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Home visits for frail older people:

a qualitative study on the needs and preferences of frail older people and their informal caregivers

Abstract

Background

A number of studies have examined the effects of home visits and showed inconsistent results on physical functioning, institutionalisation, and mortality. Despite continuing interest from professionals in home visits for older people, reports on older people's needs and preferences for such visits are scarce.

Aim

This qualitative study aims to explore the views and needs of community-dwelling frail older people concerning home visits.

Design and setting

A qualitative study including interviews with frail older persons and their informal caregivers living in the area of Nijmegen, the Netherlands.

Method

Semi-structured interviews were conducted with frail older people and informal caregivers. A grounded theory approach was used for data-analysis.

Results

Eleven frail older people and 11 informal caregivers were included. Most participants emphasised the importance of home visits for frail older people. They felt that it would give older people the personal attention they used to receive from GPs but miss nowadays. Most stated that this would give them more trust in GPs. Participants stated that trust is one of the most important factors in a good patient-professional relationship. Further, participants preferred home visits to focus on the psychosocial context of the patient. They stated that more knowledge of the psychosocial context and a good patient-professional relationship would enable the professional to provide better and more patient-centred care.

Conclusion

Patients' expectations of home visits are quite different from the actual purpose of home visiting programmes; that is, care and wellbeing versus cure and prevention. This difference may partly explain why the effectiveness of home visits remains controversial. Future studies on home visits should involve patients in the development of home visiting programmes.

Keywords

frail elderly; house calls; patient preference; primary health care.

INTRODUCTION

In many western countries, such as the UK, US, and the Netherlands, there is debate about the need for home visits to frail older people. In several other countries, such as Denmark and Australia, preventive home visits for older patients are already part of national policy.¹⁻³ The context and actual organisation of home visits differ across countries. In the Netherlands, the GP is the coordinator of primary care and acts as gatekeeper to secondary care. GPs were the professionals who used to visit their older patients regularly, not only when a patient had a problem but also unsolicited. These visits were mainly friendly, and focused on the wellbeing and social context of the patient. However, due to perceived job pressure and time constraints, unsolicited home visits have been decreasingly deployed over recent years. In western countries including the Netherlands, the number of home visits by GPs has decreased.⁴⁻⁶ Theile *et al* conducted semi-structured interviews with 24 German GPs to explore their attitudes with regard to home visits. The GPs mentioned that visits of a social nature had mostly been discontinued. They also described home visits as unsatisfactory, in particular with respect to reimbursement and time constraints.⁶

In the last few years there has been increasing interest in home visits, especially for frail older patients. This is mainly

because the needs of frail older people are not well met by the current office-based, primary care model.^{4,5,7} At present, under the Dutch National Care for the Elderly Programme, unsolicited home visits for frail older patients are once again being promoted. It has become increasingly common that primary care nurses have replaced GPs in conducting these visits.⁸

However, studies on the effects of home visits report inconsistent results in relation to physical functioning, institutionalisation, and mortality. This can be demonstrated by the results of several literature reviews and meta-analyses. Van Haastregt *et al* found no clear evidence for the effectiveness of preventive home visits for older people.⁹ Bouman *et al* also found no significant favourable effects of home visits on mortality, health status, service use, or costs.¹⁰ Huss *et al* showed inconsistent results on all outcomes; however, they found a positive effect on mortality in younger study populations.¹ This effect was also reported by Stuck *et al*.² The conclusion of this report was that these visits appear to be effective when the provided interventions are based on multidimensional geriatric assessment and include multiple follow-up visits and target persons at lower risk for death.² Reports with more positive results can also be found; for example, Elkan *et al* concluded that home visiting was associated with a significant reduction in mortality and

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How this fits in

Despite inconsistency in the results of studies on the effects of home visits, primary care professionals have a continuing interest in home visits for older patients. However, reports on the needs and preferences of older patients concerning home visits are scarce. The results of this study show that patients' expectations of home visits are quite different from the actual purpose of home visiting programmes. Future studies should involve patients in the development of home visiting programmes to increase the effectiveness of these programmes.

