arrival at the A&E department actually resulted in a higher chance of admission to hospital. However, one criticism of this study was that collecting data over such a short period of time, i.e. one month, may have biased the findings as admission rates may fluctuate throughout the year depending on the season and the general health of the population.

Changes in the provision of primary health care, in particular access to emergency treatment or advice, may also contribute to GP referral rates. A report by the Chief Medical Officer (Calman 1997) examining the provision of emergency services in the community, discovered that there was a need to co-ordinate emergency care so that access for patients could be expanded to cover a 24 hour period. It was also recognised that there was a need to ensure that people could recognise an emergency and act swiftly. The report therefore recommended that other models of out of hours care should be investigated. Of particular interest was the provision of nurse - led telephone health advice. This type of advice has been demonstrated to reduce the number of A&E attendances in one study in Canada (Wilkins 1993). It was anticipated that similar results would be achieved in the National Health Service, thereby ensuring that the public received first class care immediately, and GP out-of-hours services would be able to concentrate more on patients who actually needed emergency care. However, one important point to note about the Canadian study was that it was based within a paediatric hospital and offered health advice to parents of sick children. The experience of users in this scenario is debatably very different to, for example, an elderly person living alone with a chronic health problem. Nevertheless, in 1998 the first pilot sites for a new telephone advice line (NHS Direct) were commenced. NHS Direct has subsequently been adopted across the UK.

Calman (1997) did argue that there was a need to evaluate the service. Consequently the first evaluation was conducted in 1998 (Munro *et al.* 1998) and it concluded that there was little useful empirical evidence to suggest that telephone help lines reduced the demand for health care. In addition, Lattimer *et al.* (1998) conducted a randomized controlled trial examining the safety and effectiveness of nurse telephone consultations during out-of-hours periods, such as during the night and weekends. Patients were randomised either to receive advice from a nurse rather than the GP, or to receive the usual GP consultation. Results demonstrated that the overall GP workload was reduced by 50% and there was no associated increase in adverse events, such as death within seven days. However, the study was only conducted within one geographical area, and there were slight differences in the number of patients randomised in each arm of the trial, potentially complicating the interpretation of the findings.

A further study conducted by Lattimer *et al.* (2000) looked at an economic evaluation of nurse consultations using decision support software. It was discovered that this form of consultation might reduce costs in the long term. However, the economic evaluation was unable to determine the cost benefits to the NHS in terms of quality improvement or patient satisfaction. A follow up report presented to the Department of Health (Munro *et al.* 2000) demonstrated that the service was having a positive impact on GP out-of-hours workload, but not on attendances to A&E departments or ambulance calls. This is perhaps because some A&E attendees refer themselves to the department without contact with either their GP or any other health professional. Sanders (2000) and Wise (1997) have reviewed the literature related to the inappropriate use of A&E departments by patients. One of the findings was that many self referred patients could have been treated by their own GP.

The use of the term 'inappropriate' is highly problematic within the health care setting, as there is a distinct lack of any universally accepted definition of the term. Sanders (2000) identified that A&E staff viewed patients attending as non-accidents, non-emergencies or with conditions or symptoms greater than 24 hours old as inappropriate. Sanders (2000) reviewed 50 empirical published studies focusing on patients' reasons for attending the A&E department and suggested that the patient often viewed their condition as an emergency, even if the health professional did not share this view. It could be said that there is a potential for mis-diagnosis or poor quality care as a result of these differing perspectives. Walsh (1990) discovered that patients identified by staff as inappropriate, were just as likely to require treatment in the form of antibiotics and analgesia as those identified as appropriate. Additionally, there is no strong evidence to suggest that patients who self refer to A&E departments are more likely to be inappropriately seeking health care than those that are referred by a health professional. Jenner (1985) for example, examined the mode of referral and severity of illness for 94 patients in an A&E department. It was found that there was no difference in terms of characteristics between patients that self referred and those that were referred by their GP. However, this was a relatively small study and it was noted that 28 out of 55 of the patients who had supposedly self-referred to hospital had attempted to contact their GP, but had been told that he was away, ill or unable to see them for another reason. Therefore, over 50 per cent of the patients in this study were given no choice but to self-refer to the A&E department. Nevertheless, 45 of the 55 self-referred patients were subsequently admitted to hospital.

Appropriateness versus inappropriateness within healthcare has received considerable attention within the literature both in relation to A&E attendances and emergency hospital admissions. The issue of inappropriateness in health care is considered in greater detail in the next section.

2.2.4 Inappropriate admission to acute care

Variation in admission rates may be explained, at least in part, by differences in length of stay and inappropriate emergency admissions between different areas. There is a considerable body of literature regarding this subject, although there is marked variation in reported incidence. For example, inappropriate admissions rates for acute (adult) medical patients range from 1% (Victor and Khakoo 1994) to 50% (Anderson *et al.* 1998; Coast 1996; Department of Health 2000a; Tsang and Stevens 1995). Studies examining lengths of hospital stay also indicate a wide variation (Bowman *et al.* 1999; Coast and Peters *et al.* 1996; Smith 1997). One of the most plausible explanations for such apparent diversity is the differing methodological approaches used within the studies. The most common method of determining 'appropriateness' within an acute setting is the utilisation of criteria-based tools such as the Appropriateness Evaluation Protocol (AEP)(Gertmann and Restuccia 1981), the Intensity-Severity–Discharge-Adult (ISD-A) tool or the Managed Care Appropriateness Protocol (MCAP) (Kalant *et al.* 2000)

The ISD-A tool relies on a set of diagnosis-independent criteria which can be applied to specific levels of care such as critical, acute or post acute care and to different body systems, such as the cardiovascular system or the renal system. Each criterion consists of three sections: illness severity, intensity of service and discharge factors. The patient is then assessed using these criteria on admission, and on each subsequent day after admission to determine their need for treatment at a given level i.e. acute, critical or post-acute.

The AEP has been the most widely utilised and tested instrument with reasonable reliability and validity (Department of Health 2000b and Smith *et al.* 1997). However, as was the case for inappropriate A&E attendances, an explicit definition of the meaning of ‘appropriate healthcare’ has also been neglected in much of the published research. Nevertheless, a definition of appropriateness is often implied in these studies by the use of tools such as the Appropriateness Evaluation Protocol

(AEP). Appropriateness, as determined by the AEP, is the extent to which a patient is dependent on medical intervention (Gertmann and Restuccia 1981). Patients are judged by a set of admission criteria and a set of day of care criteria which relate to the illness severity of the patient and the level of service/intervention required.

Kalant *et al.* (2000) conducted a study to compare the MCAP, AEP and ISD-A with a panel of experts and found that the tools only demonstrated poor to fair validity when compared to professional experience. For example, in this study the panel of experts considered 92% of admissions to be appropriate, whereas the ISD underestimated appropriateness and the MCAP and AEP overestimated it. The tools also only showed poor to fair validity compared to using a panel of experts to achieve the same task. This raises a number of serious questions regarding their usefulness particularly as utilisation tools are often based on hypothetical situations rather than real or actual situations. For example in a study conducted by Victor & Khakoo (1994) it was discovered that only 1% of patients were deemed to be inappropriate. In this instance appropriateness rates were studied within the context of a real situation, taking into consideration the availability of alternatives to acute admission. In general Kalant *et al.* (2000) cautioned that although utilisation tools are widely accepted, the validation problems experienced in their study indicated that perhaps, they are not after all the most effective approach for determining appropriateness. However, their hypothetical nature may make them useful for planning or modelling exercises which are valuable particularly when there is a need to identify alternative approaches.

2.2.5 Acute bed occupancy rates

The need to improve the use of hospital beds by reducing the numbers of avoidable or inappropriate admissions is another way of approaching the problems associated with acute bed occupancy rates. One of the key issues highlighted within current research is the varying level of bed occupancy rates between NHS hospitals. The report from the Emergency Services Action Team following the winter of 1997/98 (Department of Health, 1998) demonstrated that bed occupancy rates of 85% or more decreased a hospital's ability to respond to increases in demand. This has been supported by Bagust *et al.* (1999) who used a theoretical modelling exercise to determine daily bed requirements. Results from this study demonstrated that at bed occupancy levels of 85% or more, a hospital could expect some bed shortages. At occupancy rates of 90% or more bed shortages would become a regular feature within the hospital. It has also been suggested that decreasing numbers of acute hospital beds are one of the main reasons behind increasing bed occupancy rates (Department of Health 2000b). However, hospitals with more beds do not necessarily have fewer bed crises or shorter lengths of stay; in some cases the opposite has been demonstrated (Department of Health 2000b). The reasons why some acute trusts appear to have lower occupancy rates than others have not been made totally clear within the literature. However, this lack of clarity in relation to the management of beds and emergency admissions has emerged as an overwhelming theme during this review.

2.2.6 An ageing population

An ageing population has been identified as being closely related to the increase in hospital emergency admission rates, and the need for greater numbers of hospital beds. The apparent rise in the rates of elderly emergency medical admissions is another concern facing the NHS (refer to **section 2.2.1** for statistics) as patients over the age of 65 are perceived to place a strain on the NHS (Department of Health 2000b). This report also suggested that, as the population ages, more elderly patients would experience at least one hospital stay per year. This might be loosely associated with an increased demand for more hospital beds. In contrast, an earlier study by Weinberg (1995) used a simulation model to look at the impact that an ageing population might have on the need for acute medical beds. It was found, that at the level of a district general hospital, demographic changes appeared to have less impact than previously thought. It was proposed that a reduction in the length of hospital stay, and changes in admission policies might have a greater impact than demographic changes.

Statistics regarding the impact that older patients have or may not have on future health care provision can be interpreted in a number of ways, and challenge the assumption that an ageing population increases healthcare expenditure. For example, as Frankel and Ebrahim *et al.* (2000) highlighted, the actual incidences of ill health in this age group that require hospital intervention will be confined to the time just before death. Much of the cost is therefore compressed to the final few years of a patient's life. A report by the Standing Nursing and Midwifery Advisory Council (2001) also challenged the assumption that older people have greater health needs. However, only close scrutiny of the situation over time will help to clarify the issue of ageing and health service requirements.

2.2.7 Admission avoidance strategies

One method of reducing any strain that an ageing population might have on emergency and acute care services is by preventing or avoiding where possible the admission of these patients to hospital. The National Service Framework for Older People (Department of Health, 2001c) suggested that there was a real need for appropriate and timely interventions and services to prevent patients, particularly the elderly, from being admitted to hospital unnecessarily. Following this, a report published by the Audit Commission (Audit Commission 2002) identified that there was a failure by the system to invest in other services that were perhaps better suited to patient needs, for example, services directed towards preventing an admission. This failure results in a vicious circle, leading to increased pressure on acute beds and then community services (Audit Commission, 2002). Studies published prior to both these reports concurred with, and indeed informed, the reports themselves. Coast and Inglis *et al.* (1996) determined that at least 10 % of patients who might ordinarily have been admitted to acute care could be treated in an alternative setting. A later study by Sanderson and Dixon (2000) was largely in agreement with the study by Coast, demonstrating that swift access to acute care alternatives could prevent many unnecessary hospital admissions. A further review conducted by Glasby and Littlechild (2000), identified that patients with chronic health problems or lower level health requirements had been largely ignored by government health policy until the point at which they suffer a sudden health crisis. It was at this juncture that these same people then became patients within the acute sector, frequently as emergency admissions.

However, the beginning of a shift towards proactive measures rather than reactive care started to become evident as early as 1997 (Department of Health, 1997) and even more so with the publication of The NHS Plan (Department of Health 2000a). Nevertheless, one of the many criticisms levelled at these studies and reports by Glasby and Littlechild (2000) was that they relied too heavily on economic and organisational factors with very little emphasis on patient preferences and individual patient factors. Both, it is argued, could have a profound influence on admission rates. More recent policy, in particular policy published since commencement of this study, gives greater emphasis to the patient and the phrases 'patient centeredness' and 'patient-led' appear more frequently within both policy documents and research studies. The extent to which these studies really examine the patient experience vary considerably. This area of the literature will be explored in more detail in **section 2.4**.

2.2.8 Intermediate Care

The preceding section has detailed some of the key issues pertaining to prevention rather than intervention within the provision of healthcare services. The main point made was that there is a real need for easily accessible alternatives to acute care in order to prevent admission to hospital occurring in the first instance. Many of these alternatives are grouped in the literature under the heading 'intermediate care'. The following explores the literature within this area.

A number of services have emerged to address the need for alternatives to acute hospital care. Many of these have been developed in response to government policy and healthcare demand. The term 'intermediate care' appears to be the most widely used when describing these services. Steiner (1997) recognised that a number of varying definitions existed regarding intermediate care. In response to this, a working definition was proposed to aid clarity.

> *'The range of services designed to facilitate the transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patient's discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired'.* (Steiner 1997 p 24)

This purpose of intermediate care and the services that the definition has encompassed has evolved over time. The definition has also been adjusted to take account of these developments for example:

> *'Those services which will help to divert admission to an acute care setting through timely therapeutic intervention which aim to divert a physiological crises or offer recuperative services at or near a person's own home'.*
> (Vaughan and Lathlean 1999 p1)

Services that have emerged in response to increasing demand on the acute sector have been many and varied, ranging from hospital at home and early/supported discharge schemes to nursing and residential homes and nurse-led services (Department of Health 2000b; Griffiths, 1997; Griffiths *et al.* 2000). Nevertheless, little consistent evidence is available to support the assumption that intermediate care services actually reduce acute bed usage. Firstly, the heterogeneity of intermediate care services, and subsequent evaluation studies, make it very difficult to draw definitive conclusions regarding effectiveness (Department of Health 2000b). Secondly, intermediate care services may not reduce acute bed usage but actually increase it initially (Department of Health 2000b). A further review conducted by Steiner (2001a) indicated that there was insufficient evidence to support the implementation of one intermediate care service over another.

In addition, Willliams and Last (1998) and Ferriman (2000) recognised that intermediate care services are also used inappropriately. Ferriman (2000) demonstrated that patients were often sent to intermediate care before they were medically fit in order to reduce the strain on acute medical beds. Williams and Last (1998) discovered that 54% of patients within a community hospital had unidentified needs and 90% of these did not require the level of input they were receiving. This raises another issue regarding the cost effectiveness of intermediate care services; a key report from the Audit Commission recognised that older people in particular often occupy expensive acute care beds because alternatives are not available (Audit Commission, 1997). However, little reliable evidence exists to demonstrate that intermediate care services are a cheaper alternative or likely to reduce acute bed usage. A study by Griffiths and Wilson–Barnett (1998), for example, identified that nurse-led care increased the length of patient stay, resulting in greater costs. A further study by Griffiths and Harris *et al.* (2001) noted similar results, with similar cost implications. This finding has been further supported by Steiner and Walsh *et al.* (2001) who noted that whilst initially length of stay was longer for patients within nurse-led care, this difference actually became statistically non-significant when transfers to community hospitals were taken into account.

There remains considerable scope for further research within the field of intermediate care to assess whether, in the long term, such services are effective in reducing acute admission and improving outcomes for patients.

2.2.9 Section summary

This section has presented the literature pertinent to the potential influences on emergency admission to hospital. The body of literature reviewed was therefore quite extensive and a brief summary of the main points of **section 2.2** are detailed below.

Emergency admission to hospital does not occur in isolation as there are many factors that appear to have an influence. Certainly the organisation of care within the community has some impact on when and how a patient is admitted to hospital. GPs are therefore at the forefront of this process, along with NHS Direct and other services that provide alternatives to acute care or admission to hospital. It appears that emergency admission rates to hospital are increasing, although even this assumption has been challenged in the literature. Two possible reasons cited for the steady increase in the emergency admission rate are, the general ageing of the population, and the rate of inappropriate admissions to hospital. However these two assertions can be interpreted in several ways, depending on the setting and the validity of the research. In general then, **section 2.2** has identified that there remains considerable disagreement in the literature regarding emergency admission to hospital and the possible influencing factors.

2.3 Local hospital and regional level influences

Certainly **section 2.2** has indicated that there are other issues that appear to have an influence on emergency admission to hospital, such as individual hospital occupancy rates and the availability of intermediate care facilities in the local area. The problems related to increasing bed occupancy rates in particular could be symptomatic of the way in which care is organised within individual acute NHS hospitals. The NHS plan (Department of Health 2000a) advocated a re-design in the way that the health service is operated, for example, involving patients more centrally in the planning of services to make the pathways through the hospital smoother and less problematic. It would seem, (from preliminary work for this study and data collection during the pilot phase) that problems within the healthcare system, and the pathways of patients through the hospital still exist despite the recommendations of the NHS plan. Therefore, the following sections will explore the literature and policy documents pertinent to the organisation and delivery of care at a local hospital and regional level.

2.3.1 Organising acute care

A working group was assembled (Houghton and Hopkins 1996) to identify the areas of concern related to the organisation of acute medical care. Several areas were identified which included problems with the organisation of medical care, particularly junior medical staff taking admission calls and patients admitted to inappropriate specialities. In general there was concern that too few senior and experienced doctors were available to care for patients and make patient care decisions. Another concern was that GPs and consultants did not communicate effectively regarding patient needs.

A working party combining representatives from the three colleges (Royal College of Physicians, Royal College of Surgeons and Royal College of General Practitioners) was established in 2000 to examine these concerns more closely (Working Party of the Federation of Royal Colleges 2000). The outcome of the report was a series of recommendations on the training and provision of consultants with a responsibility for acute medicine. It also identified, that there was a need to adopt measures to increase patient throughput and develop closer liaisons with other specialist physicians. Wallis and Guly (2001), in their review focussing on the provision of A&E services highlighted that improvements in standards of care would require several approaches; greater supervision and training of less experienced or junior medical staff and increased availability of senior or middle grade doctors. Another recommendation of the Working Party Group was to develop medical admission wards. Despite these recommendations, a report by The Audit Commission (Audit Commission, 2001) highlighted that only 50% of A&E departments surveyed had access to a medical admissions ward. Nevertheless, the usefulness of such wards is also dependent upon the availability of beds (both on the admission ward and elsewhere in the hospital), the availability of medical and nursing staff and the ease of access to diagnostic services. Evidence suggests (Martinez *et al.* 2001; Williams *et al.* 2000) that medical admissions wards and/or observation wards can reduce lengths of stay and overall bed days whilst improving the management of patients.

2.3.2 Care of older patients within acute hospital settings

A considerable proportion of an acute hospital workload is related to the care of the older patient. Their needs can be quite distinct and often include medical and social complexity, frailty and dependency (Standing Nursing and Midwifery Advisory Council 2001;Department of Health, 2001c). Older patients are also prone to iatrogenic deterioration within acute hospitals, which can greatly affect the speed of their recovery, placement within the hospital system and the need for support when discharged from hospital. The form that this deterioration takes varies, but can range from cognitive deterioration, to loss of muscle tone, bone density and functional decline. Creditor (1993) and Lefevre *et al.* (1992) identified that iatrogenic deterioration in the elderly medical patient is likely to be quite common. In the study conducted by Lefevre, 58% of patients exhibited some form of iatrogenic deterioration. Reporting of this type of deterioration is, however, highly problematic and subjective. For example, it may be very difficult to differentiate iatrogenic deterioration from natural disease states resulting from the ageing process.

However, delays in the hospital system due to the inefficient organisation of care can cause deterioration of patients in all age groups, not just the elderly. One possible way of improving the outcome for patients is by transferring them promptly to rehabilitation or intermediate care services or preventing them from being admitted to hospital in the first instance (Audit Commission 2000; Department of Health 2003b; Department of Health 2001c).

2.3.3 Organisation of acute hospital care - delayed discharge

Whilst it is recognised that there is a pressing need to move patients promptly to alternative forms of care, patients are often left to wait on wards even though acute medical and nursing intervention is no longer being received. The term 'bed blocker' has been used to describe patients that are occupying an acute hospital bed long after the medical or nursing need for that bed has ceased. However, the use of the term bed blocking has been discouraged in policy as it has been shown to carry negative connotations. The House of Commons Health Committee (House of Commons Health Committee, 2002)) in their third report determined that the use of the term 'bed blocking' was offensive and counter productive as in many cases it was a problem within the system that caused the blockage not the patient. The use of alternative terms such as 'delayed discharge' or 'delayed transfer' of patients from hospital was encouraged as this was felt to be less offensive and often provided a more accurate picture of the nature of the problem or delay. The report also identified that many of the problems with delayed transfer were related both to the interface between acute hospital and the community, but also to organisational and delivery of care issues within individual acute hospitals.

The 'cash for change' initiative or incentive recognised many of these issues and proposed to give individual regions a share of £300 million to address some of the issues associated with delayed transfers or delayed discharge from hospital (Department of Health, 2001d). However, the most specific target was for individual regions to end delayed discharge by 2004, thereby freeing 1000 beds across the NHS. Assistance to regions and hospitals with the worst problems was provided in the form of the Change Agent Team, although in general each individual hospital and region had the scope to invest the money in the most appropriate way.
More recently, the Department of Health published their Hospital Discharge Workbook (Department of Health, 2003a), which outlined some of the key problems

in this area. It was recognised in this publication, that discharges from hospital were often delayed, poorly managed from the patient and carer perspective, too early, or to environments that were unsafe. The reasons behind the discharge problems were varied but were reported to relate to internal organisational issues, poor access to external resources (such as intermediate care beds), and lack of involvement and choice for patients and carers in discharge arrangements. Finally, it was noted that discharge from hospital was not an isolated event and needed to be considered as part of a whole system of care. Pearson *et al.* (2004), in a recent study examining decision-making surrounding hospital discharge, concurred with the above report and noted that there needed to be a shift away from symptom management, with more emphasis placed on the patient's quality of life.

In contrast, a report published by Glasby *et al.* (2004) indicated that research into the area of delayed discharge was often weak due to methodological inconsistency and lack of defining terms. In general, there was a failure within published studies to include any form of patient perspective or any suggestions for improvements within the local context.

2.3.4 Section summary

This section has identified that there are many issues related to the organisation of patient care that are associated with the combined influences of admission and discharge processes. Much of the literature reviewed in this section relates to government policy documents as these are the publications that inevitably guide strategic management of NHS hospitals and organisation of care. Certainly, this section has highlighted that there is a need to view admission and discharge as part of a whole system of care, which includes services outside the acute hospital system. However, in doing so, some consideration needs to be given to the patients' experience of these processes. In general much of the published research ignores or fails to address adequately this important area.

The final section of this review explores the literature that is pertinent to the patients' experience of admission to hospital and health professional perspectives of this process.

2.4 Patient and professional level influences

Understanding and appreciating the patient's experience of hospitalisation is an important aspect in determining and improving how care is organised and delivered in a patient centred way. However, the experience of admission to hospital is closely linked to the perspectives and decision-making processes of health professionals working within the hospital. Therefore, this chapter would not be complete without exploring the literature related to both the patient's experience of hospitalisation and the health professional's perspectives on this issue.

2.4.1 Health professional perspectives

There is a large body of healthcare literature demonstrating a divergence between patient, family and health professional perspectives regarding care (Hyatt 1980; Phelps and Shepperdson 1998; Rose *et al.* 2000; Simeonsson *et al.* 1995; Tomes and Chee Peng 1995). These studies have been conducted in very different healthcare settings, involving different patient groups yet, all demonstrate that health professional perspectives of the issues related to care delivery and quality of care are not always attuned to the reality of these issues for patients.

Phelps and Shepperdson (1998) presented the results of a pilot study to look at two factors. Firstly, health professional perceptions of the importance of non-clinical factors in the emergency admission of a patient to hospital. Secondly, to gain an idea, from the perspective of the health professional, of the type of services required to help the patient avoid admission to hospital. The authors selected 90 patients (originally) to take part in the study, although only the data from 48 patients were used as the remainder of the patients either died or declined to continue with the study.

Semi-structured interviews were carried out with both the patients and the health professionals to determine the factors perceived to be responsible for the patients' admission. These interviews were examined in some depth to determine if there were any differences in perspectives between the two groups. Results demonstrated that health professionals within the study had a general perception that social factors (e.g. being widowed, living alone, social deprivation, etc.) played a disproportionate role in the emergency admission of older people to hospital. Data from the patient admissions indicated that the majority of elderly patients were admitted for medical need and that in reality, the social component was not significant in the decision to admit.

Dempsey (2000) also looked at the admission of patients to hospital, although in this study more than one method for data collection was used. The first part of the study was conducted using the AEP tool (described in **section 2.2**), and discovered that 19% of the patients studied were found to be inappropriately within a hospital bed. The second part of the study involved qualitative interviews with eight physicians responsible for making admission decisions. The most prominent theme emerging was highlighted as 'a sense of situation'. A sense of situation was described as the way in which the physician based the decision to admit a patient to hospital on the patient's condition, the level of care required and the social situation of the patient. Other factors identified were the physician's trust of other health professionals and their perception of their own decision- making autonomy within the clinical setting. The criticisms of this study were similar to those levelled at all studies using criterion-based tools such as the AEP. It was noted that the most common reason for considering a patient to be receiving inappropriate acute care was if they could have been cared for within another health care setting, even if this was not actually available. This definition concurs with Victor and Khakoo (1994). However, Victor and Khakoo adjusted their level of inappropriate admissions to take account of the deficit of available alternatives, which was a methodological strength of their study, given the limitations of the AEP. Recognition of the availability of alternatives did not appear to happen in Dempsey's study. In addition only health professionals were interviewed and therefore the patient's perspective appeared to be entirely ignored within this study.

In contrast, Phelps and Shepperdson (1998) tentatively demonstrated that health professional perceptions of the factors influencing admission to hospital were not necessarily apparent when specific patient cases were examined in practice. The acknowledgement of the patient's perspective within Phelps's and Shepperdson's study was also unusual. The majority of published studies have ignored this aspect despite the potentially life changing effect an admission to hospital can have on an individual.

Whilst the patient perspective was largely ignored in the larger studies detailed above, they did indicate that health professional perspectives could have an important impact on the way in which care decisions were made. The following section reviews the literature related to health professional decision-making.

2.4.2 Health professional decision-making

The changing pattern of GP referral decisions has been suggested as one of the proposed reasons for increased numbers of A&E attendances and emergency admissions to hospital. Several empirical studies have been conducted to examine the influence of GP decision-making on referral to hospital. Newton *et al.* (1991) used qualitative interviews with 15 GPs in one small geographical area and identified some important themes related to the decision to refer a patient. For example, there was a desire of the GP to protect themselves and their practice against litigation, to share the burden of care with other health professionals and to test the availability of hospital services. The factors of uncertainty, in relation to patient diagnosis and GP and patient conflict were also raised within these interviews.

Evans (1993) conducted a similar study examining the referral decisions made by 19 GPs in several practices. Initially the GPs were asked to record data from consultations with patients during which they considered making a hospital consultant referral. The GPs were then interviewed with a view to understanding their referral decisions. The data collection sheets were referred to for specific cases. This study suggested that GPs varied in their acknowledgement of patient wishes and diagnostic data; with some encouraging active patient participation in decision making and others discouraging it. In general the GPs in Evan's study rarely felt pressed for time during consultations and many did not attach more weight to the patient's past history than their current presenting symptoms when determining whether to refer or not. One major weakness of this study was that patients who were admitted to hospital as an emergency admission following GP referral were excluded from the study as were patients with gynaecological complaints. Other potential weaknesses of this study were that the GPs interviewed were self selected and therefore highly motivated and not necessarily representative of the GP population as a whole. Also, the GP sample selected only came from one small geographical area.

These studies suggest that patient need is not the only issue of importance when making patient care decisions. Pickard *et al.* (2004) conducted a study in an A&E department to examine the impact of clinical decision making on hospital resources. Twelve patient cases were followed from their point of arrival and the decisions made throughout their initial period of hospitalisation were noted. Results demonstrated that when a system is working to maximum capacity, certain clinical decisions seemingly benefit one patient whilst disadvantaging others. In Pickard's study, this manifested itself as long waits for an admission or referral decision, frequent patient ward moves and cancelled elective operations.

Some consideration needs to be given here to the various decision-making theories that are proposed in the literature. Three of these theories appear relevant to this study. Normative theory is based on what people should do, assuming that they wish to be totally rational decision-makers. It assumes that everybody in the decision-making process is equally well informed about this process and the various implications of every decision that is made. It is generally based on mathematical and statistical formulae that are not always easy to apply within health care settings. Simon (1955), in much earlier work, demonstrated that people usually do not make decisions within a normative theoretical framework. In accordance with this, Miguel *et al.* (2004) stated that many empirical studies examining decision-making demonstrate that decisions made in reality deviate markedly from normative theory.

Descriptive decision-making theory in contrast, describes how people actually make decisions in real life. Simon (1955) suggested that most people, due to their inability to process large amounts of information, adopt more simplistic approaches toward decision-making which do not always result in a good decision. This is problematic, as determining right from wrong and good from bad within the healthcare setting is not a straightforward activity. Nevertheless, much of the published research examining decision-making is studied in relation to descriptive decision-making theory (Dhami 2003; Miguel *et al.* 2004; Pickard *et al.* 2004). Offredy (2002) attempted to compare and describe the decision strategy utilized by both nurses and doctors. Case notes were used and the decisions made by the two respective professional groups were noted. It seemed that, in general, nurses and doctors shared a very similar decision-making strategy. Within healthcare and health professional decision-making, a number of strategies for actually making decisions have been described. For example, the hypothetical-deductive model assumes that data collection is the first step in the process of decision- making which then helps the formulation of a hypothesis. Over time, more data are collected and the hypothesis is tested re-defined and re-tested until a desired outcome is achieved (Buckingham and Adams 2000). However, the danger of this strategy is that important signs may be ignored if the original focus is too narrow. Certainly, this might appear problematic for patients with complex and multi faceted problems. As Simon (1955) stated, most people find it difficult to manage large amounts of information simultaneously; therefore another decision-making strategy employed is that of heuristics (alternatively termed 'rules of thumb'). This strategy indicates that health professionals reduce and simplify choices in order to make these decisions. How this is achieved is highly subjective and relies amongst other things on personal biases, pre-ceding knowledge, age and ethnicity (Andre *et al.* 2002; Dempsey and Bekker 2002; Thompson 2003).

Finally prescriptive decision-making theory assumes that human beings on the whole are poor decision-makers. Therefore there has been a proliferation in the development of decision support tools to aid personal and group decision-making and improve the decisions that are made (Craig *et al.* 2001; Lewis and Belmonte-Mann 2002; Sakallaris *et al.* 2000).

This section has indicated that health professionals make patient care decisions in a number of ways. It also indicates that decisions are not just based on the clinical or health indicators of the patient, in actuality subjective health professional factors can have a profound influence on the way in which decisions are made. Understanding and indeed appreciating the impact of individual and group health professional decision-making is important as it can have a profound influence on whether or not patients receive care and what their experience is of this care.

2.4.3 Patient experience of hospital care

Determining how a patient experiences care, and to what extent healthcare decisions impact upon their satisfaction of this care is an important aspect of healthcare research.

One method of determining and improving patient outcomes and satisfaction with the hospital experience is the use of patient satisfaction surveys. A number of studies have taken this approach (Bruster *et al.* 1994; Charles *et al.* 1994; Cohen *et al.* 1994; Cohen *et al.* 1996). The main aim of these has been to understand the patient's satisfaction with the process of hospital care. A telephone survey conducted by Charles *et al.* (1994) asked patients about their hospital stay. Several outcome measures were identified prior to the survey, for example: provider-patient communication; attentiveness to the patient's physical needs; patient education; communication with the patient's family; pain management; and hospital discharge arrangements. Several questions were asked relating to each of the study's main outcome measures. Patients in Charles's study reported problems with communication on several levels, in particular information about the daily hospital routine, side effects of medication, test results and discharge planning. In contrast over 90% reported a positive relationship with their physician and felt involved in decision-making. Bruster *et al.* (1994) interviewed a random sample of patients from 36 NHS hospitals. Results from this study were not dissimilar to Charles's study. For example, patients also reported problems with communication, pain management and discharge planning. Cohen *et al.* (1996), in a later study utilising a postal survey, looked at the impact of age and the patient's health status on their satisfaction with hospital care. Results showed that patients considered it important to be involved in their treatment and decision-making about this treatment. However, dissatisfaction appeared to increase with age, and there was a weak association between the patient's health and pain status and their dissatisfaction with their care.

There are several issues that need to be considered when examining the results of patient satisfaction surveys, particularly if changes in the organisation of care are being considered within NHS hospitals. For example, both Cohen's and Charles's studies were based in North American healthcare systems; results from similar studies in the UK or Europe could present very different results. However, a recent study conducted by Coulter and Cleary (2001), analysed patient surveys conducted in Germany, Sweden, Switzerland, United Kingdom and the United States. Results demonstrated that problems with the co-ordination of care, physical care and emotional support were very apparent in all five countries irrespective of the way in which healthcare was organised.

Another issue for consideration is that each of the aforementioned studies uses a different methodological approach. Cohen's study employed a postal questionnaire examining retrospective patient satisfaction amongst a variety of age groups. It was difficult, however, to ascertain how long the patients had been discharged from hospital; for some patients the ability to recall information might have been hampered due to the time between leaving hospital and completing the survey. In contrast, Charles *et al.* (1994) used a face-to-face interview technique to determine patient satisfaction. In this example patients were asked specific, pre-determined questions about their hospital stay. There are many potential problems with this approach. For example, the presence of a researcher, the wording of the questions, the context and the time delay between discharge from hospital and interview can all have an influence on the type of response received. Bruster *et al.* (1994) interviewed patients within two to four weeks after discharge using a structured questionnaire. The authors concluded that asking patients about what happened to them in hospital rather than how satisfied they were provided more useful information for health service planning and organisation. Moreover, Williams and Coyle *et al.* (1998) indicated that high patient satisfaction scores can actually hide many negative hospital experiences, as patients will often reply positively in a questionnaire even if their actual experience was less than positive.

More recent studies examining patient satisfaction have tended to combine methods in an attempt to circumvent some of the limitations of patient satisfaction surveys. Hyrkas and Paunonen (2000a/b) conducted a study in two parts. Part one utilised a questionnaire on three different hospital sites and part two (Hyrkas and Paunonen

2000b) utilised an interview technique based on the themes within the questionnaire. They found that the questionnaire was of limited use in providing informative data on quality and satisfaction; much more detailed information was obtained from the interview. The main criticism made by the authors was that using mixed method approaches required more time and personnel hours. However, it could be argued, that despite the time consuming element of mixed data collection methods, this approach actually adds greater depth and detail regarding patient satisfaction and perceptions of care. Other authors have strongly advocated this approach (Merkouris *et al.* 2004).

The issue of combining methods in order to obtain greater detail about patient satisfaction and experience has some parallels to this study. Within this research study, a number of different data collection methods were employed in order to gather detailed data from various different sources. It was anticipated that utilising this approach would provide significantly more detail about the factors influencing the patient's emergency admission to hospital.

2.4.4 Involving patients and relatives in care decisions

One of the proposed ways of improving patient satisfaction and experience of care is to actually involve patients more in the care process. There has in recent years been a shift in healthcare thinking and planning towards the care of people with more long term and complex health needs, such as those patients with diabetes, heart disease and asthma. The Government's National Service Framework initiative attempts to address the consistency and quality of care of these conditions and improve patient choice and experience. The National Service Framework for Older People (Department of Health 2001c) places great emphasis on the need to treat people as individuals and enable them to make informed decisions about their needs and care. This is further supported by The Expert Patient (Department of Health, 2001a) which acknowledges that patients with long term conditions are often very well informed about these conditions and need to be encouraged and empowered to be the decision-makers in their care rather than passive recipients (Anderson *et al.* 1991; Anderson *et al.* 1995; Anderson 1995).

