Nurse-led multifactorial care in community-dwelling older people

Outcomes on daily functioning, experiences and costs

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Community-dwelling older peoples’ experiences with nurse-led comprehensive geriatric assessment and care coordination

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Submitted
Abstract

Background: A qualitative analysis can help to explore the appropriateness of complex care interventions for community-dwelling older people. Therefore, the aim of this qualitative study is to explore community-dwelling older peoples’ experiences and views on nurse-led comprehensive geriatric assessment and care coordination.

Methods: We conducted semi-structured interviews with fifteen participants from the intervention group of a cluster-randomised trial with multifactorial interventions and nurse-led care coordination to prevent functional decline. All interviews were audio recorded, transcribed, and analysed independently by two researchers using a thematic analyses approach.

Results: Participants appreciated nurse-led comprehensive geriatric assessment and care coordination because of the feeling to be looked after. The attention to their psychosocial needs and well-being strengthened their relation with the general practice and routine check-ups contributed to the feeling of reassurance. However, for specific medical problems they indicated there was little room for substitution by the nurse.

Conclusion: Community-dwelling older people valued nurses paying attention to their psychosocial functioning and checking their general health. However, they felt that surveillance of all medical care should remain in the hands of the GP and can not be delegated to nurses.
Introduction

Over the past decades, complex healthcare interventions including comprehensive geriatric assessment (CGA), multifactorial interventions and nurse-led care coordination for community-dwelling older people to prevent or postpone functional disability have been widely implemented in primary care settings. A CGA in primary care is a multidisciplinary approach often conducted by a community care registered nurse (CCRN) during a visit at the home of the older person and is followed by multiple home visits to create, discuss and evaluate an individually tailored care and treatment plan based on multifactorial interventions. It has been suggested that a proactive, integrated care provision for community-dwelling older people might help to enable independent living, improve quality of life and address needs and preferences of community-dwelling older people. Earlier meta-analyses and reviews demonstrated that complex healthcare interventions had beneficial effects on overall functioning. Nevertheless, more recent primary care studies on prevention or postponement of functional disability showed neutral findings. Qualitative analyses on the experiences of community-dwelling older people can help to explore the appropriateness of complex care interventions for community-dwelling older people. Therefore, we performed a qualitative sub-study among Dutch community-dwelling older people in a recent cluster RCT, to explore community-dwelling older peoples’ experiences and views on task delegation of comprehensive geriatric assessment and care coordination toward the CCRN.

Methods

Participants

Participants were community-dwelling older people aged 70 years and over, taking part in the intervention arm of a cluster randomised trial. Details of the study have been published elsewhere. Participants were eligible for the present study if they met all three following criteria: 1) an increased risk on functional decline (based on the Identification of Seniors at Risk – Primary Care Screening Questionnaire (ISAR PC)); 2) received at least one home visit and 3) one or more interventions according to their care and treatment plan (CTP) (n= 926). Participants were purposively selected to reflect the health and education spectrum of the studied population. We aimed for variation in gender, age, living situation, level of education, multimorbidity, polypharmacy, number of home-visits, GPs and CCRNs (Table 1). Prior to the interview, participants were contacted by phone by the researcher (NH or MvR) to determine eligibility. They were asked whether they remembered the home-visits and if they consented to participate in an interview.
Interviews and data collection
We conducted semi-structured interviews with 15 participants at their homes that lasted approximately 40 to 90 minutes. A topic list was developed prior to the interviews and focused on participants' experiences with the home visits, including nurse-led comprehensive geriatric assessment (CGA), multifactorial interventions and care coordination. The interviews started with a short introduction on the study aim, followed by the open question ‘What were your experiences with the home-visits by the nurse?’ or ‘What do you remember of the home-visits?’. After this question the interview was semi-structured, based on the topic list and the intention was to let the participants elaborate on their experiences and the potential role nurses may play in care for older people.

Analysis
All interviews were audio recorded and transcribed verbatim to written text. We analysed the data according to the thematic analysis approach of Braun and Clarke following six phases. First, to get familiar with the data two authors (NH and MvR) interviewed participants and read and re-read the transcripts. Then NH and MvR independently generated codes and searched for the main themes. The identified codes were grouped into themes based on similarities, and connections were made between the different codes and themes derived through open coding. After every interview, the independent code lists were compared, discrepant interpretations discussed and it was decided whether the identified themes had enough data to support them and which of the themes had to be removed. After twelve interviews, data saturation was reached as no new themes or issues emerged during the code process of the remaining three interviews. Then, a final thematic and coding structure was developed. Finally, illustrative quotes were selected and data were reported relating the final analysis to the research question and existing literature.