admission to long-term institutional care.¹¹ However, they found no effect on hospital admission, health status, or functional ability. Ploeg *et al* studied the effectiveness of preventive primary care outreach interventions aimed at older people, for example, home visits.¹² They found a 17% reduction of mortality and a 23% increased likelihood of continuing to live in the community. Recent publications on home visits are mainly systematic reviews and meta-analyses of previously published articles. One of the most recent reports on a randomised controlled trial of home visits was published by van Hout *et al*, which was unable to demonstrate preventive effects of home visits by nurses to vulnerable older persons.¹³

Some authors argue that preventive activities such as preventive home visits should be further developed to concur with older people's needs and wishes, which may improve outcomes.¹⁴ Nevertheless, the needs of older people are still overlooked in home visiting programmes. A number of studies have examined the effects of home visits, but it has not been possible to find studies that report on the needs of older people. Consideration of older people's needs and preferences for home visits may improve processes and outcomes of care as well as patient satisfaction. This may, consequently, increase the effectiveness of home visits.¹⁵

To clarify older people's preferences, this qualitative study was established with the aim of exploring the needs and preferences of community-dwelling frail older people and their informal caregivers concerning home visits in primary care.

METHOD

Participants

Frail patients aged ≥ 65 years and/or their

informal caregivers were approached for participation, between February 2009 and January 2010. Frailty was defined, according to the Dutch College of General Practitioners' standpoint, as having one or more of the following problems: multimorbidity, polypharmacy, cognitive disorders, disabilities, psychosocial problems, and loneliness.¹⁶ Exclusion criteria were inability to communicate in the Dutch language, serious problems with hearing, life expectancy of less than 6 months, and serious cognitive disorders, as these would impair individuals' ability to answer the questions reliably or to make an informed decision about participation.

Purposive sampling was used to obtain a diverse study population, reflecting the diversity in health care and welfare problems of frail older people. The study aimed for variation in the characteristics of frailty, living situation (home or older person's home), and socioeconomic status.

Data collection and analysis

Semi-structured interviews were conducted at the homes of participants. The topic list for these interviews was developed after a review of the literature and a consensus meeting among members of the research group. The first version of the topic list was piloted on two frail older persons living in a home for the older people, after which adjustments were made. Subsequently, topics were adapted during the study whenever preliminary analysis of data demonstrated that this was required. Outlying statements were thoroughly explored in further interviews. The final topic list is shown in Box 1. The interviews were conducted by one of two researchers; both researchers are medically qualified and neither was involved in the treatment of participants. Interviews were audiorecorded and transcribed verbatim to written text by the interviewer. If there were any doubts about what the participant meant by a certain statement, the interviewer contacted them by phone and asked for additional information.

Data analysis was performed using the grounded theory approach.¹⁷ Atlas.ti software was used to support the analysis process. All transcribed interviews were coded by both researchers independently. Codes were then compared and discussion followed until consensus was reached. Interviews were conducted until theoretical saturation was achieved (that is, no new concepts came up during the interviews). During the interviews and analysis it was found that no new topics were introduced

Box 1. Final topic list"

1. Experiences with primary care professionals

(primary care professional: GP, primary care nurses)

- Positive and negative experiences?
- What is important?
- What is missing?
- What makes a good primary care professional?

2. Home visits

(home visits: a primary care professional will visit the patient periodically to assess their status)

- Experiences? What is being done in these visits? What is missing?
- The need? Where does this need come from?
- Preferences?
- Who? GP — primary care nurse

Table 1. Demographics of participants: patients

Characteristic	Patients, n = 11
Median age, years, (range)	80 (65–90)
Sex, n	
Males	2
Females	9
Living situation, n	
Independent, alone	8
Independent, with others	1
Nursing home	2
Socioeconomic status, n^a	
Low	4
Middle	3
High	4
Frailty characteristics, n	
Cognitive disorders	2
Multimorbidity	6
Polypharmacy	10
Disability	6
Psychosocial problems	2
Social isolation	5

^aBased on education, occupation, and occupation of spouse.

after 10 interviews with patients and 10 with informal caregivers. After two more interviews, it was concluded that saturation was reached.