The use of the term 'patient empowerment' has become more widespread within healthcare literature, especially in a climate of finite resources. Patients who are empowered and informed about their condition and their treatment become more independent, more stable and are therefore less likely to need traditional healthcare resources. The principle of patient empowerment can cause tensions within traditional medicine, as empowering patients requires specific skills that have not always been inherent in medical and nursing education. A study conducted by Ford *et al.* (2003) demonstrated that the real level of patient participation in decision-making was much lower than the patients themselves actually wanted. This was further supported by a literature review of 301 research articles conducted by Scheibler *et al.* (2003).

A recent study by Jones *et al.* (2004) examined patient involvement and GP decision-making. It was discovered that whilst GPs were aware of the ethical and practical advantages of involving patients in decision-making about their care, in practice, patient involvement was utilised to ensure compliance with GP-determined treatment. The authors concluded that there was a very noticeable theory-practice gap and that an improvement in patient involvement required more research into the problems of patient-doctor communication and more emphasis on developing patient empowerment skills within health professional education.

Whilst there continues to be a policy drive to increase patient's knowledge and involvement in healthcare, there is also emphasis on treating patients as individuals. Robinson and Thomson (2001) noted in their study that some patients did not wish to be included in decision-making about their own care and in fact preferred the doctor to make important care decisions. This trend varied with age, socio-economic status, and illness severity. Ford *et al.* (2003) demonstrated that up to 35% of patients in their study were content to let the doctor make important decisions. None of these studies are without their methodological limitations. However, the results do have important implications for future policy developments within the area of shared decision-making, as they emphasise the need to acknowledge the individuality of patients and their decision-making desires and capabilities.

The previous paragraph has discussed some of the implications of involving patients more centrally in healthcare. However, discussions regarding patient involvement and experience of healthcare would not be complete without a consideration of the involvement of their family and carers. Research has demonstrated that the presence or absence of family, friends, relatives or other forms of social support can have a significant influence on admission to hospital, discharge destination and ongoing ability to cope with a chronic illness. For example, Zureik *et al.*(1997) studied the hospitalisation outcome (outcome in this context defined as discharge to either home or residential care) for 510 elderly patients and discovered that by far the most influential factor in the patient's ultimate discharge destination was the family or carer's wishes. A further study by Mackenzie and Chang (2002) examining the factors that had an impact on quality of life following a stroke, discovered that physical disability and levels of social support were extremely important in determining outcomes of stroke rehabilitation, and therefore quality of life.

It would seem that social support is integral to the overall wellbeing of the patient and it is interesting to note that both these studies had similar findings despite the diversity of the patient group. However, a recent study by Glazier *et al.* (2004) examining patient, family and health professional perspectives on targets for rehabilitation, noted that family and health professionals' perspectives differed markedly. The authors discovered that family members were more likely to identify spiritual, psychological and social needs for their relatives, whereas health professionals identified mainly functional needs. Another interesting aspect of this study was that family members identified more goals for the patient than did the patient themselves.

2.4.5 Summary

The problems associated with differing health professional and patient/family decision- making and perspectives could create significant problems with both the organisation and the delivery of patient care. The importance of exploring and attempting to understand how patients experience care and then make decisions is an important step in helping to alleviate these problems. Recent research has started to acknowledge that understanding patient experience should be a starting point for the organisation and planning of care, not something that occurs as an afterthought. This study has acknowledged the importance of the patient experience in relation to the emergency admission to hospital and was consequently designed to explore this experience in detail within the context of contemporary government policy.

2.4.6 Chapter summary

To recapitulate, the following provides a brief summary of the current state of knowledge regarding the patient's emergency admission to hospital and subsequent organisation of hospital care.

- Literature from many sources including empirical research, professional comment, policy documents and personal opinion has demonstrated that emergency admission rates to hospital continue to rise. This rise is evident in all age groups, but is more apparent for patients who are 65 years and older.

- A considerable amount of uncertainty surrounds the factors underlying the rise in emergency admissions, not least because of the different sources of information and the different methodologies and approaches used within published research.

- The factors identified in the literature include: the provision of and access to primary care services; admission to hospital alternatives; the organisation of acute hospital care; the provision of doctors with appropriate skills; and the ageing of the population.

- The literature review also identified that there are other less well understood factors that appear to have an impact on the emergency admission to hospital and organisation of care including health professional perspectives, decision - making and the involvement of patients in the planning and delivery of healthcare services.

- This review has demonstrated that there remains considerable scope for improving and increasing the body of knowledge in this area further, particularly in relation to decisions about admission, patient experience and perspectives.

Chapter Three - Research Design and Methods

3.1 Introduction

The purpose of this chapter is to provide a full and detailed description of the research theory, design and methods utilised during this study. This chapter commences with details of the research questions used to guide the study and the impact of the pilot phase on the development of these questions.

The pilot phase was an integral part of the overall study and was designed to follow three patients for four days, starting from the point of their admission to hospital. A number of changes were made to the main study after conducting the pilot phase and details of this have been incorporated into the appropriate sections within this chapter. Some of these changes were quite fundamental to the overall research design of this study at both a practical and methodological level. For example, the pilot phase was highly informative on a number of issues such as the time frame used for data collection, accessibility of patients and the feasibility of the research design and methods. It therefore helped to clarify points related to the main research questions including their appropriateness and applicability within the clinical setting. A brief synopsis of the patient cases recruited during the pilot phase can be found in **Appendix One**.

3.2 Research aim and questions

The main aim of this study was:

> *To explore the factors that influence the emergency admission of patients to hospital, and the impact of these factors on the patients' hospital experience and the delivery and organisation of patient care*

Two main research questions were developed in order to address this aim.

> *What are the factors that influence the emergency admission of a patient to an acute medical bed and the organisation and delivery of care thereafter?*

How do these factors impact upon the patient's hospital experience?

These questions were developed after a lengthy period of exploratory work, which included the pilot phase. The questions that were initially developed to guide the pilot phase differed considerably and are detailed below.

3.2.1 Pilot phase aim and questions

To explore the factors that are perceived to influence the decision to admit a patient to an acute medical bed and the extent to which these factors appear in individual patient cases

How do these factors influence patient care decision-making and opinion?

How do these issues appear to impact upon the management of emergency beds and patient care?

The pilot phase questions differ from the questions finally used to guide the research study on two main points; firstly, by focussing upon decision-making and opinion and secondly, by emphasising the need to explore the management of emergency beds. It became apparent that the original research questions were too restrictive. On one hand, they concentrated too closely on the time period around the actual point of admission and on the other hand, they were too expansive and it was felt that the questions were trying to address too many issues. The pilot phase indicated that whilst it would have been interesting to explore the factors related to bed management, it was simply not possible to access data in sufficient depth or detail to actually address this question. Also, importantly, it was apparent that the pilot phase questions were actually leading the research study further away from the heart of the case, which was the patient's experience of emergency admission to hospital and subsequent hospitalisation. Therefore the research questions were adjusted to take account of these issues.

3.3 The main research design

This study explored the processes involved in an emergency admission to hospital, in particular concentrating on how the events of the admission were interpreted by those individuals involved. As a result, this study was complex, with exploratory, descriptive and explanatory components and was designed to be inductive rather than deductive in nature.

Since sensitivity to the social world and the processes within it were central to this study, the research design and the data management strategy needed also to be sensitive, flexible and adaptive. These main characteristics (sensitivity, flexibility and adaptability) indicated that it was firmly rooted within the qualitative research tradition. Mason (1996) described the various key elements of qualitative research. For example, it should be systematic, rigorous, flexible, contextual, reflexive, generalisable and ethically conducted. Patton (1990) suggested that qualitative research facilitates the investigation of issues in detail, whilst being unconstrained by predetermined categories.

The factors influencing the choice of research design within this study were based on the need to address the research questions in the clinical context in which the study was based. Choosing a research design that was sympathetic to the nature of the research questions and context of the study has been advocated by a number of authors, most notably Patton (1990) and Secker (1995). In addition Murphy *et al.* (1998) has encapsulated the latter in the phrase *'horses for courses'*, encouraging researchers to choose research designs and methods that produce the most comprehensive answers to the questions being asked.

3.4 The case study

The focus of this research study was the need to examine a naturally occurring system with minimal intervention. To do this required an approach that was flexible enough to facilitate access to data from a variety of different sources using a variety of different methods. A case study approach favoured these requirements.

The case study approach has been used in a variety of settings, from education and healthcare to business and anthropological studies (Hammersley 1992). Due to the variety of disciplines using this approach, no single case study design exists. Rather there is a general acceptance that it is an approach (Yin 1984; Yin 1989; Yin 1993) that facilitates the understanding of complex phenomena within a given context, whilst utilising a variety of data collection methods.

3.4.1 The principles of the case study approach

Yin (1984) described the 'case' in case study research as the unit of analysis. This unit of analysis can be an individual, organisation, event or phenomenon. In addition, Miles and Huberman (1994) have suggested that the case in case study research can also represent a temporal event, such as the development of an innovative teaching program over time or a person to person encounter. This would seem to imply that the case could be a range of things only limited by the imagination of the researcher and the time available to conduct the research. In contrast, Stake (1995) has suggested that the case is a specific integrated system with defined boundaries. This view of the case has been reiterated by a number of authors such as Merriam (1998), Miles and Huberman (1994) and Yin (1984).

3.4.2 The overarching research design

Intrinsic fascination with the particular rather than the general is one of the key features of case study research. Intrinsic and instrumental case studies have been identified in a number of texts, most notably Stake (1995) and Yin (1984). It is important to have a thorough understanding of the intentions of a study as the methods employed within an intrinsic or instrumental case study can differ markedly. For example, in this study, whilst each patient case was intrinsically interesting, the real strength of this study was the collective experiences of the eight patients and the factors influencing their admission to hospital and delivery of care. For this study then, the heart of each case was the patient's admission to hospital and their subsequent hospital stay. Each case (i.e. the patient and their hospital admission) was instrumental to understanding and then exploring the factors that influenced the broader issues of hospitalisation and the organisation and delivery of care.

3.5 Setting boundaries around a case

Setting boundaries (Merriam 1998) has practical and methodological advantages, as it is associated with how finite or restricted data collection needs, or is intended to be. Without boundaries, in theory data collection could continue indefinitely with no restrictions on what and who should be included. Therefore, the major methodological advantage of bounding a case relates to time management during data collection and the acuity of the research study. Two factors required consideration within this study in relation to boundary setting. Firstly, who and what to include as part of the case study and secondly, how long in terms of time should be spent collecting the data for each case.

The time frame for data collection was adjusted quite dramatically following the pilot phase. Originally, it was intended that data collection would only occur for a maximum of four days including the patient's admission day. This remained the same for each case, even if the patient remained in hospital after this period of time. However, the pilot phase revealed that many of the issues related to the hospital admission and the patient's experience only began to emerge several hours and even days after the patient was admitted to hospital. Therefore, ceasing data collection on day four and collecting the majority of data around the point of admission actually resulted in the loss or lack of some very interesting and informative data. In one case (during the pilot phase), the patient, despite being well, was still occupying an acute hospital bed on day four of her admission. No decisions had been made regarding her discharge and she was unaware of the specific decisions being made about her care. If data collection had continued beyond day four, a greater insight might have been gained into the discharge arrangements, the organisation of care and the rationale underpinning the decision to keep her within an acute medical bed. As a result all the cases within the main study were followed for their entire hospital stay, which ranged from 24 hours to three weeks. Data collection, and hence the study boundaries, were then extended to include people and events related to both the patient's admission and their entire hospital stay.

The healthcare environment in which this study was conducted was highly complex and multi–layered. It was not always possible to decide before entering the field who, and what would be observed or interviewed and to what extent the data collected would be informative. Hence, the boundary around the case within this study needed to have a degree of flexibility in terms of the data collection process. However, the time frame (the patient's entire hospital stay) was finite and this for practical purposes provided a fixed end to data collection.

3.6 Sampling

Sampling is not purely confined to the selection of a case; within each case a milieu of available information must be sampled. Deciding when, how and whom to sample presents a number of dilemmas, as ultimately the limits that are placed on the sample will influence the conclusions drawn from the study.

A multiple case study approach was used within this study, and maximum variation among the cases sampled was sought. On the basis of this decision, purposive sampling was adopted. Patients were sampled so that a cross section of the emergency medical admissions population would be achieved. The intention was not to obtain a representative sample; rather it was to identify cases that would address the research aim and questions, whilst maximising what could be learned about the phenomena. Therefore, the patient cases recruited into this study were all admitted at different times of the year, day and week and were selected from two different age groups, those over 65 or those under 65. Details of the recruitment protocol are indicated in **section 3.6.1** and **Table 3.1** provides details of the sampling characteristics of each case in this study.

3.6.1 Patient selection

The patient's named nurse acted as an intermediary between the selected patient and the researcher at the point of recruitment. The patient was only approached after they had expressed to the named nurse their willingness to participate in the study. A thorough explanation of the study and an information sheet was supplied to each patient. A consent form was then signed and retained by the patient; one copy of this consent form was placed in the patient's medical notes. However, certain criteria were considered important in the selection of patients, these were as follows:

- The patient must have been admitted to the A&E department during one of the following time frames: Anytime during a public/bank holiday; Monday to Friday between the hours of 9 am and 5 pm; during the weekend (between the hours of 5 pm on Friday and 9 am on Monday); at night, anytime between the hours of 5 pm and 9 am.
- The anticipated admission must have been for 24 hours or longer.
- The patient must have been willing and able to consent.
- The patient must have been admitted to the hospital via the A&E department.

It was originally anticipated that in addition to these sampling criteria, each patient would be recruited on a rotational basis from one of the three major access routes into the hospital which were the A&E department, The Emergency Medical Admissions Unit (EMAU) and The Elderly Emergency Admissions Unit (EEAU). This was certainly the intention of the pilot phase, and relevant permissions had been granted to collect data from each of these areas. However, the EMAU and the EEAU rarely had any available beds due to the problems arising from bed availability in the hospital. Patients were consequently re-directed to the A&E department to wait until a bed became available. The lack of available beds appeared to be a regular occurrence within both the EMAU and the EEAU. As a result the sampling framework for the cases was adjusted so that patients were only recruited from the A&E department.

Data collection for both the pilot phase and the main study occurred between June 2001 and August 2002.

Table 3.1 - Patient sampling characteristics

	Sampling characteristics	
Patient Case	**Admission day/time/month**	**Patient age**
4 - Susan	Weekday, during the day (9am-5pm) **October**	86 yrs
5 - Lillian	Weekday, during the night (5pm - 9am) **October**	89 yrs
6 - Mark	Public holiday **January**	42 yrs
7 - Betty	Public holiday **April**	77 yrs
8 - Gail	Weekday during the night (5pm - 9am) **May**	68 yrs
9 - Nigel	Weekend **June**	83 yrs
10 - Norman	Weekday during the night (5pm - 9 am) **July**	75 yrs
11 - Vera	Weekday during the day (9am - 5pm) **August**	58 yrs

3.6.2 Determining sample size

In addition to making choices about case sampling there were other considerations regarding sample size. Within case study research, there are no pre-determined sampling formulae or universally accepted ways to determine the size of a sample. However, it is the quality of data within case study research rather than the quantity that is important (Sandelowski 1996; Stake 1995). For example, too large a sample may result in loss of detail and case study depth; too few cases may negatively influence the credibility of the study. Additionally, the homogeneity or heterogeneity of the population can have some influence over the sample size. Therefore, a study employing a purposeful maximum variation approach towards sampling needs at the very least to include cases that represent all of the pre-determined variables.

Lincoln & Guba (1985) identified that informational redundancy, alternatively termed 'theoretical saturation', influences the point at which sampling in qualitative research should cease. This suggests a purposeful inductive approach towards sampling. Data for this study were collected across the seasons and time frames for a period of one year. Data collection only ceased when this was achieved, although, experience during the pilot phase of this study indicated that there were important variables that needed to be represented in the cases. One example of this was the selection of a medically expected patient referred to the A&E department. This was a patient that needed hospital admission after they had been reviewed by their GP in consultation with a member of the hospital's medical team. The A&E department were alerted to their imminent arrival and a bed on an appropriate ward was reserved for them. It appeared that medically expected patients accounted for a significant proportion of emergency admissions.

3.7 Data collection methods

This study utilised various different data collection methods, namely interviews, observation and documentary analysis. This section will examine how these methods have been used within this study. Firstly, however, consideration needs to be given to the influence of the pilot phase on the data collection methods employed.

One of the main purposes of the pilot phase was to practice, and then improve, the data collection techniques and refine where necessary the data collection methods (interviews, observations and documentary analysis). During the pilot phase it was originally intended that only one patient interview would be conducted and this would occur at or around the point of admission. Experience of collecting data during the first two cases in the pilot phase indicated that the patient interviews were actually one of the most informative data collection methods. The patient interview helped to complete the picture of the hospital admission and provide details that were difficult to obtain from documentation, observation or other health professionals. Therefore, it was decided that where possible daily interviews would be conducted with the patient and these would be manually or tape-recorded depending on circumstance and the preference of the patient.

3.7.1 Interviews

Within this study a combination of interview techniques or approaches were employed to gather detailed data. Several interviews were conducted per case depending on the accessibility of the patient and health professionals. The patients were interviewed daily to explore factors that were important in the lead up to their admission and their ongoing hospital experience. It was discovered that the interviews often helped to answer questions that arose from the documents, the interviews with other health professionals and the observations, whilst providing a real insight into the patient's experience. Other interviews were conducted with health professionals involved in the admission process and included the admitting doctor and the referring doctor and nurse if appropriate. These interviews had similar advantages to the patient interviews, although it was often more difficult to access the health professionals. Therefore, some of the interviews were tape-recorded whilst others were less formalised exchanges of information where written notes were taken. The final group of health professional interviews in this study were conducted with health professionals who worked at a strategic level within the area of acute emergency admissions. These health professionals were identified using a snowball sampling technique. For example, towards the end of each health professional interview, the health professional was asked to identify another person who had either specialist knowledge or could inform the study further. This health professional was then in turn approached for an interview and the process continued.

Guba & Lincoln (1981) argued that it is almost impossible to gain access to an individual's experience and perception without some form of face-to-face contact. Therefore, perhaps one of the greatest advantages of the interview, is the opportunity to learn about the situation or phenomenon from another individual's perspective. In addition, but equally important, the unstructured interview can also fill in the gaps and the missed information that can be left by other data collection methods such as observation and documentary analysis. Particularly pertinent to this is the use of interviewee prompting. Appropriate probing within the unstructured interview can help to clarify terminology, explore unclear issues and obtain a greater understanding of the phenomena or situation (Barriball and While 1994). The additional benefit of appropriate probing or prompting is increased interactive opportunities between researcher and interviewee and the minimisation of socially desirable answers (Patton 1990).

Despite the obvious advantages of this approach in practice, unstructured interviews are not without difficulties and drawbacks. Firstly, it is not always possible to have control over the context in which the interview is conducted or the individual being interviewed. There are a number of factors that can, and do influence the quality of the interview, such as the nature of questions, mood of the researcher and interviewee, background noise and activity. Secondly, reliability of the information obtained can also be open to question. This particular issue can be difficult to minimise, although Guba & Lincoln (1981) and Stake (1995) suggest that maintaining an open approach and establishing trust with the interviewees can help the situation immensely. It could also be argued that the unstructured interview does not actually exist; rather that there are various levels of structure, from highly structured to loosely structured.

Finally, the interview enables an insight into alternative perspectives and belief frameworks. However, as a data collection method it is highly dependent on the spoken word and the information that the respondent chooses to share with the researcher. Uncovering meaning from a verbal exchange and interpretation of the interview data is a complex and subjective exercise and it does not necessarily facilitate access to tacit knowledge. Therefore, two other data collection methods were chosen to complement the interview. For details of the interview schedule refer to **Appendix Two**.

3.7.2 Observation

The main purpose of the observational periods within this study was to become familiar with the context in which admission decisions were made, and care organised. Observations were particularly important in order to gain an insight into complex natural settings, such as a clinical area. The observational periods within this study were mainly used to examine the events directly related to the patient's admission, for example, patient related ward meetings, ward rounds, shift change meetings and case conferences. Some of the events observed had a definitive purpose, which aided the systematic recording of the data. It was also found that observing the general milieu of the ward provided interesting insights into the ward context. This point became particularly apparent during the pilot phase of this study as it was obvious that decisions regarding patient care were often made informally after or before ward rounds or meetings. It was therefore important to capture this information and this was only possible by observation. The result was a collection of unstructured observations. The observations were then transcribed from the field notes and researcher comments or insights were added to the text using footnotes. For clarification of the type and number of interviews, observational sessions and documentary analyses conducted per case refer to **Table 3.2**.

Guba & Lincoln (1981) offered four main areas that require careful consideration when planning to use observation as a data collection tool. These loosely fall under the headings of, setting, logistics, method and researcher. Perhaps the greatest concern of observational research is the influence the researcher may have on the observed setting and the disruption this may cause (Denzin & Lincoln 1998). It is extremely difficult to predict the extent to which observational periods influence the setting, although it is safe to assume that some degree of disruption occurs (Guba & Lincoln 1981). An important part of the observational periods and later analysis is to be aware of this disruption and interpret findings in the light of it.

Logistically, a single researcher can only spend a finite period of time within any observational setting. Within this study, the time available for observation was limited and therefore the events being observed required careful consideration. It would be quite possible to leave the observational setting with a mass of unstructured and unsystematic observations not necessarily related to the study. This highlights the next criticism levelled at observational approaches, that of lack of structure. The extent to which structure can be applied to the observational periods relies heavily on the purpose of the study and the questions being asked. Within this study, some of the observational periods were well defined, for example they had definitive start and end times. However, an equal number of the observations did not have a definitive start or end time and were essentially unstructured. Choosing when to cease the observation was problematic at times. Whilst I tried to consider the overall principles of observing within a natural setting, I did find that my concentration began to wane after prolonged periods of observation. It was at this point that the observational session ceased as lack of concentration might have led to loss of detail. After an alternative activity such as documentary analysis, it was possible to return to the activity of observation.

Guba & Lincoln (1981), Merriam (1998), Miles & Huberman (1994), Stake (1995) and Yin (1984) identified that observational approaches towards data collection are highly subjective. Miles and Huberman (1994) proposed that the researcher should highlight any pre-conceived notions about the event or phenomena to be observed prior to observation, whereas Denzin & Lincoln (1998) suggested that validity be maintained by the use of multiple teams of observers or multiple observations over a variety of settings. These various strategies would seem to indicate that it is desirable and possible to obtain a degree of objectivity when using observation as a data collection method. In this way reliability and validity can be maintained. However, it could be argued that it is almost impossible to gain objectivity when using observation as a method for data collection; the researcher selects what is to be observed, and then subjectively decides what is to be recorded. If the latter argument were adopted, then neither of the two strategies identified above acknowledge the subjective nature of observation. However, since within this study observation was not the only data collection method used, it was anticipated that using other methods of data collection alongside would help to maintain the credibility of the data collection process.

3.7.3 Documentary analysis

It was not practical in this study to examine the documents separately for emergent themes, as out of context they appeared meaningless. The main documents used in this study were the nursing and medical notes, which were re-produced in the research notes as faithfully as possible. These documents were very useful when it came to confirming a contested event or issue such as an X-ray or blood test, although the documents, perhaps unsurprisingly, were not always accurate or up to date (Hobbs *et al.* 1997).

The process of documentary analysis can help to identify and clarify points emerging from both observation and interview methods but also help highlight more questions. Gathering data using documentary analysis requires similar skills to interviewing and observation in terms of being organised, systematic and alert to emerging new ideas and themes. One of the criticisms of documentary analysis is that much of the detail is lost in the analysis as Larsen (1991, cited in Denzin and Lincoln 1998) stated,

> *'when trying to break texts down into quantifiable units (words, expressions), analysts in fact destroy the very object they are supposed to be studying'* . (p.43)

The ease of accessing documents can have an advantage over the use of interviews and observation, which can require lengthy negotiated access. However, the value of documentary analysis is dependent upon how accurately the information is recorded in the first instance, and then reproduced in the researcher's notes. The researcher's ontological and epistemological position also has some bearing on the use of documents in research. In essence, if the researcher perceives that reality is tangible, then, an insight and understanding of this reality can be obtained by collecting and then studying written documents (Mason 1996).

3.8 Negotiating access for data collection

This study was conducted within a number of clinical areas in a large acute hospital trust, and considerable time and effort was needed in order to gain access to the clinical area in the first instance. Several presentations were given to the various stakeholders and the heads of the clinical areas where the research was to be conducted. On the whole the study was received positively; however, it was still necessary to re-negotiate access on a number of occasions whilst the study was in progress. This was particularly apparent within the A&E department, as teams of health professionals were constantly changing due to their shift patterns. It was therefore necessary to reintroduce the study each time a different member of staff appeared in the clinical area. It was also necessary to re-justify the study and the study intentions at it seemed that every member of staff had their own interpretation of the study and the potential findings. Additionally, as a matter of courtesy, prior to looking at the medical or nursing notes, permission was always obtained from both the patient and relevant health professional and this was in accord with the ethical considerations of informed consent.

3.9 Adopting the researcher role

There were some considerations associated with attempting to balance the personal and professional researcher roles during this study. This particular issue required some detailed scrutiny prior to data collection as these roles had important implications for the overall conduct of the study. Stake (1995) identified that the case study researcher has many varying roles. The role that the researcher adopts within the study is personal and often changeable depending on the context. My role within this study included aspects of the role of listener, observer, biographer, interpreter, and advocate. It is often not clear (Stake 1995) which is the better role to adopt and it is not always reasonable to assume that the researcher can maintain the same role throughout the case study as the context changes. Therefore, in order to continue to collect data in case study research, the researcher must also adapt. Indeed Yin (1989) suggested that conducting case study research actually places more of a strain on the researcher's ego, intellect and emotions than any other methodology. At times during this study this strain was very apparent, particularly when the patients were experiencing a prolonged hospital admission as it was necessary to be present in the clinical area conducting different types of data collection in rapid succession. For example, it was necessary in this situation to concentrate for long periods of time often without a break.

The professional background of the researcher can also have important implications for the researcher's role. One of the most interesting and difficult aspects of managing the researcher role in this study was balancing my professional background of nursing against a pure researcher role. In the end several factors influenced the role that was adopted.

Firstly, I was not entering the field with the intention of providing clinical care or giving a professional opinion; the study design did not require this, As a result, this was made explicit to the patient at the point of recruitment to avoid any possible confusion. Secondly, a conscious decision not to disclose my professional background to other health professionals was also made. I did not want health professionals to feel unduly influenced by my presence in the clinical area or for them too assume that I had prior knowledge of a subject or event. This was partly because I wanted to be able to ask questions that might have been considered naïve or obvious from someone with a health professional background. Thirdly, I wanted to remain as objective as possible during the data collection phase of the study.

Constant reflexivity during the course of the study was necessary to understand and adapt to the researcher's role. Despite the conscious efforts made to avoid confusion of roles during data collection, it was not always easy to balance the two. It became particularly difficult when the patients would ask advice or questions, which I knew I could answer. In these instances, I would refer them to the nurse or doctor responsible for their care. Nevertheless, there were many positive aspects of being both a nurse by background and a researcher. For example, I was familiar with the general hospital system and language used and therefore interpreting written documentation was easier, as was following the path of the patient through the hospital system.

3.10 Ethical issues

Discussions surrounding the principles of research ethics have tended to focus more on ethical codes principally agreed for use within the biomedical field (Murphy 1998). At the centre are four main ethical principles, the principle of autonomy, non-maleficence, beneficence and justice.

A number of ethical issues were apparent within this study and have been considered in relation to these four principles. These issues are described in the following paragraphs.

3.10.1 Informed consent

Informed consent was obtained from the study participants (in this instance patients and clinical staff) after they have been fully and truthfully informed of the purpose of the study. Within this study informed consent was achieved primarily by ensuring that the patients could understand the study purpose and data collection methods. Secondly, it was also important that the patients were given sufficient information and time to make an informed decision without undue influence from the researcher. Consequently, each patient was approached upon their arrival to the A&E

department (or soon after), only after they had been assessed by a nurse for their ability to consent. The study was then explained to them and they were given an information sheet to read. It was then explained that they were free to ask any questions and were free to decline to participate without their care being influenced (**see Appendix Three for patient and health professional information sheets**).

Traditionally, informed consent would normally be obtained at the beginning of a study, and is subject to the participant understanding the purpose of the study and their involvement in it. Difficulties arise when there are doubts about the participant's ability to consent, or where unforeseen changes occur within the study. The former can be approached by limiting, or excluding, the involvement of participants whose ability to provide informed consent is in question. In this study certain inclusion criteria were applied with these issues in mind (**refer to section 3.6.1**).

Changes in the study or unforeseen events may require re-negotiation of informed consent on an ongoing basis, known as process consent (Munhall, 1993). One issue that arose during this research study was the involvement of the patient's relatives, particularly during interviews. In this scenario a consent form was not signed, although the patient's relative was made fully aware of the study and was only interviewed in the presence of the patient and with their express permission. However, this does illustrate some of the potential ethical dilemmas that are encountered during the course of a study.

3.10.2 Right to privacy

All of the study participants were informed of the confidential nature of the research and that their anonymity would be maintained within any reproduced data or reports. Each patient signed a consent form with this in mind. However, maintaining total anonymity during data collection was not possible and inappropriate. For example, it was constantly necessary to ask the health professionals about the patient's wellbeing, results of tests and discharge arrangements. All the health professionals within the clinical area knew which patients were involved in the research study; often they themselves were taking part. Nevertheless, all the information divulged during the research study was confidential and the only exception to this was when, or if it was necessary to disclose information to a third party in order to prevent harm to the patient. Fortunately this did not occur at any point in the study.

3.10.3 Protection from harm

Protection from harm is referred to as the principle of non-maleficence within biomedical ethics. During the planning stage of this study it was presumed that the potential for harm would be minimal. It was recognised, that an emergency admission to hospital often represents a point of crisis in an individual's life and during this study extreme care was needed when deciding to approach an individual patient. There was also the issue of whether the benefits of conducting this study outweighed the potential harm that the study could cause. Certainly this study never intended to intervene in the care of the patient. However, it did contain a degree of intervention in the form of interviews (Patton 1990), which also have the potential to cause emotion and harm. When this happened within the study, the patient was asked if they wished to finish the interview. It must be reiterated that the role adopted within this study was one of researcher, not nurse or therapist, and the prime aim was to collect high quality data. Nevertheless, the welfare of the patient or the health professional had a higher priority. It was therefore necessary to be flexible during the interviews in terms of approach and timing to allow for patient ill health or reluctance to participate. If it became apparent that the study was uncomfortable for the patient, they were given the option to withdraw. However, this did not actually happen at any stage during the study.

The formative stages of the study design required the submission of a research study proposal to the Local Research Ethics Committee for approval. The submission included details of the study and the study sample and outlined any ethical issues that might have had an impact on the study participants. The Local Research Ethics Committee then determined whether they considered that the study would cause any unnecessary physical or emotional harm to the participants. They subsequently gave their full approval with a few minor amendments in April 2001. The main amendment to the study design was for the researcher to use an intermediary (for example, a nurse) to approach the patients within the A&E department. This was included in the final research study design.

3.11 Establishing rigour

Conducting a study rigorously requires considerable thought and attention both at the initial design phase and throughout the progression of the study. Hammersley (1992) and Wolcott (1995) suggested that the two paradigms, qualitative and quantitative have very different criteria for assessing rigour within research studies. In general it is accepted that the positivist approach, which utilises internal validity, external validity, reliability and objectivity, is not an appropriate measure of rigour within qualitative research (Guba & Lincoln 1989 and Wolcott 1995). Guba & Lincoln (1989) have suggested an alternative, for example credibility, transferability and dependability. It is the latter set of criteria that was most useful for this study.

3.11.1 Credibility

Patton (1990) indicated that the credibility of a study relies on three related issues; the rigorous collection and analysis of high quality data, a researcher with appropriate skills and training and a fundamental appreciation of naturalistic inquiry. Miles and Huberman (1994) have viewed rigorous data collection methods and subsequent analysis as central to achieving credibility within a study. Wolcott (1995) in contrast perceived the dialogue related to obtaining rigour as a means of conceptual self-defence and cautions against getting too embroiled in the debate prior to engaging in a research study. With these various perspectives in mind, this research study was designed to be as credible as possible. Certain design characteristics have aided this process and are detailed below.

Triangulation of data collection methods is a recognised way of achieving credibility within qualitative studies (Patton 1990) particularly as a means of checking the consistency of data. However, the use of triangulation within this study was for the purpose of gaining a rich description of the patient's experience of admission to hospital rather than as a device for ensuring consistency. For example, the patients were interviewed in order to understand their admission experience and health professionals were interviewed to obtain their views of the patient and the admission. Observation and documentary analysis was performed to see at first hand what was happening to the patient and obtain details about medication and diagnostic tests. There was no doubt that considerable inconsistency existed between nursing and medical documentation and the patient's account of their own admission. However, it was felt that much of the inconsistency noted during data collection was actually related to the very different viewpoints and perspectives that existed and this enriched the study rather than diminished the credibility.

In light of these issues, it was important to handle the data produced in a way that would maintain the detail. The interviews were therefore transcribed verbatim as were the documents. When observations were performed, care was taken to record systematically details regarding the verbal exchange of information and contextual factors such as those related to the nature of the environment. All notes were made at the time (where possible) or soon after the observation. When the cases were integrated, care was taken to be as descriptive as possible, taking the time to use all forms of evidence when drawing attention to a particular issue.

3.11.2 Transferability

It has been suggested by Koch (1994) and Guba and Lincoln (1989) that transferability is dependent upon the similarity between settings. The researcher must provide sufficient contextual information to make comparisons between different sites possible. Wolcott (1995) acknowledges that qualitative studies are not purely about description they are also a way of generalising. However, generalising within this context and within this study refers to theoretical generalisation and sharing rather than statistical generalisation to a relevant population. Therefore, this study has been presented as descriptively as possible. Sufficient detail regarding the study context has been provided, so that readers can make meaningful comparisons to their own clinical areas.

3.11.3 Dependability

Koch (1994) suggests that the dependability of a study relies on how easily it could be audited by a third party. This again does not relate to the positivist view of audit but more to the principle of maintaining a decision trail that could be followed if necessary. This study has attempted to do this by demonstrating a clear picture of the analysis strategy, for example, by providing verbatim descriptive and contextual information and by discussing the findings of the study with colleagues.

3.12 Data analysis

The pilot phase provided an opportunity to practise the data analysis process and data management strategy that would be utilised in the main research study. The sheer volume of data obtained from the cases during the pilot phase had a significant impact on the entire study design. For example, it took considerably longer than anticipated to transcribe all the data collected from the audio tapes and the research notes. The original idea was to select a new case every two weeks for a year. However, the pilot phase indicated that this was simply not feasible and actually detrimental to data management. It quickly became apparent during the pilot phase that data from each case needed to be transcribed soon after it was collected to maintain clarity. Additionally, in order to be able to differentiate between individual cases, it was necessary to construct a patient story utilising all the various data sources before commencing a new case. It was therefore only possible during the main study to commence a new case every month.

Practising data analysis and management was not one of the original aims of the pilot phase, although some important lessons were learned which were subsequently applied to the main study. The most important lesson was the need to get to know the data. This was only possible if data were collected in detail and then dealt with systematically. It was necessary during the main study not only to build in additional time for data management but also additional time for the researcher to absorb the data and construct a working story. Examples of the patient story can be found in **Appendix Four**.

The data obtained from this study were in many forms, from transcriptions of loosely structured interviews to observations of ward events and notes from interviews with health professionals. The purpose of this section is twofold; firstly to outline how the emergent data were managed and secondly to provide a detailed description of the analytical process utilised during this study.

Miles and Huberman (1994) identified three components of data analysis; data reduction, data displays and conclusion drawing and verification. These components are not intended to be sequential; rather they demonstrate the various interactive stages within the process of data analysis (**refer to Figure 3.1**). It is important to appreciate that data analysis in qualitative research is not an activity assigned to the latter stages of a research study (Silverman 2000). Rather, it is an ongoing, interactive, inductive and reflexive process that occurs throughout the study from the initial conception of the idea to the production of the final report.

