

# Early Supported Discharge for Older Adults Admitted to Hospital with Medical Complaints: A Qualitative Study Exploring the Views of Stakeholders

Susan Williams<sup>1</sup>, Clíona O'Riordan<sup>1</sup>, Fiona Steed<sup>2</sup>, Aoife Leahy<sup>1,3</sup>, Elaine Shanahan<sup>3</sup>, Catherine Peters<sup>3</sup>, Margaret O'Connor<sup>3,4</sup>, Rose Galvin<sup>1</sup>, Ann-Marie Morrissey<sup>1</sup>

<sup>1</sup>School of Allied Health, University of Limerick, Limerick, Ireland; <sup>2</sup>Department of Medicine, University Hospital Limerick, Limerick, Ireland;

<sup>3</sup>Department of Ageing and Therapeutics, University Hospital Limerick, Limerick, Ireland; <sup>4</sup>School of Medicine, University of Limerick, Limerick, Ireland

Correspondence: Susan Williams, School of Allied Health, Faculty of Education and Health Sciences, Ageing Research Centre, Health Research Institute, University of Limerick, Limerick, Ireland, Email Susan.Williams@ul.ie

**Introduction:** Early supported discharge (ESD) is well established as a model of health service delivery for people with stroke. Emerging evidence indicates that ESD also reduces the length of stay for older medical inpatients. There is a dearth of evidence exploring the views of stakeholders on ESD as a model of care for older medical inpatients. The overall aim of this study is to explore the views and perceptions of older adults, family carers and healthcare professionals on the potential role of ESD for older adults admitted to hospital with medical complaints.

**Methods:** Purposeful sampling was used to recruit older adults and family carers for interview. For Healthcare Professionals (HCPs), snowball purposeful sampling was used. Phone interviews took place following a semi-structured interview guide. Focus groups were moderated by A-MM. Braun and Clarke's approach to thematic analysis was used. Ethical approval was granted by the HSE Mid-Western Area Regional Ethics Committee in November 2021 (REC Ref. 096/2021).

**Results:** Fifteen HCPs took part across three focus groups, with six older adults and two family members participating in one-to-one interviews. Three themes were identified: 1. Pre-ESD experiences of providing and receiving older adult inpatient care, 2. Navigating discharge procedures from acute hospital services, 3. A vision for more integrated model of care and a medical ESD team.

**Discussion:** This study provided insight into the current discharge experiences of older adult care in the acute setting, the potential role for ESD in this population and the key factors that would need to be considered for the running of an ESD service for older adults admitted to hospital with medical complaints.

**Conclusion:** This research highlights the barriers and facilitators to ESD for older medical inpatients from the perspectives of key stakeholders. Given the adverse outcomes associated with prolonged hospital stay, these findings will help inform the development of a feasibility trial, examining patient and process outcomes for older adults admitted to hospital with medical complaints who receive an ESD intervention.

**Keywords:** early supported discharge, older adults, hospitalised, qualitative, medical inpatient

## Introduction

Approximately half of older adults ( $\geq 65$  years) presenting to Emergency Departments (ED) are admitted to hospital.<sup>1,2</sup> With the number of older adults expected to double from one billion in 2019 to 2.1 billion by 2050, health services worldwide need to prepare for the anticipated increase in demand for their services from this population group.<sup>3,4</sup>

Early supported discharge (ESD) is a discharge intervention aimed at linking inpatient care and community services to allow patients who are medically fit to return home with direct access to healthcare professional (HCP) input in their own home, who would otherwise have been delayed in being discharged from hospital while awaiting further inpatient

HCP input.<sup>5</sup> A Cochrane review of 17 randomized controlled trials (RCTs) by Langhorne and Baylan<sup>5</sup> demonstrates that ESD reduces the inpatient length of stay (LoS) for stroke patients as well as reducing long-term dependency and admissions to long-term care. In medical older adults admitted to hospital, a systematic review by Williams, Morrissey, Steed et al<sup>6</sup> demonstrates significant reductions in LoS in older adults who receive an ESD intervention when compared to usual care (MD = -6.04, 95% CI -9.76 to -2.32).