Ethical considerations

Because of the nature of the study, the researchers' local ethics committee stated that no formal approval was required. Nevertheless, the participants were asked for informed consent.

RESULTS

Participants

Eleven frail patients aged ≥ 65 years and 11 informal caregivers were included. The demographics of the study population are shown in Tables 1 (patients) and 2 (informal caregivers).

When analysing the data, no striking differences were found between the interviewed patients and the informal caregivers in relation to their views on the selected topics. For this reason, it was decided to describe the results of patients and informal caregivers together.

The need for home visits

Most participants said they would like to receive home visits. This was independent of whether they already had experience with them. They gave various reasons why they would like to have home visits. One reason often mentioned was that the care patients received from GPs and other primary care professionals in the past was better than the care they currently receive, mainly because of the perceived time constraints and the impersonal attitude of the professionals nowadays. These participants thought that home visits by primary care professionals would give them the personal attention they used to receive and currently miss:

Informal caregiver (IC) 7: *'In the past when you went to the GP he had time and asked, for example, how my grandchildren were doing, when I was only there for my leg. That is no longer the case ... they just don't have time for it.'* [55-year-old wife of a patient with a cognitive disorder]

IC11: *'The care is becoming more impersonal and individualistic, you're more and more required to take initiative yourself. It is not like 40–50 years ago ... [There is] no general interest in the patient, they hardly know anything about you.'* [64-year-old daughter of a patient with a cognitive disorder]

Another statement made by some

participants was that they did not want to bother the GP. When they had a problem, they would not consult the GP quickly. They would wait until it was no longer possible to handle the problem themselves. They felt a home visit would give them the opportunity to talk about their problems:

Patient (P) 8: *'People like me don't ask for help. But I sometimes have problems I want to talk about but I don't want to bother my children with that. I would appreciate it when a professional is visiting me and I can talk about my problems.'* [85-year-old woman with psychosocial problems and loneliness]

Further, participants mentioned that home visits would give the patient increasing trust in primary care professionals, facilitating increased patient satisfaction. Participants mentioned trust as one of the most important contributing factors in a good patient–professional relationship:

P1: *'[about home visits] that also gives you some more confidence and support because you know someone pays attention to you.'* [85-year-old woman with psychosocial problems and loneliness]

IC10: *'I am visited by a nurse of my GP ... And I think, maybe, it is the attention you receive that is a good thing because you know that the nurse and the GP have a good picture of your situation ... It gives you more trust in the GP.'* [80-year-old wife of a patient with a cognitive disorder and multimorbidity]

There was also scepticism, as some participants could not imagine that a GP or other primary care professional would have time to make these home visits:

P11: *'Do those people have time for that? ... They are always so busy ... And then I don't want them to visit me voluntarily.'* [80-year-old woman with multimorbidity, a disability, and loneliness]

Not all patients were convinced of the added value of home visits. Some patients said that they were already satisfied with the care they received. Others suggested that home visits should be made for patients who have major problems or for frail older patients only.

P5: *'I have no problems at the moment and*

I'm feeling well. So I think it's not necessary that a GP will spend time on visiting me.' (90-year-old woman with multimorbidity and polypharmacy)

P10: *'The GP can go through his patient records to see which patients need a home visit, which patients really need it.'* (65-year-old woman with disabilities and polypharmacy)

Preferences for home visits

Participants were asked for their preferences in home visits. They reported three main themes: the psychosocial context, continuity in professionals, and the patient-professional relationship.