The choice of data management strategy and data analysis process had a significant impact on all aspects of the study including the method of data collection. The following few paragraphs will detail how this process has influenced data collection and analysis.

Description was the key word throughout the study. All activities related to data collection and analysis where performed with the intention of providing a rich description of the phenomena under investigation. The following briefly indicates how each data collection method (interviews, observation and documentary analysis) was managed in order to facilitate the data analysis process. It is important to note that initially each case was dealt with separately.

3.12.1 Interviews

The interviews were conducted on a daily basis (where possible) and then transcribed promptly. They were then read or re-read several times and notes were made about any salient points or themes emerging.

3.12.2 Observations

During the observational periods as much detail as possible was recorded. This included details of noises, activities and patient and staff interactions. All the details were recorded descriptively either during the observation or promptly afterwards. Each observation was then handled in a similar way to the interviews but with constant reference to the other types of data collected.

3.12.3 Documentary analysis

The main documents for review during this study were the patient's medical or nursing notes. The documents were recorded verbatim and then cross-referenced with both the interview and observational data.

The method of data management during the data collection phase had implications for the analysis phase. Throughout this study, data collection and data analysis occurred concurrently with the understanding that this approach had the potential to influence the study design and sampling framework. However, in actual fact no changes were considered necessary to the overall study design or the sampling framework.

3.12.4 Data analysis strategy

Figure 3.1 illustrates the data analysis process utilised during this study. The diagram demonstrates that there were several stages in the data analysis strategy although it has been indicated already that many of these actually occurred concurrently. For ease of description this process will be described as sequential even though in reality it was iterative with constant movement back and forth between data collection, conclusion drawing and verification.

Step one - data collection

Data collection was the first step in the analysis process as even in the very early stages, themes and concepts began to emerge. This stage of data analysis was important in terms of making the adjustment to more abstract ways of thinking. However, as time progressed and experience of the data grew, these initial themes became less important. During the data analysis step of the process, I made the first attempts towards constructing a patient story. By doing this it was easier to visualise how each piece of data related to the next and the construction of this, albeit in a very basic form, made it easier to handle the data in step two.

Step two - data reduction

Step two, data reduction, was the most time consuming activity in the analysis process. This was the chance to get to know the data in detail, and due to the sheer volume of data, this took considerable time (**see Table 3.2 for a breakdown of data sources per case**). Each document or interview or observation, once transcribed, was read and re-read several times. It was at this point that a data management software package (NUDIST 6) was introduced so that data could be managed more effectively. This software package had great advantages over manually storing the documents as notes and memoranda could be attached to each of the documents as thoughts progressed. The first attempt to construct a group of themes was achieved in this stage. A considerable period of time was taken to achieve this step, largely because the processes within it were very circular. For example, data would be reduced to a collection of around 40 themes. Then each text unit within this theme would be examined to see if it was appropriate to that theme or if it needed to be coded somewhere else. Usually at this stage, other themes would be identified and the number of themes would increase again until the next cycle of data reduction occurred. Gradually, during each cycle of data reduction, several themes would remain unchanged as a picture of the data was constructed. An example of an interview transcript at various stages in the data reduction cycle is located in **Appendix Five**.

Step three - data description

The data collection phase in this study lasted for a period of one year; data description therefore occurred alongside data reduction. The initial stages of data reduction focussed on individual case data and it was from these data that the first patient stories were constructed (**refer to Appendix Four**). The main aim was to use all data sources to help illustrate a point or a theme and build a descriptive picture of each patient case. In this respect the data reduction and the data description phases of analysis occurred side by side. Miles and Huberman (1994) have referred to this process as clustering by conceptual group, or trying to make connections or gain meaning from the text. However, the overall aim of the analysis strategy was to produce a detailed description of the collective themes emerging from the eight patient cases, moving away from focussing on the individual case analysis to focussing more on collective case analysis. One drawback of collective case analysis was that some of the intrinsic detail of the individual case was concealed or suppressed within the collective description. It was because of this concern that considerable time was taken to construct patient stories and understand individual data.

Step four - conclusion drawing and verification

Conclusion drawing and verification occurred to some degree at every step of the analysis process. Certainly active data collection also aided this step as invariably the more case data that were available the easier it was to verify patterns and themes. Each time data were collected the next round of data reduction and description would occur, which would then lead to modification of the conclusions. In addition, discussions with supervisors and other professionals in the field aided this process substantially. In the latter stages of thesis construction, conclusion-drawing and verification continued into the writing of the findings chapter. Therefore many of the early conclusions were subsequently re-visited as the data matured or other events such as new health policy highlighted important issues that were being reflected in the data. Data analysis only finally ceased after the findings, discussion and conclusions chapter had been written. **Table 3.2** illustrates the number and type of data sources for each case.

Table 3.2- Sources of data collected per case

		Data sources		
Patient Case	**Length of admission in days**	**Interviews**	**Observation**	**Documentary analysis**
4 - Susan	3	PInt x 3 HPInt x 2	ObsGen x 2 Obsround x 1 ObsCombi x 2	DocMNHP x 3
5 - Lillian	21	PInt x 13 HPInt x 8	ObsGen x 11 Obshand x 1 ObsCombi x 3	DocMNHP x 18 DocSpec x 2
6 - Mark	7	PInt x 5 HPInt x 4	ObsGen x 5	DocMNHP x 7 DocSpec x 1
7 - Betty	1	PInt x 1 HPInt x 2	ObsGen x 2 ObsCombi x 1	DocMNHP x 2
8 - Gail	1	PInt x 1 HPint x 2	ObsGen x 1 ObsCombi x 1	DocMNHP x 2
9 - Nigel	3	PInt x 2 HPInt x 2	ObsGen x 3 ObsCombi x 1	DocMNHP x 3
10 - Norman	5	PInt x 4 HPInt x 1	ObsGen x 2 ObsCombi x 1 Obsround x 3	DocMNHP x 4
11- Vera	2	PInt x 1 HPInt x 2	ObsGen x 3	DocMNHP x 2
Non specific	--	HPInt x 5	--	--

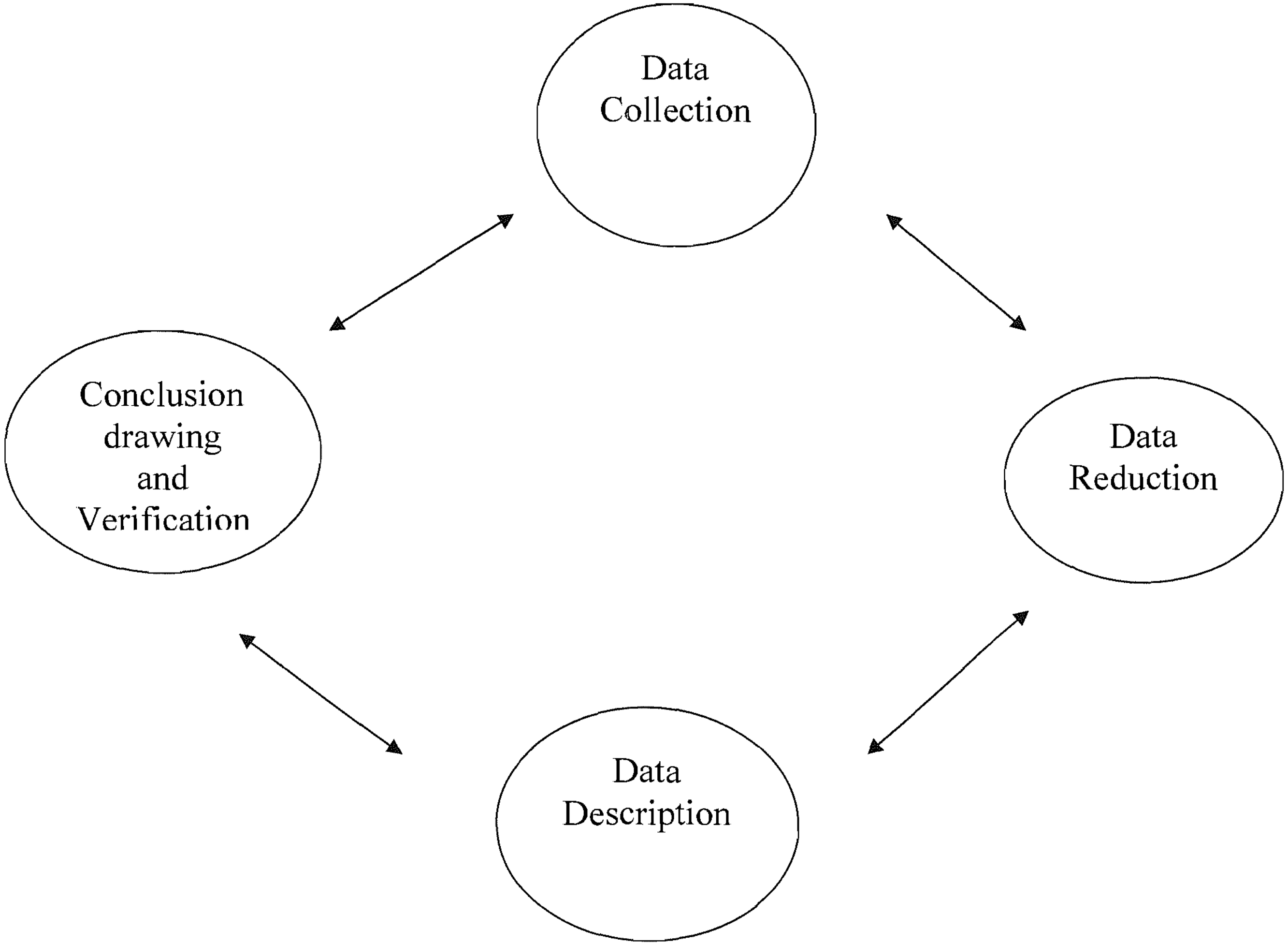
Key to abbreviations

PInt	Patient interview
HPInt	Doctor, nurse or other health professional interview
ObsGen	General ward observation
Obsround	Observation of ward round
Obshand	Observation of nurse handover
ObsCombi	Combination of general observation and ward round/nurse handover
DocMNHP	Documentary analysis of doctor, nursing and other health professional notes
DocSpec	Documentary analysis of specific documents i.e. discharge documentation

3.13 Chapter summary

This chapter has provided a clear description of the research design underpinning the study and has indicated some of the practicalities of using this design within a clinical setting. It has demonstrated that a case study approach using three different data collection methods was the most appropriate strategy for gaining an understanding of the complex nature of this phenomenon. Utilising a case study approach has provided an opportunity to explore the influences on the patients' emergency admission to hospital and afforded a unique insight into the patients' experience of this process. This chapter has also demonstrated that data analysis within case study design needed to be a dynamic, yet flexible process in order to allow for concurrent stages of analysis that would make optimal use of the data collected. The following chapter presents the findings from the study.

Figure 3.1 - Data analysis process



Chapter Four - Research Findings

4.1 Introduction

The chapter begins with a brief description of each of the cases and **Table 4.1** provides a summary of the key characteristics of each case. The emergent themes are then grouped and presented with respect to three overarching categories: the pre admission period, the post admission period and organisational considerations.

4.2 Case description

This section serves to describe each of the cases in terms of their personal and contextual data. Names are pseudonyms and some details are omitted or disguised in order to preserve anonymity,

Susan

Susan was an 86-year-old widow who lived alone in a house on the outskirts of her village. She was essentially independent at home despite a degree of arthritis and a pronounced visual impairment. However, the visual impairment impacted quite markedly on her ability to be independent outside her home, for example, she was unable to walk anywhere unaided. This problem was greatly exacerbated in the winter when the days were darker. As a consequence she relied on others for assistance with activities such as grocery shopping and paperwork. On the whole she managed to pass her time whilst in her house by listening to taped books, the radio and baking, but since this was all she could do because of her visual impairment, she often became bored and lonely

Susan had two daughters, both married and in their late 50's and early 60's. Neither of them lived in the local area. One daughter had a chronic illness and found it difficult to drive, and the other had never been able to drive. Therefore, neither found it very easy to visit their mother. Susan's financial affairs were partly managed by her son in law and both daughters telephoned their mother each day or at least every other day. Susan did visit her daughters and, at the point of her admission to hospital, she was staying with one of her daughters.

Susan had had some previous contact with other health professionals over the last 10 years, specifically for her palpitations, which on occasions had caused her to lapse into unconsciousness. She had visited her GP regarding these palpitations, but had been told that there was nothing much that could be done for her. After a number of years, Susan sought a second opinion from a private neurologist, who informed her that she should take Aspirin daily. Until the point of admission to hospital, Susan had been quite well. Immediately prior to her hospital admission, on a Saturday evening, Susan started to experience pain in her chest. The pain subsided over time and she awoke the following day feeling better. However, on the Monday morning the excruciating pain returned. Her daughter contacted the GP and was told to go straight to the A&E department. Susan arrived at the department at 9:50 am and was finally transferred to a ward four hours later. She remained in hospital for three full days and was discharged with a diagnosis of angina.

Lillian

Lillian was an 89-year-old woman who had been widowed for many years. She lived alone in a second floor studio flat in a warden controlled development. The development was situated quite close to the city centre, and Lillian was able to walk independently into and out of town to perform her errands. She had no other form of transport but enjoyed the independence and freedom of walking. In addition, until relatively recently Lillian had enjoyed going swimming at the local public pool in the mornings.

Lillian had a large family. She had two surviving sons and a number of grandchildren and great grandchildren. She had a close relationship with the wife of her eldest son (deceased) who lived within the local area and helped Lillian when it was necessary. Lillian told me that her other two daughters in law lived over 50 miles away in different areas and that it was more difficult for them to visit.

In general Lillian had maintained very good health over her lifetime and had only had minimal contact with the health service. Thirty-five years ago she had been admitted to hospital for a hernia operation. More recently she had seen a consultant concerning arthritis in her right knee. She was currently on the waiting list for a knee replacement, but had been told that this could take up to 18 months. Lillian's only other previous contact with the health service was when she went to see her GP. She was currently taking Thyroxine for hypothyroidism and Voltarol for her painful knee. Her only visit to her GP at the time of the study was to obtain a repeat prescription for these two drugs, but she did not actually see the GP. Since Lillian had been taking Thyroxine for over 40 years, she was no longer sure whether she still needed it, but it continued to be prescribed.

On the morning of Lillian's admission to hospital she had woken and got up as usual at around 7 am. She immediately felt breathless and felt that her heart was racing. She called the warden (since she lived in a warden controlled flat) and asked for assistance. The central control that handled all calls was unable to locate the warden; nevertheless an ambulance was then called and she arrived at the A&E department at around 8 am. Lillian remained in the A&E department for seven hours before being eventually moved to a ward. She stayed there overnight and was then moved to an elderly care ward for the remainder of her stay. She was diagnosed with pulmonary emboli (PE) and remained in hospital for 21 days including the day of her admission. She was discharged home and was moved to a different flat on the ground floor as she no longer felt able to climb stairs.

Mark

Mark, a 42-year-old man, ordinarily resided with his wife and two teenage children in a house within a few miles of the local hospital. He worked for the local city council as a manager but had previously been a labourer. Mark had suffered from asthma for 25 years and had recently been diagnosed with diabetes. Until recently, he had usually managed his asthma and asthma attacks successfully at home with medication. His diabetes was managed by medication and his GP preferred to test Mark's blood sugar levels in the surgery rather than encouraging Mark to do this at home.

Mark had first begun to experience difficulties with his asthma earlier in the year. During this time, he required regular contact with his own GP. However, on one particular day his asthma had worsened to such an extent that, after seeing his GP, he was referred to the asthma clinic at the local hospital. He was stabilised and then sent home on the same day. Later that evening his asthma deteriorated to such an extent that he had required hospitalisation. This was the first time that he had been an in-patient in hospital. Nevertheless after about a week he recovered sufficiently to be discharged home to await an out-patient appointment.

His second admission (the one during which he participated in the study) followed a similar path. Mark had not had an out-patient follow up appointment from his first admission (which had been five weeks before) when, he awoke around 7 am and went downstairs to use his nebuliser; he immediately started to feel unwell. Instead of beginning to relieve his symptoms the nebuliser actually began to make him feel worse. Mark's wife telephoned the respiratory unit who informed her that Mark should continue to take his medication and one of the nurses would come out to visit him as soon as he/she could. However, Mark was unable to wait due to his rapidly deteriorating condition; his wife telephoned for an ambulance and he arrived at the A&E department a little after 8 am.

Mark was stabilised in the A&E department and then transferred to the EMAU at around 1 pm. He remained in hospital for six days including the day of admission. The cause of his exacerbated asthma was not discovered during his admission.

Betty

Betty was a 77 year old woman who lived alone following the death of her husband four years earlier. Betty had continued to lead a very active life after the death of her husband and continued to work up to the age of 65. However, she missed going to work so much that she decided to take a job in a charity shop. Ten years later, at 75, she decided that she really did not want as much responsibility and she decided to retire from work completely.

Betty had two children, a son and a daughter, who both lived within the same region. She also had three grandchildren. However, on the whole, she spent quite a lot of time on her own which she did not always like.

She had not had much previous contact with health professionals, other than for the removal of a malignant melanoma in the 1980s and an exercise test 18 months previously to determine the cause of an episode of chest pain. She had visited the doctor during this time and had been told that her blood pressure was very high. However, no problems were found during her exercise test and she was sent home without any treatment.

Betty began to feel unwell again at about 7:30 am on the morning of her admission to hospital; it was a public holiday. She had a headache and felt quite dizzy and found it difficult to stand up and do anything. Therefore, she sat down in her living room and waited for the symptoms to subside. Because it was a public holiday neither of her two children were at work on that day. They both telephoned her to see if she was improving. When she did not improve, Betty's son telephoned her again with the number for NHS Direct (a nurse advice line), which she called.

The nurse handling Betty's telephone call was very concerned and suggested that Betty went to hospital immediately. The ambulance was called and Betty arrived at the A&E department at midday.

It was a busy day in the A&E department and the hospital was experiencing a bed shortage. Betty was kept in the A&E department for nine hours before finally being allocated a bed on the EMAU at 9 pm; she was moved to another bed on the admissions ward in the early hours of the morning. She remained in hospital overnight and most of the following day and was discharged home with some pain killers, but without a clear diagnosis.

Gail

Gail, a 68 year old widow whose husband had been dead for over 25 years, lived alone. Gail had two children; a son and a daughter. Her daughter lived within Gail's home town and Gail was able to see her daughter regularly. Gail was actually on holiday with her son when she began to feel unwell. She visited her son quite frequently as they had commitments which made it difficult for them to visit her.

Gail had been in good health, although recently she had experienced breathlessness and dizziness whilst on a holiday in another part of the country. She had been admitted to hospital on that occasion for five days and her family had rushed to visit her. However, the hospital then was unsure of the problem and suggested to Gail that she might be suffering from heart failure. The doctors suggested that she needed an echocardiogram but that she would have to get this in her home town. At the point of her second admission (the one in which she participated in the study) she was still waiting for this test and was unsure of when she would receive it.

On the day of her admission to hospital, she was alone at her son's house. This was unusual as her daughter-in-law was usually present. She was cooking the evening meal and began to feel dizzy; she consequently sat down and waited for her relatives to return. When they returned her son called his GP, who then visited Gail at home and suggested that she was taken immediately to the A&E department.

Gail and her family arrived at the A&E department at around 7 pm that evening. She was given a seat in the department until a bed became available. This bed did not have any monitoring equipment attached to it, so she was moved again. Gail was allocated a bed on the EMAU at around 11 pm and was monitored overnight. She remained in hospital for just over 24 hours and was discharged back to her son's house to continue to wait for an echocardiogram as the doctors had been unable to access one during her admission. She was discharged with a diagnosis of tachycardia and high cholesterol.

Nigel

Nigel, an 83 year old man, lived alone in his own house. He did not have any close relatives. His neighbours were of some help to him, however, and he had recently made an arrangement with one of them to come to his house and do a little light cleaning and washing. He was finding it increasingly difficult to do these two particular activities as he got older. On the whole, he managed all other aspects of his life independently.

Nigel suffered from chronic obstructive airway disease (COPD) which he managed at home with the help of his GP. He had had problems with his breathing for some time but mostly it had been controlled with nebulisers and steroids at home. Nigel complained that part of the reason why he was now so breathless was that he had gained weight as a result of the steroids.

Nigel had begun to feel increasingly breathless two days before his admission to hospital. He contacted his GP who assured him that he would feel better if he continued to take his nebulisers; he then began to feel slightly better. However, two days after seeing his GP he had woken up in the morning at around 8 O'clock, feeling very breathless. It was a Sunday and he was unsure of what action to take so he immediately called his neighbours who lived a few houses away. His neighbour then called for an ambulance and Nigel was taken to the A&E department, arriving at 8:30 am.

Nigel was very pleased by the care that he received in the A&E department as he claimed that he had been given every conceivable test. He was finally moved to the EEAU at 1 pm. He had been told by various health professionals that he would be in hospital for 24 hours. He actually stayed in hospital for three days. However, within a few hours of his admission to hospital he immediately felt much better. He was discharged home with 'exacerbation of COPD' as a diagnosis.

Norman

Norman, a married 75 year old man, lived with his wife. He had two children with whom he had regular contact, and a number of grandchildren. He had a very active social life and both he and his wife enjoyed going to Bingo on a weekly basis. They also did all of their own shopping in the town centre and regularly took the bus into and out of town to pick up household essentials. They had no additional help in the house and all the domestic chores were performed either by Norman or his wife.

He had an extensive history of major surgery related to his heart, and had been a hospital patient several times in the past and, on some occasions, in emergency situations. However, despite this, he had been very well for several months leading up to this admission and had had no symptoms of ill health at all until the morning of his admission to hospital.

Norman awoke early on Monday morning at around 5 am, feeling very breathless. He was unable to talk to his wife without gasping for breath. His wife, who was used to this type of situation, asked him what she should do and Norman advised her to call an ambulance immediately. The ambulance arrived within a few minutes and Norman was taken to the A&E department at the local hospital. He was given oxygen and within a short period of time felt much better and less breathless. He remained in the A&E department until 4 pm when he was given a bed in a side room on the admissions ward. However, he was moved from there after two hours to one of the respiratory wards. The doctors had queried a blood clot on the lung during his admission. Nevertheless, the test used to confirm this was not conducted until Norman had been in hospital for five days. The test was subsequently negative and Norman was discharged with no definitive diagnosis.

Vera

Vera, a 58 year old woman, was married and lived with her husband. She had two children, both of them in their thirties, but no grand children. Vera did not work outside the home and did not drive so she had to do all the household shopping by travelling by bus. Both Vera and her husband enjoyed cycling and had in fact been out a day or two before Vera's admission to hospital.

Vera had experienced excellent health and had not had any previous admissions to hospital. The only condition that she mentioned suffering from was indigestion, which apparently was a common problem in the family. When she awoke one Wednesday morning with a pain in her chest she dismissed it as indigestion. She began to take her usual indigestion treatment every four hours in order to get some relief from the pain, but on this occasion it did not seem to work. At this point both Vera and her husband decided to go for a bicycle ride to try and relieve some of the pain; however upon returning the pain was still present. Vera telephoned the doctor and was told that she could not have an appointment until the following day (Thursday).

On Thursday Vera woke at the usual time and noticed that the pain was still present. She continued her day as normal and caught the bus to the local supermarket. She returned and again telephoned the doctor and was offered a cancellation at her local surgery. The doctor examined her and suggested that she went straight to the local hospital as he suspected that she might have a blood clot on one of her lungs.

Vera arrived at the A&E department at 11 am; she was taken for an X-ray and was given a bed on the ward at 4 pm. She remained there for a few hours and was then moved to another ward where she stayed overnight. She was taken for a test to rule out the presence of a blood clot on her lungs and when this proved to be negative she was sent home later that day without a clear diagnosis. She had been in hospital for a little over 24 hours.

The following table (**Table 4.1**) provides details of some of the key characteristics of each case.

Table 4.1 - Patient case characteristics

Characteristics	Cases							
	Susan	Lillian	Mark	Betty	Gail	Nigel	Norman	Vera
Health professional contact prior to admission	Yes/GP receptionist only (telephone)	No	Yes/asthma clinic nurse	Yes/NHS Direct	Yes/GP/home visit	Yes/GP/surgery visit	No	Yes/GPs/surgery visit
Diagnosis pre admission/chronic health condition	Palpitations	No specific problem	Exacerbated Asthma	No specific problem	Previous admission for heart failure	COPD	Previous heart condition	No specific problem
Diagnosis post admission	Yes	Yes	Yes	No	No	Yes	No	No
Living status	Lives alone	Lives alone	With spouse	Lives alone	Lives alone	Lives alone	With spouse	With spouse
Mode of referral to hospital	Relatives prompted GP referral	Referred by Warden	Relative prompted self referred	Relative prompted NHS Direct referral	Relative prompted GP referral	Neighbour prompted self referral	Relative prompted self referred	GP referred
Mode of transport to hospital	Self/relatives	Ambulance	Ambulance	Ambulance	Self/relatives	Ambulance	Ambulance	Self
Length of stay in A&E (hrs)	4	7	5	9	4	4.5	10	5
Number of bed moves starting in A&E	1	2	5	2	1	1	3	3
Number of wards excluding A&E	1	2	3	1	1	1	2	2
Length of hospital stay (days)	3	21	7	1	1	3	5	2

4.3 The pre-admission period

The main focus of this section is the time leading up to the patients' admission to hospital and the main themes emerging during this time. The main source of data was the patient interviews. Themes are grouped but this is solely for ease of description as there are many interconnections between and within the themes. These connections will be explored in greater detail in **Chapter Five**. The themes described within this section are:

- Living with fluctuations in general health
- Taking control of personal health concerns
- Accepting and adapting to changes in life and general health
- The day-to-day difficulties of living alone
- The involvement of family and friends

4.3.1 Living with fluctuations in general health

All the patients in this study lived independently before their admission to hospital. Five lived alone, whilst the other three lived with their respective spouses. Ordinarily, none of the patients in this study were receiving regular routine input from health professionals other than the occasional visit to the GP, although two did have chronic health problems, asthma and COPD, one had a history of heart surgery and another had undiagnosed palpitations. In general, even taking into account these aforementioned long-standing problems, fluctuations in their health were tolerated or dealt with at home either by ignoring the symptoms or by waiting for them to subside. It was only when symptoms became too uncomfortable, that additional health advice was sought. By the point of admission to hospital these patients had been living with deteriorating health issues for days, weeks and even longer before seeking any help. This was particularly illustrated by two of them, both women living alone. Lillian reflected on her condition after she had finally been admitted to hospital.

> *'[The doctors] they are blaming the coach trip. I think it has been coming on a lot longer. Looking back on it, I have been walking round to get my pension and I was sitting down half way, I saw nothing wrong, then I would put the rent in the bank and have to sit down in the same spot on the way back. I was breathless and tired, I think it has been coming on and the coach trip didn't help'.* **5/PInt/d4**

Similarly, Susan only sought additional help after several months of feeling unwell.

> *'At one stage, probably three years ago, I was having palpitations two or three times a week. Not so bad, but three times a week was more than I wanted to cope with and I was getting very anxious. In the last two years they have been very quiet, my heart just beats a bit faster and perhaps I will go and lie down. Not that I have been afraid of it I soon learned that it wasn't killing me off'.* **4 /PInt/d1**

4.3.2 Taking control of general health concerns

Taking control of personal health was certainly an important aspect of living with a chronic illness. One of the factors that influenced the independence of many of the patients in this study was their ability to take control of and cope at home with their personal health concerns. The amount of support received to do this varied, depending on the nature of the health condition and the patients' living arrangements. It appeared that the patients in this study were admitted to hospital only when their pre existing chronic health concerns could no longer be coped with or tolerated at home, or there was an indication that their health problems may have become serious or even life threatening.

There were varying degrees of health professional contact, even for those patients who had significant chronic health concerns and were potentially vulnerable to deterioration. This fact was particularly apparent for those patients who lived alone. In general, the main point of contact in the community for health related issues was the patient's own GP. Lack of reference to the GP sometimes resulted from perceived lack of availability. For example, Betty complained that it took a long time to get an appointment and even then she was unable to see her own GP.

> ***'Researcher:*** *How involved has your GP been with this?*
> ***Patient:*** *Not at all. He wouldn't even know me. There are quite a few, if I do go I just go and see anybody who's available, otherwise if you wait for one particular doctor you would wait a couple of* weeks '. **7/PInt/ad**

In other instances, the patient did not feel it was necessary to see the GP. For example, Lillian had been on regular medication for 40 years but was not even sure whether she still needed it as she had not visited her GP for some time.

> *'I have been on Thyroxine for my thyroid for 40 odd years, after all this time, 'I wasn't absolutely certain whether I was taking it for an under active or overactive thyroid.*
> ***Researcher:*** *'And how often do you see your GP?'*
> *'I don't go to the doctor. I have the Voltarol tablets for the arthritis and I put in the repeat prescriptions, I get a note saying I have to go in for a blood test, otherwise no I don't'.* **5/PInt/ad**

Mark in contrast was accustomed to managing his own asthma so did not contact his GP when his condition began to deteriorate, but did take the advice given by his GP on a previous clinic visit. As Mark said

> *'I started feeling bad again which was about Friday. So I upped my steroids again to eight, because the GP always told me to do this'.* **6/PInt/ad quote 1**

All but two (Lillian and Norman) of the patients in this study attempted to seek some level of advice from a primary or community healthcare professional immediately prior to their admission to hospital, although patients were not always sure about who to contact and at what point when they began to feel particularly unwell. (Norman for example, arrived without contacting primary care at all in the three days before his admission, but he had had a very lengthy history of major surgery). Three of the patients went to see their GP or had the GP visit their home at some point within the three days before their admission, although this was after a day or more of feeling unwell. The other patients ignored their symptoms and waited to feel better or involved their family and friends who then made the decision to contact a health professional or the emergency services. For example, Mark related to me the events leading up to his admission.

> *'This morning I was fine when I got up, I got dressed, washed went downstairs. I started to use the nebuliser and it started just building up and building up, and really got so bad that I couldn't do anything. I couldn't even take the rest of the nebuliser. We phoned the nurse at the asthma clinic and she said she would get a nurse out to us as soon as she could, she said "take some steroids". But I couldn't take them. Well I just couldn't wait. So my wife called the ambulance and they rushed me in here'.* **6/PInt/ad quote 2**

Nigel realised that calling the GP probably was not the best course of action:

> '***Researcher:*** *When you were feeling ill in the morning, did you call your GP?*
> ***Patient:*** *Well it was Sunday and more than likely if I had rung my GP I would have been told to go to this other surgery, there is nobody there on a weekend.*
> ***Researcher:*** *Do they have a deputy service at a weekend?*
> ***Patient:*** *I don't know, no that was the trouble'.* **9/PInt/d1**

The latter quote illustrates that patients do not always have either awareness or an expectation of the availability of primary care services, particularly during the weekend or public holidays. Similarly, another patient, Betty, chose to contact NHS Direct, rather than her own GP when her condition started to deteriorate.

> '***Researcher**: So did you think about calling your GP at the time?*
> ***Patient**: I didn't know whether to bother him or not.*
> ***Researcher:*** *Do you think you would have called someone if your son hadn't suggested it?*
> ***Patient:*** *No, maybe I wouldn't, I would have sat there and waited to feel better'.* **7/PInt/ad**

There were instances throughout this study where the level of service through the GP was insufficient to meet the patient's needs and the patient was forced to access help elsewhere. This was demonstrated in the case of Mark (as indicated above in quote **6/PInt/ad quote 2),** but also in Susan's case as she had been informed by her GP that there was no treatment that would alleviate the discomfort of her palpitations:

> '***Researcher:*** *Was it at that point that you suggested that you needed to see a neurologist, or did the doctor suggest it?*
> ***Patient:*** *No I suggested it. I think it was a little bit because I began to feel that there was perhaps more that they could do, or suggest testing for something. I was expecting too much perhaps. So I thought, since it had been such a long time and they are never going to say it, I thought well, I thought that [a second opinion] was the next step'* . **4/PInt/d4**

Vera was also not able to access her GP immediately when she began to feel unwell.

> *'So we got on our bikes and rode off and came back, it [the chest pain] was still there. I thought I better phone the doctor at that point [on Wednesday].*

I couldn't get an appointment until Thursday until a quarter past four. The receptionist told me to phone in the morning [Thursday] and she said "if there is a cancellation we can probably get you in earlier". So yesterday morning at seven o'clock I got up as normal, went to the shops, did my shopping. The pain was still there but it was a dull ache and I thought that I would be all right. So I got on a bus did my shopping came home and phoned the doctor. Luckily enough they had an appointment free which was at a quarter past ten on Thursday morning'. **11/PInt/d1**

4.3.3 Accepting and adapting to changes in life and general health

For some of the patients in this study living with pre existing chronic health problems and fluctuations in general health were considered inevitable and, as long as they were not too severe, they were tolerated and appropriate adaptations made. For example, as Norman said

> ***'Researcher:*** *Were you frightened when you were admitted?*
> ***Patient:*** *No I wasn't to be quite honest, I thought well, it has happened, it's happened. I have had a lot of past health problems'.* **10/PInt/d1**

And Susan talked about her similar acceptance of her condition:

> *'[The angina]It doesn't worry me. I feel I have had all the worry with my palpitations, it hasn't been pleasant. This is at least a pain that will be controlled. I haven't had the control with the palpitations, I must accept these things'.* **4/PInt/d2**

Acceptance was also apparent in cases where the patient had had no experience of hospitalisation. For example, Nigel said:

> *'I don't like being here, I prefer to be on my own property, but I suppose it comes to it sometime. But in 83 years it is the first time I have ever been in hospital'.* **9/PInt/d1**

and Gail said:

> *'I don't know whether I could put up with that fainting feeling all the time, so as long as that has stopped I will be all right'.* **8/PInt/d1**

For some of the patients in this study, relief and acceptance seemed to be mixed with a real concern either about losing their independence completely due to their deteriorating health condition, or that their independence would be compromised. Gail summarised this feeling:

> *'The thing that worried me yesterday and really upset me was is this going to mean that I can't just please myself and get up and go, because I have done that for so many years. It knocks your confidence. I would hate to be obligated to anybody as I have always been independent'.* **8/PInt/d1**

Lillian shared a similar concern even though she accepted that life would be different for a while following her admission:

> *'I am hoping that I can carry on when I get back, you know life as it was more or less. I shan't be able to walk up to the park or into town for a while apparently. I like to be independent'.* **5/PInt/d3**

Acceptance and adaptation was a consistent theme running through many aspects of the patients' pre- and post-admission lives. Nevertheless, despite the concern regarding loss of independence, the reality for some of the patients was that the hospital admission precipitated changes in their daily living arrangements to accommodate their physical deterioration. In these examples, additional help was required on a daily basis but was arranged by the patient with assistance from a close family member or neighbour rather than a health professional or other support service.

For example, as Lillian concluded:

> *'I told my daughter-in-law to say that I have decided that I will move from the top flat down to a downstairs one, I don't want to go downstairs but I will do it. She's going to see the warden and the secretary at the flats for me'.* **5/PInt/d9**

And Nigel said:

> *'I have been living alone and I have just made arrangements with my neighbour that she should come in and do the cleaning and the washing for me. All I have to do is make sure she is there when I go home. She will have to be paid of course'*. **9/PInt/d1**

For Susan, who ordinarily resided alone, the hospital admission forced her to think more seriously about the need for a more supported living environment as it was becoming increasingly difficult for her to cope at home.