Older adults transitioning from hospital to home have previously reported concerns regarding a lack of follow-up in the community once discharged home.<sup>7</sup> In one-to-one interviews with 17 older adults and their 19 caregivers, caregivers reported that the hospital discharge was often rushed and they felt unprepared, with a lack of communication from the hospital.<sup>7</sup> Caregivers spoke positively of the role of one key case worker involved in the care of their relative, reporting that when numerous healthcare workers were involved in the discharge process, it led to confusion as to who does what.<sup>7</sup> Wolff, Freedman, Mulcahy and Kasper<sup>8</sup> surveyed 1,916 caregivers to older adults with activity limitations, who highlighted that safe, efficient, and high-quality care was a key priority in the care of older adults. In a telephone survey study of 6,021 older adults recently discharged from hospital in the US, communication with doctors was the strongest correlate of overall satisfaction, with the second most influential being communication with nurses.<sup>9</sup>

In the stroke population, ESD is used widely to accelerate discharge home while still providing appropriate rehabilitation within the patients' home.<sup>10</sup> In an interview study carried out by Nordin, Sunnerhagen and Axelsson<sup>10</sup> exploring patient expectations of an ESD service, patients commonly reported nervousness and anxiety about returning to their home with changed abilities and different environmental conditions, although they felt positive about the prospect of being able to begin their "new life" in a familiar environment. All ten participants reported feeling confident in the support they would receive from the ESD team in helping them regain their independence. In a UK-based qualitative study exploring patient and carers' experiences of ESD interventions post stroke, the majority of people with stroke reported that they felt home was a better place for their rehabilitation to occur, although some reported that the transition to additional community services was poorly managed.<sup>11</sup> Of the nine carers interviewed, most carers reported feeling some strain on their personal life in terms of their ability to carry out leisure/social activities but felt that the ESD team calling to the home gave them some respite time from their carer role. On the contrary, in a respiratory population, COPD patients who received an ESD intervention reported feeling that they had been discharged from hospital before they were ready, and that they were generally unable or unwilling to negotiate with hospital staff about the timing of their discharge.<sup>12</sup>

In a mixed methods UK study exploring the views of staff and patients on their ESD stroke service, staff commonly highlighted the need for communication both within their ESD and across services in the stroke care pathway.<sup>13</sup> HCPs also commented on the differences in providing a service to rural versus urban areas in terms of resource demands, the importance of involving carers in the rehabilitation plan and the key role therapy assistants can have supporting the high-intensity service provided. Osborne and Neville<sup>14</sup> carried out a qualitative review of six studies exploring the views of ESD patients, their caregivers and healthcare staff. All three groups interviewed stressed the importance of communication between all parties involved in the process.

While extensive research has been carried out exploring the views of stakeholders on ESD for stroke, as far as the authors are aware, the views of stakeholders on the potential role of ESD for older adults admitted to hospital with medical complaints has not yet been explored. The overall aim of this study is to explore the views and perceptions of older adults and HCPs on the role of ESD for older adults admitted to hospital with medical complaints.

## Methods

We conducted a qualitative interview and focus group study at University Hospital Limerick (UHL) from November 2021 to January 2022. The conduct and reporting of this study is in accordance with Consolidated criteria for reporting qualitative research (COREQ), see [Appendix 1](#).<sup>15</sup>

## Study Participants

Purposeful sampling was used to recruit patients for interview.<sup>16</sup> Inclusion criteria for older adult inpatients were as follows:

- Older adults ( $\geq 65$  years) admitted to UHL with medical complaints (admitted to hospital under the care of a medical consultant) and subsequently discharged home.
- Patients who received multi-disciplinary team (MDT) input while an inpatient at UHL.

MDT members working on medical wards in UHL identified potential participants to SW, who then screened the patient's details to ensure suitability for inclusion. SW approached patients on the ward, providing them with written information about the study and giving them appropriate time to consider their participation. Patients who were happy to partake gave written consent on the ward to SW, and an appropriate time was scheduled for the phone interview. SW is a PhD Candidate at the University of Limerick (UL) and physiotherapist at UHL, working in critical care at the time of recruitment and data collection. There was no therapeutic relationship between potential participants and SW prior to recruitment.