Participants reported that attention to the wellbeing and psychosocial context of the patient is particularly important in home visits. They thought that more knowledge of the psychosocial context of the patient would enable the professional to provide better and more patient-centred care:

P1: *'[about the content of home visits] Ask about your personal situation, your wellbeing. How do you value your life and how the circumstances are at home, are you lonely, can you go out alone?'* (85-year-old woman with psychosocial problems and loneliness)

Participants reported the importance of continuity of professionals. As an example, some participants mentioned that they trust their own GP. When they visited a new GP or a substitute, however, they did not immediately trust this person. Participants preferred their own and trusted GP or professional, also for home visits. They also felt that trust is one of the most important factors in a good patient-professional relationship and that a good patient-professional relationship is extremely important in home visits. Patients said that they only discuss their problems with professionals with whom they have a good relationship and with whom they trust. Other contributing factors mentioned by participants included respecting and listening to the patient:

P11: *'Last time I had another doctor and I can't get used to that. They have all information about me in their computer but I still have the feeling they don't know me ... I'd rather have my own GP, she knows me and I know her.'* (80-year-old woman with multimorbidity, a disability, and loneliness)

IC11: *'Home visits should be done by*

someone who can gain confidence of the patient ... and this might require two, three, or even four visits of the professional.' (64-year-old daughter of a patient with a cognitive disorder)

P10: *'Trust, when I don't trust a person, I don't believe the things he says easily and I would do less for that person.'* (65-year-old woman with disabilities and polypharmacy)

Most participants would prefer the GP doing home visits, because this is the primary care professional they trust most. Yet, they presumed GPs would not be able to do the home visits because of time constraints. Participants reported that nurses could do the home visits as an alternative. However, they mentioned that these nurses would need to know how to treat older patients, and they felt continuity in nurses was important:

IC5: *'I understand the GP doesn't have time for that, but I'd rather have the GP performing such visits ... A nurse needs to pass on information to the GP and she cannot immediately help us.'* (85-year-old wife of a patient with multimorbidity and disabilities)

P10: *'Why not a nurse, a nurse practitioner instead, to do these home visits? The doctor has better things to do.'* (65-year-old woman with disabilities and polypharmacy)

Participants stressed the importance of visits made at patients' home. They felt that with a visit at the older person's home, the real situation could be considered:

P3: *'People are more natural and relaxed in their own home.'* (65-year-old female with multimorbidity and polypharmacy)

IC4: *'They need to take a look at the homes of these patients ... just to see how it really goes, how the situation really is ... I think many older people conceal a lot.'* (71-year-old wife of a patient with a cognitive disorder)

DISCUSSION

Summary

The results of these interviews give insight into the perceived needs and preferences of frail older people regarding home visits in primary care. Most participants emphasised the importance of home visits for frail older people. One of the reasons was that they stated it would give older

Table 2. Demographics of participants: informal caregivers

Characteristic	Caregivers, n = 11
Median age, years, (range)	51 (55–87)
Sex, n	
Males	2
Females	9
Relationship to relative, n	
Partner/spouse	7
Child	3
Other	1
Living situation, n	
With relative	7
Without relative	4
Socioeconomic status, n^a	
Low	3
Middle	3
High	5
Provides care with, n	
Housekeeping	5
ADL	5
IADL ^b	8

^aBased on education, occupation, and occupation of spouse. ^bCommunity mobility, health management and maintenance, financial management. ADL = activities of daily living. IADL = instrumental activities of daily living.

people the personal attention they used to get from GPs and that they miss nowadays, which would give them more trust in the GP. Some participants mentioned that trust is one of the most important factors of a good patient–professional relationship. Further, most participants preferred home visits focusing on the patient’s psychosocial context. They felt that the professional would be able to provide better and more patient-centred care if he had more knowledge of the psychosocial context and if there was a good patient–professional relationship.