> *'I would like to be in a place where my daughters could visit me. I don't want to stay in my own village. I would be just as lonely, if I haven't got anybody popping in now, they are not going to pop in when I live in a home. What a sad story, it is a story that a lot of us could tell. I think this will have shaken [my daughters]them up a bit, they take care of me, well I don't need much taking care of, they think I am too independent anyway'.* **4/PInt/d2**

In contrast to the aforementioned examples, another patient, Norman, was annoyed at the inconvenience and the disruption that the admission had caused to his daily routine.

> *'**Researcher**: So how do you feel about this admission to hospital?*
> ***Patient:** Annoyed, I could have done without this. Normally, we go to Bingo on Monday, shopping on Tuesday, I finish off the shopping on Wednesday. We then go into town on a Thursday, have lunch in town and pick up any odds and ends. Friday if we can, we go to Bingo and at the weekend we relax. It will be a bit backwards this week'.* **10/PInt/d1**

4.3.4 The day-to-day difficulties of living alone

Most of the patients in this study lived alone for the majority of their time and they illustrated the difficulties of living alone, often with a chronic health problem and minimal day-to-day contact with other people.

It was perhaps no surprise that the issue of loneliness and being lonely emerged during the patient interviews. Loneliness was endured by at least two of the patients – Susan and Betty - and it was expressed as one of the most difficult aspects of daily life. Neither of these patients had frequent physical contact with relatives, let alone neighbours, often for days or even weeks at a time. As a result it seemed that two patients in particular found that the difficulties of daily life were exacerbated by being so isolated. As Susan said:

> *'It's the loneliness, I haven't got neighbours, I've got people who we speak to, we have a five-minute chat On some days, you know from 6 am in the morning when I wake up until I go to bed. On those days, well I don't see*

> *anybody, hear anybody or speak to anybody'.* **4/PInt/d2**

Betty similarly lived alone following the death of her husband some years previously.

> *'When I am at home all day and you don't see a soul, you miss not having a chat with someone'.* **7/PInt/ad**

Daily routines such as cleaning the house, paying bills, buying food and passing time was another aspect of life that appeared difficult for some of the patients in this study to maintain, particularly those that lived alone. For example, Susan had considerable difficulties in all these aspects of life.

> *'It is the small things; there is a slow worsening all the time. Very slow and suddenly I'll notice something or other. But I can't see that well, but it is gradual. I don't think about it a lot, I just get frustrated that I can't read, you know because when you can't read it's a poor world when you can't read. I can't read newspapers or look at magazines, read my cookery books, do a jigsaw or playing cards'.* **4/PInt/d1**

For others, the problems with routines was related to lack of transport or money For example, as Betty said regarding her weekly shopping trip,

> *'There is quite a good taxi service and the lady opposite gave me these tokens for the taxi because she didn't use them. I don't usually get a taxi because it makes the shopping very expensive. My daughter's husband has to collect me on Friday and we do the shopping then'.* **7/PInt/ad**

4.3.5 The involvement of family and friends

Family and friends played an important role in helping to minimise the day-to-day difficulties of living alone. Their involvement ranged from supporting the patient, as in the above quote (**7PInt/ad**), to prompting their admission to hospital. All but one of the patients involved a family member, neighbour or other support network in the admission process.

In all but one of the cases it was a significant person in the patient's life that prompted the ultimate admission to hospital and in some cases transported the patient to the hospital. The involvement of family and neighbours with the patients that lived alone was even more prominent. For example, as Betty said

> *'About half past seven, I felt so ill, it was such an effort to go and do anything. I had a headache. When I went to get up I would fall back. My daughter knew that I wasn't well and she rang me. She then rang my son to tell him that I wasn't well. He rang me back and said "why don't you ring this number" and he gave me a phone number to ring. It was a help-line and they advise you what to do. Anyway it was a man that came on, and he was very very nice and he said that he would ring back within a few minutes, which they did within a few minutes. [The nurse on the telephone] said "I don't want to frighten you, but I think you ought to have an ambulance" '.* **8/PInt/ad**

Similarly, for Susan (and Gail), who ordinarily lived alone but who were on this occasion holidaying with family, it was the family that finally took the initiative that prompted the admission.

> *'**Researcher**: So the pain started at about 9am?*
> ***Patient:** Yes, My daughter asked me "well what do you think"? I said it is exactly the same as the one the other night, it really is very painful, it hurts a lot. I wanted to reassure her, it is just there, it doesn't spread, it doesn't thrash about, it is not in my arms. But I think perhaps you had better ring the doctor and describe my symptoms, which she did. The receptionist asked the doctor and he suggested that she [my daughter] take me to the hospital, so we came here, it is a good thing we did really. I might of struggled through the second one and then gone home'.* **4/PInt/d1**

Gail's admission too was prompted by close relatives:

> *'I didn't feel ill on Monday and yesterday [Tuesday] I went shopping and after that my daughter -in -law went out and every time I went to do anything I went giddy. So I got on the floor because I thought well I might fall, I was there on my own which was unusual. They [son and daughter-in-law] came in and they had a conversation and called the doctor. I went to see their GP and he said get me over to the hospital because of what had happened five weeks ago, which they did'.* **8/PInt/ad**

In turn, Norman's situation was influenced by his wife:

> *'My wife normally asks me if she should ring the doctor and I say no to the very last minute. She said to me this time "what's up" I told her I couldn't breathe and she went straight downstairs and phoned an ambulance. Before*

> *she finished dressing it was there'.* **10/PInt/d1**

Supporting their relative on a daily, weekly or monthly basis was the other major contribution family, neighbours and friends made to the patient's ability to continue to live independently. In the majority of cases, the patient's independence was greatly enhanced by the support of another family member or a friend in the community. This was particularly apparent for Susan:

> *'I can't read instructions on packets; my friend has to read them. This friend will write my cheques for me, I can see to do bits, but it is very tiring, because I have to look at it and get my magnifying glass and see and then I have to put my magnifying glass down to hold the pen. My son- in- law deals with my financial affairs, he's very good and doesn't charge me. We have a lot of phoning as the literature it all comes to me. If I can decipher the top line to give me sufficient information to see where it is from and see what it is about in the first line then I can tell them on the phone'.* **4/PInt/d1**

For those patients who did not have family living nearby or who did not have any family at all, it was neighbours who provided the social support necessary for them to continue living independently. The importance of social support appeared throughout the entire admission and is discussed again in the following section.

4.3.6 Section summary

The preceding section has explored the data emerging from the eight patient cases. In particular it has explored the themes that related to the lives of these patients and their experiences of dealing with health concerns and ultimately admission to hospital. A brief summary of these themes are detailed below.

Living with fluctuations in general health described how patients learned to live with chronic and sometimes deteriorating symptoms with very little external health professional help. Therefore, they controlled their personal health concerns by managing their symptoms, only seeking help when it was absolutely necessary. Seeking help was not always easy as it was sometimes difficult to access healthcare advice, additionally, due to the nature of their condition many of the patients were forced to make adaptations to accommodate changes in their life and general health. Despite the adaptive nature of the patients, daily living for some was still quite difficult and often isolation and loneliness was an everyday feature. However, the involvement of family and friends in many respects made it possible for the patients to remain reasonably independent within their own home.

The next section examines this experience further and also incorporates data from a variety of other sources in conjunction with the patient interviews. The next section looks exclusively at the time frame following the patient's arrival at the A&E department until their discharge from hospital.

4.4 The post-admission period

The purpose of this section is to provide an in-depth description of the patients' experience of hospitalisation and the themes surrounding the delivery of care during this period. The themes described have emerged from analysis of three different data sources collected over the course of eight patient cases - observations, interviews and documentary analysis.

- Information gathering
- Making patient care decisions
- Working together as a team
- The exchange of information
- Patients' experience of the delivery of hospital care
- The involvement of family and friends in the delivery of care

4.4.1 Information gathering

For all the patients in this study the first 24 hours were almost totally dedicated to the process of gathering information in order to determine a diagnosis. This process was conducted by a number of doctors and nurses. A considerable amount of questioning occurred and some, if not all, of the diagnostic tests were also performed during this time frame. However, there were two major characteristics of information gathering that were apparent in all of the patient cases and these are discussed below.

Repetition was a major theme emerging from the study data and it seemed to occur frequently in the first 24 hours of admission to hospital. Generally, the information extracted related to the patient's past medical history, the lead up to admission and their social situation.

It seemed that information was requested from the patient repeatedly by doctors, nurses and sometimes also other health professionals. The information extracted during this questioning was then recorded equally repetitively in either the medical and /or nursing notes. For example, in Lillian's case:

> ***'Researcher:*** *When you got to A&E, what happened then?*
> ***Patient:*** *Two girls in green or blue came and took my blood tests and an ECG and my blood pressure.*
> ***Researcher:*** *So then you had all those tests and saw a doctor, what did he say?*
> ***Patient:*** *He thought that perhaps he didn't think that there was anything wrong with my heart; "you might have a touch of angina. Have an x-ray". I don't know what has happened with that, they don't tell you. I have seen another doctor, but she just asked the same sorts of questions and looked at me as if she didn't believe me'.* **5/PInt/d1**

Another example of repetitive questioning was taken from the observation notes made in relation to Susan.

> *'On arrival to the ward [elderly admissions ward}, the patient was reviewed by the admitting nurse, who recorded her medical history. This was now the third time that her history had been repeated. No new information was recorded and nothing recorded about her profound visual impairment, or that she lived alone. Within a few hours of admission to the ward, she was also seen by the ward doctor. Her medical history was requested once again. This was then the fourth time that the admission history had been requested in six hours'.* **4/Obs/ad**

Even the health professionals were aware that duplication and repetition were features of day-to-day delivery of care. This was illustrated by the following comment noted during an interview with one of the A&E doctors.

> *'I tend to take things as far as I need to in order to decide whether someone comes in or goes home, because above that, the inpatient team will want to go through it anyway. So it will be duplicated. They will take a much more detailed history and go over things much more thoroughly. Whereas once I have decided that she is coming in, it is not an efficient use of my time'.*
> **4/HPInt/ad**

It was interesting to note that the health professionals in this study had the impression that a more thorough examination of the patient and their medical and social history would be performed at a later stage in the patient's admission. There were, however, multiple examples of repetition which did not necessarily equate with more detailed or accurate information. In fact inconsistencies in written and verbally communicated information occurred frequently throughout the eight cases in this study. These inconsistencies ranged from communication related to the patient's need for physical comforts such as a bath or a blanket to details related to discharge arrangements, plans of care and diagnosis. For example, as Mark said,

> *'the Pharmacist didn't know I was on one of those medicines, because it is not on the drug chart to take. She couldn't understand why I was taking Atrovent, because I said I was nearly out of this one, she said well you're not supposed to be taking it according to the chart, but I am because I know I am but it wasn't on the chart'.* **6/PInt/d5**

This was in contradiction to the admission documentation which clearly stated Mark's current medication.

> **'PMH [Past Medical History]**
> Asthma type II Diabetes tablet controlled
> **Medication**
> Salbutamol
> Atrovent
> Zocor
> Serovent
> Prednisolone? 40mg od'. **4/Doc/ad**

4.4.2 Making patient care decisions

Throughout the admission of the eight patients in this study decisions were made regarding treatment, diagnostic tests, drug regimes, care delivery and discharge arrangements. There were several factors that emerged that had a degree of influence over how and even when patient care decisions were discussed and then final decisions made. For example, only two patients in this study had an immediately identifiable problem upon arrival at the A&E department. Therefore, for the majority of the patients in this study there existed a degree of uncertainty surrounding their presenting symptoms and the way in which they were subsequently dealt with. For four of the patients in this study this uncertainty pervaded their entire hospital stay as a definitive diagnosis was never achieved.

For example, there seemed to be uncertainty about whether to admit two of the patients in this study despite the fact that their blood results did not indicate a problem and that they had rapidly improved on admission to the A&E department.

> *'The senior doctor seemed to think that it was a pulmonary emboli [PE]. It was then confirmed that the test used to help rule out a PE had been negative The registrar really wasn't sure what to do, he told me that he thought he would definitely admit him anyway as the D-Dimer test [blood test used to diagnose a PE] was relatively new and he said he would like to refer him for a VQ scan [type of X-ray traditionally used to diagnose a PE], just to rule out the chances of a PE. I asked him if he thought he would get that today he said "no it would probably be tomorrow now" '.* **10/HPInt/ad**

A similar incident had occurred involving Vera. She had been referred to the A&E department for the same condition.

> *'The Senior House Officer [SHO] related the patient's history and told the consultant that all the blood results had been returned and they were negative. The SHO didn't seem to think that the patient had any predisposing factors that would cause her to have had or have a PE. She put the phone down and I went to speak to the patient; she told me that the consultant had thought that it was better if the patient was admitted. The SHO told me that she didn't really agree with the decision to admit her but she could see why he was concerned enough to bring her in. The SHO thought it was a waste of a bed'.* **11/Obs/ad**

Uncertainty was just one aspect of making patient care decisions, but it did seem to be partly related to the availability of diagnostic tests.

The aforementioned quotes (**10/HPInt/ad, 11/HPInt/ad**) demonstrate that uncertainty and a lack of trust exist surrounding certain diagnostic tests, even if they are actually frequently used and readily available. In both cases, trust or indeed lack of trust resulted in the patient being admitted to hospital for further diagnostic tests. For both it was later discovered that the original test had been correct and that neither of them had a pulmonary emboli. There are several inter-related factors involved in patient care decisions. In more than one example in this study, the availability and usefulness of diagnostic tests were of significance to the patients' overall admission to hospital.

For example, Gail had been waiting for an echocardiogram for some time. Her need for this particular test was recorded repeatedly in the medical and nursing notes.

> ***'Medical notes. Time 20:10***
> *68 year old female generally fit and well. Several episodes "odd" feeling in chest. No nausea. 5/52 admitted to hospital T, onset SOB. Resolved quickly with Frusemide. Awaits outpatient appointment and echo.* ***Plan:*** *Cardiac monitor, 12 lead if another episode, U&E CK Trop I CK chol Rpt Trop 1. Will need echo and 24 tape.*
> ***GP Letter:***
> *Many thanks for seeing this patient. She was recently on holiday where she developed sudden onset SOB & peripheral oedema and was admitted for acute heart failure. She was discharged it appears on Frusemide 40mg only. She developed sudden onset, light headedness and dizziness PMH Acute heart failure -apparently awaiting echo'.* **8/Doc/ad**

However, it appeared that even though she needed this test and had been waiting for some time it was unlikely that she would receive it during her admission to hospital, as evidenced by my observation notes.

> *'I talked to the doctor outside the room and he said that if the patient's blood test came back and was normal she could be discharged home to wait for her cardiac echo. When asked how long that would take, he said that he didn't know and the fact that he didn't know was a real issue'.* **8/Obs/d1**

Later conversations with a member of the senior medical team revealed that tests of this kind are apparently readily available in the hospital.

> *'We did originally have some echocardiogram slots, formal echo cardiogram slots but actually it was easier for them to just fit the patients in between others, so we now just go up and in fact a lot of the inpatient investigations, the cardiac investigations are done quite quickly for inpatients. If the patient was on the ward they should be done the same day or the following day, it would be unusual for them to have to wait more than twenty four hours for an echocardiogram'.* **HPInt/2406**

Even if the diagnostic tests were performed quickly, the usefulness of the results in terms of helping to determine a diagnosis or make an admission decision seemed to vary. This was indicated in both the extracts above for Norman and Vera **(10/HPInt/ad, 11/HPInt/ad)** and in the following discussion observed during Nigel's admission.

> *'The doctor who had initially reviewed Nigel when he was admitted to the ward arrived and went through the notes with the consultant. She read the notes and thought perhaps he had a degree of heart failure, the consultant didn't think that there was good evidence to support that. The team of doctors then went over to the X-ray viewer to discuss the chest X-ray. They pondered over it for a little while and then the consultant said "well it is not a very good one you can't tell much from that", they then returned to the patient'.* **9/Obs/ d1**

In this study there were several incidences where the plan of care for the patient deviated from the original plan when a more senior clinician became involved. For example, Gail's admitting doctor provided information about her anticipated plan of care.

> *'Well we will get an echo because she was awaiting the echo to follow up the episode of pulmonary oedema. She will probably need a 24-hour tape to get recorded episodes of both the sinus rhythm and whatever the other rhythm is so we can compare the two. It may just be a 24 hour tape and an echo and observation until we see another episode of this heart rhythm'.* **8/HPInt/ad**

Gail was actually discharged home without any of the aforementioned diagnostic tests. It seemed to be very difficult to categorise some of the patients in this study and then apply the appropriate treatment as invariably it seemed that different health professionals had different opinions on the best way of treating and caring for a patient. This was confirmed in a group interview conducted in the A&E department.

> *'I noted that there were several algorithms on the wall around the department relating to asthma and patient falls. I asked the doctors if they used them often. A general discussion ensued and the doctors said that they didn't use them that often as they said it was a lot to do with commonsense. In addition, one of the doctors said that patients don't fall neatly into a category and what do you do when the chart says you discharge a patient but you don't think they look well enough. He thought that in that instance he would*

> *probably refer them on to be admitted. The other doctor pointed out that they are supposed to be research based so he wasn't sure how you would stand if you chose to ignore them'.* **G/HP (s)Int/ad**

Inexperience also had an impact on the health professional's ability to make the final decision regarding access to diagnostic tests or authority to influence when treatment would be given. As a member of the senior medical team said:

> *'In terms of the actual admissions, you know people sort of coming in at the front door you can very often get people investigated the same day or in a day or two, but it relies on a senior doctor actually going and finding the doctor who does the test and asking him to do it. If I had the time to do that I can do it and I can go down and I can actually get something done. If I send a house officer down they'll be sent away saying it'll be done next available, if I go down myself I know I can get it done but of course you know that takes me probably half an hour per test per patient and I don't have that time in the day to do that for everybody'.* **HPInt/2406**

Problems related to discharge from the hospital also appeared to be a problem when a more junior member of staff was involved.

> *'We agreed that some consultants would come in and do weekend reviews and interestingly I thought they would come back to me saying "well this is the problem". Some of the more vocal ones were saying "well I'm not going to do this; it's going to have no benefit whatsoever". They came creeping back and one of them discharged ten patients on the Sunday on a bank holiday weekend and what he made explicit was that this was not about any problems with the system, but it was about the fact that named nurses and junior medical teams were not communicating about the plans for patients'.* **HPInt/1610**

Lack of agreement relating to the patient's admission and plan of care appeared to occur regularly during the patient's hospital stay. The impact of lack of agreement had considerable connections to the way in which decisions were made, inconsistency and the uncertainty of health professionals. Lack of agreement then seemed to have a profound influence on the way in which patient care was delivered and indeed received. Lack of agreement was particularly apparent with Mark.

> *'**Researcher:** You are having less oxygen today.*
> ***Patient:** Yeah one keeps putting it up and one keeps putting it down. One puts it up and the other one comes in and brings it down again. One doesn't like it*

> *up high and the other likes it down low. The same with the mask, they want me to take this [an inhaler with a mouth piece]. I prefer the mask but the other one doesn't like me taking the drugs [the inhaled drugs] with the mask because it gets in your eyes, she said it's better to take it that way'.* **6/PInt/d3**

Lack of agreement was also apparent in discussions surrounding discharge arrangements.

> *'At the moment I am going to another flat and it's got to be decorated because it has been empty for a few months or more. I would like to stay in [in the hospital] until they have already moved me, that is what I would like to do. The consultant did say that I could stay here during the transition, you know, go straight out into my new flat'.* **5/PInt/d13**

The following extract in the medical notes was entered the next day.

> ***'Medical notes – Ward Round***
> *Pt well. Moving to ground floor flat also warden controlled. Will need to stay here until flat re-painted'.* **5/Doc/d14**

And then later that week

> ***'Patient:*** *It has come as a big aggravation now you know, and they are making such a fuss. According to the consultant, I could have gone out of here and walked home you know. So now they have said I can remain here until Monday, until Monday but if they have an emergency I will have to go. I said "but I can't, I can't because there is no warden at the flats over the weekend"*
> ***Researcher:*** *Yes, and what was the response to that?*
> ***Patient:*** *Oh, there was no change it was still out'.* **5/PInt/d17**

4.4.3 Working together as a team

It is apparent from the previous extracts that differences in opinion and disagreements between health professionals can have a profound influence on the way in which care is delivered and the patient's experience of this care. Therefore, it would seem that the delivery of care is highly reliant on the various health professionals working together as a team.

Data from this study demonstrated that there were many problems related to the exchange of information and delivery of patient care that were exacerbated by the fact that staff did not always appear to work together as a team. For example:

> *'The doctors had been trying to contact the on call surgical team to refer an A&E patient. The SHO who was supposed to be on call didn't answer his bleeper. The doctor then gave up and tried the registrar but she still didn't have any reply. She had been trying to contact someone for 30 minutes. The other A&E doctor said in exasperation "this is ridiculous - we have these problems everyday". The doctor then tried to contact the consultant; one of the other doctors told her that she thought the consultant was quite fierce, the first doctor replied "well I don't think I will ever have to work with him". She then continued to try and contact someone for a further 10 to 15 minutes. The Sister asked the doctor if she had referred the patient to the surgical team yet. The doctor said "well I have been trying but I haven't managed to contact the surgeons". The Sister said "what time did you first make the call", the doctor told her that it was around 9:50 am, the sister then said "well take that time and record it then" '.* **5/Obs/ad**

Lillian related another incident connected to problems with team working.

> *'The young nurse [who deals with coordinating social packages for patients in the first few days following discharge from hospital] sat on my bed and said "it is fine for them [the doctors] to say you don't need a bed, get her out, she doesn't need a bed, but we've then got to tie up all the ends at short notice". According to the doctor, I could have gone out of here and walked home'.* **5/Pint/d17**

Other comments regarding team working and the difficulties associated with this were extracted from interviews with health professionals working within the hospital. These health professionals were involved with the delivery of patient care, but on an organisational rather than ward level. For example:

> *'Beds are the biggest nightmare throughout the trust for every directorate and because medicine spills out into every directorate, that is received very badly. Nurses from surgery ring us up as if we are personally responsible for these patients. You know, get this patient out of our bed. They are not polite, they are not rude, but they are distant. I had a call from a staff nurse on one of the other surgical wards - we had 70 outlying patients on this particular morning. She bleeped and said "I need you to take your medical patient back as I need to admit one of our patients, is it OK to send your medical patient to A&E". I told her she couldn't do that as the patient was in a bed, you can't send an in-patient to A&E. If you need to admit someone you will have to send your admission to A&E. She said, "Oh, that's really nice, are you trying really hard enough". I told her that I was trying really hard as we had 68 outliers amongst this trust, there was nothing I could do, as I couldn't*

> *take my medical outlier back and they had to look within their own beds to see what they could do. The answer was, they were able to admit the patient. Sometimes they say that they haven't got beds and they have, they just want the medical patients out'.* **HPInt/2006**

In contrast, there were also many positive comments from health professionals working at the organisational level about working together as a team. For example:

> *'Bed Managers are all strong personalities I guess, because there are not very many of us. When you have all this inter-directorate rivalry, the bed managers have to work quite closely together, especially on a day like today when we are using our virtual beds as we call them, those beds aren't empty. Spending time with nursing staff it makes them realise what we do and why it is so important that they let us know when they cancel a discharge or when someone is going home'.* **HPInt/1610**

Apparently the issue of team working had definitely improved over the years and this had significantly helped working conditions and the ability of some health professionals to perform their role.

> *'The biggest change over the years has been the co-operation from consultants. The nursing staff also found it very difficult as they had never experienced bed managers before and they did what they wanted with their beds and sent the patients home when they chose. The patients were staying until six o'clock if they wanted. Now we are forcing them to send their patients to the discharge lounge to get them out much sooner than they would normally go'.* **HPInt/2006**

The theme of improved team working seemed also to extend beyond the hospital to a more strategic level within the county. The following comment was extracted from an interview with a hospital manager.

> *'The collaborative working with the Primary Care Trust [PCT} and Social Services is much much better. It is much much better with the city than the county. The county has done a lot and they've done it with the PCT but they tend not to discuss things with us and we've found that quite difficult. The city have found it difficult because they are explicit about what they have done in terms of investing and many of the things that they have invested in are of benefit to the county and they have this feeling that the county are benefiting from all these things they've done but not communicating with them'.*
> **HPInt/1309**

The theme of team working at an organisational level will be explored further in section **4.5**.

4.4.4 The exchange of information

The need for uninhibited information exchange and flow was essential to ensure good patient care and effective working. However, problems with the exchange of information between the various groups within the hospital setting (patients, relatives and health professionals) existed in every case during this study.

From observation and interviews with patients during data collection it was noted that much of the information exchange with the patients and the patients' relatives was conducted indirectly rather than directly. Direct information exchange was observed only in certain circumstances, usually taking the form of questioning in order to extract information from the patient regarding their medical and social history. For the remainder of the time patients were generally left to their own devices. Certainly there did not appear to be much information flowing back to the patient about their care or their discharge arrangements. This had important implications for the patient regarding the care they received and their experience of hospitalisation.

For example, in many circumstances, the patients within this study were not given any information about what was happening to them or their plan of care. In some instances there were lengthy discussions at the patient's bedside with the patient listening, but often not understanding the terminology used.

> *'**Researcher:** Did they explain to you what they were talking about?*
> ***Patient:** They were asking me all these questions about how I felt, what do I think is wrong. Then that doctor was talking to the other doctors and the registrar, I suppose he thought I was listening to what he was saying. I didn't understand not really, they were saying all these big words about what was wrong or what could be wrong, but he wasn't happy about something, I don't know what it was '*. **10/PInt/d1**

The following was observed on a later ward round.

> *'Returned to the ward at 11:30am, Norman's medical team had now arrived and I was just in time to see them go into his bay. He was asked a series of general questions about his health and then he told them that he was suffering from gout. He was then prescribed a series of further drugs for this. The consultation was quite brief. After the doctors went away I went to say goodbye to Norman; he then asked me if I knew whether he was going to get the scan today. I said that I didn't know but advised him to ask his doctors. They had made no mention of the scan to him when they had reviewed him, I then left the bay. There had been no nurses present on this particular ward round'.* **10/Obs/d2**

In other situations, after the initial admission activity, the patient (Nigel) was left to wait with very little information and no idea of when and if tests were to be performed.

> *'**Researcher:** Then when you got to the ward what happened then?*
> ***Patient:** Well, nothing happened for quite a long while and I made enquiries about it because I had had nothing to eat and nothing to drink you see, and they said the doctors are making up their minds about what treatment you are going to have'.* **9/PInt/d1**

Lack of information exchange did not seem to be solely confined to patients and the following was observed (although not directly related to any of the cases in this study) during a general ward observational period.

> *'A couple of relatives approached the nursing station and asked the nurses sitting at the station if they knew the results of a blood test that had been performed on their elderly father. The first nurse turned to a neighbouring nurse and said '"yes he has had a small MI," she then turned back to the relatives who were literally the other side of the nursing station and could hear everything she said. She replied "we do know, but we are not allowed to tell you because we are nurses, the doctors will tell you when they get here"'.*
> **G/Obs/ad**

In contrast, there were other incidents involving patients where the information exchange was effective and the patient's needs appeared to be addressed.

As Vera said:

> *'I hadn't had any dinner. I said to the nurse that I hadn't had anything all day and I have been here since eleven. She went to see what she had got in the fridge, and she brought me four little triangle sandwiches and a jelly and an ice cream. It was something. I was grateful for that. Then they moved me on to here and I had a cup of tea. I didn't have any toiletries or anything personal with me so that lovely little nurse got me a toothbrush and toothpaste and a pair of clean underwear, vital stuff'* . **11/PInt/d1**

A large number of information exchange problems related to patient care delivery were apparent when there was inconsistent or insufficient information exchange between various health professionals. These problems were identified to some degree in every case in this study. Moreover, maintaining consistent information appeared problematic especially in an environment where teams of doctors changed regularly and the patients themselves were moved from ward to ward within the hospital.

One senior doctor related some problems connected to health professionals not informing one another of services.

> *'After the tape ended we continued to talk briefly about the various clinics that were available. Consultant A identified that it was often difficult to know who was running what clinic, especially if they were run on different sites by other consultants. Sometimes the GP would call up and ask if their patient could access the Jaundice clinic and he [the consultant] wouldn't know anything about it even though they all work in the same trust. This is partly because nobody had informed him of all these other clinics so sometimes it came as a bit of a surprise'.* **HPIntnotes/2406**

The issue of patient bed moves will be considered under this theme as it appeared to have a significant influence on both information exchange and consequently patient care. Bed moves or ward transfers were a constant feature during the patients' hospitalisation. The majority of patients in this study were moved more than once, one patient five times. For example:

> *'I returned to the admissions ward on the day following Vera's admission. She was no longer in the observation bay and had in actual fact been moved*

> *to another ward. The time of her third move had been noted as 19:30'.* **11/Obs/d1**

The entry in the nursing notes regarding this move was as follows.

> ***'Nursing Notes - medical ward***
> *Reason for admission/ visit ?PE. Provisional diagnosis ?PE (pulmonary emboli)*
> ***14:00***
> *Patient admitted onto ward following referral from GP she was suffering from a sudden onset of left sided chest pain since yesterday. Radiating to back and worsening on inspiration. Obs stable.*
> ***19:20***
> *Transferred to respiratory ward*
> **19:30**
> *Received on D6 settled and orientated to ward'.* **11/Doc/ad**

In some instances the patients themselves seemed resigned to the bed moves.

> ***'Researcher:*** *So when they moved you to the other ward how long where you there?*
> ***Patient:*** *Two or three hours, then they moved me to this ward. I suppose they have got their reasons'.* **10/PInt/d1**

In another case the patient was moved so frequently over the course of a few hours he actually began to find it quite amusing,

> *'It was quite an escapade last night, no one could find me, even I couldn't find me! I didn't know where I was going'.* **6/PInt/d2**

Not only were patients moved between wards, they were also moved around various medical teams within the hospital. Consequently details of the patient's care were not always transferred from the old medical team to the receiving team, or as in the following example the patient was simply forgotten.

> *'I was interested in talking to Lillian's doctors about her care. I saw two doctors and three medical students disappear into the bay, I asked them if they were looking after Lillian, they looked at her and told me that they didn't know. They then went out of the bay to find another doctor and asked her, she didn't know either and hadn't been aware that Lillian was there. Then there was a discussion between the three doctors as to who should see her. Apparently the female doctor was covering for two teams. Finally they*

> *decided that the two male doctors who were in the bay already would review her'.* **5/Obs/d2**

Other problems related to the exchange of information between health professionals led to a great deal of confusion regarding the patient's condition and plan of care. Often it appeared that information transferred verbally between health professionals was inaccurate and therefore so were the written records. One of the major drawbacks of this was that in some instances very important clinical information was simply not exchanged between health professionals. The following extract was recorded in Lillian's nursing notes on day one of her admission.

> ***'Nursing notes***
> *Self caring with hygiene needs this am. Remains on bed rest 100% non re-breath mask in situ. Seen by Dr. Attended VQ scan. Confirmed PE, can mobilise around bed area. For Warfarin reducing dose of Enoxaparin'.*
> **5/Doc/d1**

However, the information regarding Lillian's diagnosis did not appear to be exchanged with all the health professionals responsible for her care. For example,

> *'I asked the nurse currently taking care of Lillian what was happening with her care, she replied "I'm really not sure why she is still here, usually they have a discharge sheet and she doesn't appear to have one". She told me that she would check with one of the doctors about what their continuing investigations were. She said "I have been doing her observations, they were 97% [oxygen saturation levels], this morning". The nurse then went over to the doctor standing at the desk. The doctor said in response to the nurse's enquiries "I'm not sure which patient that is, oh yes the PE". The nurse didn't appear to know that she had had a PE. The doctor replied "yes, she has had a positive VQ scan"'.* **5/Obs/d7**

Other problems with information exchange were noted. For example, drugs were not given even when prescribed.

> ***'20:20***
> *- Comfortable afternoon*
> *- Obs stable pyrexic (sic) @ 37.5*
> *- Paracetamol given*
> *- Indomethacin prescribed although no stock therefore not given'.*
> **10/Doc/d2**

Or tests were not performed because they were not ordered or the order form was lost in the system.

> *'Apparently after he [the doctor] had spent some time on the phone he was none the wiser about what time the VQ scan would be conducted but that it would be conducted the next day [Friday]. It had apparently been ordered on the Tuesday afternoon; however the card had been lost in the department and therefore it had only been found and queried on the Thursday. The registrar told me that they ordered these tests and then they just had to wait. I asked if cards often got lost or tests delayed she said "yes they do, too often" '.* **10/Obs/d4**

Sometimes lack of care in relation to information exchange about patients was actively observed. For example:

> *'Activities seemed to be dropped so that the phone could be answered. On one occasion a relative called about a patient on the ward, the nursing auxiliary shouted across the ward to the nurse looking after the patient, the nurse shouted back across the ward, "I'm giving him an enema at the moment"'.* **4/Obs/d2**

4.4.5 Patient experience of the delivery of hospital care

The final group of themes for consideration are those that relate specifically to the patient's adjustment to hospitalisation.

The majority of patients in this study had been quite well in the previous weeks before their admission to hospital and were not at all familiar with the feelings related to being a hospital in-patient. However, upon admission to hospital, they immediately became one of several hundred sick patients that needed to be diagnosed, admitted and treated. Therefore, a considerable amount of adjustment to the hospital routine and learning how to behave within this routine occurred in their first few hours after admission. The way in which patients behaved also had an influence on the way in which care was delivered.

As described before, the patients in this study lived independently, either alone or with another close family member. Therefore, a certain amount of adjustment was necessary upon admission to hospital as usually each patient was expected to share with other patients, often in mixed sex wards.

There were many comments from the patients in this study regarding the mixed gender ward situation.

> '***Researcher:*** *Does it bother you having a mixed bay?*
> ***Patient:*** *Normally it would, but I think I am not going to be here for long anyway'.* **8/PInt/d1**

And

> '***Researcher****: How do you feel about mixed bays?*
> ***Patient:*** *Well I don't like it, I don't like it. But it is my first experience, but in here I suppose, we're old you know, but I don't think I would like it if I was younger'.* **4/PInt/d1**

Additionally, on a daily basis, patients had to adjust to the noises and disturbances that seemed to be characteristic of the hospital environment. For all the patients in this study, their first taste of hospitalisation came when they were admitted to the A&E department. For example, as Norman said:

> '***Researcher:*** *What did you think of A&E?*
> ***Patient:*** *How can I put it, it was quite reasonable at 6 a.m. this morning. There were about five or six patients, then the patients started coming in left right and centre and they started to put two in per bay'.* **10/Pint/d1**

The following observation was made during Norman's admission to A&E:

> *'It had become very noisy and busy within the A&E department and Norman was surrounded by people either side of him wretching and vomiting with only a moveable screen to divide them'.* **10/Obs/ad**

Some of the patients in this study found the noise and general milieu of the hospital environment very disturbing, particularly during the late evening. As Susan said

> *'But one thing, they are a bit noisy during the night, for old people and for people wanting to go to sleep. At changeover with the night staff, they laugh and chatter about 10:00 o'clock and for an hour or more they are very noisy. It probably sounded much louder than it was, even before the lights went off'.*

4/PInt/d2

And Lillian commented:

> *'There is a lot going on here at midnight you know, it is like Piccadilly Circus every night. They are giving out pills. This lady here is rather a disturbance, she cries a lot in the night. She calmed down a bit I think when the lady over there rang the bell'.* **5/PInt/d10**

In other situations the patient's wishes about their care and their desire to maintain certain standards of hygiene were not addressed by hospital staff. For example, Lillian said

> *'**Patient:** You go out of your ordinary life. All my life I go to the toilet and then I wash my hands. Here, we have bed pans, commodes, they take them away and your hands aren't washed from first thing in the morning. My daughter in law has brought me in some of those wipes. It just struck me as so peculiar certainly in a hospital but they don't hand you something like that you know, toilet paper of course but it's not as hygienic. You come into hospital and you wash your hands at seven o'clock in the morning and you don't wash them again until the next morning.*
> ***Researcher:** And you know when you use the cutlery do you ask for a bowl of water?*
> ***Patient:** Oh goodness no, we wouldn't. Well I think they'd look at you, they've got enough to do they couldn't possibly run in and out with bowls of water, they couldn't do it'.* **5/PInt/d9**

There were certain other situations were nursing staff were not available to attend to the needs of less able patients. Susan made the following comments during an interview.