For HCP recruitment, snowball purposeful sampling was used.<sup>16</sup> Snowball sampling was used over random sampling as the authors wanted to recruit HCPs with specified career experience in working with older adults, with the importance of participant experience deemed to be more important than achieving a random sample.<sup>17</sup> HCPs who were working with older adults with medical complaints in either acute or community settings were included. Participants were initially identified by the researchers through word of mouth and by email invitation. Researchers then encouraged participants to recruit further participants who are information-rich in their field, and so on, to ensure continuation of sampling through social networking.<sup>18</sup>

## Data Collection

The phone interviews were performed by SW. All interviews were guided by a semi-structured interview guide with open-ended questions to allow participants explore and discuss their experiences in being discharged directly home from hospital.<sup>19</sup> The interview themes included the following: experiences of hospital admission and subsequent discharge home and views on a potential ESD service including barriers, facilitators and supports for the service. Data collection continued until data saturation was met. Data saturation was considered as the point when during the interviews, the interviewer was hearing the same comments over and over, as described previously by Francis, Johnston, Robertson et al<sup>20</sup> and Saunders, Sim, Kingstone et al.<sup>21</sup>

Focus groups were moderated by A-MM, with CO'R present as an independent note taker. A-MM (PhD) is an occupational therapist working as a lecturer at UL, with previous experience in moderating focus groups. CO'R (PhD) is a physiotherapist and lecturer at UL. Both A-MM and CO'R are working in supervisory roles with SW in her PhD. SW was not involved in the focus groups to reduce the conflict of interest in the participation of the HCPs from UHL. A semi-structured interview guide was used, with themes including experiences with the current models of care and the discharge process, the potential role for an ESD service and what this ESD service would look like.

## Data Analysis

Braun and Clarke's approach to thematic analysis was used.<sup>22</sup> All interviews and focus groups were audio recorded and transcribed verbatim by SW. SW, A-MM, RG and C'OR all coded two transcripts (one patient interview and one focus group) independently. All four authors met to ensure inter-coder agreement across all codes. Once the authors were satisfied with the coding agreement, SW and A-MM independently coded all remaining transcripts, and then met to ensure inter-coder agreement for all transcripts. Codes were grouped into potential themes by SW and A-MM independently and reviewed together to allow for refinement. A thematic map was created to ensure potential themes covered the coded extracts and the entire dataset. Themes were refined to determine the specifics of each theme ensuring there was no duplication across themes, creating clear names and definitions for all themes. An overview of themes was sent to a subset of participants to member check the collated data.

## Ethical Considerations

Ethical approval was granted by the HSE Mid-Western Area Regional Ethics Committee in November 2021 (REC Ref. 096/2021). The study complies with the Declaration of Helsinki. All patients received written and oral information about

the study prior to inclusion. It was clearly stated that participation was voluntary and that participants could withdraw from the study at any time without any impact on their routine care. Informed consent was obtained prior to the focus groups and interviews. Informed consent included publication of anonymized responses. All participants were anonymized prior to data analysis.

## Results

Six older adults were interviewed within one month of their discharge directly home from UHL along with two family members/informal carers between December 2021 and January 2022. Fifteen HCPs took part across three focus groups that took place in November 2021 on site in UHL. Two older adults initially consented to partake in the interviews but were not contactable at the time of interview. The mean age of older adults was 79.6 years, with two males and four females participating. A larger subsample of HCPs was recruited when compared to older adults due to the restricted availability of older adults for recruitment and due to time limitations in carrying out one-to-one interviews. Data saturation occurred at the end of the last focus group. Participant characteristics are summarized in [Appendix 2 Tables 1–3](#). Thematic analysis resulted in three themes (see [Appendix 4](#) for a thematic summary and [Appendix 3](#) for abbreviations list).

### Theme 1: Pre-ESD Experiences of Providing and Receiving Older Adult Inpatient Care Barriers to Timely Care

Staff, patients and family members reported difficulties in accessing timely care in the acute setting. Provision of care within resource limited acute services was described as difficult at times; access to certain services and receipt of therapy services fluctuated, with accessibility depending on factors such as funding for services or medical governance.

I think that depends actually on what part of the hospital the patient is admitted to, because it varies just to what access they have to various services. (HCP 2)

Patients and family members reported their experiences of their rehabilitation being limited by a lack of staffing and resources, while HCPs reported a sense of guilt knowing that the limited input they gave their patients significantly impacted their progression. ESD was highlighted as a manner of promoting early access to services for patients, while providing acute hospital staff with re-assurance that their patient would be seen in a timely manner.