Strengths and limitations

This is the first time that the needs and preferences of frail older patients concerning home visits have been studied. These interviews have provided some new insights into the needs and preferences of frail older persons and the findings may have implications for the future development of home visiting programmes.

Small groups of patients and informal caregivers were interviewed in this study. Although small groups were interviewed, saturation was reached and the researchers believe that the results are a reliable representation of the diversity of needs and views of the whole population.

Patients with serious hearing problems and serious cognitive disorders were excluded. It is recognised that, by excluding these patients, a group of very frail patients was excluded. An attempt was made to overcome this limitation by interviewing informal caregivers of these patients.

Some limitations were also experienced when conducting the interviews. First, not all participants had actually experienced home visits. However, most of them had experience with friendly visits in the past or a GP visiting them when they were ill, and some participants had regular appointments with a practice nurse. Second the depth of some interviews was limited — mainly those with participants with mild cognitive disorders or a low level of education. Because of the abstract nature of some topics, it was difficult for these participants to express their needs. In these cases, more direct and closed questions had to be used to obtain useful responses. Because this problem only occurred in a very small proportion of the participants, the authors do not think it had a great impact on the results.

Comparison with existing literature

Most participants of this study perceived home visits as important; however, this was for quite different reasons than the actual purpose of these visits nowadays. Most

home visiting programmes mainly focus on prevention of health problems, disability, and dependence.^{1,10,11,13} However, the study results have shown that patients want home visits that focus on their social background and wellbeing. In an integrative research review of preventive home visits among older people, Fagerström *et al* also found that many older people had positive experiences with preventive home visits. The interviews in the present study found that patients appreciated similar aspects; such as, the opportunity to discuss problems, the possibility of talking to the visitor, and the attention and support the older person received from the visitor.¹⁴

Participants often stated that they were reluctant to visit their GP with minor complaints because they did not want to bother them. Williamson and colleagues discussed this 40 years ago:

‘Most old people do not report their complaints to their doctor until the condition is advanced. They stated that a GP service based on the self-reporting of illness is likely to be seriously handicapped in meeting the needs of old people.’^{18,19}

Home visits give patients the opportunity to discuss their problems and needs with a professional. This makes a home visit not just a health check, but also an opportunity to meet individual needs that may be important for older people to stay independent.²⁰

Furthermore, participants reported that they miss the friendly visits of GPs. They think that such social visits increase trust in their GP and will improve the patient–physician relationship. However, current home visits in the Netherlands are increasingly conducted by nurses and not by GPs. In the Netherlands these nurses play an increasingly important role in the primary care team. Accordingly, the study participants reported that they prefer GPs to do the home visits; however, they said that primary care nurses were a good alternative. Participants emphasised that these nurses have to invest in a good relationship with their patients and that continuity is important. McNaughton reported a synthesis of qualitative studies investigating the home visiting practice of public health nurses in the context of maternal and child health. Although this research was done in a different patient population, the study underlined the importance of a good patient–professional relationship in home visits.²¹ Further, Liebel *et al* conducted a literature review and

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Ethical approval

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Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

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synthesis of 10 nurse home visiting trials targeting older adults with disability, in an attempt to identify successful components of these trials. They recognised the importance of nurse–patient relationships in successful interventions, as this enabled professionals to tailor interventions to patients’ individual needs.²²

Implications for future research

Studies on home visits have shown inconsistent results. Home visits in these studies especially focused on cure and prevention. The present study revealed that frail older people wish for home visits; however, their expectations are quite different than the actual purpose of home

visiting programmes nowadays. This difference may also explain why the effectiveness of home visits remains unclear. In future studies of home visits, the needs and preferences of patients should be incorporated by involving patients in the development of home visiting programmes. This would not only result in designing an intervention that meets their wishes, but may also assist in defining the outcomes best suited to measuring their effectiveness. It is clear that we should not only focus on outcomes such as physical functioning, institutionalisation, and mortality, but also incorporate outcomes related to wellbeing and quality of care.

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