> *'About 5:30am I woke up and Mr E [the patient opposite] was standing next to my bed like my guardian angel, with his night shirt hanging off his shoulders. He wasn't saying anything, but obviously thought it was time I was up. So we rang the buzzer and got him back to bed. Since breakfast, well there aren't many of us in, so not much has been going on so he begins to talk, he has been talking about an hour, he just kept on. I could see the nurses laughing. I know it is difficult when you have to put up with the rubbish and the nonsense, but it might be me mightn't it'.* **4/PInt/d2**

And

> *'It is very difficult you see, I don't know how many patients are around about*

> *and need to be looked after in here, He's [the patient opposite] the most difficult, but you can't help thinking, well they can't rush, you can't rush to every patient. He came down to the end of his bed [the patient opposite] because he wanted to go to the toilet and he stood and he kept on calling. We were just being washed, but nobody paid any attention to him. Simply nobody paid any attention and I thought surely somebody can hear him from somewhere. Not long after a male nurse rushed in and said to him "Sit down; here's your bread roll". That breakfast had been there all that time and people had been in and out, but nobody has offered to try and feed him his breakfast'*. **4/PInt/d2**

However, Susan's case was not an isolated incident. For example:

> *'I had moved to the nursing station to write up the notes and watched what was happening to the patient opposite Betty. He was trying to get himself comfortable in bed and had managed to dismantle his bedside rail. One of the other patients in the bay called for assistance but there where not any nurses only ward clerks'*. **7/Obs/d2**

The patients in this study seemed to accept much of the care they received without question. This was particularly the case if the care resulted in frequent bed moves, extended lengths of stay, lost medication and delayed tests. For example, as Gail said when questioned about her admission.

> *'No I don't ask, no I don't really know a lot about medicines I have been lucky, I don't question much. My daughter perhaps will more than I would. I don't really question. But they know what they are doing'*. **8/PInt/d1**

There were other examples where health professionals appeared to override the patient's knowledge of their own condition and their ability to independently manage it.

> *'**Researcher**: So at home do you test your own blood sugars?*
> ***Patient**: No the GP said don't do it he'd rather I went in there every three months and have it tested with them than me do it at home because he said "it's a waste of time you doing it at home because you won't know what you're doing"'*. **6/PInt/d3**

And

> *'**Patient:** I prefer to take the nebuliser with the mask but the other one [nurse] doesn't like me taking that with the mask cause it gets in your eyes, she said it's better to take it that way [inhaling the nebuliser using a plastic*

> *mouthpiece].*
> ***Researcher:*** *Does it make any difference to you in terms of benefit?*
> ***Patient:*** *Personally I think it's better with [the mask], but that's my opinion. Whether it is or not I don't know [but] that's their preference'.* **6/PInt/d3**

Another side to the willingness to accept the care received with little questioning was the need to 'fit in' and not appear to be too challenging. This related to all aspects of care. For example Susan did not particularly like the way the doctors and nurses spoke to her, saying:

> *'**Patient:** I will admit I don't much care for the language, you know the way some of the doctors speak "do this for me, do that for me", the nurses calling you darling and dearie and ducks and that. Ducks and dearie,that I don't care for.*
> ***Researcher**: Do you interrupt them when they are speaking to you like that?*
> ***Patient:** Well, it is the way they do it, they would be very surprised now. They would consider you to be stuffy or you know or upper crust'.* **4/PInt/d1**

The majority of patients in this study arrived at hospital with a real sense of urgency due to a rapid deterioration in their health. However, once assessed by the A&E staff and given immediate treatment if necessary, the sense of urgency rapidly diminished and the patients were then left to wait for several hours or even days. Waiting then became a serious activity and permeated the entire hospital stay. Patients waited for tests, ward rounds, meals, information and simply for time to pass. It appeared that for the patients in this study a large proportion of their time was spent passively in or near their bed. For example, as Norman said:

> *'That's the thing about being in hospital it is the waiting and not having any information. If the nurse walked in and told me that I was having so and so at such a time and so and so at such a time, you know what you are doing'.* **10/PInt/d3**

And as Mark said:

> *'You know once I'm over the worst of it in the morning that's it, I can be like this now until tomorrow morning, I'm just sat here watching paint* dry '. **6/PInt/d3**

4.4.6 The involvement of family and friends in the delivery of care

Family, friends and relatives played an important part in many aspects of the patient's hospitalisation. One of the key roles of the friend or relative during hospitalisation was that of patient advocate. This was particularly apparent when the patient was too ill to ask for or demand the care themselves. As Lillian said,

> '***Researcher***: *Did you get your breakfast?*
> ***Patient:*** *No I didn't get anything at all, nothing at all. Everything was going on so much that you don't think about food. I was dying for a cup of tea. At two o'clock in the afternoon my daughter in law came back and we asked if we could have a cup of tea. She [The nurse] said "yes of course". Then I had nothing else at all until I came up here'*. **5/PInt/d1**

However, the patient advocacy role filtered into all aspects of the patient's care from ensuring that they received enough nutrition (as in the above example) and the right treatment, to enabling them to be safely discharged home. All the patients in this study were reliant on the presence of family and neighbours in order to be discharged.

The need for patient advocacy was also apparent during Lillian's admission.

> *'Well yesterday lunchtime, I met the consultant and she said "you can remain here until Monday, but if we have an emergency you will have to go". I said, but I can't, I can't because there is no warden at the flats over the weekend. But there was no change, it was still out until my daughter in law and my granddaughter went and had a talk to the desk last night. They said "there is no way she can go back and be dropped off in the car park to walk up three flights of stairs to an empty flat, no way". So they then acquiesced'.* **5/PInt/d17**

The patients themselves encouraged and indeed needed the involvement of family and friends in all aspects of their admission from calling the ambulance to helping them pass the time. Health professionals, however, had at times differing views on the involvement of family and friends in the patient's admission to hospital. For example, in my observations I recorded the following:

> *'I asked the doctor about Lillian and if she was staying in hospital over the*

> *weekend. I was a little unprepared for the emphatic response. She replied that Lillian was perfectly all right to go home and was medically fit but her daughter in law 'threw a strop' and that was the only reason why she was in hospital. She appeared to be really angry. I then asked her whether Lillian would be discharged at the weekend if they needed the bed. Again the doctor reiterated that Lillian did not need to be here, " we have a massive bed crises on in the hospital at the moment and apparently she can't go home because there is no warden cover in her flats over the weekend. It is ridiculous we have a patient down the corridor that needs medical attention and we have Lillian in an acute medical bed blocking it because her family doesn't want her to go home, why couldn't her family cover the weekend". Lillian's family were trying to establish some home support for her prior to discharge. The doctor then told me that she didn't care if Lillian couldn't hoover the flat, it was not her problem, "she goes off on coach trips, she has got money, she could pay for someone to come in". She continued to say that somewhere during Lillian's admission one of the consultants had said something about home care and the family had picked that up and run with it'.* **5/HPInt/17**

However an entry in the nursing documentation from the previous day indicated that both Lillian and her relatives had been given the option of a support package earlier in the admission.

> ***'Nursing notes, time 15:00***
> *Social service referral faxed today re social package. Physio for stair assessment which was carried out with no problems. Tried to contact daughter in law to enquire whether she could make daily visits to see Lillian and so not require SS input. If this is unrealistic then continue with plan to put in home support package prior to discharge'.* **5/Doc/d16**

Expectations, particularly those related to family members, were mentioned as another problem that imposed a strain on the organisation of care and in particular bed availability.

> *'The expectations of families have changed. Our Philippino nurses are another group who find it so challenging culturally. The thing that they can't accept is, why don't the patient's family take them home. So many people are working, the involvement of the family is "well it is not my problem now, it is yours". Also now people use hospitals as a safety net and they end up in a hospital bed'.* **HPInt/0706**

One senior health professional felt that the family should not be allowed to dictate care.

> *'Relatives are also allowed to dictate more than they should, they are sent off to look for nursing homes and they just dither and they fiddle and they don't like this home and they don't like that home. There should be one found and if they don't like it then in their own time they should go and change it if they want, but they just tend to be allowed to say "no sorry, there is no nursing home and we want our mother to stay here"'.* **HPInt/2006**

4.4.7 Section summary

Section 4.4 has explored the themes that emerged in relation to both the delivery of care and the patient's experience of this care. The preceding section has also indicated that the organisation of care can have a significant impact on subsequent delivery. Therefore, organisational influences need more detailed consideration and are explored in the following section. However, for clarity, a brief summary of the themes identified in this section (**section 4.4**) is provided below.

Information gathering was an important activity in relation to the care of the patient. However, this process had several distinct characteristics, repetition and duplication of the patient's records and associated inaccuracy and inconsistency. Making patient care decisions, particularly the admission decision, was another important activity. This too had a number of characteristics for example; uncertainty in relation to the patient's clinical signs, the availability of diagnostic tests; the experience of the health professional and finally; the extent to which health professionals agreed with one another. Working together as a team was therefore another important theme raised, and the characteristics of poor team working were associated with the information exchange issues apparent in the hospital. Information exchange had many related and connected themes for example; information exchange appeared to occur in one direction, patient to health professional; that patients were moved and transferred repeatedly and finally; that there was fragmented and inaccurate care delivery. The patients' experience of care delivery also highlighted a number of themes and related themes. For example that care was often delivered in mixed gender wards and that this was not always acceptable to the patients; that the patients found the ward environment noisy and disruptive; that specific patient wishes and needs within the clinical environment were sometimes not addressed; that patients were accepting of the need to be in hospital and that this need often involved substantial amounts of passive waiting. Finally in this section, there were a couple of themes related to the involvement of family and friends in the patient's admission. For example; family members were shown to adopt the role of patient advocate when their relative was admitted to hospital; and the expectations of the family placed additional strain on the organisation of care.

4.5 The influence of organisational considerations on care delivery

This section concentrates specifically on themes from an organisational perspective. Data used to construct this section were obtained from interviews conducted with senior health professionals working at a more strategic level in the hospital. Therefore, **section 4.5** assists the overall understanding of the organisational context in which this study was conducted and patient care delivered and then experienced. Some of the data derived from the senior health professional interviews have been incorporated into previous sections, for example under the heading 'team working'. However, in general, the themes derived from these interviews were specifically related to the management of care, although they had considerable influence on the delivery of care at a ward based level.

The hospital in which this study was based had undergone a considerable period of change prior to data collection and, during the study, other organisational changes were underway or being planned. Much of this change was in response to problems within the hospital. The following theme explores this area in more detail

4.5.1 Organisational limitations – health professional perspectives

It appeared that there were many issues within the hospital system that led to difficulties with the organisation and delivery of patient care. However, what was very interesting was that every health professional interviewed had their own perspective on the nature of these issues and the effects on care organisation and delivery. Issues relating to the physical availability of hospital resources are described in this section. **Section 4.5.2** explores the themes specifically related to health professionals and the organisation of care and finally **section 4.5.3** examines some of the solutions proposed by the health professionals in order to deal with the apparent organisational problems.

There was little agreement about the core issues; the only problem that all the interviewees appeared to agree upon was that there were too few beds within the hospital. For example:

> *'We have done a lot of work to identify what the problems are and how we can address them. We have actually done a lot of modelling exercises in relation to the activity, and what has been established is that we have 81 beds too few and that was no great shock'.* **HPInt/0706**

And

> *'I think the big problem is capacity, sort out the capacity and then at least we won't be moving the patients round quite so much and then we can get on to the other things'.* **HPInt/1302**

And

> W*hat are the problems? Yeah okay, I mean I think the real problem is the availability of beds and that at the point of referral for a patient there often isn't a bed to admit the patient into*'. **HPInt/2406**

The number of beds was not the only concern. For example, available beds were not considered to be in the right place or on the right ward and often were not easily accessible. Furthermore, there was variation expressed regarding the reasons *why* there were too few beds. As one consultant said:

> *'Well in terms of a patient arriving the first blockage is that there is not a bed on medicine. Times of the day vary, it is easier to get a bed later in the day because of the way GPs work'.* **HPInt/2406**

Or as one manager said:

> *'No beds. I think there are not enough beds full stop. The trust has shrunk since I started this job, we have lost beds to pay for the DVT [Deep Vein Thrombosis} and the respiratory centre and although they do a very good job at turning people around we have still lost those beds'.* **HPInt/2006**

Losing beds to other services was also mentioned in another health professional interview.

> *'In previous years beds have been lost to cost improvement schemes and whole wards were lost, and if you don't keep them off it [the physicians], they will keep reminding you that this was the ward that had all their cubicles, which helped them to manage the infectious disease problems and the MRSA problems, so it's partly that'.* **HPInt1309**

Another possible reason given by one senior manager was that beds were being blocked.

> *'What is really clearly identified is that it is a conflict of need that causes a lot of problems. Some of it is waiting for a bed in another organisation; some of it is for nursing and care home packages or waiting for assessment. We have a significant number in the trust. The hospital has purchased care at one time I think it was ten places or beds. This city did have a glut of nursing home beds, but that has all changed now'.* **HPInt/0706**

This was further supported by another manager who worked closely within the same clinical area.

> *'Have you heard about bed blockers? We run constantly on a hundred or just over or slightly under, they are all nursing home waiters and community waiters; social packages. They are medically fit to go and they do not need to be here for medical reasons'.* **HPInt/1610**

Additionally there seemed to be other problems related to the hospital's admission policy. For example,

> *'In Medicine we have now become the default area. Patients who have broken a bone should go to Orthopaedics. However if there is no intervention required, then they come to Medicine. If somebody had a Neurological condition then they also come to Medicine. So we need to tighten things up, have better admission policies, so if they come to A&E with a broken bone then they go to Orthopaedics. This will help our capacity'.* **HPInt/0706**

Finally, it seemed that one of the reasons why there were insufficient beds was that patients were often waiting for tests and other investigations for long periods of time. For example:

> *'We know that a lot of our beds are blocked by patients who are being delayed in the organisation for one reason or another people are just sitting around waiting for different types of investigations. They need an endoscopy or a CT scan. Even internally, if those procedures could be done a lot quicker, we could get those patients out quicker. They spend two or three days just waiting for an investigation. So we have our own internal problems'.* **HPInt/0706**

Another group of problems was identified in relation to patients. The first was that patient numbers were increasing yet the hospital infrastructure seemed unable to respond. As one health professional said:

> *'The amount of patients that we have to outlie [find a bed in another speciality as there are insufficient beds within the medical speciality] indicates to us that we don't have enough beds to cope with the local community population increase. People keep saying that it is elderly people- that the elderly are living longer and causing more problems, I don't think that that is all together true. I think it is a very rash thing to say that because you are old you are causing all these problems. Year on year we have seen an increase in patients coming in and needing admission, lots of reasons, population of the city, the ageing population. Also, the expectations of the public has changed'.* **HPInt/0706**

Another health professional seemed to agree with the above.

> *'We do need more beds, we do not have enough beds to cope with what we've got. I don't think that it is anything to do with age, I think it is more to do with the population increase over the last five years. The hospital hasn't responded to this, it has actually shrunk'.* **HPInt/2006**

4.5.2 Health professional issues and the delivery of care

During the interviews many issues were cited in reference to health professionals. One particular issue was the lack of staff in certain areas. As one senior manager said:

> *'My responsibility is to ensure that from the nursing perspective quality of care is at a high standard, the right number of nursing staff with the right skills are in the right place at the right time. With any role there are things that stop you dead. Lack of staff in the right area is another thing that will take priority that will override whatever you have got planned. Whilst we can make sure that we've got the best structure possible, with all the best laid plans they fall apart sometimes'.* **HPInt/0706**

Lack of nursing staff was also mentioned by one of the managers.

> *'I mean when they built this place, thirty years ago I guess, wonderful, a thousand beds or just over, what a wonderful place, staff were abundant, you know. Now, we haven't got enough beds and we haven't got enough nursing staff'*. **HPInt/1610**

Lack of staff was not the only issue raised. There was some concern that skills were being lost because there were insufficient numbers of *experienced* staff.

> *'One of the things that quickly came through is that we've lost all our skills in discharge management, we have lost all our skilled nurses and we're replacing them with overseas nurses who don't understand discharge management and the consultants have become disempowered because they didn't know what to do, so if the nursing team said someone was waiting for the OT, they would have sat and waited and they didn't know what was happening or didn't know what to do to take that forward'*. **HPInt/1309**

However, a lack of medical staff also seemed to have an impact on discharge management for example,

> *'We were so thin on the ground in terms of medical teams that they focused on the emergencies or the sick patients and not on the patients who needed discharging'*. **HPInt/2406**

It emerged from these interviews that workload pressures often seemed to precipitate uncooperative working practices and dissatisfaction amongst health professionals, sometimes causing health professionals to leave which then had a significant impact on the delivery of care. For example,

> *'There are a lot of people leaving and looking for other jobs. They just feel unsupported. I think the admissions ward staff are supported to a point, but when there is a bed crisis everyone rushes to support A&E, nobody supports the admissions ward. I get really angry when they go on about A&E being busy, when none of the staff on the admissions ward have had a break. They have this impression [on A&E] that we have all these empty beds and they just don't want the patients'*. **HPInt/2006**

And

> *'When we are busy we often have our medical patients sitting in A&E. It is very hard for A&E, because it is not the model they want. So that really*

> *harms the morale of the nursing staff because they feel that they are A&E nurses and they end up with groups of patients that should be sitting somewhere else. I hope the average nurse on the ground appreciates that it is not the fault of medicine; it is the overall scheme of things. I think it is important not to end up in the situation were there is a blame culture'.* **HPInt/0706**

The senior health professionals interviewed within this study were often at the forefront of organisational change due to their strategic position in the hospital. However, it seemed that one of the aspects of their job was controlling the impact of hospital changes on health professionals at the ward level. There were many comments in the senior health professional interviews about the impact of change on health professional dissatisfaction, as one senior health professional said:

> *'I think it was a long and painful process, when we did merge the nursing staff didn't want to be part of a bigger directorate, they didn't want to come to the medical meetings, they still wanted very specific isolated functions. I think part of the problem was that they were at very different stages in their career, they had responsibility for budget and recruiting, they had taken on a very big remit. We are working in a completely merged way, and whether people all like it, well I couldn't really answer that. I would hazard a guess and say that it would be naïve to think that there are not people around who are not hankering for the way it was before'.* **HPInt/0706**

Another senior health professional made the following comments about the 'merge'.

> *'The morale up here did go down quite a bit when the merger first happened, because we felt we had been left up here floundering. As I say, you either put up or shut up, you just had to carry on, I mean we are here for the patients at the end of the day'.* **HPInt/1610**

And the 'merge' was again mentioned in the following extract.

> *'**Health professional:** They realised during the merge that they needed to have one central admissions point rather than two separate ones, but they couldn't do it or wouldn't do it and now we are two years down the line.*
> ***Researcher:** Why do you think they wouldn't do it?*
> ***Health professional:** I think they thought that it would be too much change for everybody, the elderly care consultants just weren't keen to have an admissions ward downstairs. They wanted to keep their own thing going upstairs. Over the two years since we have been merged, it is such a huge directorate now, it is just totally unmanageable, it had to be all brought into*

> *one entrance rather than be fragmented'.* **HPInt/2006**

The issue of team working initially emerged in relation to the delivery of care. Within this section team working also emerged as an important theme although within the wider context of the organisation of care, for example restructuring wards and whole clinical areas.

There was an assumption in some of the interviews that the merging of two clinical areas had been completed successfully and that the various health professionals involved now worked together. However, comments from other managers indicated that, in their view, this was not the case.

> *'It wasn't working as a combined directorate; it was combined about two and a half to three years ago and it still has two separate entry points. It also had quite separate nursing structures. Certain things have moved forward, on the nursing front they have joint meetings and things but I think people felt more that they belonged to medicine or elderly care. The management structure really are struggling to bring that together, the doctors in elderly care and medicine really didn't work together in a combined team, and still don't, but I think it's moved on much more in the last year. There was a lot of angst about that because elderly care was running very smoothly as a directorate and medicine was not. Essentially there was a presumption that elderly care was going to sort out medicine and within medicine the assumption was that they were taking over elderly care and we were going to ruin all the good work that they'd done'.* **HPInt/1309**

One of the other managers was also in agreement with the above.

> ***'Researcher*:** When *the directorates merged, how did this impact on your role?*
> ***Health professional*:** *It hasn't actually touched our role at all,* they *[elderly care] have continued to do their own thing. They work completely separately, although that is about to change at the end of this year, there won't be a bed manager for elderly care, there will be one bed manager doing the whole lot'.* **HPInt/2006**

On occasions it seemed that lack of team working resulted in individual clinical areas being actively obstructive.

> *'Sometimes they [other clinical areas] say that they haven't got beds and they*

> *have, they just want the medical patients out. I can see their point of view, but it is a very personal attack on me, you know as if I am responsible. I have been shouted at by one of the surgeons on occasions, an ITU consultant and in the early stages I was hauled down to the A&E department and humiliated in front of the entire A&E staff. The consultant was in my face saying, "what are you going to do about this"'*.**HPInt/2006**

However, difficulties related to team working did seem to extend beyond the hospital and also seemed to be related to inter-agency working.

> *'I mean we do get irate with social services, but they are under pressure as well. But I seriously think that the hospital and social services could get together. I think at the end of the day, this all boils down to money. If patients are waiting for a nursing home or a rest home and they are not privately funded, they have to keep going before a panel and relatives can't always afford the top up fees. Again it boils down to money '*. **HPInt/1610**

4.5.3 Generating solutions

The previous themes have indicated that there were many organisational issues that resulted in delivery of care difficulties within the hospital. Whilst there were many difficulties, there were also many apparent solutions with hospital managers working relentlessly to alleviate bed shortages and delays in the system. Generating solutions to difficulties in the hospital appeared as a theme in all the interviews with senior health professionals. Some of these solutions were already underway whilst others were in the planning stage. This section examines some of the themes related to the generating of solutions.

One solution proposed was a service where patients could be seen and treated very quickly in order to expedite their discharge. For example:

> *'We have the term bewitching hours, which are after the evening surgery. The patients that the GPs visit at home are the ones that need to be admitted because if they were well enough they [the patients] would have gone to the GP's surgery. So we end up with that sort of peak. We know the way that the local GPs work, so in order to do something about that we have developed a rapid response. Rapid response in elderly care works in one way, whereas in medicine we have a slightly different system. On an average day the consultant in charge of the rapid response within medicine will see about eleven patients who the GP has either wanted an opinion on or who has wanted to be admitted. The consultant has become very well known by the*

> *local GPs who like the service, they like to know that if someone has chest pain, the GP can talk to someone and ask them if they can suggest something else. The consultant will then say, well why don't you bring him up and they can be fast tracked through scans as we have additional places in scanning'.* **HPInt/0706**

However, the consultant in question cautioned that despite the good idea, in practice it was not always easy to access tests.

> *'The only things we've actually managed to negotiate formally are exercise test slots. We've got one exercise test slot a day that we've managed to negotiate which basically would otherwise be an in-patient slot. So if it is not used for an out-patient they use it for in-patients and we have one exercise test slot a day. We did originally have some echo cardiogram slots, formal echo cardiogram slots but actually it was easier for them to say "look, we'll just fit your patients in between others". So we now just go up and in fact a lot of the in-patient investigations, the cardiac investigations are done quite quickly for in-patients. The tests that have long delays are CT [Computerised Tomography Scanning] of body, chest and body and to a slightly less extent CTs of brain'.* **HPInt/2406**

Another scheme was intended to divert patients from actually being admitted to a ward. As one health professional said:

> *'First of all there was diversion, which means what doesn't need to come into this directorate and what could be managed in a different way. So the first thing we did was to support A&E in establishing an observation bay which although built was at that time not funded, and was not going to be commissioned. There are four nurses allocated to open that area. Unfortunately, they're having terrible recruitment problems as you probably know and have not been able to do that, but in fact we opened it after the August Bank holiday as a temporary measure and we'll do that again. [A&E] are intending to eventually use it as a clinical decision making area, you know, making quick decisions about patients and trying to manage their care and get them home from there'.* **HPInt/1309**

Finally, it was recognised by more than one senior health professional, that there needed to be a radical change in the way that the hospital was staffed and run.

> *'Patients are coming in the door 24 hours a day 7-day a week; we need a service that does the same all those hours. What we shouldn't be having is a service that closes at five o'clock, we shouldn't be reducing teams, we should have all the support services of Physios [Physiotherapists], OT*

> *[Occupational Therapists] and Social Workers, because we know that by reducing those services at the weekend, you are actually back a step by the time you get round to the Monday. So really the sooner we get into 24 hour 7 day working, nurses do, doctors do. I think that is the true concept of emergency care* '. **HPInt/0706**

This was further supported by another senior manager.

> *'I think, we need to have seven-day working across the board. There was a Pharmacy over the bank holiday weekend but for limited times. Transport is also an issue over the weekend, it all falls to the county ambulance and if they are busy with 999 calls all the transfers out of the hospital are always left until quite late. Then you get another service to do it, which costs us an absolute fortune. Also, the community hospitals at the weekend are difficult to gain access to. We do have discharge liaison teams in over the weekend, although if the patient is heavy and dependent the wards will refuse to take them'*. **HPInt/2006**

Section 4.5 has demonstrated that there are many influential factors at the organisational level that have a real impact on the delivery of care at a ward based level. Gaining an understanding of these themes is vitally important in order to fully appreciate the process of care delivery and ultimately the patient's experience. A summary of the main themes identified in this section (**section 4.5**) is provided below.

A number of themes in relation to organisational limitations were identified, these related mainly to the availability of resources. For example; the hospital had too few available beds and these beds were not always in the right place at the right time; beds were blocked by patients awaiting discharge and other procedures and finally that the number of patients needing a hospital bed was increasing. Other themes emerged in relation to health professionals and the way in which care was delivered. It was apparent that there were insufficient numbers of staff with the right skills and that staff had left the organisation because of the pressure of work and dissatisfaction in relation to organisational changes. Additionally, the theme of team working was identified in relation to the difficulties associated with delivering care in an organisation where uncooperative working practices existed. Finally this section identified a number of themes in relation to generating solutions to organisational problems. For example; improving the access to diagnostic tests; diverting patients in order to reduce admissions and finally changing the working patterns of the hospital to cover a 24 hour a day, seven day a week period.

4.6 Chapter summary

The aim of this chapter has been to explore extensively the themes that were apparent at all stages of a hospital admission. Whilst this chapter has been divided into three distinct sections, it is very clear that there are considerable connections between and even within the themes in the various sections. Therefore it is the intention of the following chapter (**Chapter Five**) to explore these connections in detail and examine how they relate to one another and to the research questions that guided this study.

Chapter Five - Discussion

5.1 Introduction

It has already been identified earlier in this thesis that the rates of emergency admission to hospital have been increasing **(section 2.2)**. Much of this increase has been attributed to population changes, changes in patient needs, policy directives and the availability of resources and services. Previous research within this area has tended to adopt a strategic or organisational approach and has neglected largely to include any reference to the way in which the patients, and patient associated factors, influence this process. It was therefore the purpose of this study to increase the knowledge of this area by exploring the factors influencing the patient's admission to hospital, the organisation and delivery of care, and the impact of these factors on the patient's hospital experience. The two main research questions guiding this study were

> *What are the factors that influence the emergency admission of a patient to an acute medical bed and the organisation and delivery of care thereafter?*
>
> *How do these factors impact upon the patient's hospital experience?*

With the research questions in mind, this chapter has been divided into three main sections, which are: the influence of the patient's living arrangements and way of life on admission; the delivery of acute hospital care; the context of care delivery. Within each section, a number of grouped themes and related factors are discussed. It is important to note that, even though there are three sections, the nature of this research, and the factors emerging, mean that there are many connections between and within the sections of this chapter. A summary of the factors discussed can be found at the end of the chapter.

5.2 The influence of the patient's living arrangements and way of life on admission

The ability of the patients in this study to access health information and advice and the availability of this health advice in the community seemed crucial to whether or not the patients in this study ultimately became an emergency admission to hospital. However, as with many of the factors emerging from this study, there were more complex elements that assisted or hindered this process. This section will discuss the findings in detail and consider how certain aspects of the patient's life, and their living arrangements, impacted upon their ultimate admission to hospital.

For many of the patients in this study, living with and experiencing a chronic health problem appeared to be one of the most influential factors that finally precipitated a hospital admission. However, simply having a chronic health problem alone, it could be argued, was not sufficient to cause a hospital admission. After all, many of the patients in this study lived independently for months and even years without encountering a problem that required hospitalisation. This would seem to suggest, that there are other factors that have a significant influence on the final hospital admission. One such factor was the presence or absence of a recognised or diagnosed condition. It would seem that patients with a pre-existing (diagnosed health condition i.e. asthma prior to admission) diagnosis were more likely to have access to a specific healthcare service or clinic than the patients that did not. In this study, those patients who had a diagnosis often had more access and contact with their GP who helped to manage their condition. Where community-based management was not possible the patient was referred to an outreach service or clinic at the local hospital. Even though patients with a pre-existing diagnosis had more contact with healthcare services and professionals, it must be noted that this contact was still minimal. Another point was that largely these patients did not need regular health professional contact as they managed without help from health professionals and continued to manage even when symptoms worsened.

Another group of patients in this study suffered from chronic symptoms which remained undiagnosed. These patients had no pre existing health label, for example 'asthmatic' or 'diabetic' and as result no system of planned surveillance, regular follow up by a community health professional, or even brief contact with their GP. When the health of this group of patients deteriorated to a critical point, there appeared to be no alternative healthcare services and the only realistic course of action was to admit the patient(s) to hospital via the A&E department.

Evidence indicated that access, even minimal access, to a healthcare service or clinic for a specific condition, enabled some of the patients in this study to live with their symptoms, or manage symptoms sufficiently to carry on their daily routines without interruption. Therefore, they could continue to live independently in their own homes. Certainly targeting treatment and primary care or hospital services in the first instance was easier to do with those patients who had a pre-existing, diagnosed condition. However, in all other respects for the majority of patients in this study, the existence or absence of a pre-existing diagnosis seemed to confer little overall benefit once admitted to hospital as hospital experience differed little between those with or without a diagnosis prior to, or after, admission.

This study would suggest that, even when they knew about alternative services, patients were not always able to access the healthcare services (e.g. General Practitioner, Practice Nurse, Out of Hours Care, out-patient tests and appointments) that they needed or indeed wanted. Even some of the health professionals working within the discipline were unaware of how to access a service, or even that a service was available. In essence then, two major issues seemed to contribute to the ease of access to health information and related services; firstly, the patient's knowledge of a service, and secondly, their ability to access it. Patients did not appear in general to know what to do and who to contact in an emergency apart from contacting 999 emergency services. Other patients, even those that had a pre existing diagnosis prior to admission and some access to their GP, had little awareness about GP working hours and availability, NHS Direct or indeed any other community healthcare services. Therefore, a vicious circle ensued as the patient's knowledge about a service was directly influenced by their ability to access health professionals in the first instance.

The Calman Report (1997) suggested that it was necessary to increase the awareness and education of patients regarding the signs of a pending health emergency and also what to do, and who to contact in the event of a crisis. This study would indicate that many patients remain unaware of the alternatives to admission and some of this lack of awareness was related to health professionals not making this information explicit. It could also be argued that it is unrealistic to expect patients with no healthcare background to decide between, for example, a heart attack and a bad case of indigestion when even health professionals within this study could not be sure.

The second point raised above was one of patient choice. In this study, when the patients presented to the A&E department their needs were urgent. Even those that accessed alternative services, such as their GP or NHS Direct, with the help of their relatives became emergency admissions. Therefore, in reality at that point in their lives the patients in this study did not appear to have a realistic choice; they needed immediate help to breathe or manage other potentially life threatening symptoms. It could be argued that the availability of alternative services for the patients in this study at best only delayed the emergency admission and at worst allowed the patient to deteriorate further whilst waiting for an appointment with a doctor, attention from a community practitioner or even, in one situation, a follow up appointment after a previous emergency admission.

What is perhaps required then is identification and targeting of community healthcare services to the members of the community who need it most, for example those with chronic and multiple healthcare needs. Healthcare policy must also take into consideration that this group often have physical and psychological health problems that influence their ability to access and retain information regarding the availability of services and what course of action to take in a crisis. At the moment it would seem that the onus is on the patient to find out about the services and access the information, rather than the health service and health professionals, taking this responsibility. In reality, it is not as simple as this, as often the information does not appear to be readily available to health professionals either. Therefore, if those working within the NHS environment do not know about a particular service, or are not kept informed by those running the service, then there is very little chance of the patients learning about it. Additionally, there seem to be a number of services that are poorly staffed and resourced and therefore unpredictable in their response; this was certainly evident in this study. If a service has been developed to respond to a specific patient need, but at the point of crisis fails to address this need, then it would seem inevitable that patients will lose confidence in the service and probably opt not to access it again.

This study also demonstrates that, at the present time, there would seem to be a real problem with the ability of community-based healthcare services, and indeed hospital-based outreach services and out patient departments to actually respond promptly to patients in a health crisis other than by admitting them to hospital. Ironically the purpose of admission avoidance services, such as asthma outreach and DVT (deep vein thrombosis) clinics, is to prevent or divert these crises from occurring in the first instance. In this study, even those patients with a recent emergency admission were left for weeks to wait for appointments or relevant diagnostic tests. If patients are to be managed effectively in the future and to have confidence in the services that the NHS provides then service provision needs to be well resourced. This does not necessarily imply that more resources are needed, more that the resources available are redistributed in a planned way that will ensure success of a healthcare service not failure. In conjunction with this then, healthcare services need also to be well publicised and targeted at specific patient populations. This study has demonstrated that community based healthcare services, and acute care services, were haphazard and inconsistent, allowing the health of many of the patients in this study to deteriorate largely without intervention.

Current health policy indicates that more healthcare services are required for patients with chronic health conditions. For example, The Expert Patient Initiative (Department of Health 2001a), The National Service Framework for Older People (Department of Health 2001c) and The NHS Improvement Plan (Department of Health 2004b) indicates that there is a need to implement preventative services so that patients, particularly those with complex chronic conditions, do not deteriorate to crisis point and require admission to hospital. In essence, these policy documents encourage health professionals and associated services to move away from simply responding or reacting to a crisis to actually preventing them from happening in the first instance. One of the proposals is a general system of surveillance for patients with chronic diseases or chronic health conditions. The NHS Improvement Plan (Department of Health 2004b) details plans to recruit practitioners (Community Matrons) who will endeavour to provide care to patients in the community by way of case management. Case management has been described as a process by which the need for care is assessed, planned, coordinated and managed on an individual patient basis (Department of Health 2000d), thereby helping to provide a general surveillance role. The overall intention of these practitioners is to minimise health deterioration in patients, particularly those with a chronic health problem, and ultimately reduce emergency admission rates to hospital. A recent report by Hutt *et al.* (2004) for the King's Fund has detailed that there is little evidence to demonstrate that implementing case management nationally will have a positive influence on reducing emergency admissions and the use of A&E departments. The report indicates that, in some studies, emergency admissions had actually risen. The aforementioned report certainly raises some serious questions regarding the usefulness of community matrons for reducing emergency admission rates. However, Hutt *et al.*'s report did note some improvement in the general health status of patients and that functional deterioration was prevented as a result of case management.