I suppose the lack of staff meant I had less time with the staff that were there? Which in turned affected my progress and meant I was in hospital longer than I needed to be. (Patient 4)

It unfortunately creates a huge amount of guilt amongst therapists because they feel that if they are more on the ground that they could physically get back to that person, that person would potentially have more input we would probably have a better outcome and get home faster. (HCP 6)

### Poor Communication Between Hospital Personal and Patients and Family

Patients reported that they found it difficult to retain information while unwell, with medical terminology and inappropriate methods of communication used leading to a lack of knowledge transfer to the patient. Patients reported receiving mixed messages on their care plan from different HCPs, often leaving them lost and unsure of what was happening.

I don't understand why they just can't talk to me, any time they did they used fancy medical language that I didn't understand... I just wasn't told about anything or informed of what was happening, the doctors didn't talk to me. (Patient 1)

Family members found it difficult to contact the hospital or ward their relative was on to get updates, with HCPs noting that with this limited communication discharge planning was more challenging, with family members often acting as the patients "voice."

It was hard to get in contact with the ward the phones were just ringing out. (Family Member 1)

## COVID-19 Has Resulted in Restricted Access to Inpatient and Community Services

Within the last two years, COVID-19 policies and restrictions have made it more difficult for patients and staff to navigate inpatient care. Visiting restrictions have led to more isolated and lonely older adults, with family members commenting on how difficult it was for them to see how their relative was doing.

The last two years have been so lonely and isolating. (Patient 5)

A reduction in specialized community services such as integrated care services made it more difficult for patients to transfer from hospital to home with appropriate supports, while reduced General Practitioner (GP) access left some patients with no options but to attend the ED. In the acute setting, timely access to diagnostics and high levels of staff absenteeism adversely impacted patient care. COVID-19 outbreaks in the acute hospital setting and stepdown/rehabilitation facilities were reported as a common occurrence by HCPs, with associated adverse outcomes for patients.

We have patients that have picked up COVID in here and it's dangerous...getting the patient's out it's definitely saving lives like we've had patients that have passed away after contracting COVID in here...it's a difficult one to explain to families. (HCP 10)

## Theme 2: Navigating Discharge Procedures from Acute Hospital Services

### Enhancing Resources; Processes and Personnel

HCPs reported a lack of staff and resources in the acute setting to support safe and effective discharges of older adults. Demand exceeding capacity for acute and community services made it more challenging for HCPs to facilitate a safe discharge, while a lack of detail in discharge summaries from the acute setting made the link to the community services more fragmented. Staff reported that they often took on the role of other HCPs to facilitate a discharge due to staff shortages, making the process more time-consuming. Patients often recognized the pressures staff are under, reporting that they felt all HCPs were experiencing reduced staffing levels.

If I had a euro for every time I've had to go back and forth and sort out different things...You know, I'm still papering over a gap that's there. I guess I am, but I'm just doing it for the patient. (HCP 9)

But it was just kind of annoying knowing I could potentially be doing more for myself. And as I said it's not their fault, they are all so kind and caring but there just isn't enough of them. (Patient 4)

The availability of a fully staffed MDT to provide comprehensive care to these older adults, with access to services as required by the patient was deemed as optimal care for older medical inpatients.

It's the importance of full MDT really that look for everything. (HCP 13)

### Delayed Discharges are Multifactorial and Result in Adverse Outcomes for Older Adults

HCPs reported discharges were commonly delayed due to reduced access to services in the acute setting. Issues such as access to diagnostics particularly on presentation to the ED, access to specialty consultations in ED and delayed time to admission for treatment all impacted on the patient's discharge. Medically discharged patients were often kept in the acute setting while awaiting stepdown/rehabilitation beds or home care packages to be set up.

The availability of beds in things like step down or rehab for patients who require further physio input or occupational therapy input. Because then they're staying in the hospital for so long, and sometimes they can get hospital acquired infection and that. (HCP 13)

All stakeholders highlighted the potential consequences of delayed discharges for older adults, including deconditioning, increased dependency, and increased infection risk. HCPs identified that the discharge planning process is not initiated at initial hospital presentation, and typically begins to be considered when a patient is more medically stable. However, HCPs acknowledged that ideally discharge planning should begin from the patient's presentation to the ED to facilitate the discharge process from early on in the patient's admission.