Results
Fifteen participants aged 76-97 years were interviewed from eight different general practices. The overarching theme was ‘the appreciation to be looked after’ and consisted of four subthemes: 1) lowering the threshold to the GP practice, 2) attention for psychosocial functioning, 3) reassurance through check-ups and 4) professional care and task delegation between nurse and GP.

Appreciation to be looked after
The interviewees appreciated to be looked after. They wanted to be taken seriously, talk with someone they could trust and feel that someone was listening and paying attention to them.
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Table 1. Characteristics of interviewees

<table>
<thead>
<tr>
<th>Interviewees N=15</th>
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<tr>
<td>Age, Y, median (range)</td>
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<tr>
<td>Female, N (%)</td>
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<tr>
<td>Born in the Netherlands, N (%)</td>
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<td>Level of education, N (%)</td>
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<tr>
<td>Primary school or less</td>
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<td>Secondary school or vocational education</td>
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<td>College or university</td>
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<td>Married or living together, N (%)</td>
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<td>Comorbidities, median (range)</td>
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‘Yes, because I like the idea that there is someone who pops by occasionally to see how things are going, because then I know whenever there is something the matter, they’ll keep an eye on you.’ (P1, female, 91 years)

Nevertheless, most interviewees experienced that the GP often did not have enough time for them. They said that during GP consultations they narrowed the conversation down to medical questions because of perceived time constraints by the GP.

‘Well, I understand the GPs. They have become so busy with other things. They have other patients who need them much more I think [...] So then it is a waste of time of the GP, I think. No it is not necessary. And we are quite satisfied. That uh, if I need him, than he will come.’ (P10, female, 91 years)

Lower the threshold to the GP practice

Interviewees felt that talking to the nurse lowered the threshold to discuss matters for which they would not easily contact the GP. They valued the additional service advice from the nurse. Overall, the participants found it important to build a trusting relationship with the nurse, with sufficient continuity over time. The nurse was perceived as a safety net around potential future problems. Some interviewees indicated that they would first contact the nurse in case of a new medical problem to discuss whether a GP consultation would be warranted.

‘Yes, because you always need someone to stay in touch with, someone you can trust. Because that’s another thing [...] Contact and uh .. if there is something wrong, she will immediately contact the doctor, she shares the conversation and all the difficulties with the doctor, so then I don’t have to go there. Indeed, then I don’t have to go there at all. Ah, what problems do I have anyway? I only have minor things for which I ask myself: “Do I have to see the GP for that?”. Honestly, I don’t see a doctor very often.’ (P6, female, 89 years)
Attention for psychosocial functioning
Generally, the interviewees thought the home visits had been especially useful with respect to their psychosocial functioning, because this was something they often missed from their GP. They stated that attention for the psychosocial context is essential in a good patient-professional relationship.

‘I was just happy that I could pour my heart out, tell her what was bothering me. And yes, you also talk about your illnesses for a brief moment. And just about problems. Yes, she asked about our problems.’ (P3, female, 88 years)

‘The loss of loved ones and friends, that should always be addressed. Since the loss of loved ones and friends is a major life event. It is important that we talk about everything that is important. There are a lot of taboos, such as loneliness. If you’re not looking for loneliness, then you will not find it.’ (P8, male, 97 years)

Reassurance from check-ups
Interviewees often liked to know whether they were doing well with regard to their physical and mental health or their health status in general. It gave them a sense of security to know that they scored well on physical and mental health parameters, such as blood pressure, walking speed and mini-mental state examination. Interviewees generally felt reassured by the check-ups that the nurses performed.

‘They checked my physical and mental state, or actually it was a check-up. It was kind of a reassurance, they check me, if everything was still OK. They looked at my well-being, which I found pleasant, because today you’re still here and you don’t know what tomorrow will bring.’ (P1, female, 91 years)

Professional care and task delegation between nurse and GP
Interviewees stated that the professional and medical background was a crucial prerequisite for the nurse to be a liaison between them and their GP. When compared to a visit of a volunteer, interviewees preferred a nurse, because of her knowledge with all kinds of medically oriented issues.