Another factor of prominence in this study was that many of the patients appeared to demonstrate a marked reluctance to initially seek help when they began to feel unwell, instead choosing to tolerate symptoms and wait, rather than access healthcare advice and information. Certainly this reluctance was in part related to the lack of choice and responsiveness of the available services. However, another characteristic of these patients was that they lived alone and coped alone with symptoms of ill health and chronic disability, so fluctuations in their illness state were not uncommon and were often dealt with without external help. In this study, these patients only requested help when their symptoms became too severe to cope with or manage at home. Also apparent in this study was a fear of the implications of an emergency admission on life outside hospital. There seemed to be a preference to sit and wait to feel better, in the hope that the problems would subside rather than risk losing independence within a hospital or other form of supported living environment. Therefore, it was felt that the health of some patients in this study deteriorated, partly through an inability to recognise symptoms of ill health that could lead to a crisis, but also because of the fear of hospitalisation and all that it implied. This was particularly apparent in the cases where the patient had had no previous hospitalisation experience. Interestingly, at no point in the admission was the patient's fear of losing independence acknowledged or addressed by health professionals. In the end the decision to remain inconspicuous to the health service was overridden by their unpleasant symptoms or pressure from relatives. In either case all the patients in this study eventually sought help or had help sought on their behalf.

Whilst in one respect the emergency admission provided a sense of relief from unpleasant symptoms for some patients, in another respect the patients were actually taking a risk with their independence by exposing themselves to the health service rather than remaining in obscurity. Yet, it is probably this group of patients that would benefit greatly from preventative chronic health management which might help to minimise the chances of them becoming an emergency admission. This also raises an issue about patient independence in the face of a health crisis. Patient independence appears from this study to be a very fragile state and some patients did not have confidence that a hospital admission would increase their independence; rather they viewed the hospitalisation experience as one that would decrease it. Current health policy emphasises the need to involve patients more centrally in their own care (Department of Health 2001a), in effect enabling a more reciprocal health professional and patient relationship in the management of chronic diseases. However, in order to be successful in the long term there needs to be an appreciation by policy-makers that there are those patients that either do not wish to be independent, or are afraid of the implications of independent health management and increased access to health services. It is debatable whether it is realistic to assume that all those with chronic disease want to be self managers and, in this case, the challenge is adapting health policy and healthcare services to acknowledge the wishes of this patient group.

Another major influence on whether or not a patient was admitted to hospital as an emergency admission, was when a member of the patient's close social network became involved. The social support received at this critical point came in two different forms. Primarily, family involvement took the form of advice and referral. In this situation it was the family member or neighbour who persuaded the patient to contact the GP or provided the patient with the relevant information to do this. The other form of involvement by family was as direct action, for example, calling the ambulance. It would seem that the gulf between home and acute healthcare in this situation was actually bridged by the patient's family or neighbour rather than a community based healthcare professional. In effect, the family not only acted as the patient's safety net in a time of crisis, but in many of the cases sustained the patient at a reasonably stable level so they could continue to live independently. The substantial involvement of family and friends in the lives of the patient, and the influence they had on the patient's ultimate access to health advice and information appeared to be ignored by the acute hospital until it became necessary to discharge the patient.

In general there appears to be a real problem with the current provision of preventative healthcare in the community as it still appears to be inconsistent and unresponsive to patients who need it most. As a result a chasm between community care and acute care existed in this study and was initially bridged by a member of the patient's social network rather than a health professional or service.

There would seem to be little doubt that improving access to services will improve chronic disease management for some patients. However, there is a failure on behalf of healthcare policy to recognise that some groups of patients will always require emergency care no matter how accessible alternative services become. Certainly the results from Hutt *et al.*'s report (Hutt *et al.* 2004) regarding rising emergency admission rates, even with case management, supports this theory. Evidence from this study would suggest that this is mainly because one aspect of living with a chronic health problem is recognising that it is unpredictable. A rapid deterioration in the patient's health may occur without warning for the patient, and sometimes the health professional overseeing the patient's care. Therefore, the difficulty for the health service is determining which patient and patient groups are more at risk, not an easy task when many patients find it difficult to access community healthcare in the first place.

5.3 The delivery of acute hospital care

Arriving at the A&E department was for many of the patients in this study the end of a journey punctuated with chronic health problems, uncomfortable symptoms, isolation, fear, adjustment and finally acceptance. However, whilst one journey finished another journey through the acute hospital system was just beginning. This new journey had new experiences and issues that the patient needed to adjust to, endure, tolerate and in some instances, finally accept. This section will discuss the factors that emerged in relation to the patient's admission to hospital and in particular, will discuss the factors that appeared to be important in the organisation and actual delivery of care. The impact of these factors on the patient's hospital experience is also discussed.

The A&E department essentially acted as a processing and holding area for all those patients deemed too ill to be sent home. Nearly all the patients in this study arrived at the A&E department with a degree of urgency, and were then triaged. What became apparent was, despite the urgency with which they arrived and the often 'urgent' or 'very urgent' label that was applied to them, there seemed to be no difference in priority of treatment, and the emergency aspect of their care diminished rapidly after arrival. After all, once their condition was stable the actual care that was required was essentially routine, not necessarily life saving. It was not always a lack of interest in the patient that caused the lack of attention in the A&E department. It was observed in this study that, due to the design of the department, there were frequently more than double the numbers of patients than available cubicles, with new patients arriving at roughly 15 – 20 minute intervals. Staff within the A&E department were, as a result, constantly managing and trying to find space for new patients sometimes with more acute symptoms.

The use of the A&E department as a holding area for patients was certainly not the original intention for the department. However, constraints further into the hospital system such as delayed discharges, difficulties finding beds within appropriate medical specialities and accessing diagnostic tests all resulted in a number of patients simply waiting for a space on a ward. It seemed that this was by no means a new problem as healthcare policy (Department of Health 2000a) has stipulated that patients should not have to be within an A&E department for longer than four hours. There were many examples within this study where the patient was detained in A&E for much longer (**Table 4.1**); the average length of stay in A&E for the patients in this study was nearly five hours. In many of the cases there appeared to be no alternative for the patient, but to wait. It was clear from observations of the A&E department that the process of care actually involved very little active nursing or medical intervention after the initial admission activity, such as blood tests and chest X-rays. Any care received after this_was essentially task-orientated, an occasional blood pressure or temperature measurement, for example. However, even this diminished rapidly the longer the patient remained in the department.

Certainly the original intent of the acute hospital in this study was to admit patients directly to either of the two admission wards, thereby bypassing A&E (HPInt 1610; HPInt 2006); in reality this situation seemed to be rarely achievable due to the constraints mentioned above. It appeared that this situation did not meet the needs or expectations of either patients or health professionals within the department. For example, the longer the patient remained in the A&E department the less likely it was for their needs to be accommodated, and the more likely they were to be forgotten about or their needs neglected. From a health professional perspective, there was some concern by managers that A&E staff morale was suffering because staff were required to care for patients that had less acute needs than 'normal' A&E patients. This might explain why the urgency status of patients decreased rapidly upon arrival as A&E health professionals have a different perspective of what constitutes an emergency. Difficulties occur when this perspective is not shared by patients, other community health professionals and health professionals further into the hospital system. As a result tensions arise between the various health professional groups, exacerbated by the fact that patients cannot be moved out of A&E quickly. Until these tensions are resolved patients are caught in the middle.

The development of medical admission units (MAUs) or emergency medical admissions units (EMAUs) was encouraged (Working Party of the Federation of Royal Colleges, 2000) in response to the need to move patients quickly out of A&E departments. The original intention of these wards was to alleviate unnecessary pressure on A&E and reduce tensions within the hospital due to bed shortages and delays. However, it appeared that the medical admission unit (MAU) within this study was largely failing to help alleviate the pressures on A&E. In fact the MAU in this study was experiencing similar pressures to A&E in terms of delays and bed shortages and becoming another holding area for patients.

More recently, there has been a drive within healthcare policy to improve emergency care, for example, to hasten the movement of patients through A&E departments and improve the patient's A&E and subsequent hospital experience. One proposal is to establish a Clinical Decision Unit (CDU) (Department of Health 2001e) to specifically concentrate on speeding up the assessment and diagnosis of patients. This is not necessarily a new idea as this was the original intent and aim of the MAUs identified above; therefore CDUs may well experience the same difficulties. However, it is hoped that lessons have been learned from the establishment of such units and that as a result the CDU will help to alleviate some of the pressures. Certainly the only way this is possible is if health professionals in all areas of acute care work together to make clear decisions and improve access to diagnostic tests. However, it is reasonable to say here that as more patients live longer with chronic long term conditions it is likely that pressures will only increase within A&E. Indeed A&E departments are likely to encounter more difficulties with the categorising and channelling of patients. It remains to be seen whether CDUs are capable of addressing the needs of patients with complex conditions any better than MAUs, especially given that, for some patients with complex problems, achieving a definitive diagnosis is not always possible.

The issues and difficulties associated with making the patient admission decision was a key factor that emerged in the first few hours following the arrival of the patient. It seemed that once within the A&E department a process was initiated which was similar for all patients irrespective of presenting condition or age. The main aim was to achieve some level of categorisation for each patient admitted, usually taking the form of a diagnosis or health label. For some patients a blood test or an X–ray would clarify the problem, a label could then be assigned to the patient and the appropriate patient pathway accessed. In general it would seem that very little individuality was observed or indeed needed in these circumstances. The process of categorising and channelling patients also only appears to work effectively for a small group of patients with defined problems, specifically those problems that could be identified and treated quickly. The real difficulties in the system seem to arise when patients are not so easily categorised or channelled into an appropriate pathway. This was certainly an issue for some of the patients in this study who presented with an uncertain symptom or symptoms. The IDEA (Ideal Design of Emergency Access) programme, (Department of Health, 2002b) was concerned with hastening the patient's journey through A&E in order to reduce waiting times to a maximum of four hours. In order to achieve this, it was recognised that patients needed to be categorised to some degree so that services could be targeted more effectively. Earlier attempts at this categorisation relied on grouping patients with similar conditions. Within a short period of time, however, this approach was shown not to be effective as patients with similar conditions had very dissimilar clinical requirements. In accord with the findings from this study, even greater difficulties were experienced with those patients who had multiple problems or ones that could not be identified quickly. The next strategy attempted was to categorise patients in terms of the processes they experienced. For example, patients who needed minor assessment and discharge were treated in one area and patients who needed lengthier assessment and possible admission were treated in another area. It was anticipated that this would alleviate unnecessary queuing and that available diagnostic tests were used more appropriately. However, it was obvious that, despite the work of the IDEA programme, there were still significant problems with the categorising and channelling of patients.

Evidence from this study also suggests that the availability of tests did not necessarily reduce the level of uncertainty felt regarding admission decisions. On the contrary, if the result received was unexpected then this actually seemed to precipitate more uncertainty. This could have important implications for the usefulness and success of CDUs (identified above) and also the chosen mode of patient categorisation and channelling. For example, it seemed that the decision to admit a patient to an acute medical bed was made long before the results of the tests were returned. When the test was returned and the result was contrary to that expected this created a scenario where personal judgement was weighed against the available factual data. Certainly, the decision-making strategy utilised in the A&E department is similar to heuristics or rules of thumb decision-making (**section 2.4.2**). There were a number of other factors related to uncertainty that seemed to have an indirect influence on patient admission decisions. For example, fear and concern about missing a diagnosis featured in decision-making around admission. This fear and concern seemed to override even negative diagnostic test results. In certain situations tests and X-rays were utilised to reinforce the health professional's instincts about a patient. A dilemma then occurred when the diagnostic tests contradicted this, in practice it seemed that the health professional ignored the test result and admission to hospital still occurred. It could be argued that, if decisions within A&E are made utilising this strategy, there is no realistic advantage to having another unit such as a Clinical Decision Unit with increased access to diagnostic tests. Additionally, the categorising of patients as detailed in the IDEA programme is made even more difficult if the care and the process that the patient is channelled into is dependent on factors such as decision-making, clinical experience and health professional perspectives.

The confidence of the health professional to make an admission decision seemed in part to be related to their level of clinical experience. This study demonstrated that when a dilemma between instinct and diagnostic test result occurred it was actually the more senior doctor that tended to be more cautious and admit the patient. Arguably, the more experienced a doctor, the less his or her tendency to rely on diagnostic tests to help inform decision-making. For more junior members of staff it was the diagnostic test that seemed to actually influence the admission decision. Certainly it could be argued that health professionals with more experience and more knowledge of a given clinical area probably have more experience of missed diagnoses and the implications of this for both the patient and the health professional.

Section 2.4.2 has provided details of the main decision-making theories abundant within the literature. A study conducted by Andre *et al.* (2002) indicated that the rules of thumb approach towards clinical decision-making is utilised more by senior rather than junior clinicians and the rules are learned and integrated generally by word of mouth. If this is the case, this has implications for improving decision-making. In fact Andre identified that this approach might explain why education has a very slow impact on decision-making practices and strategies. Current medical training has started to incorporate the use of evidence based medicine which relies on the critical appraisal or the systematic interpretation of evidence by assessing validity, reliability and relevance. Parkes *et al.* (2001) looked at a number of studies examining the influence of teaching critical appraisal skills on health professional's knowledge, the process of care and patient outcomes. Results demonstrated that there is a large gap in the literature related to how teaching critical appraisal actually impacts on decision-making and patient outcomes, and the authors were therefore cautious about making assertions as to the usefulness of this in education.

This study has demonstrated that many factors impact upon the way in which health professionals make patient care decisions. Dempsey & Becker (2002) suggested that the decision to admit patients are made sometimes without the support of diagnostic tests and in an environment which includes pressure from patients, relatives and fellow health professionals. Pickard *et al.* (2004) indicated that when decisions are made in this type of context difficulties arose in relation to communication between health professionals, long waiting times and frequent patient bed moves all of which then had further influences on clinical decision making. These difficulties were all apparent throughout the cases in this study. It seemed that decisions regarding admission and discharge were often made when it was apparently difficult to locate certain resources such as key health professionals, specialist beds and diagnostic services. The subject of clinical decision-making is a complex area but extremely important, particularly as decisions made at admission had a significant impact on the subsequent process of care for the patients in this study. Evidence from this study indicated that there is a need to understand more about how admission and care decisions are made as the combination of difficulties associated with decision-making actually resulted in the process of care stalling. As a result some patients were kept in hospital longer than was necessary with little or no intervention.

However, the fact that decisions about patient care are sometimes made without the support of diagnostic tests, and in contradiction of evidence, is not necessarily a situation that should be totally discouraged. Certainly there were patients that benefited from an admission to hospital simply because it gave them some time to recover from symptoms whilst receiving some support. The danger, it could be argued, is that patients may be refused admission because health professionals rigidly stick to guidelines or protocols that do not incorporate any aspect of flexibility, particularly for those patients with complex conditions. In reality the best approach toward improving decision-making is to promote guidelines that take into account the social and contextual factors associated with patients with chronic or complex illnesses.

Despite the many considerations above, the patient's initial experience of being 'processed' within the A&E department appeared positive. Patients seemed to feel more cared for if a number of tests were performed and if several members of the health professional team examined them. This was apparent even if the actual processing had very little influence or impact on the overall course of the admission to hospital. As identified above, once the battery of tests and initial questioning had ceased, patients just waited, sometimes with no further contact with medical, nursing or ancillary staff. For some patients the A&E department was less than comforting as, due to the organisation of the department, existing patients were pushed further and further into corners and privacy became almost impossible to maintain as the only available barrier between patients were moveable cloth screens. Consequently, the patient's feelings of isolation, which very often had been a feature of their pre-admission lives, persisted whilst in the A&E department. At this point the social support networks that were so important in the pre-admission period again became imperative. It was observed that family members and friends adopted a patient advocacy role and co-ordinated, when necessary, the acquisition of attention from health professionals.

This section would not be complete without some consideration of the role of family and friends. There was no doubt from this study that having a supportive family was essential to the patient's overall admission experience, particularly at the point of crisis. From the patient's perspective the support of the family was needed in almost all aspects of the hospital admission. In some instances this support was vital, in order that they could act as the patient's advocate in both the A&E department and in facilitating the planning and discharge of the patient from hospital. Indeed, many of the patients in this study would not have been able to remain independent without the considerable input of family and friends. It was not surprising that patients in this study continued to rely on the same family and friends once admitted to hospital. It emerged that the involvement of relatives and close friends was essential for several purposes, in particular, to assist the patient to obtain care and to chase up results of tests. In addition, relatives helped to sustain the patient's morale over the long hospital days and prevented them from feeling isolated from the outside world. Relatives also had an important link role to perform during the admission to hospital and during the period of hospitalisation.

In general, relatives were an essential asset to the information exchange pathways between patient and health professional and certainly no other agency or health professional seemed willing or able to bridge this gap. Health professionals did not seem to appreciate the impact and contribution that relatives had on the patients' lives, let alone the contribution they made to the patients' hospital experience. The contribution of relatives was largely ignored or not sought, to the detriment of the delivery of care and discharge planning. In some instances the involvement of relatives was viewed quite negatively by health professionals, yet for the patients the involvement of relatives was not only desired, but essential. For example, a study conducted by Glazier *et al.* (2004) focussing on multi -disciplinary team geriatric assessment noted that the patient's family actually identified more achievable goals for the patient than the health professionals. In general the identified goals tended to be focussed on the patient's future functional, psychosocial and spiritual needs.

Therefore for the patients in this study, it was unfortunate that in some circumstances the health professionals chose to ignore the contribution of relatives, particularly as the success or the failure of the admission in many cases relied heavily on their involvement. Healthcare policy also states the importance of including relatives (Department of Health 2001c). The attitude towards patients' relatives in this study would seem to suggest that health professionals are failing to address or acknowledge current healthcare policy, even policy that has been in the public domain for some time.

The recent introduction of Matrons to hospitals is another attempt to improve the patient's experience of hospitalisation by, amongst other things, helping to improve lines of responsibility for patient care. This was also one of the aims of both the named nurse concept and primary nursing. The principle behind primary nursing was that each patient had a nurse who was responsible for the planning, implementation and assessment of their care during their admission (Evans 1998; Goode and Rowe 2001; Jack 1995), thereby improving the continuity of care received. Certainly this system of nursing was in operation in the hospital where this study was undertaken, yet there seemed to be a real problem with continuity of care in both the A&E department and further into the hospital. It could be argued that adding another health professional to improve lines of responsibility and patient care would indicate that primary nursing as an initiative, has not managed to achieve this aim. Although, simply adding another tier of management will not help to improve continuity of care if the reasons behind these problems are not fully understood.

Another key factor prominent in this study was the way in which information was exchanged. Health professionals were content initially (usually around the first few hours following admission) to use the patient as a resource, such as asking the patient about their history and how they managed their symptoms. In fact, the patient often had very valuable information for speeding their own recovery and alleviating problems at discharge. For example, the patient was familiar with which drugs worked best for them and in which way, or which test had been performed and when. However, after this initial questioning period, information exchange largely occurred in one direction; patient to health professional. Indeed, health professionals in general seemed to be reluctant to work alongside patients and acknowledge their contribution to their own recovery, or share information with patients in a way that they could understand. It was difficult to ascertain why information seemed to only flow in one direction during this study. Certainly many of the health professionals were busy. Additionally, whilst it was the patient's priority to know why and when they were being admitted to hospital and what their overall plan of care was it often appeared that the health professional did not seem to share this priority.

The exchange of information was not just confined to the patient and health professional interface. Issues relating to the inadequate and sometimes inaccurate exchange and transfer of information occurred between health professionals working in the same clinical area, different health professional groups and strategic hospital managers. It was apparent that information exchange was so poor on occasions that even senior clinicians were unaware of the availability of services within their own hospital or clinical area. Therefore, much of the reluctance of health professionals to share information with their patients was because very often they were not in receipt of this information themselves. Also, organisational factors such as patient bed/ward moves confounded information exchange even further. Patients were moved frequently in order to accommodate the organisation of medical care and the bed management strategy. The result was that information exchange between wards and health professionals was often disrupted or completely absent. This in itself often lead to more bed moves whilst the patient waited for someone to locate a test result and then make a decision regarding discharge. It appeared that there was considerable strain on the availability of hospital beds and that, in order to keep the process of care moving within the hospital, it was necessary to transfer patients frequently. But this in truth actually caused more difficulties within the hospital as information exchange pathways were not streamlined or efficient enough for the information to move with the patient. Also inaccurate or confused information (for example, inaccurate drug records, confused diagnoses, inaccurate records of test results) seemed to exacerbate the problems related to patient care still further.

The impact of inadequate information exchange on the patient's admission and their admission experience varied between cases, although patient dissatisfaction was present in every case irrespective of presenting condition and outcome of admission. Patients appeared initially frustrated by the apparent lack of information within the hospital, although this seemed to be rapidly followed by a sense of powerlessness. The sense of powerlessness that appeared during the patient's admission was an alarming feature of a process that in theory was intended to promote independence, not decrease it.

Much of the literature regarding iatrogenic deterioration within acute hospitals concentrates on the elderly population and acknowledges that prolonged hospitalisation can lead to physical and psycho-social deterioration (Creditor 1993; Le Fevre and Feinglass 1992). This study would seem to indicate that it is not just elderly patients that suffer psycho-social deterioration after lengthy hospitalisations but patients of all age groups. Also the hospitalisation does not have to be particularly lengthy for the first signs of deterioration and powerlessness to begin to emerge. Yet, it was the patients who appeared to have to make the majority of role adjustments. Every time a patient in this study was assigned another bed on another ward or had to meet another member of the health professional team they needed to re-assess how they could and should act without causing alienation or upset. Hospital routines appeared to remain the same irrespective of patient needs and workload. Patients were moved around the hospital whenever health professionals considered it necessary and for reasons often undisclosed to the patient. Additionally, patients and, in many cases, the patients' relatives also worked hard to maintain a level of knowledge and awareness about their diagnosis, test results and discharge arrangements in a culture that did not appear to encourage patient participation.

It is perhaps no surprise that hospitalised patients tended to look after each other and share their collective experiences and anxieties. Emotional support in hospital seemed largely to be supplied by fellow patients and the patient's family and friends, with health professionals dealing with the physical aspects of care. The longer a patient was hospitalised the more their emotional needs increased, to a point where emotional rather than physical support was a priority.

The issues raised in this section appear to be in line with the published literature on empowering patients within a clinical setting (Jones *et al.* 2004). The Expert Patient Initiative (Department of Health 2001a) indicates that there is a need to encourage and empower patients to become active participants in their own care. This is further supported by Anderson *et al.* (1991); Anderson (1995) and Anderson *et al.* (1995).

Certainly there were times in this study when health professional to patient information exchange was less than empowering. It is important to consider the issue of patient individualism here. Thus far, this section has discussed that the patients' needs for empowerment in this study were not being addressed. In contrast, however, there were patients in this study who did not wish to be involved in their care or want to know why they had been prescribed certain drugs (Robinson and Thomson 2001). The challenge for healthcare policy and therefore practice is respecting the patient's individualism and their need or, in some circumstances, lack of need for information about their care.

5.4 The context and politics of care delivery

The hospital was undergoing a considerable period of change, for example, wards had been moved and their purposes re-defined and medical provision was being altered in order to provide more consistent and comprehensive medical coverage to wards and departments. The impetus for this change was to improve the management of hospital beds and reduce the number of delayed discharges, thereby increasing the hospital's overall bed capacity. This hospital, like many others across the country, had benefited from a sum of money from the 'Cash for Change' initiative (**section 2.3.3**) and it seemed that managers in particular were working very hard to overcome many of the difficulties associated with insufficient capacity. However, this study has revealed that there were many other factors that both helped and hindered this process.

Health professional perspectives, as demonstrated by Phelps *et al.* (1998), have been shown to influence admission and discharge decisions. However, **section 4.5** demonstrated that health professional perceptions also influenced the interpretation of organisational problems and, therefore, how these problems were prioritised and addressed. This was particularly apparent in relation to the management of beds. There appeared to be a general consensus that the causes of the organisational problems in the hospital were due to insufficient capacity. However, a general consensus was not shared regarding the reasons why there was insufficient capacity in the first place. It is not surprising then that there are such varying perspectives on the nature of the bed capacity problems given that the causes of these problems are not made explicit in the literature. A report by the Department of Health (2000b) identified that bed capacity problems were not necessarily a national issue. Certainly, hospitals with more beds did not automatically mean that they would experience fewer capacity problems; often the opposite is true. Also, it was clear from some of the interviews in **section 4.5** that further work was required to truly understand all the issues that lead to difficulties with the management and organisation of care.

Despite this, changes had been made to the function of beds and other changes were underway or in the final planning phases, without it seemed, a full understanding of the problems faced by the hospital and hospital staff. Tensions were therefore apparent in the hospital. In addition, previous hospital re-organisation had resulted in conflict between and within the various clinical directorates making the pathway of change problematic. An alternative interpretation is that whilst at an organisational level there were many changes occurring within the hospital, these were not filtering down to the health professionals at a ward-based level.

As a consequence, health professionals seemed at times to be suspicious of organisational change as they felt it had the potential to increase already quite large workloads. Also, health professionals felt uninformed and resentful that changes were occurring without their involvement or input, and this in turn led to lack of cooperation between different clinical areas. Other difficulties associated with team working occurred when differing opinions between medical consultants gave rise to different approaches to the care of an individual patient. Again, many of these problems seemed to be related to the exchange of information or simply in some instances, the individualism of the consultant. It did however make decision-making more difficult for junior members of staff who relied on some guidance or consistency from more senior or managerial staff. Certainly this was an uncomfortable position for all concerned, but the resultant impasse had bigger implications for patient care. The outcome seemed to be to blame other colleagues, but more specifically other clinical areas, for lost beds, lost tests and insufficient access to diagnostic services.

Access to diagnostic services was also identified as a factor influencing the patient's admission and discharge. Given that this discussion has identified real problems with information exchange it could be argued that access to diagnostic tests would be less problematic if teams worked more effectively together, junior medical staff were supported, their decisions respected and that information actually flowed. With these issues in mind, the perceived problems of bed capacity are less influential when considered within the entire context of care delivery. Certainly there are many factors here that could and do influence patient admission and delayed discharge other than insufficient capacity.

Another factor that emerged was that there appeared to be no single person taking the responsibility to manage patient care, either at a ward or managerial level. Perhaps this is one of the problems associated with team working as changes in staff invariably seemed to indicate that information and indeed patients get lost in the system. In theory, many of the wards that received patients from this study were using primary nursing (as discussed in **section 5.3**) yet fragmented care and inaccuracies were apparent. Much of the care observed in this study seemed to be focussed and organised around specific tasks. Therefore, patient care was often planned and delivered with no single health professional understanding the full picture of care. Unfortunately for some of the patients in this study even senior clinicians seemed to have difficulty overseeing the pathways of patient care and in some instances even believing that there were significant problems or improvements that could be made. This was exacerbated by the fact that (**refer to section 4.5**) there appeared to be insufficient health professionals with the right skills or experience in certain areas, such as discharge management.

The ability of health professionals to actively manage patient care is highly dependent on them having a good knowledge of the plan of care or actual care delivered, tests available, access to test results and how to facilitate discharge. In this study there were fundamental difficulties with these issues in all of the patient cases. It could be argued, that on a day-to-day basis with changing shift patterns and inconsistent levels of staff it was easier to be task orientated. Certainly, patients largely received the care they needed although not necessarily in a timely fashion and sometimes more by accident than actual planning.

Powerlessness of health professionals as well as patients was evident in this study. Health professionals, often due to the problems within the system, appeared and felt powerless, even if in reality they were not. This was apparent at all levels of the hospital organisation, from ward to managerial level. Sometimes the problems associated with staffing the hospital were so acute that plans could not be implemented and crisis management would take precedence until some solution could be achieved. In many cases in this study, powerlessness in relation to health professionals resulted in total inertia in the care process. There were several examples where health professionals did not know how to access information to move the patient's care forward or how to access the correct health professional to make a decision regarding a test result or discharge. As a result, active care for the patient ceased until someone or something, such as a crisis of bed availability or a re-lapse of the patient, initiated movement. Even then, with no one to sustain and oversee the pathway of care, often the process of care would stall again until the next crisis. As a consequence care seemed to be delivered falteringly until the patient became well enough to be discharged. Again many of these issues are linked to information not being readily available or in the right place when decisions regarding patient care were being made. Nevertheless, the health professionals were not powerless. Information about the patient or the result of a test was available, but it needed someone to take the responsibility to search for this information or manage it so that it was readily accessible. In this study the person willing and able to take that responsibility appeared to be missing. There appeared to be no clear lines of accountability. For some of the cases in this study it was even difficult to locate the doctor responsible for the patient's care. It would seem, that better forward planning and information management is needed in order to break the delivery of patient care inertia that results from a gap or chasm of the information exchange pathway.

All health professionals share a common goal, which is to care for patients in an effective way in order to hasten where possible their recovery and discharge. The reality can be somewhat different and the factors that confound the process can seem insurmountable. In this study, for example, the actual management of care and beds and subsequent organisation within the hospital caused problems and sometimes rivalry and disagreement between the various clinical directorates (Surgery, Medicine, Orthopaedics, etc.). Disagreements between health professionals within and between the various directorates were also apparent, so much so that the needs of hospital in-patients actually appeared to become a lower priority (**section 4.3.2** extracts **5PInt/d13, 5/PInt/d17, 5/Doc/d14** or **section 4.3.3** extract **HPInt/2006**). For example, the constant movement of patients around the hospital seemed to be related as much to appeasing the various directorates who were unhappy that their beds were being filled by the patients of other directorates as to the need to place the patient appropriately. Nevertheless, changes occurred and the managers and the health professionals appeared to work tirelessly on the problems to accommodate the various health professional perspectives.

Some consideration needs to be given to the literature regarding change management in the NHS and how this appeared to relate to and influence the context of this study. It was clear from the managerial interviews that system modelling had been conducted in order to understand some of the key problems in the organisation. The modelling exercise revealed that the hospital was trying to operate with too few beds. Modelling exercises are useful for simulating and testing alternative interventions and help to create general insights into complex management issues (Wolstenholme, 1995). A similar approach has been used by Bagust and Place *et al.* (1999), although they used a theoretical hospital situation and adjusted their model to take account of potential flu epidemics and disparities between admission and discharge. More quantitative modelling exercises are useful for determining whether a bed would be available for a patient given a certain set of circumstances (such as a specific time point during the week) but do not help to identify some of the more specific delivery of care issues or help to implement change in large organisation. They do, however, indicate a need for change or at least that change to the organisation should be considered.

Other authors have detailed that problems related to change emerge when the 'psychological contract' between employer and employee is breached (Purvis and Cropley 2003; Flannery Jr 2002; Cooper 2002; Abraham 2000; Cavanagh 1996). The psychological contract has been described as a set of perceptions, beliefs and obligations that both employer and employee exchange in relation to their respective contribution to the organisation, in this case an acute hospital. Evidence suggests that when large scale organisational change occurs, other problems are often evident which include lack of managerial support, meaningful participation by clinicians in the process of change and poor communication, all leading to breaches in the psychological contract (Covin and Killmann 1990).The implications of this breach are varied but can include exiting the workplace, neglect of work duties and hostility (Abraham 2000). There was evidence in this study to suggest that organisational change had not been received well by all those concerned, and that some of the problems emerging in relation to directorate rivalry were as a direct result of a breach in the psychological contract. Conner (2001) proposes that networks based on informal professional relationships have ensured the delivery of care to patients for many years and that only recently has the influence of networks been acknowledged. Conner (2001) also suggests that networks are given the freedom to develop free of interruptions. It could be argued that when a significant amount of organisational change occurs these networks become disrupted and it can take time for them to re-build to a level that will have a positive influence on patient care. The theory of networks might explain why it is difficult to get a full and complete picture of the factors that influence admission and discharge because many of them are unrecorded and only alluded to in conversations with health professionals. Also network theory might partly explain why health professionals do not know about available patient services and therefore cannot access them.

National Health Service policy also seems to cause difficulties with the management and delivery of care by imposing targets that, realistically or not, need to be achieved within a given time frame, for example, reducing A&E waiting times to four hours (Department of Health, 2001e) and reducing waiting times for surgical operations (Department of Health, 2000a). Hospital organisation is also potentially divisive, as clinical areas are structured according to speciality, such as medicine or surgery, and health professionals working within these environments have a tendency to become territorial about their own beds, patients, and work practices. Patients, and patient care, within this study, could at times be neglected by the inconsistency, and there was a sense that many of the patients were literally discharged out of the other end of the acute hospital process largely by luck rather than any active management. In some cases no actual diagnosis had been achieved or specific care delivered but sufficient time passed for the patient to feel well enough to return home.

5.5 Summary

This study indicated that some patients became an emergency admission partly because they were not receiving the level of healthcare service that they needed. Several factors influenced this situation. For example, the accessibility of admission alternatives, or healthcare advice in the patient's community; the responsiveness of these services to the needs of patients; the ability and willingness of the patients to access these services; and the patients' and health professionals' knowledge of these services in the first instance. In addition, the involvement of relatives and friends was important, as in many cases, they were shown to instigate admission when the patient was unsure of what course of action to take. Access to healthcare was also influenced by the present or absence of a diagnosis. This study has demonstrated that having a pre existing diagnosis slightly increases the patient's knowledge of healthcare services and therefore their access to them. However, in the main, the presence or absence of a diagnosis in the pre-admission period has no influence on the patient's experience post admission, or their chances of leaving hospital with a diagnosis.

A circle of unmet need would seem to exist. Patients who may need healthcare input are often ill-informed about the existence and availability of services and as a result, do not come to the attention of health professionals. Consequently, their health deteriorates to a point where they require hospitalisation. At this stage their health needs are dealt with to some extent. However, on discharge from hospital, there is a potential for the circle to reform, especially if all of the patient's health needs were not addressed during their hospital stay, which often appeared to be the case.

Once admitted to hospital the patient's hospital experience is further affected by a variety of interrelated factors, which were apparent from the moment the patient arrived within the A&E department. For example, care within the A&E department and further into the hospital system appears far from individualistic and patients are 'held' and then 'processed' in A&E rather than diagnosed and treated. Whilst it is recognised that, due to complex health issues, it is sometimes difficult to determine a patient diagnosis the problems associated with this were exacerbated further by other factors such as individual health professional decision making; absence of easily defined symptoms; difficulties accessing diagnostic tests; health professional inexperience and perceptions; and finally, fragmented and inaccurate information exchange. The latter aspect in particular seemed to contribute to the process of care stalling, and the difficulties associated with categorising and diagnosing patients then persisted into the remainder of the patient's hospital stay. The result is faltering care and a longer hospital admission than is necessary, as perceived by patients and health professionals alike. As the delivery of care slows, effective patient care and patient empowerment seems to become less and less likely.

Information exchange and therefore the delivery of patient care, have also been shown to be further confounded by the absence of a patient care manager, in effect a health professional that takes responsibility for keeping the process of care moving. Organisational change and restructuring has a direct influence on these factors and can lead to a break down in team working and a lack of cooperation between various clinical areas. However, a lack of understanding of the capacity and resource factors of relevance to the hospital also causes difficulties with the delivery of care as changes are made without a full understanding of the implications.

5.6 Chapter summary

The purpose of this chapter was to explore the factors that influenced emergency patient admission and organisation of care and the impact these factors had on the delivery of patient care and the patient's hospital experience. The chapter has demonstrated that many of the factors emerging in relation to organisation and delivery of care have a profound influence on the patient's subsequent hospital experience. The following chapter will conclude the major points emerging from the study and present some of the main implications of these conclusions for further research and practice.

Chapter Six - Conclusions and Implications

6.1 Introduction

The following chapter has been divided into four sections. This section presents the main points that have emerged from this study. **Section 6.2** examines the wider implications of the findings in relation to healthcare practice and policy. **Section 6.3** examines the potential scope for further research into the area of emergency admission to hospital and the patient's experience of the emergency admission. **Section 6.4** examines the various strengths and weaknesses of the study design. **Section 6.5** provides a brief summary of the conclusions and recommendations. This is particularly in relation to the aim and the research questions that guided this study, and the way in which this study was able to address them.