We need to start discharge planning earlier on from when they initially present. (HCP 13)

### The “Silos” of Acute and Community Services; IT Systems and Resources

The lack of integrated services between acute and community services was commonly identified by stakeholders as a barrier to supporting safe and efficient discharge home. HCPs felt strongly about the need for integrated resources particularly shared IT systems and administration staff to facilitate this sharing of information. HCPs agreed that a mutually shared IT database across the hospital and community setting would facilitate a reduction in duplication of patient information across disciplines and settings of care, while allowing for more accurate and time-efficient follow-up to take place.

We have to acknowledge the lack of an IT system where both sides speak to each other. That two-way communication from the hospital out and from the community in. (HCP 11)

Both patients and staff reported issues with GP follow-up, with staff reporting GPs often did not receive discharge summaries. For the patients, they reported that this made follow-up more challenging as the GP had no information on their recent admission. Patients reported that the burden of knowledge transfer often fell to them, which may not always have been accurate and expressed concerns that they may have left out important information regarding their admission.

My GP hasn't a clue what I'm on about if I ask him about it, he has no record of me being there. (Patient 1)

The resources available within acute and community settings was another factor voiced by HCPs who noted that the only way older adults had access to specialties and diagnostics was through presenting to ED and subsequently being admitted to hospital. Geographical and age restrictions were also raised as barriers to patients accessing services when transitioning from the acute to community settings.

I understand why we have to have limitations, but a patient should have access to ESD regardless of where they live. (HCP 4)

## Theme 3: A Vision for More Integrated Model of Care and a Medical ESD Team

### Importance of Timely Follow-Up Care

For an ESD service to be effective, stakeholders outlined the importance of timely and effective follow-up care. Patients expressed concerns that their follow-up post discharge might not occur, having been told in the past they would receive a service for it not to happen.

I'd just be worried that those people would actually call out to the house, and we'd get the service. (Patient 1)

HCPs highlighted that ESD feeds into more long-term management of older adults at home, not just managing in the short term after a hospitalization, therefore follow-up needs to be targeted to achieve this.

It's not looking at it episodic like hospitalization or post hospitalization. It's kind of looking at the immediate, medium, and long term. And that's what it needs. It needs to be integrated. (HCP 8)

Family members were open to an ESD model of care, although they were apprehensive about the formal supports they would receive in conjunction with an ESD intervention. Similarly, family members and patients were concerned about what would happen after the ESD intervention in terms of further follow-up.

And just say I still needed home help or whatever after my few weeks of this was finished, would I still get that or would that be compromised then? I wouldn't want to shoot myself in the foot in the long run either. (Patient 4)

### The Appetite for a Medical ESD Team

Stakeholders were broadly positive about the introduction of a medical ESD team for older adults, with benefits identified for both the patient and the hospital. The potential benefits of an earlier discharge while reducing the risks of delayed discharges were positively received by patients and their family members.



Yeah, that sounds great in theory really. If it was there for (my wife) she would have got home a lot sooner definitely. (Family member 1)

The quality of the service provided to patients was a key factor for HCPs in terms of being able to provide an evidence-based intervention with appropriate staffing, as well as the logistics of the service in terms of time to referral from the acute setting to the ESD team, access time to the service and strict inclusion/exclusion criteria. Similarly, comparisons were made to the successful ESD model of care for stroke patients in place at UHL, with positive patient and process outcomes discussed as being transferable to medical older adults.

I imagine in terms of patient outcomes that's beneficial and that's most important, right? (HCP 12)

The stroke ward is the perfect example of that. If they're there, they get kind of fully optimized care with ESD. (HCP 1)

### Beliefs About the Selection of the Medical ESD Team

While adequate staffing and resources were deemed essential for the service to be successful, the need for specialized senior staff with clinical experience in working with this population group was highlighted by HCPs.

So, I think that that's also key that you need at minimum you need at least senior staff in each role in each ESD team. (HCP 5)

The concept of a "key worker" for each patient as their main contact point was considered vital in terms of maintaining an open chain of communication between all stakeholders.