‘I think such a nurse has experience with all kinds of things and stuff. Well, and then you have this or that or a small wound. Well, then I also sometimes ask, will you take a look? I think it is nice that a nurse visits me, instead of a volunteer for example. Yes, she knows more than simply a volunteer.’ (P10, female, 91 years)

However, for more complex medical issues the interviewees would prefer to see the GP.
'I think I ask the nurse more than the doctor, or there must be something serious. Things about medication for example, I prefer to ask the GP for that.’ (P14, female, 85 years)

The interviewees thought that the visits of a nurse could, in part, substitute for some roles of the GP in the care for older people, especially with regard to psychosocial problems, more general issues on well-being, and some elements of a regular check-up (including anthropometric measurements and blood pressure). Most interviewees welcomed the visits of the nurse, they appreciated that someone was interested in their thoughts and needs and spent time with them. Often they thought the nurse was a nice and friendly person, who listens and gives attention.

‘The physician focuses on the disease and the nurse focuses on the person who has the disease.’ (P8, male, 97 years)

Discussion

Community-dwelling older people participating in a cluster RCT on complex interventions to prevent functional decline appreciated nurse-led comprehensive geriatric assessment and care coordination because of the feeling to be looked after. The attention to their psychosocial needs and well-being strengthened their relation with the general practice and routine check-ups contributed to feeling of reassurance. Although participants thought that nurses could take over some primary care tasks, they felt that the surveillance of their medical care should remain in the hands of the GP.

Strength and limitations

This qualitative study addresses the experiences of community-dwelling older participants in a recent cluster RCT on comprehensive geriatric assessment (CGA), multifactorial interventions and nurse-led care coordination. Most interviews took part several weeks to months after the last home visit. This could have introduced recall bias. To overcome this limitation the final five interviews took place among older people still receiving home visits according to the original study protocol (2). Furthermore, as the aim of our study was to explore experiences with nurse led geriatric care and treatment coordination, we selected participants who had, according to our administrative data, received a care and treatment plan. Therefore we did not interview participants who declined a CGA and/or care and treatment plan and therefore may have missed less favorable experiences or opinions.

Comparison with existing literature

The appreciation to be looked after, is a theme that was previously described 16-19. Bayliss et al, reported ‘being heard’ as main theme in a study on
processes of care in older people with multimorbidity. Older people preferred health-care professionals who would listen to and acknowledge their needs, appreciate that these needs were unique and fluctuating, and have a caring attitude. Vass et al. stated that preventive home visits conveyed the message to them, that they were ‘not forgotten’. Behm et al. found that very old participants felt that preventive home visits made them more visible and emphasised their human value. In accordance with our findings, older people in similar studies were satisfied with the home-visits. Interviewees regarded the nurse as a liaison with the general practice. Bindels et al. found that older people see the nurse as someone who could help them to get access to other professionals and services. Van der Pol et al. stated that older people felt that the participation of nurses in primary care could improve accessibility to care.

Van Kempen et al. also found that most older people preferred home visits focusing on the psychosocial context. Van der Pol stated that GPs and nurses adhere to their professional perspective and are more medically oriented, while, for most patients the perspectives of their well-being and mutual understanding of personalised communication are more important than their actual medical condition.

In our study, the check-ups during the home visits gave the interviewees a sense of security to know they scored well on physical and mental health parameters. The sense of safety by being ‘checked up on’ was also found by Ligthart et al. More studies described an increased feeling of safety as an important benefit of preventive home visits for older people.

Finally, van Kempen et al. also reported that, according to older people, nurses could do the home-visits instead of the GP, provided that these nurses have the professional expertise to treat older patients. However, they also expressed the desire to be able to discuss their problems directly with their GP, without nurse involvement. This is consistent with our findings on medical problems, for example medication related issues. In a similar studies, many patients held the traditional view of the nurse’s role as an assistant to the GP.

**Implications for research and practice**

Although recent studies on complex healthcare interventions to prevent functional decline in community-dwelling older people found neutral or very small effects, nurse-led comprehensive geriatric assessment and care coordination appears to be generally appreciated by community-dwelling older people. Community-dwelling older people valued nurses paying attention to their psychosocial functioning and checking their general health. However, they felt that surveillance of all medical care should remain in the hands of the GP and can not be shifted towards nurses. Further research is needed on the role of CCRNs in primary care for older people; in particular on preferences of older people regarding the role of GPs and CCRNs.
References


16. Bayliss EA, Edwards AE, Steiner JF, Main DS. Processes of care desired by elderly