Prior to considering the implications of the findings for practice, policy and research, it is worth recapitulating the important findings from this study. The study demonstrated that current alternatives to hospital admission, particularly those targeted towards patients with pre existing chronic conditions, are failing to respond adequately to the needs of these patients. Whilst the presence of a pre-existing diagnosis influences the patient's knowledge and experience of services before admission it appears to have little or no influence on their experience in the post-admission period. Other patients who may, or may not, have a pre existing condition prefer to remain largely in obscurity until a crisis occurs. As a result both groups of patients become an emergency admission, as their needs are not being addressed by current healthcare provision. Furthermore, evidence from this study would indicate that some patients require an emergency admission to hospital primarily because they need time, within a supported environment, to recover from their health crisis.

Hospital admission decisions are influenced as much by the health professional's perspectives, experience, uncertainty and ease of access to diagnostic tests as by the patient's clinical signs and symptoms. As a result, the A&E department can become a processing, categorising and holding area for patients rather than an area for diagnosis treating and discharging. Further to this, admissions wards (EMAUs) are, in certain circumstances, becoming another holding area for patients, whilst they wait for tests and discharge, which was not the initial purpose of these units.

Acute care in many areas, including A&E, is delivered in a routine and ritualistic fashion with little regard given to the patient's individual requirements. As a result patients are not central to the care process and cannot make a significant contribution to their own care, even though they may have valuable insights into their own condition and needs. Similarly, the significant input of relatives is not being recognised in practice and, in some circumstances, family are excluded, even though they play a substantial role in both preventative care and discharge planning.

Despite the need to maintain the flow of patients through the system, patient care often stalls due to the difficulties associated with the information exchange pathways between health professionals and patients. This problem is exacerbated further by the fact that no health professional seems to be taking the overall responsibility for the care of individual patients in hospital. As a result health professionals become disempowered as they do not know how to move care forward, or how to access a specific healthcare service.

Intra-hospital rivalry exists as different clinical specialities attempt to deliver patient care in a climate of competition for resources. This problem is compounded by fragmented information exchange and lack of understanding of the influences on capacity and resource shortages. Furthermore, there is additional pressure to achieve healthcare policy targets within a constantly changing healthcare environment.

In general there is a significant disparity between healthcare policy, healthcare services and the experience and needs of patients who become an emergency admission to hospital.

6.2 Implications for healthcare practice and policy

This section explores the practical and policy implications of the findings from this study and their relationship to the wider issues of current interest to NHS practitioners and policy-makers.

It is of some concern that patients who have access to targeted healthcare services intended to prevent emergency admissions are still being admitted to hospital. This would indicate that there is considerable uncertainty in relation to the needs of patients in the community, inadequate coverage of present services and/or lack of patient education in terms of what to do and who to contact in a crisis. This presents a clear challenge to both policy-makers and healthcare professionals. One approach for ensuring better care in the community for patients with chronic health conditions is the introduction of 'case management' led by Community Matrons. However, there is little evidence to suggest that case management is actually useful in reducing emergency admissions to hospital (Hutt *et al.* 2004). Furthermore, a network of community based practitioners already exists who work with patients on a daily basis in their own homes, or at a local GP surgery. Yet, despite the presence of such practitioners, there still appear to be many missed opportunities where health professionals could facilitate patient education, but do not. Therefore, what is required in practice is a person or group who will help to establish better lines of responsibility for patient care, the lack of which was a major theme running through this study. It may not be realistic to expect Community Matrons to reduce hospital admissions, particularly emergency admissions in isolation. However, Community Matrons and the case management approach may be valuable in helping to re-define and tighten lines of responsibility, thereby improving both patient care and patient education. Whether or not this approach will be able to meet the needs of patients who prefer to remain in obscurity is debatable. However improving the opportunities for contact with health professionals and improving information exchange between health professionals might prevent many of these patients being lost to preventative services following discharge.

One of the strengths of this study was that it afforded an insight into both the patient's experience of community and acute care, and the interface between the two. It is likely however, that a fully integrated NHS as supported in healthcare policy may take some years to become totally effective. In the meantime, patients will continue to present to A&E departments with conditions that may not be immediately life-threatening, but nevertheless need investigation and treatment. However, the current rhetoric in the A&E department is one of immediate crisis management; diagnose, treat and discharge if possible. Patients with chronic and complex conditions do not easily fit into the diagnose-and-treat model of healthcare, yet alternatives for many patients are not feasible at the present time. Furthermore, there is evidence from this study that there are patients that primarily need time to recover from their health crisis in a supported environment and, in the absence of realistic alternatives, A&E departments are the only option.

Therefore, certainly in the interim, health professionals working in interface areas such as A&E require more strategies to care for patients with chronic diseases and improve the patient's experience, especially since many patients still remain within A&E for longer than four hours whilst they are processed. This is beginning to happen with the introduction of matrons and housekeepers into A&E departments, although the approach, both in policy and practice, seems to be to add another professional group to take on the tasks performed previously by nursing, medical and ancillary staff. Nonetheless, the addition of such professionals may well help to improve some aspects of the patient's experience. Other approaches could make a major contribution to the patient's experience within the A&E department, and may well be easily delivered by existing staff without significant resource implications. These include: keeping the patient informed of their care; delivering care in a calm environment with consideration given to patient privacy; and finally, acknowledging patient fears and physical requirements in a timely fashion. There is no doubt that policy is beginning to acknowledge the need for such approaches with the appointment of modern matrons. Nevertheless, the findings from this study demonstrate that these approaches are taking considerably longer to influence practice than anticipated by current healthcare policy.

Of course, health professional perceptions play an important role in the process of emergency admission to hospital and the patient experience, notable in this study in two distinct ways: firstly, in the way that health professionals made the decision to admit the patient to hospital in the first instance; and secondly, influencing whether or not they valued the patient's and relative's contribution to their care. It was clear that the patient and family contribution is not viewed as an important component of the care process even though the inclusion of patients in their own care is actively encouraged within healthcare policy (Department of Health 2001a), suggesting that this is one avenue by which quality of care could be improved.

However, bringing about a change in health professional behaviour in relation to both decision-making and the involvement of patients in care is not something that can be achieved quickly. Many of the problems would seem to be firmly ingrained and, until relatively recently, accepted. Nevertheless, health professional training and education is beginning to incorporate more of a patient-centred emphasis and the evidence from this study demonstrates that this may, in the longer term, have a beneficial impact on the patient's experience. In the shorter term, however, it is unrealistic to expect a radical change in health professional perspectives and decision-making. It might be better to look at other ways of ensuring that care is patient-focused and that health professional's perceptions, uncertainty and inexperience do not play a disproportionate role in admission decisions. One idea, the modern matron, is being championed within the NHS, but focuses on essential elements of care rather than on patient involvement. However, it is felt that there is still a gulf between the health professional's perceptions of care delivery and the patient's actual experience of this care.

Another strategy proposed within policy (Department of Health 2000a) is an increase in spending on Information Technology within the NHS to improve choice for patients and information exchange between various health professionals and agencies. However, this is unlikely to be fully integrated into NHS hospitals across the country until 2008 at the very earliest. In the meantime, it would seem essential that some consideration is given to improving current information exchange without disrupting the elements of patient care delivery that do appear to be working. The results from this study suggest that small changes may be just as significant to the patient's hospital experience as major hospital re-structuring.

The information exchange problems inherent in this study were not unique to this hospital. It is realistic to assume that some extrapolation can be made between the hospital at the centre of this study and other NHS hospitals of a similar size and patient population. With this in mind, it seems imperative that individual hospitals examine the nature of their information exchange problems in order to gain an understanding of where information is lost. At the moment, there seems to be a general acknowledgement that there is a problem with the management of information, but no real understanding of why these problems exist. Indeed there was evidence to suggest that managers were trying, by way of meetings with health professionals, to address them, yet little change was evident in the actual delivery of care.

Consequently, health service managers need to formalise information exchange pathways, for example, by making explicit which direction information should travel, and at what point in the patient care process the exchange of information should occur. Information technology may well make this process easier in the longer term. However, until all those involved with patient care are familiar with the technology, the full advantages are unlikely to be seen. Re-configuring the delivery of healthcare to allow a single health professional, or a specific team of health professionals, to take responsibility for a particular step in the information exchange process may well help to alleviate some of the other problems that were inherent in this study, for example, the patient care inertia, powerlessness, intra-hospital rivalry and the frustration felt by some health professionals in relation to the delivery of care. Interestingly, the case management approach that is proposed for the community might be as beneficial within acute hospitals. On some elderly care wards this is already a feature and operates within the multi-disciplinary team. This approach may be equally useful for patients on other wards throughout the hospital, although it is felt that the key to success is having a single individual or team specifically responsible for keeping the process of care moving.

Finally, it was evident in almost every step of the patient's hospital experience that there were difficulties associated with translating healthcare policy into practice. The policy-practice divide is certainly exacerbated further by the fact that information is not exchanged efficiently between healthcare management and those individuals actually delivering care. Utilising some of the strategies mentioned above may help to lessen this divide. Also this study did indicate that the hospital's capacity, resource and personnel problems were not well understood and, therefore, the impact of policy within this environment was unpredictable at best and ineffective at worst.

6.3 Areas for further research

During data collection and analysis a number of areas for future research became apparent. Some of these relate specifically to issues raised by this study which require clarification and exploration prior to further research. Others refer to the possibilities of expanding work in this area beyond the original aim of this study.

There would appear to be some ambiguity in relation to the needs of patients living in the community with chronic health needs. Without doubt, this is a prominent focus of current NHS policy and healthcare services, even though at times there is conflicting evidence to support these policies and services. Therefore, it would seem prudent that a full understanding of the realities of patients living with chronic conditions is gained prior to the commencement of a new service or further development of policy; in practice this does not appear to happen. However, the need to explore this important area of patient care remains. Future research should focus on a number of key areas. These areas include: exploring the healthcare service needs of patients with existing chronic health problems; examining the extent to which people know about current healthcare services and how to access these services at the point of a health crisis; and finally, exploring the experiences and perceptions of patients who have fears about the consequences of involvement with health care services. The latter area remains largely untouched in the literature, possibly because this group of patients, or future patients, are very difficult to access, yet current healthcare service providers are not aware of their specific needs or even that their needs exist.

There are very few studies that examine the impact of delivery of care on the patient's experience. In addition, those that do have tended to use a questionnaire approach, which does not necessarily facilitate access to the details that are important to the patient's experience. The need for further research into this area is twofold. Firstly, more research is needed that specifically concentrates on the impact of a service or a process on the patient's experience. Secondly, there needs to be more emphasis on the use of patient interviews in combination with other methods, such as questionnaires and observation.

It was striking that there are still many healthcare services that are operating daily without a full understanding of the needs of their target population and without adequate and rigorous evaluation. This indicates a further area for research as it would seem important that part of the process of establishing a new service should be to include adequate provision for evaluating this service. Theoretically, this should be the case for all services, irrespective of size, as it is important to determine that publicly funded services are fulfilling the needs of patients in the longer term.

Individual hospitals certainly need to understand their local capacity, resource and communication problems; as a lack of understanding of these issues was apparent in this study in a number of areas. For example; the availability of staff with appropriate skills; availability of beds in acute medicine; delayed discharges and finally the impact of local demographic changes on the need for acute beds.

This indicates another important area in need of further research. Certainly, healthcare system modelling and process mapping exercises would be suitable for exploring some of these areas in more detail. In particular, mapping exercises would be useful for tracking the pathways of information exchange and investigating why and how important information related to patient care is lost in the system. However, it is vital that process mapping, like evaluation, is an integral and regular feature of the healthcare environment as even small changes can have a profound influence on hospital processes.

Finally, comparative research might shed further light on some of the factors that influence emergency admission to hospital and the patient's experience. One possible approach could be to compare the experiences of patients on different geographical sites. By doing so, this might help to indicate the extent to which the hospital at the centre of this study was typical or atypical of others.

During the course of data collection and subsequent data analysis many areas of interest for further research and expansion of this work became apparent. However, one area of particular interest was an exploration of the lives of patients, particularly the events leading up to the emergency admission to hospital. Indeed, it was felt that a thorough understanding of the processes at work for the patients during this time, and the services available, was needed. Without doubt, understanding in greater detail the patient's experiences of this time and their decision-making processes may actually aid the targeting and development of future community and acute healthcare services. Designing a study to address this does not seem insurmountable and, in a similar vein to this study, it would require the use of multi-method approaches, and access to healthcare professionals and services.

6.4 A critique of the research approach

A considerable period of time was dedicated to the design of this study, especially since the study itself was originally intended to incorporate a large scale audit and statistical modelling exercise. It was felt that this approach would not facilitate an insight into the elusive issues related to the patient's hospital experience and, because of this, the study was re-designed. The revised study design appears to have worked well and has been flexible enough to accommodate necessary changes, such as an extension of the study period as mentioned in **Chapter Three**. There were, however, a few issues in relation to the chosen design that require some consideration.

The focus of this study was altered at a very early stage in the pilot phase to concentrate on the patient's entire hospital admission rather than the first few days. On reflection, I feel that this was an entirely appropriate adjustment. However, there were many aspects of the patients' pre-admission lives that appeared to have an impact on their admission and hospital experience. Due to the focus of this study, only a brief insight into this period of time was gained, although considerable detail was still achieved. Nevertheless, as mentioned in the previous section above, there is considerable scope to examine this area in greater detail.

This study used a variety of methods to address the chosen research questions. One such method was the analysis of documents, predominantly the analysis of medical and nursing documentation. Collecting the data from these documents was extremely labour intensive as I wanted to reproduce the documents as faithfully as possible and it was inappropriate to photocopy the records. Furthermore, it was discovered over the course of the study that the documents were often inaccurate and did not necessarily reflect what was happening to the patient and therefore, I had to be cautious in their use. Certainly, the scarcity of quotes from documents in **Chapter Four** is quite evident and this is not a fair representation of the amount of data that were collected from this source, but rather an indication of the quality. Nevertheless, triangulation of data sources is important in this type of research, but it is recognised that some data sources have precedence over others (e.g. interviews with patients) when trying to understand such phenomena as patient experiences. The fact that the documents were often inaccurate and of little use in terms of clarifying patient care, was an interesting finding in itself, especially given the amount of health professional time devoted to recording medical and nursing notes. In reflecting on the quantity of patient records, it might have been better to collect documentary data only once a day rather than three times, which was sometimes the case. However, the collection of documentary data did mean that I spent more time in the clinical area and, therefore, had greater opportunity to observe certain aspects of patient care.

Another aspect to consider is my sampling framework. Eight patient cases were followed from the point of their admission and each patient was selected because they were admitted at a specific time of the day or week. Data collection only ceased when all the sampling criteria had been achieved. However, it might have been feasible to cease data collection after only five or six cases as the issues and factors emerging became quite repetitive after this point. Nevertheless, continuing to eight cases confirmed further the robustness of the study design and also indicated that, despite the heterogeneous nature of the patients in this study, their experiences of hospitalisation were very similar.

One of the key considerations during the design phase of this research study was the implications of trying to balance multiple roles, for example nurse and researcher. The reality was much simpler than I had previously thought. I did not encounter any particular dilemmas that could not be solved by a brief word with a health professional in the clinical area. Patients and health professional rarely asked me about my background. In most cases where patients asked me about their care, I was able to suggest to the patient that they asked the nurse or doctor that managed their care, or I asked permission to do this on their behalf. At no point did I experience an uncomfortable clash between nurse or researcher roles. However, it was important to reflect upon this prior to the commencement of the study as there may have been issues emerging that could have caused discomfort or ethical dilemmas. In addition, I was required to have a plan for dealing with distressed patients. As a result I was careful to respect patient privacy and their need for time alone with their family. In fact, it became apparent that the data collection periods often became a highlight in the patient's day, particularly for those that did not have regular visitors. For example, patients seemed pleased to see me when I arrived for an interview or to review their medical or nursing documentation and often asked when I would be returning. I believe that this reflected a positive researcher and patient relationship and that this relationship definitely enhanced the quality of this study.

6.5 Summary

To conclude, this study was designed to address the following aim:

> *To explore the factors that influence the emergency admission of patients to hospital, and the impact of these factors on the patients' hospital experience and the delivery and organisation of patient care.*

And was further guided by two main research questions:

> *What are the factors that influence the emergency admission of a patient to an acute medical bed and the organisation and delivery of care thereafter?*
>
> *How do these factors impact upon the patient's hospital experience?*

It was felt that this study has addressed both these research questions in some depth and has, therefore, provided a unique and valuable insight into the factors that influence emergency admission to hospital from the perspective of the patient. It reinforces and adds to current knowledge in a number of key areas: that there is a lack of understanding of patient needs prior to emergency admission; that there is ambiguity in relation to local resource and capacity problems; that the translation of policy into practice is unpredictable in terms of the impact on care delivery; and finally, that the patient's experience of hospitalisation remains largely unchanged despite national healthcare policy and local organisational developments.

The key recommendations for practice arising from this study are detailed below.

- Care within the acute hospital seems to be delivered falteringly with no single individual overseeing the patient's care and ensuring that information is transferred accurately and in a timely fashion. This is despite the presence of primary and team nursing. This element of care delivery requires some further consideration and the introduction of specific patient case management in the ward setting may well be beneficial to ensuring better information exchange and therefore patient care.

- Improvements are needed in the exchange of information between health professionals.. The proposed introduction of case management using community matrons may help to tighten lines of responsibility and communication between health professionals in the community but will not impact on acute care settings.

- The A&E system of diagnosis, treatment and discharge does not work well with patients with chronic long term conditions and their experience is not always positive. Therefore a different approach is needed for these patients that takes into account their multiple needs, ongoing problems and complex social context

- Involving not only the patient but the patient's family and friends requires re-emphasis in practice, as there is still reluctance on behalf of health professionals to include patients and family in the care decisions. This appears to be despite the fact that both have a valuable contribution to make to the delivery of care.

Appendix One – Patient Cases – Pilot Phase

Maureen (Case 1)

Maureen, an independent and mobile 74 year old woman lived with her husband in a bungalow approximately ten miles from the hospital. She did have a history of rheumatoid arthritis, but was able to manage very well with the assistance of her husband. She had had a mild heart attack a few years previously, but had not suffered from shortness of breath. When she had woken in the early hours of the morning with breathlessness, her husband had telephoned the GP and was given the number for NHS direct on the answer phone, which he called. NHS direct advised Maureen to go to hospital and she arrived in at A&E department before 6am. She was finally transferred to a bed on the admissions ward at 11 am. Maureen remained on the admissions ward until 4:30 am the next morning when she was transferred to one of the respiratory wards. She remained on this ward for a further three days and data collection ceased before a diagnosis was achieved

John (Case 2)

John a 55 year old man was admitted to hospital following a two-day history of headaches and memory loss. John had a full-time job and lived with his wife and three children in a house approximately four miles from the local hospital. He had no previous medical history. When John began to feel unwell, he went to see his GP, who on the advice of a hospital registrar referred John onto the A&E department. The intention was to send him directly to the emergency admissions ward. However, due to the lack of bed availability John was forced to wait in the A&E department for six hours until obtaining a bed. He remained on the admissions ward for two days awaiting tests and on the third day was moved to the neuro medical unit. At this point data collection ceased.

Mary (Case 3)

Mary an 83-year-old woman was admitted to hospital on the advice of her GP. Mary was referred directly to the elderly emergency admissions ward and arrived by ambulance. She had been suffering from nausea, vomiting and loss of appetite for three weeks prior to her admission. She lived alone in a first floor flat and whilst mobile in her flat, she was unable to go out unaided. She had no surviving relatives, but did have supportive neighbours.

Mary was taken straight to the elderly admissions ward upon her arrival to hospital. She remained on this ward for all of the first day of her hospitalisation with very little activity. At 1 am she was taken to the X - ray department and then returned to the ward around 2 am. Another day passed and Mary was moved to another bed on the same ward until she was discharged home on day three with a diagnosis of anaemia.

Appendix Two – Interview Schedule

Interview Schedule

Health Professional Interviews (hospital management)

Information on the individual's previous experience/time in the health service will be requested. Question examples:

- Could you please tell me about your role and how this relates to the management of emergency admissions?
- What are the specific problems and more general problems associated with emergency admissions in this hospital?
- What services/ facilities does the hospital provide to cope with emergency admissions?
- How do you think that these services etc have impacted upon emergency admissions to hospital?
- What services/facilities are needed if not provided?

Clarification of issues raised in interview or previous interviews.

Health professional interviews (ward based)

Details regarding individual patient cases will be requested, specifically information related to:

- The patient's clinical condition
- Anticipated plans of care
- Knowledge of tests results etc
- Discharge arrangements

Patient Interview Schedule

Guiding Questions

General information will be requested from the participant in order to provide background to the individual patient case and to help put the patient at ease.

General health and well-being questions

The patient will be questioned about the events leading up to the onset of their illness and their general health prior to this. Information regarding previous contact with health professionals will also be sought.
For example:

- Did you try and get help prior to the admission?
- Who made the decision to come to hospital?
- Did you consider any alternatives?
- How did you feel about your admission to hospital?
-

Details about the patient's general living arrangements

Information regarding the patient's living arrangements will be requested and information regarding any support they have at home. For example:

- Do you live alone?
- Do you have support at home?
- What prior to your admission would be your daily routine?

The patient's perspective of their admission will be sought

- What has happened to you today?
- Have you had any test etc? Do you know the results?
- Do you know what your plan of care is?
- Any discussion about discharge?
- What about care? What are your feelings about this?

Appendix Three – Information Sheets

PATIENT INFORMATION SHEET

(Headed Paper)

Dear Patient,

Re: A study investigating the factors that influence the admission of a patient to an acute medical bed and organisation of care thereafter.

I am a Ph.D. student at the University of Southampton and a qualified nurse. You are being invited to take part in the above study. Before you decide, it is important that you understand why the study is being carried out and what it will involve. Please take the time to read the information on the reverse of this letter carefully and discuss it with your family, friends and hospital staff if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part in the study.

The purpose of the study
Emergency admissions are rising nationally. It is important to understand all the factors that might be leading to this rise so that improvements can be made in the health service. This research is designed to provide some of this information. I am keen to understand what happens during and immediately after the admission of a patient to an acute medical bed.

If you require further information you can speak to your hospital doctor or nurse. You can also contact me directly on (telephone number) or ask a member of staff to contact me.

Thank you for taking the time to read this and for considering taking part in the study.

Yours sincerely,

Jennifer Beattie

A study investigating the factors that influence the admission of a patient to an acute medical bed and the organisation of care thereafter.

What will the study involve?

Part of the study time will be spent talking to patients and staff, whilst at other times I will be observing the care that you receive whilst you are in hospital.

Why have I been chosen?

We are trying to involve a number of people admitted at different times of the day, over the course of one year. You were admitted during one of these times.

Do I have to take part?

It is up to you to decide whether or not to take part in the study. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form, a copy of which you can keep. If you do decide to take part you are free to withdraw at any time and without giving a reason. This will not affect the care you receive in any way.

What will happen to me if I take part?

I would like to talk to you soon after your hospital admission and then briefly on every day during your hospital stay. The purpose of these informal interviews is to find out about your hospital admission. With your permission I would like to tape-record these interviews. I will also be spending a period of time during your hospital stay observing activities on the ward related to your admission and reading documents. This includes your nursing and medical notes.

What implications are there for me becoming involved in this study?

If you agree to take part, I will be contacting your hospital doctor and nurse to ask them about your admission and inform them of your involvement in the study. Parts of the study will be presented to other people interested in this subject. However any information that is collected during the study will be treated as confidential. In addition, any findings will be anonymised so that those taking part cannot be recognised in any publications or presentations.

Who can I contact for further information?

Please contact me (Jennifer Beattie) if you require any further information.

Thank you

HEALTH PROFESSIONAL INFORMATION SHEET

(Headed paper)

Dear doctor/nurse,

Thank you for your interest in the study. I am a Ph.D. student at the University of Southampton. The study is concerned with investigating the factors that are influential in the admission of a patient to an acute medical bed.

The research will focus on a collection of patient cases admitted to this hospital as emergency medical admissions over the course of a year. I am particularly interested in exploring the views of staff regarding the factors that are influential in this process. I have included a more detailed description of the study protocol on the reverse of this letter.

I may well be approaching you about individual patients. If you require more information about the study or do not wish to be approached you can contact me at any time in person, or on 02380 598201 or e-mail jlb@soton.ac.uk.

Yours sincerely,

Jennifer Beattie
Research Student
University of Southampton

A study investigating the factors that influence the admission of a patient to an acute medical bed and organisation of care thereafter.

Name of Researcher: **Jennifer Beattie**

Research protocol

The study commenced in May 2001 and will run until September 2002. The study will be conducted in the following way.

Patients will be selected and consented to participate in the study on admission or as soon after admission as possible. The patient will be involved in the study for the full duration of their hospital stay. Data regarding their admission will be collected in the following three ways.

1-Interviews

Patients will be interviewed promptly after admission to an acute medical bed and on every subsequent day of their hospital stay. They will be asked about the admission process, the events preceding their admission and events occurring during their hospital stay. The patient interviews will last about 30 minutes and will be tape-recorded and transcribed. Hospital staff involved in the admission process will also be approached and briefly questioned about the patient's admission and any factors that were perceived to be influential. These interviews will last between five and ten minutes and notes will be taken. In addition more in-depth interviews with staff will be conducted over the course of the 12-16 months. It is anticipated that a cross section of hospital and community staff will be approached in order to gain an understanding of all the factors that are considered important in an emergency admission. Each member of staff will be approached separately for this. These interviews will last between 30-60 minutes and will be tape- recorded and analysed.

2-Analysis of medical notes and other documents pertinent to the admission process

This will be performed in order to provide contextual information and information about the patient's past medical history and previous health care professional contact.

3-Observation

I will spend some time observing events related to the admission process and the care of the patient in the days following their admission. In particular I will be observing activities such as medical ward rounds, patient related ward meetings and any other events directly related to the patients in the study. It is anticipated that the periods of observation will be short. I will inform staff and patients prior to any period of observation. The main aim of the observation is to understand the context in which decisions regarding patient admission and discharge are made.

Confidentiality and anonymity

All information obtained during the study will remain confidential. Notes taken during periods of observation and interviews will be anonymised prior to publication or presentation.

If you would like any more information about this study please do not hesitate to contact me on 02380 598201 or alternatively e-mail me at jlb@soton.ac..uk

Thank you for your time

Appendix Four – Patient Stories

Susan

Susan was admitted to the A&E department on a very wet and windy autumn Tuesday morning. The following is a summary of this admission and includes detailed reference to all the data sources collected, such as interviews, documentary analysis and observation notes.

Susan, an 86-year-old widow ordinarily lived in a house on the outskirts of a village. She described her home as **'a house with stairs and everything'** which overlooked a green with large trees and bushes. Susan indicated in the interviews that she was essentially independent within her home despite a degree of arthritis and pronounced visual impairment. As Susan said, the visual impairment impacted quite markedly upon her life, as she was unable to go out of her house unaided, and relied heavily on the assistance of others, in particular one neighbour. ***Refer to Patient interview 4.11 paragraph seven for details of the support the neighbour provides.*** Once within her home, Susan was able to cook, clean and look after the garden. However, she was beginning to find the garden increasingly difficult to manage and this was clearly upsetting her ***'It is getting so I can't do the garden, a very sad business that I can't do the garden'.***

Susan had been widowed for several years, but had retired to her current house with her late husband nearly a quarter of a century earlier. Susan inferred that neither had been particularly sociable and Susan acknowledged that it was difficult to make social contacts when retiring to a new area. As a consequence, she knew her neighbours but only to ***'say hello too'.*** She was also involved in the local church but again viewed these individuals as acquaintances rather than friends. As a result, Susan often felt lonely ***several references to loneliness/isolation in patient interview transcripts 4.11/4.12*** as she was increasingly confined to the house as a result of her visual impairment. This was particularly problematic for her in the winter months, as she felt uneasy about venturing outside when it was dark. ***'You know from when I wake up until I go to bed. On those days, well I don't see anybody, here anybody or speak to anybody, I used to have a cat, but she died and the girls ring up. Other wise, if I am not well and I can't get out, I can go a week, except for a phone call and not see anybody because it is a quiet little estate on the edge of the village. Refer to patient interview 4.12 where she discusses this in a bit more detail***

Susan related details of how she managed to pass the time in these instances, for example listening to taped books, the radio, and baking. However, since this was all she felt she could do because of her visual impairment, she became bored and found it difficult to fill the time. Susan also highlighted that other people assumed she had lots of time to engage in activities that interested her, ***'people think that you have all the time in the world, you can do all this and do all that. I find I can hoover the carpets, and flick the dust around. It is all I can do really' Patient interview 4.12.***

Susan's family

Susan had two daughters, both married and both in their late fifties and early sixties. Neither daughter lived in Susan's local area, and one daughter had a chronic health condition and found it difficult to drive. The other daughter has never been able to drive. It was therefore very difficult for them to visit Susan. In addition Susan's visual impairment meant that she had some difficulty dealing with her own financial affairs, consequently her son in law managed this for her. However, all the paperwork initially was posted to Susan and she had developed strategies for deciphering the top line of the letter. By this method she was able to determine whether to send the paperwork to her son-in-law or keep it herself. She had also developed other strategies to circumvent her visual difficulties. This included the use of a magnifying glass given to her by the eye hospital so that she could bake and also sign cheques ***'I looked at some talking scales in the shop for the blind, but I couldn't live with that man telling me that" you now have six ounces"'. Refer to patient interview 4.11 for coping strategies.***

On the whole, Susan seemed to have accepted that she would need to have more help in the future and expressed a desire to live somewhere where both daughters could visit her more easily. She had been thinking about a home ***' I don't want to stay in my own village, I would be just as lonely, if I haven't got anybody popping in now, they are not going to pop in when I live in a home'.*** Her daughters had been unwilling to discuss the prospect of a home with her and this seemed to concern her ***'I really would like the girls to talk about it, but you know children and their parents'.*** Nevertheless she was optimistic about the future, as she knew that when the time came she had sufficient funds to provide for herself. However, at this moment in time she still felt quite independent.

Susan's health

Susan had had some previous contact with other health professionals over the last ten years, specifically for her palpitations, which on occasion caused her to lapse into unconsciousness. She had learned to cope with these over the years ***'once I had learned that it wasn't going to kill me and I was still here, I stopped getting so anxious'. Talks about her past health in patient interview 4.7/4.8.*** Susan had visited her GP on a number of occasions and had been told that nothing could be done for palpitations, despite this however her GP prescribed Propanolol. After a number of years she suggested to her GP that she thought she should perhaps see a Neurologist, her GP replied ***'well you can, but if you wait on the NHS it will be 2 years'.*** She opted to see the Neurologist privately and after a series of tests the consultant confirmed that he couldn't find any abnormalities. He suggested that Susan take one Aspirin tablet per day. ***She talks about this consultation in patient interview 4.8.***

The admission

Susan started to experience pain on the Saturday evening soon after she went to bed. She described it as 'heavy' but it stayed in the centre of her chest and didn't radiate outwards. She was convinced that it was indigestion and after three hours and a couple of indigestion tablets later, the pain began to subside. By the following morning the pain had completely disappeared and she felt well again. Susan awoke again on the Monday morning in excruciating pain, but still attempted to reassure her daughter that she was all right. Her daughter then contacted her own GP surgery and spoke to the receptionist who related the symptoms to the GP. He suggested that Susan should be taken directly to the A&E department. Since Susan's daughter did not drive, a neighbour had to be contacted and asked if she could drive both Susan and her daughter to the A&E department[1].

Susan arrived in the A&E department at approximately 9:50 am. ***'It was around 10am when I arrived in the department, all ten trolleys were occupied by patients. Patients seemed to be arriving in the department at intervals of approximately twenty minutes, which meant that some of the bays were occupied by more than one patient. In this instance moveable screens were positioned between the patients to provide a degree of privacy. Taken from a&e observation notes 4.6.*** I noted that despite the number of patients, the staff did not appear to be as frantically busy as had been witnessed on previous visits to the A&E department. The details of each patient were recorded on a white board. It was obvious from the board that although the trolley bay was full, many of the patients had already been seen and were now awaiting other tests, or referral to other areas. The phones rang incessantly and there were constant calls over the paging system for various members of staff. Susan had been admitted to the A&E department with the symptoms of chest pain and palpitations; she was assigned to a triage category of 'very urgent'. ***Refer to documentary notes 4.3.*** Susan's medical history was requested and recorded by the nurse on arrival, she was then attached to a cardiac monitor, given an ECG and oxygen and was taken by a porter for a chest x-ray. This all occurred within 90 minutes of arrival to the A&E department. When I spoke to Susan, she appeared well and was no longer complaining of any pain.

The next person to speak to Susan was the A&E doctor. She was reviewed in the A&E department within two hours of arrival to hospital, whereupon the history was taken and recorded and a diagnosis of chest pain and palpitations recorded. ***Refer to a&e document notes 4.3.*** Essentially the notes recorded by the doctor were a slightly more detailed version of the notes recorded by the nurse on arrival. Notably, the medical assessment included a list of required tests and a brief review of the tests already performed and one line regarding Susan's social situation. Susan's treatment was recorded as ***'Pain free at present, referred and accepted on elderly admissions ward' Document notes a&e 4.3.*** There didn't appear to be any mention of Susan's past visit to a neurologist.

The A&E doctor indicated that Susan's admission was warranted, as she had symptoms of chest pain, which were new to her. ***Doctor interview 4.13.*** Susan confirmed this in a later interview ***'I have had nothing like this before, there was nothing to tell me it was about to happen' continues to describe the pain 4.11.*** The doctor suspected a heart attack but was unsure, as Susan's symptoms appeared vague. As a consequence, she decided to be cautious and referred Susan to the team of doctors in charge of elderly care. The doctor anticipated an admission of at least 24-hours, which would depend on Susan's blood results. Of particular concern to the doctor was Susan's lapses into unconsciousness, which she discovered by asking Susan questions about her past medical history within the A&E department. The doctor suspected that Susan had not told anybody about these. In subsequent conversations with Susan it became apparent that she had actually had these investigated by a neurologist and her GP was fully aware of the situation. When I

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[1] No body suggested to Susan or her daughter that they should contact an ambulance, or found out whether they had transport or not.

asked the A&E doctor if Susan's GP would be contacted, the doctor replied '***you can phone the GP, but I tend to take things as far as I need to decide whether someone comes in or goes home. The inpatient team will want to go through it anyway, so it will be duplicate and it is not an efficient use of my time' A&E doctor interview 4.1.*** From later discussions with Susan, it became cleat that a telephone call to her GP might have helped the A&E doctor gain more details about Susan's past medical history. In particular that she had already had the 'blackouts' investigated by a specialist. It did appear that Susan had not informed the doctor of this. Susan's GP was consequently not contacted at any point during her admission.

Admission to the ward

Susan was transferred to the ward at lunch time after four hours in the A&E department. She was settled into a mixed sex bay of four patients opposite the nursing station, Susan's bed was in the far corner near the window. She remained attached to both a cardiac monitor and oxygen, although she was finding the oxygen mask difficult to tolerate and kept removing it, ***Observation 4.6.*** The cardiac monitor did not appear to be visible from the nursing station.

On arrival to the ward (elderly admissions unit) Susan was reviewed by the admitting nurse, who recorded Susan's medical history. ***This was now the third time Susan had had her history repeated, there was no new information recorded and nothing recorded about her profound visual impairment, or that she lived alone. Refer to documentation 4.3.*** Within a few hours of admission to the ward, Susan was also seen by the ward doctor. Her medical history was requested once again. This was the fourth time that Susan's admission history had been requested in six hours. In addition, a number of abbreviations and symbols were used and in places the notes were difficult to read. Essentially the information recorded in the medical notes repeated previous notes. Nevertheless, a more detailed physical assessment was recorded with a more definitive diagnosis, this was based on Susan 's presenting symptoms ***'Angina – unstable by definition' Documentary notes 4.3*** and a discharge date recorded. The consultant identified the diagnosis although he utilised the same information as the A&E doctor. Later results demonstrated that Susan had in fact had a heart attack and this was explained to her as a **'small MI'**. Susan seemed to understand the relevance of this.