I think that a case management approach is the ideal for this patient cohort, but in acknowledging that, that the case manager would be responsible for, I suppose identifying the patients primary need in terms of rehabilitation and coordinating which discipline is to take the leads on the basis of that. (HCP 6)

The role of a pharmacist, dietician and social worker were all deemed as core elements to the ESD team, outside of the traditional roles of physiotherapists, occupational therapists and speech and language therapists in the MDT. HCPs identified the inclusion of a therapy assistant as a method of reducing the workload for therapists while still allowing the patient to receive necessary therapy time. A shared care model between the acute medical team and the patient's GP was suggested by HCPs to ensure the patients receive timely medical care if required.

I think it needs to be the specialist teams as well. You know we're not generic teams. With specialist teams and specialist knowledge to be able to link it together that would be the ideal situation. (HCP 4)

## Discussion

This study provided insight into the current discharge experiences older adult care in the acute setting, the potential role for ESD in this population and the key factors that would need to be considered for the running of an ESD service for older adults admitted to hospital with medical complaints.

Within the current experiences of discharge, experiences reported by both patients and HCPs were predominantly negative, with a lack of adequate staffing and resources in both acute and community settings a common barrier identified. As a result, HCPs reported feelings of guilt, knowing that the limited input they could give their patient directly impacted on their patients progress and ultimately slowed down their journey out of the hospital. Our findings are mirrored in a qualitative study of 13 older adults and 38 HCPs working in an acute setting with older adults where Tauber-Gilmore, Addis, Zahran et al<sup>23</sup> explored the key components to maintaining patient dignity while in the inpatient setting. Staffing levels were a dominant theme identified, with HCPs reported that they often had to rush patient care consequently reducing the dignity given the patients, which morally distressed HCPs. This sense of not being able to do enough for patients was recognized by all stakeholders involved in our study, with family members and patients acknowledging the burden of work HCPs were having to take on. HCPs identified ESD as a potential measure to reduce the strain on their fellow HCPs, outside of improving patient and process outcomes.

HCPs recognized the adverse effects of prolonged hospitalizations for older adults, including increased infection risk, hospital-associated deconditioning (HAD) and increased mortality rate. Similarly, family members and patients were keen for older adults to return home as soon as possible to maintain their independence. This narrative is in-keeping with the findings of a recent systematic review and meta-analysis of 15 studies carried out by Loyd, Markland, Zhang et al<sup>24</sup> which found the combined prevalence of HAD in older adults admitted to the acute setting to be 30% (95% CI: 24%, 36%;  $P < 0.001$ ). Our previous review found that there is a limited body of evidence exploring the impact of ESD on clinical and process outcomes among older medical inpatients.<sup>6</sup> However, our findings demonstrate a significant reduction in LoS, indicating the potential for ESD to reduce the incidence of HAD among older medical inpatients.

A breakdown in communication between HCPs and their patients/families and between acute and community settings was frequently mentioned by stakeholders in terms of the difficulties often faced in older adult care. In a qualitative interview study with eight older adults transitioning from hospital to home after acute illness, the older adults identified being suitably informed and involved in their own care by healthcare workers as a key priority for them.<sup>25</sup> Patients in our study often spoke of how they received minimal if not any communication from their HCPs, feeling isolated and uninformed. HCPs spoke of how they found communication to be the greatest barrier between acute and community care services. In an Australian-based study, over 20% of discharge summaries sent from the hospital setting took over one week to reach the patients' GPs, resulting in fragmented follow-up care, while only 19% of patients received a written care plan on hospital discharge.<sup>26</sup> As identified by the HCPs in our study, a dedicated key worker to each patient case could facilitate a link between acute and community staff as well as between staff and the patient themselves. This aligns with a qualitative meta-summary of 13 studies carried out by Hestevik, Molin, Debesay, Bergland and Bye<sup>27</sup> exploring older adults' experiences of being discharged from hospital to home, with participants reporting that they had no central contact point to use if needed and were often unsure who to contact with queries.

In 2017, the World Health Organization published their guidelines on integrated care for older adults, aiming to maximize care co-ordination and create a continuity of care for older adults from hospital to the home setting.<sup>3</sup> Treating older adults within their home setting as much as is feasible and safe to do so was a key recommendation made, aligning with the ESD model of care. In a scoping review of patients' experiences of integrated care, older adults defined their experiences in relation to timely access to services, feeling cared for and having their care coordinated across different settings, all of which were raised by our stakeholders.<sup>28</sup> Integrated care, through models such as ESD, allows for patients to receive timely, specialized care within their own environment while creating the link between acute and community services.

The strengths of this study include the timeliness of patient interviews – interviews took place within one month of the older adult's discharge home from hospital to facilitate timely and accurate recall of their experiences. Focus groups were composed of mixed professions working across both acute and community settings, providing a rich variety of experience. A reflexive approach was used in terms of data collection and analysis, with A-MM leading the focus groups and two authors independently coding all transcripts and carrying out the thematic analysis. Limitations to this study include the potential generalizability of the findings as we only included participants from a single acute hospital. Furthermore, patient interviews were carried out over the phone due to COVID-19 restrictions, which may have limited discussion between older adults about their experiences.

## Conclusion

This qualitative study was the first to explore the views and perceptions of older adults and healthcare professionals on the potential role of ESD for older adults admitted to hospital with medical complaints. The current experiences and barriers to efficient and safe discharge home from hospital for older adults were highlighted by stakeholders. The potential role for ESD in this population group was discussed, as well as the key factors to be considered in running an ESD service for medical older adults. These findings along with quantitative evidence could help inform the development of a feasibility trial examining the patient and process outcomes for older adults in an ESD service.



## Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

## Funding

No funding was required.

## Disclosure

The authors declare that they have no competing interest in this work.

## References

1. Curiati PK, Gil-Junior LA, Morinaga CV, Ganem F, Curiati JAE, Avelino-Silva TJ. Predicting hospital admission and prolonged length of stay in older adults in the emergency department: the PRO-AGE scoring system. *Ann Emerg Med*. 2020;76(3):255–265. doi:10.1016/j.annemergmed.2020.01.010
2. McVeigh TP, Al-Azawi D, O'Donoghue GT, Kerin MJ. Assessing the impact of an ageing population on complication rates and in-patient length of stay. *Int J Surg*. 2013;11(9):872–875. doi:10.1016/j.ijsu.2013.07.016
3. World Health Organization. *Integrated Care for Older People: Guidelines on Community-Level Interventions to Manage Declines in Intrinsic Capacity*. World Health Organization; 2017.
4. Ellis G, Gardner M, Tsiachristas A, et al. Comprehensive geriatric assessment for older adults admitted to hospital. *Cochrane Database Syst Rev*. 2017;2017(9). doi:10.1002/14651858.CD006211.pub3
5. Langhorne P, Baylan S. Early supported discharge services for people with acute stroke. *Cochrane Database Syst Rev*. 2017;2017(7). doi:10.1002/14651858.CD000443.pub4
6. Williams S, Morrissey A-M, Steed F, et al. Early supported discharge for older adults admitted to hospital with medical complaints: a systematic review and meta-analysis. *BMC Geriatr*. 2022;22(1):1–8. doi:10.1186/s12877-022-02967-y
7. Neiterman E, Wodchis WP, Bourgeault IL. Experiences of older adults in transition from hospital to community. *Can J Aging*. 2015;34(1):90–99. doi:10.1017/S0714980814000518
8. Wolff JL, Freedman VA, Mulcahy JF, Kasper JD. Family caregivers' experiences with health care workers in the care of older adults with activity limitations. *JAMA network open*. 2020;3(1):e1919866. doi:10.1001/jamanetworkopen.2019.19866
9. Chumbler NR, Otani K, Desai SP, Herrmann PA, Kurz RS. Hospitalized older adults' patient satisfaction: inpatient care experiences. *Sage Open*. 2016;6(2):2158244016645639. doi:10.1177/2158244016645639
10. Nordin Å, Sunnerhagen KS, Axelsson ÅB. Patients' expectations of coming home with Very Early Supported Discharge and home rehabilitation after stroke—an interview study. *BMC Neurol*. 2015;15(1):1–9. doi:10.1186/s12883-015-0492-0
11. Copley CS, Fisher RJ, Chouliara N, Kerr M, Walker MF. A qualitative study exploring patients' and carers' experiences of Early Supported Discharge services after stroke. *Clin Rehabil*. 2013;27(8):750–757. doi:10.1177/0269215512474030
12. Clarke A, Sohanpal R, Wilson G, Taylor S. Patients' perceptions of early supported discharge for chronic obstructive pulmonary disease: a qualitative study. *BMJ Qual Saf*. 2010;19(2):95–98. doi:10.1136/qshc.2007.025668
13. Fisher RJ, Chouliara N, Byrne A, et al. Large-scale implementation of stroke early supported discharge: the WISE realist mixed-methods study. *Health Serv Delivery Res*. 2021;9(22):1–150. doi:10.3310/hsdr09220
14. Osborne CL, Neville M. Understanding the experience of early supported discharge from the perspective of patients with stroke and their carers and health care providers: a qualitative review. *Nurs Clin*. 2019;54(3):367–384. doi:10.1016/j.cnur.2019.04.006
15. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349–357. doi:10.1093/intqhc/mzm042
16. Luciani M, Campbell K, Tschirhart H, Ausili D, Jack SM. How to design a qualitative health research study. Part 1: design and purposeful sampling considerations. *Prof Inferm*. 2019;72(2):e10.
17. Bhardwaj P. Types of sampling in research. *J Pract Cardiovasc Sci*. 2019;5(3):157. doi:10.4103/jpcs.jpcs\_62\_19
18. Parker C, Scott S, Geddes A. *Snowball Sampling*. SAGE Research Methods Foundations; 2019.
19. Weller SC, Vickers B, Bernard HR, et al. Open-ended interview questions and saturation. *PLoS One*. 2018;13(6):e0198606. doi:10.1371/journal.pone.0198606
20. Francis JJ, Johnston M, Robertson C, et al. What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychol Health*. 2010;25(10):1229–1245. doi:10.1080/08870440903194015
21. Saunders B, Sim J, Kingstone T, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. *Qual Quant*. 2018;52(4):1893–1907. doi:10.1007/s11135-017-0574-8
22. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101. doi:10.1191/1478088706qp063oa
23. Tauber-Gilmore M, Addis G, Zahran Z, et al. The views of older people and health professionals about dignity in acute hospital care. *J Clin Nurs*. 2018;27(1–2):223–234. doi:10.1111/jocn.13877
24. Loyd C, Markland AD, Zhang Y, et al. Prevalence of hospital-associated disability in older adults: a meta-analysis. *J Am Med Dir Assoc*. 2020;21(4):455–461. doi:10.1016/j.jamda.2019.09.015