After review by the nursing and medical staff, Susan was essentially left to her own devices apart from the occasional blood pressure check. When asked, the nurse in charge of Susan's care was unable to tell me any further information about Susan as she hadn't had a chance to review the notes yet.

Day two

Upon returning to the ward the following day I took a few moments to absorb the atmosphere in which care was being provided. Many of the nursing staff where positioned at the nursing station completing paperwork and disappeared periodically to answer buzzers. The telephones rang incessantly. A male patient approached the desk and made a request to go to the shop; it took three health professionals to arrive at the decision to allow him to go the shop, the doctor having the final say. ***'an elderly man approached the station at this point, he asked one of the nurses if he could go down to the shop, she told him he couldn't. He said 'why not'. The***

nursing auxiliary said to him that he would need to ask his doctor, he asked why and she said 'because he's the doctor it is his decision'. She pointed to where the doctor was. Another nurse came back to the nursing station and the auxiliary asked if the patient could go down to the shop, she appeared quite bad tempered and said' well ' I don't know! The doctor then emerged and he was asked whether the patient could go down to the shop, he said ' well I don't see why not'. The patient then took himself off the ward. A few minutes later one of the nurses brought the patient back because she thought he had wandered off the ward. I asked the ward clerk if the patient was one of theirs. She said yes, and he's awful he really man handles female staff. She physically cringed when she said this' Refer to observation 4.9,

The nursing station seemed to represent the centre for all activity on the ward, the Bed Manager was discussing the bed situation with another nurse and said ***'they could free four beds without blinking if they wanted to' Observation 4.9.*** The telephone on the nursing station was a major feature of the ward, and it appeared to be more demanding than some of the patients. There were several observed incidences regarding the phone, for example the ward auxiliary remained at the nursing station and appeared to physically groan when she was required to answer a buzzer. However when the telephone rang and it was for the consultant she ran down the corridor to get him and returned to the nursing station out of breath ***Observation 4.9.*** A second incident occurred when a relative called to speak to a patient, the nursing auxiliary answered the phone and called across to the nurse looking after the patient. The nurse replied loudly across the ward ***'he's having an enema at the moment' Observation 4.9.***

I returned to review the documentation and noted that Susan had found the cardiac monitor uncomfortable overnight despite this the documentation stated that she had slept. It was noted that the admission documentation had now been more fully completed and included reference to Susan's visual impairment. It stated that Susan's usual state was ***'continent of urine and faeces, partially sited, cheerful lady, skin intact' Document notes 4.4***

Susan in fact had had a very uncomfortable and noisy night; she confirmed to me that she had slept for about 30 minutes and that she had been kept awake by the cardiac monitor and the noisy patients and staff. ***Refer to interview 4.11 paragraph 13 onwards and interview 4.12 paragraph 7 onwards for interesting quotes about the night and the noisy staff.*** Susan also wasn't impressed with the mixed bay situation and made the following comment ***'well I don't like it, I don't like it, but it is my first experience, we're old you know, but I don't think I would like it if I was younger. I mean they are old fellas'.*** Despite this, she seemed well, but still had the cardiac monitor attached, which continued to irritate her. She had requested a wash that morning and reluctantly the nurse had helped her with the cardiac monitor to enable her to do this and then to visit the bathroom. However, the nurse had left her in the bathroom and Susan had returned to her bed unaided. ***Patient Interview 4.11***

While Susan and I talked, the ward doctors continued reviewing each individual patient on their ward round. They came over to Susan and pulled the curtains around the bed ***Refer to Observation 4.9.*** There were four doctors and a nurse, but no direct verbal contact between the two professional groups. The doctor briefly listened to Susan's chest and told her that she had had a small heart attack. She was given the permission to walk around the ward today, even though she had already been doing this herself out of necessity. The doctor also confirmed that Susan would need a physiotherapist to assess her using the stairs, but thought this would be better on the following day. The nurse remained quiet, the doctors then moved on. Later entries in the medical notes confirmed this bedside conversation, the significant event record completed by the nurses repeat this, despite the fact that they are all kept in the same folder.

A brief interview with the consultant regarding Susan's care confirmed many of the details of the past few days. However he told me that the usual plan for a patient like Susan was a, 48 hour admission, with a four to six week hospital follow up. The admission would therefore include a number of tests and mobilisation with the aid of Physiotherapists. When asked about the possibility of alternatives to hospital admission he seemed to think that the only alternative would be one to one nursing at home, this didn't seem realistic to him. ***See consultant interview 4.2*.** The consultant suggested that Susan would need physiotherapy input to help her mobilise. In actual fact Susan mobilised herself.

Day three –discharge day

Again the nursing notes reflected that Susan had slept well ***Document notes 4.5.*** She had slept better than the previous night and had been taking herself to and from the bathroom. She told me of an incident during the night were she had awoken to find the patient opposite her standing over her like a 'Guardian Angel' ***Patient interview 4.12.*** Susan expressed concern at being isolated in the corner of the bay at night especially with the curtains pulled around her bed. The medical notes didn't reveal anything new and stated that Susan had no pain and had been mobilising around the ward. It was extremely noisy in the bay that morning, with trolleys trundling past, phones ringing and nurses and doctors talking at the nursing station. The man opposite Susan was talking to himself and Susan remarked that he had been doing this all night. Whilst observing the patient, he attempted to get up and stood in the centre of the bay and called out for help, he was ignored ***Refer to Observation 4.10.*** Susan related a story to me about the same patient and how he hadn't received any breakfast because no-body had been available to feed him ***Patient interview 4.12 paragraph 3 and 4.*** Susan made the comment ***'I rang my buzzer, and I have been ringing my buzzer ever since'.***

Susan was essentially independent whilst in hospital, but the staff failed to make allowances for her visual impairment. Susan related an incident were a cup of hot tea was placed on the edge of her locker, she was too afraid to drink it because she couldn't see it and didn't want to spill it and burn herself ***Patient interview 4.12 paragraph seven.*** In another incident Susan was given a commode when she didn't need it, the nurse replied ***'well have it anyway be lazy'.***

Susan was still awaiting the Physiotherapist at lunch-time on the day of her discharge. She was due to be collected in four hours and still not had the opportunity to try the stairs. Susan had some general comments about her hospital stay and they related to small details such as the noise at night. However one of her final comments was ***'anyway I haven't got a lot to report, they are all very caring, but then I haven't wanted much, well I haven't needed much'. Patient interview 4.12 paragraph 7.***

Some final comments

Susan's case was slightly different to local patients, who would ordinarily receive a a hospital appointment from a specialist following an admission to hospital of this nature. I was aware, as was Susan, that she was unlikely to get any follow up unless she contacted her GP herself ***see interview 4.12.*** She was unable to go to her GP with the letter that she had been given because she couldn't walk unaided to the medical centre. Even though Susan had been admitted to hospital following a heart attack, no body within the hospital setting had made any attempt to contact her GP and inform him of the results. However, despite this Susan was relieved that a diagnosis had been made, as she thought at least something could be done for angina and she could be given some pain relief, whereas with palpitations apparently nothing could be done. She didn't know whether she would be sent home with a spray for the pain as no-body had communicated this too her ***refer to interview 4.12.***

Mark

The following is a summary of Mark's admission to hospital and spans a period of seven days. The case includes references to patient interviews, observation of clinical events and analysis of medical and nursing documentation.

Mark a 42-year-old man ordinarily resided with his wife and two teenage children in a house within a few miles of the local hospital. He had suffered from asthma for 25 years and had recently been diagnosed with diabetes. Until recently, he had managed his asthma and asthma attacks successfully at home ***Patient Interview 6.17***

Mark's Health

Mark told me that he first began to experience difficulties with his asthma in November ***'Last time, it was the first attack I had ever had, I've never had an attack before. I've been able to keep it under control no problems, but last time…..' Patient Interview 6.17.*** During this time he had regular contact with his General Practitioner who monitored his worsening asthma. However, on the day of his last admission to hospital in November, Mark visited his GP who wasn't happy with his condition ***Patient Interview 6.17.*** The GP telephoned the hospital's respiratory unit for advice and the respiratory unit suggested that Mark came to the hospital to see them. ***'He (the GP) sent me up to the respiratory unit to see them, they saw me, they gave me some stuff and sent me home. So I went home, they said they would send one of the people round in the morning. Patient Interview 6.17.*** As the day progressed Mark began to feel increasingly unwell. He was eventually admitted to hospital as an emergency. He was [on that occasion] in hospital for five days.

The Admission

Mark told me that this admission followed a similar path. He woke up in the morning and went downstairs to use his nebuliser, but started to feel unwell. ***'It just started building up and building up, building up and really got so bad that I couldn't do anything. I couldn't take the rest of the nebuliser'. Patient Interview***

6.17. Mark's wife phoned the respiratory unit, the nurse told Mark to take his steroids, which he told me he couldn't, and she would get out to see him as soon as she could. However, Mark told me that he couldn't wait and his wife telephoned the ambulance. Mark arrived in the A&E department at just after eight o'clock in the morning and was triaged as urgent.

He was seen by the doctor and treated within a few minutes of his arrival to the A&E department.[2] This was confirmed by the A&E documentation, and further comments made by the A&E doctor. ***Casualty Officer Interview 6.15.*** Many of the patients within A&E that morning had been waiting for two to three hours. The department was filling up quite steadily; some of the cubicles contained two patients. Screens were used to separate the patients from each other. ***Observation 6.9. Refer to notes on discussion with doctor about algorithms (step by step protocol for dealing with certain conditions such as asthma) and comment from the sister about the nurses on the ward.*** Mark was stabilised in the department and then transferred to the admissions ward at around one o'clock in the afternoon. The history of his admission was documented briefly by the nursing staff, then a more comprehensive history was recorded by the medical staff in A&E. Mark's history was recorded again in the nursing documentation upon transfer to the admissions ward ***Refer to documentation.*** The notes indicated that the most probable cause for Mark's worsening asthma was a viral /bacterial infection. The plan was therefore to administer steroids, a chest x-ray, regular nebulisers and possibly antibiotics.

When I arrived on the admissions ward to see Mark he had been given a bed in a six –bedded male bay. On the whole, he looked considerably more comfortable ***Observation 6.10.*** I spoke to Mark, and he shared with me some of the details of his admission. During this brief period of observation, Mark was approached by a nursing assistant who took his food order, he was offered a drink by a member of the domestic staff, his observations were taken and he was given a nebuliser. He continued to wear his oxygen mask. Mark related to me in a later interview that he had been seen briefly by the consultant who had told him he could go home the next day if he had no further attacks ***Patient Interview 6.18.*** This conversation was not recorded in either the nursing or medical documentation.

Mark was only kept in the six-bedded bay for a few hours. He was moved at around ten o'clock that evening to the observation bay, which was at the other end of the ward. Within minutes of moving, Mark began to have another asthma attack. ***'I went in there, eleven o'clock I just started tightening up for no reason at all and then I just had an attack again. Why I don't know, it took an hour to come out of it' Patient Interview 6.18.*** The nursing documentation reflects the difficulty Mark was having that evening ***Refer to Nursing Documentation 6.2.*** Mark told me that he had another severe asthma attack in the early hours of the morning[3].

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[2] The triage categories appear to be almost random. Mark had a potentially life threatening condition and was triaged as Urgent, the other cases that I have followed have been very urgent but not as acute as Mark.

[3] It was unclear whether Mark saw a doctor during any of these attacks. The nursing documentation makes reference to that fact that the doctor was made aware, but not whether he/she visited Mark or not. The medical staff were on the whole quite elusive during Mark's admission.

Day One

I found Mark in the Observation bay at the other end of the ward. He had been given the bed in the corner and appeared to be struggling with his breathing ***Refer to Observation on the 6.11.*** I went to say good morning and he managed to say ***'I need a doctor'.*** There where no medical or nursing staff supervising the patients in the Observation bay ***Refer to Observation notes.*** The nurse taking care of the bay eventually returned and attended to Mark, he then disappeared again [4]. The nurse informed me that patients were moved to the observation bay in preparation for discharge. However, in Mark's case this was obviously not going to be the situation. The nurse thought that Mark also needed a set of blood gases performed and was surprised that this had not occurred yet ***Refer to Observation 6.11.*** The medical staff (despite being called to see the patient by the nurse) did not arrive to see Mark until around 11 o'clock that morning. It was noted in the medical documentation that Mark was experiencing increased shortness of breath, but that he wasn't known to the respiratory team.[5] The medical notes recommended that Mark be transferred to one of the respiratory wards. Mark told me that the doctor had said very little, but he thought he was supposed to go for another X-ray ***Patient Interview 6.18.*** Neither the medical nor nursing notes from the day mentioned anything about this. However, the medical notes from the previous day had noticed a problem with his X-ray and had requested a repeat. Nevertheless, it came to 5:30pm and Mark had still not been taken down for this repeat X-ray.

Mark informed me that at 5:30pm, the nurse approached Mark and told him that he should have gone for an X-ray, but the card had been lost. A few minutes later he was woken again and told he was moving to another ward. Mark told me what happened next ***'I was just dozing off and they said they're going to move me. Yeah well, that's not the best bit. I was just going out, he says "oh you forgot your dinner, you aren't going to get no dinner now". So I'd already had no breakfast, I'd already had no dinner, now I was going to get no supper' Patient Interview 6.18.*** The nurse managed to intercept Marks's evening meal however, he was still unable to eat it, as it was not the diabetic meal that he had requested.

Mark had been on the new ward; a respiratory ward for about 20 minutes and had just been given a drink of tea when he was told he was going for an X-ray. However, the porter was unable to find Mark, as he had gone to look for him on the admissions ward. The porter finally found Mark, but he hadn't brought enough oxygen, so while Mark was in the X-ray department, the oxygen bottle ran out. Mark finally returned to the respiratory ward without oxygen at around 8pm that evening.

Day Two to Four

Mark had been given a bed in a six-bedded bay. ***Observation notes 6.12.*** He was unable to talk to me when I first arrived on the ward so I returned to the nurses' station to observe. There were approximately 14 people standing around the station,

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[4] In later conversations with Mark, he made reference to feeling more comfortable and safe on the respiratory ward rather than the admissions ward, particularly when he was having his attacks.

[5] Mark should have been well known to the respiratory team given his previous admission. In addition Mark had telephoned them twice as had his GP. He had also attended the hospital on the day of his previous admission.

doctors, nurses and therapists, it was noisy and crowded. The majority appeared to be doctors waiting for the start of a ward round or midway through a ward round. One of the nursing sisters was having a conversation with a patient ***Interesting exchange Observation notes 6.12.*** It later transpired that despite the presence of several doctors, Mark was not reviewed until about 4pm that afternoon. This was recorded in the nursing documentation. During this encounter, Mark was informed that he probably had an infection and would need antibiotics. Whist he was started on antibiotics briefly, they were rapidly discontinued after only one or two doses. The doctor hadn't looked at the X-ray but assured Mark that no-body had told her that there was anything abnormal on it, so she had presumed there wasn't a problem ***Patient Interview 6.19.*** The medical notes recorded that Mark was improving; the general plan for the weekend was to continue with steroids, monitor peak flow and oxygen.

When I was able to talk to Mark, he told me a little more about his feelings surrounding the admission. He said that the nurse from the asthma clinic (who he had called prior to him contacting the ambulance) had turned up at 10am, Mark had already been taken to hospital. ***'she turned up at a quarter to ten, I don't think she was that happy. Well there was no way I could wait till a quarter to ten, so if she thinks I should have waited until then, , well she's got no chance' Mark makes some more interesting points about the asthma outreach later in this interview Patient Interview 6.18..***

The following day I returned to see Mark. The ward was quiet, and there were four staff nurses, each engaged in a task in one of the bays. Another nurse from the respiratory team was sitting at the nursing station reviewing the notes for several patients. Mark told me that he felt well and had felt well all day yesterday. His only difficulty was in the mornings when he felt breathless. However unlike previous mornings, he was able to take his nebulisers without his condition worsening. He remained on oxygen although the level depended on the nurse who happens to be in the bay at the time ***'one keeps putting it up, and one keeps putting it down. One doesn't like it up high and the other likes it down low. The same with the mask' Patient Interview 6.19.*** Mark told me he preferred to use a mask to deliver his nebuliser, as the effect was greater. One of the nurses on the other hand kept insisting that he used a mouth piece to deliver the medication ***'personally I think it is better with that (the mask), but that's my opinion, whether it is or not I don't know, that's (the mouthpiece) their preference Patient Interview 6.19.*** Little else had been happening to Mark; he now measured his own peak flow readings and amused himself by reading. There had been no further mention of him returning home. ***'You know once I am over the worst of it in the morning that's it, I can be like this until tomorrow morning, just sat here watching paint dry' Patient Interview 6.19.*** I spoke to the nurse looking after Mark, she informed me that she thought Mark probably did have an infection and would need antibiotics. I asked if he would see a doctor over the weekend, she told me that the patients only saw a doctor at the weekend if the nursing staff thought it was warranted. She did admit that she thought Mark had been a bit neglected by the doctors **Notes from brief conversation** ***with nurse 6.8.*** There was no further information.

The nursing staff made three further entries in the notes for the following day; they did not contain any new information.

Day Five to Six

Mark was considerably better when I returned to the ward he had been seen by the medical team, who had informed him that he could go home the following morning ***Observation 6.14.*** The plan (stated in the medical notes) was to reduce Mark's steroids and discharge him in the morning. The nursing notes repeated this information ***Medical/Nursing Documentation 6.7.*** When I asked Mark if he would receive a follow up he wasn't sure, but was emphatic about not wanting the asthma outreach team to become involved. ***'Well I mean to say you think about it, what are they just down that corridor there, do you know I haven't seen one of those people' Patient Interview 6.16.*** Mark informed me that the doctor had arrived on the ward to order his take home medication. Mark had reminded the doctor that he had nearly run out of a particular tablet. The doctor told Mark that according to his prescription chart, he wasn't actually taking that particular tablet ***'It's not on the chart to take. She couldn't understand why I was taking it cause I said I was nearly out of this one, she said "well you're not meant to be taking it according to the chart". But I am cause I know I am, but it wasn't on the chart' Patient Interview 6.16***

Mark also told me that he had felt more confident on the respiratory ward than he had on the emergency admissions ward. He felt that when he had an attack on the respiratory ward, they knew what to do and would stay with him until he felt better. He knew from his experience on the admissions ward that the nurse did not stay with him and if he used his nurse call button, there was no guarantee that they would come to help. ***Refer to interview 6.16***

When I returned to the ward the following morning Mark was no longer there. I assumed that he had been discharged. The ward clerk informed me, that in actual fact, he had been moved to a surgical ward on the previous night. Mark had been given the option of either going home, or going to another ward overnight. This information had been given to him by the nurse. However, he had also been informed that if he wanted to go home he would have to discharge himself. ***'They wouldn't say I can go home, they wanted me to say I'd go home. They didn't really want to discharge me cause if they'd discharged me obviously and anything had happened they would have been in the wrong, cause the doctor never discharged me' Patient Interview 6.20. Further extracts regarding the discharge.***

There had also been some difficulty with Mark's tablets, which hadn't arrived. Mark told me that they would have to re order them, resulting in further delays to Mark's discharge. Mark made further comments about the move. ***'Well I couldn't believe it when they told me I had to move here at half past nine last night. They said we want the bed you've got to move at half past nine. Half past nine! Then she comes up here and I just get here and she says oh by the way the teas gone, we've just had a hot cup of tea she said it's gone you can't have that. Good job I got one downstairs I said then wasn't it' Patient Interview 6.20.***

Mark was finally discharged from hospital at around 4pm that afternoon. He hadn't seen a doctor, nor were there any further entries made in his medical or nursing documentation.

General summary

Mark was admitted to hospital as an emergency. On arrival he required immediate assessment and treatment as his condition was potentially life threatening. However, after the first couple of days within hospital he was receiving very little active treatment. Several factors emerged from Mark's admission to hospital. Firstly Mark was essentially a readmission to hospital and had been in the same situation only a month previously, yet the hospital had no records of him and he was apparently unknown to them. His care appeared to be a little disorganised, not least because he was moved to five different beds during his hospital stay. It was interesting to note that Mark was quite distrustful of his care and didn't have confidence in some of the services offered to him within hospital.

Whilst it was clear that Mark was recovered sufficiently to be discharged home, no single professional would make the decision to discharge him, even when it became clear that the bed was needed. The nurse was unwilling and unable to make that decision and a doctor could not be found. Mark was therefore unnecessarily moved to another hospital bed for a further night and day in the acute hospital.

Appendix Five – Data Analysis

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Interview Transcript

4.11 Patient interview day 1

Document Description:
Case 4- Patient Interview

R- You were talking about the history of your palpitations, which have lasted ten years?

I remember being in the hospital when I was just turned 70. I remember I was wearing a green suit. he nurse said 'I hope I look as good as you when I 70'. So here I am nearly 86, it's been a long time, that was the beginning.

R- These latest feelings of heat travelling up your back and of blackouts, now are they in the last three years?

Yes, they have been the last couple of years I would say. Although now this year is very quick so we could say three. I have not had so many, I get the little ones now, now and then, I would just get this warm feeling. But the doctors didn't seem to know anything about this, they said, well the one in the hospital said 'well I'm afraid I can't help you there'.

R- Was it at that point that you suggested that you needed a neurologist or the doctor suggested it?

Yes, no I suggested it. I think it was a little bit because I thought, I began to feel that there was perhaps more that they could do, or suggest testing for something. I was expecting too much perhaps. So I thought, since had been a long time and they are never going to say it, I thought well, I thought that was the next step and my doctor said yes I would think so. He (the doctor) arranged it for me so we did that. I was a little more satisfied, but I didn't follow it up. He said there was only this little disk and I was relieved about it not leading to epilepsy, I didn't have to worry. If it kept on and I wanted to get in touch with him, but I think he (the doctor) looked comfortable enough. I thought (laughed)

R You were quite happy with the consultant?

Oh yes, yes. We had a good interview, just the same as the doctors and he wrote a very nice letter to my doctor, well like they do I forget he said 'this very witty and amusing person', that's what he said. My doctor told me this, I mean we did try to have a laugh or two. Things like when he said (the consultant) 'now, look at my nose'. I said, 'what makes you think I can see your nose, I'll look in the general direction shall I?' I'm looking at him. This elder daughter of mine doesn't like me doing these things, but it's spontaneous. She says (the daughter) was born middle aged, she says herself. But yes, it was a thorough examination and he did all the movements and all the knee jerking and things.

R: I wasn't clear about when they put you on Aspirin and Propanolol.

Well my doctors put me on, the GP put me on the Propanolol and the

Thyroxine, but it was the consultant who said because it amused me greatly, not in his presence of course as the most expensive Aspirin I have had. I said I had £50 for his consultation and I had £70 for something or other and £100 for the EEG and this other doctor's share of it, and I came away with, well not a prescription you understand. I think (the Consultant said) you ought to take a half an Aspirin to thin your blood, I would advise you to do that. I have to buy my own Aspirins after that (laugh), I am naughty, don't let me be like this.

R-The Propanolol, was your own GP?

Yes, they gave me that and yes and the Thyroxine and then at one stage, probably three years ago I was having palpitations two or three times a week. Not so bad, but three times a week was more than I wanted to cope with and I was getting very anxious. In the last two years they have been very quiet, my heart just beats a bit faster and perhaps will going and lie down anyway. Not that I have been afraid of it, I soon learned that it wasn't killing me off, so that was OK, but nothing to take. If you've got a pain they give you something to take at the time, but with these things they don't, but never mind. I had a lot of anxiety and I would wake in the night, you know, whereas they had always been in the daytime and so he gave me Propanolol. I don't take it very often now because I think I have had most of the side effects the paper says. I have such dreams and I put it down to the Propanolol. But anyway, I haven't asked him, but he keeps giving it to me on my repeat prescription if I ask for it. I don't know if I still need it or not, but I have it in the background.

R-This latest episode is different again?

Oh yes, I have had nothing like this before, there was nothing to tell me it was going to happen, I just felt the beginning of the pain. I was already in bed, it was probably about 11 o'clock, yes I was lying in bed, I thought it was indigestion, have I eaten too much? What I thought might have been the cause, thinking it was indigestion and before I got too bad. That son in law has a wheat allergy, so he has to have the wheat free flour and she has to buy all these things to make his pastry and so on. It is a bit rich, it is a devil to handle to make and roll out and all that, but she (the daughter does it all). I thought well perhaps that had been a bit too much and it was indigestion, but then it got severe and I called my daughter into the bedroom. I described it; it was just solid pain (points to the centre of her chest) there, nothing in my arms. It was just solid, except it crept on quickly if you see what I mean; it didn't just go bang. Well we (the daughter and Susan) sat a bit and we talked. And I said it is maybe indigestion and I had never had indigestion before I went onto Prozac, never. Sometimes after the Prozac I got this pain, you know. That's the stuff that made me have the indigestion and then I thought it is maybe indigestion so my daughter said, just try one or two tablets, it didn't work and if only I could burp but I couldn't. After a time it eased, well it took about three hours really altogether, but by that time they had both gone to bed and call me if you want me. But I would have liked her to be in, but I thought what's the point, you know they are asleep, I hate waking people up I the middle of the night. Then it went off and I was perfectly all right the following day, but then the morning after that, well yesterday.

R - So the pain started at about 9am?

Yes, my daughter asked me 'well what do you think'? I said it is exactly the same as the one the other night, it really is very painful, it hurts a lot. I wanted to reassure her, it is just there it doesn't spread, it doesn't thrash about, it is not in my arms. But I think perhaps you had better ring, tell the doctor and describe my symptoms, which she did. The receptionist asked the doctor and he suggested that she take me to the hospital, so we came here, it is a good thing we did really. I might of struggled through the second one and then gone home and started again sometime and then maybe never had any more. I think once I've got Angina, well that's it I suppose. He said yesterday that something had shown up and the thing was from the heart and that's it. If that's what I've got, that's what I've got, it just goes along with the other things. It could be a damn site worse, I could be blind altogether or I'd rather not have had it, it might not have been any worse than having the palpitations, I don't know how often I will have the pain. At least with angina I have got something to relieve it, which will be help and so many people seem to have angina.

R- Did your daughter speak for you when you arrived?

Yes, she did it all, they both are. Both of them once they get their teeth into it they are OK; they know all the words. But the elder daughter is a bit like a round peg in a square hole (talked about her daughter and what she did).

R- You told me that you lived in a house?

Yes, with stairs and everything.

R- Have you found that it is getting harder to manage at home?

It's in small things; there is a slow worsening all the time. Very slow and suddenly I'll notice something or other. But I can't see that well, but it is gradual. I don't think about it a lot, I just get frustrated that I can't read, you know because when you can't read it's a poor world when you can't read. The limitation in my sight, well I can't read so I can't read newspapers or look at magazines, read my cookery books, do a jigsaw or playing cards. All the things; can't read instructions on packets, my friend has to read. I have got a magnifying glass from the eye hospital, but they are getting to be not a tremendous use. This friend will write my cheques for me, I can see to do bits, but it is very tiring, because I have to look at it and get my magnifying glass and see and then I have to put my magnifying glass down to hold the cheque book to write. She'll do that for me. The younger daughter in X , because of course that son in law deals with my financial affairs, he's very good and doesn't charge me, otherwise this would have all been in top of my stockings. It would have been in one place. He is great moneyman he really is. We have a lot of phoning; you know the literature it all comes to me. Now it's got that if I can decipher the top line to give me sufficient information to see where it is from and see what it is about in the first line then I can tell them on the phone and my daughter will say 'oh yes that's so and so we will need that'. I used to read them and file them myself, but I can't do that now. We've got a system.

You know baking, I can't see the scales, but the way I have to do now is get the bowl and then get the magnifying glass to find whether I have got six ounces or not. By the time I have done that I am exhausted. I looked at some talking scales in the shop for the blind, but I couldn't live with that man telling me that ‘you now have six ounces’. This friend of mine bakes my cake. She bakes and says are you short, she is really good like that, she would do more but I don't want more.

R- You also said to me that on the whole you are quite well

Yes, I have been a healthy person, as a child, I was born in the country and lived in the country, had all the fresh air I suppose, I suppose that was just my constitution. When my husband had a cold nearly every month, I think that was perhaps where we lived, you know some dampness. No I think just the usual childhood things, I have had no big illnesses. The only time I had been in hospital was with Diphtheria and that was in my early life. There was a cemetery next door to the fever hospital, I was about 22. My sister would come and visit and she used to look out on the graveyard, I said don't keep looking out there, I'm getting better.

R-What happened to you overnight?

You know people think they have never slept. If I had 30 minutes sleep, then I guess that's all I had. It was chaotic, you think it is louder than it is, but at one stage the nurse came in and she was wearing a white coat. She asked 'are we making too much noise' I said no, but to me they were, they were chatting, wherever they were. These two patients (points to the two men opposite) both of them had these coughs, you know like old men do and talk about competition. He sounded so poorly, I mean he was in and out and shouted across to me, I thought ohhhh!! I thought I would get out of bed and unplug it all and go home.

So it was a long and tedious night, especially since every time I moved the monitor tinkled. I normally lie on my right side, then sometimes I incline onto my back, but ever since I have started having palpitations I find it difficult to lie on my left side because of the feeling. I can hear my heart too much. But I couldn't lie on my right side because this thing was attached (point to the cardiac monitor) and these leads are not that long, so I wasn't that comfortable. These sheets do go into tucks; there were tucks everywhere, tucks in me as well as the arms. Honestly I don't know which end up I was. They are a long time making the beds (talking about the bed makers) as if we are all well enough to sit out. At one stage they were all sleeping and snoring, here am I kept awake by that man over there, now he's asleep and snoring.

R- How do you feel about mixed bays?

Well I don't like it, I don't like it. But it is my first experience, but in here I suppose, we're old you know, but I don't think I would like it If I was younger, but if it has to come it has to come. I expect I would accept it, there is no good fighting about something but as wards used to be you know with ten beds either side, I don't think I would have liked it. When I visited a friend in hospital who had had her hip done, there was a mixed ward further along and as I walked through I thought I wouldn't care about that. This actual incident isn't so bad, I mean they are old fellas, when she said draw the curtains, I don't care whether you draw them or not. She (the nurse) said you must have a bit of modesty, long time since we had that. I think in general I wouldn't want it, you know a mixed bay, you know it is a different age, people are different. It's the other people now who are different, you know your lot. There is a tremendous difference in people now, you know in attitudes, a lot of them are good, but I don't think it is all-good. You have to have change. For me I lived through a time were there was very little change. But as it was the country wasn't affluent, there wasn't a lot to get, you struggled unless you really came from wealthy people. The shops weren't then full of stuff that you wanted instead, and you were happy.

There seems to be a great lack of not wanting to help anybody but yourself in a lot of people these days. But it does seem to be; I would prefer them all to be in their uniforms, the nurses. I think it is good that that attitude of matron walking behind the doctor and nurse walking behind matron, doing the round and tucking the corners, we have got away from that, which I think is much better. It's better that you can come in and out visiting. I was use to the uniformity of the patients being patients and the staff being staff. I will admit I don't much care for the language, you know the way some of the doctors speak 'do this for me, do that for me', the nurse calling you darling and dearie and ducks and that and your first name. But ducks and dearie, that I don't care for.

R Do you interrupt them when they are speaking to you like that?

Well, it is the way they do it, they would be very surprised now. They would consider you to be stuffy or you know or upper crust. I like there to be a difference, the doctors need to be approachable. I am old enough to have been brought up in a time when there were chiefs and Indians, there were a great deal more respect for people. I suppose this way is considered to be more friendly, which it is. You want to be made more comfortable in hospital, I mean it is a terrifying place to come to. I'm all for the friendliness of hospital now.

Asked about the night again

It was a very long night. I don't know the time you see, my daughter offered me her watch. I can't see the watch. Once you have lost what time it is and you are in a strange place, there is nothing to tell me what time it might be, like I didn't know what time was supper time or whether you got a cup of tea later on, which I did which was good. So through the night I had no idea and all this business went on. I kept looking to the window, there was no curtain over this part, it's not getting lighter, not getting lighter and then when she came in, she said ' it is not even breakfast time yet, you have got hours to go' I thought I can't stand it. I felt like packing my bag and going. I had no idea what time it was. It doesn't really matter they would have told me if I asked, but it's when she said 'it's hours yet before breakfast time'.

R-When did the activity start on the ward?

There seemed to be a great period of quiet. The nurse had a busy time during the night for a few hours through the night, with this one and that one. I don't think they knew I was here, but there was all that quiet. I thought they must all be having a rest. Then things began to stir, trolley went a long, but didn't stop here. That brought me to 6o'clock, it wasn't too bad. I got a cup of tea between six and seven. They said I couldn't have my breakfast. They asked if I was on the list for something, you know for not eating and drinking during the night, I said I don't know they didn't tell me. So she picked up the paper and looked and she said you are, nothing for you. I didn't know that I couldn't.

Then the medication came, I got out of bed when they started washing. I thought oh dear I wanted to go to the bathroom for a wash. I rebelled, It's silly getting all this, but I got a bowl of water and the curtains round. I was then wanting to go along to the bathroom and I thought what is the good of getting all washed and then going to the bathroom, which I did. The nurse finally reluctantly, because it was such a fag doing all this and getting it round and getting me out here (the cardiac monitor), but I insisted a bit. I said to the nurse do you wait? But when I opened the door she wasn't there, so I walked back myself. Then it was quite busy then. When I got back I thought I might be getting back into bed, but the nurse said 'oh no it is breakfast'. The ward was busy with all the washing and that and then the breakfast came. The nurse locked all my medication away, which is good because I might have taken it all during the night in desperation. The nurse then brought me this tablet.

R- What does the new tablet do?

Well I don't know I think it perhaps, I would just assume it was for supposedly angina. There was some of it in the Propanolol, but it is maybe going to thin my blood. It goes in one ear an out the other. If it stays in for two minutes.

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PROJECT: New Data analysis 19th Jan 04.

ON-LINE DOCUMENT: 4.11 Patient interview day 1

Document Description:

Case 4- Patient Interview

Taking care of own health/Expectations of primary care. **Units: 20-25**

Taking care of own health/Seeking health advice. **Units: 10-22 82-87 99-108**

Maintaining independence/Causing inconvenience. **Units: 93-97**

Adapting to physical change and deterioration. **Units: 57-67 109-117 125-156**

Maintaining independence/Difficulties associated with day to day living. **Units: 125-156**

Learning to be a patient/'Fitting in'. **Units: 170-173 220-226**

Adjusting to a new environment. **Units: 175-193 233-239**

Learning to be a patient/Feeling isolated. **Units: 234-238**

Inattention to patient needs. **Units: 234-245 265-269**

Communication/Inconsistent/inadequate. **Units: 247-257**

Confusion and lack of agreement. **Units: 247-257**

Poor or inaccurate info exchange between profs. **Units: 247-257**

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PROJECT: New Data analysis 07 April 04.

ON-LINE DOCUMENT: 4.11 Patient interview day 1
Document Description:
Case 4- Patient Interview

Managing health at home/Seeking health advice **Units:10-22 82-87 99-108**

Accepting fluctuations in health **Units:57-67 109-117**

Living with fluctuations in health **Units:57-67, 109-117 125-156**

Causing inconvenience **Units: 93-97**

Difficulties associated with day to day living **Units: 125-156**

Learning to be a patient/'Fitting in' **Units: 170-173 220-226**

Adjusting to a new environment **Units: 175-193 233-239**

Inattention to patient's immediate needs **Units: 234-245 265-269**

Ineffective inter professional communication **Units: 247-257**

Poor information flow to patient and relatives **Units: 276-280**

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