25. Nilsen ER, Hollister B, Söderhamn U, Dale B. What matters to older adults? Exploring person-centred care during and after transitions between hospital and home. *J Clin Nurs*. 2022;31(5–6):569–581. doi:10.1111/jocn.15914
26. Dollard J, Harvey G, Dent E, et al. Older people who are frequent users of acute care: a symptom of fragmented care? A case series report on patients' pathways of care. *J Frailty Aging*. 2018;7(3):193–195.
27. Hestevik CH, Molin M, Debesay J, Bergland A, Bye A. Older persons' experiences of adapting to daily life at home after hospital discharge: a qualitative metasummary. *BMC Health Serv Res*. 2019;19(1):1–13. doi:10.1186/s12913-019-4035-z
28. Lawless MT, Marshall A, Mittinty MM, Harvey G. What does integrated care mean from an older person's perspective? A scoping review. *BMJ Open*. 2020;10(1):e035157. doi:10.1136/bmjopen-2019-035157

## Journal of Multidisciplinary Healthcare

Dovepress

### Publish your work in this journal

The Journal of Multidisciplinary Healthcare is an international, peer-reviewed open-access journal that aims to represent and publish research in healthcare areas delivered by practitioners of different disciplines. This includes studies and reviews conducted by multidisciplinary teams as well as research which evaluates the results or conduct of such teams or healthcare processes in general. The journal covers a very wide range of areas and welcomes submissions from practitioners at all levels, from all over the world. The manuscript management system is completely online and includes a very quick and fair peer-review system. Visit <http://www.dovepress.com/testimonials.php> to read real quotes from published authors.

Submit your manuscript here: <https://www.dovepress.com/journal-of-inflammation-research-journal>