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## Quality care provision for older people:

an interview study with patients and primary healthcare professionals

### Abstract

#### Background

In recent years, primary health care for the ageing population has become increasingly complex.

#### Aim

This study sought to explore the views and needs of healthcare professionals and older patients relating to primary care in order to identify focal areas for improving primary health care for older people.

#### Design and setting

This research was structured as a mixed interview study with focus groups and individual interviews. Participants were made up of primary healthcare professionals and older patients. Patients were recruited from five elderly care homes in a small city in the southern part of the Netherlands.

#### Method

All interviews were transcribed verbatim and analysed by two individual researchers applying constant comparative analysis. Data collection proceeded until saturation was reached.

#### Results

Participants in the study agreed about the need for primary care for older patients, and showed sympathy with one another's perspectives. They did note, however, a number of obstacles hindering good healthcare provision. The major themes that arose were: 'autonomy and independence', 'organisational barriers', and 'professional expertise'. Participants generally noted that it is important to clarify differences in perspectives about good care between patients and healthcare professionals.

#### Conclusion

Effective primary care intervention for older patients requires mutual understanding of the expectations and goals of all parties involved. There are a number of important requirements, especially accessible patient information in the form of care plans; specialist training for nurses and GPs on complex care and multimorbidity; and training on discussing autonomy, goal setting, and shared care. Further improvement in health care for older people and its evaluation research should focus on these requirements.

#### Keywords

care homes; focus groups; health services for older people; patient-centred care; primary care

### INTRODUCTION

The Netherlands' population is ageing. In 2040, 25% of the country's inhabitants will be >65 years old.<sup>1</sup> Consequently, the number of patients with multiple chronic diseases and impairments will also increase.<sup>2,3</sup> In recent years, primary health care for this ageing population has become increasingly complex.<sup>4</sup> This is due, in part, to multimorbidity involving the complex interactions of co-existing diseases.<sup>5</sup> Other factors include the rapidly changing living conditions and supportive care for these patients, as well as their need for tailored care.<sup>6</sup> In the Netherlands, all home-dwelling older individuals and residents of elderly care homes are registered as patients with a GP. On average, Dutch GPs treat 95% of presented medical problems.<sup>7</sup> GPs arrange referrals to secondary care when needed, but remain involved in their patients' health care. This has considerable workload implications for primary care, as older patients consult their GPs and healthcare services more frequently than do younger patients with no chronic diseases.<sup>8-10</sup>

In the face of this increasing complexity, care for older people is largely provided by GPs and nurses, who are not specifically trained to cope with this intricate care provision. The primary health care support

needs for patients with complex cases vary between individuals. However, the task of determining what is necessary for effective care provision appears to be a struggle for patients and healthcare professionals alike.<sup>11-14</sup> This process is complicated because most guidelines are not developed for older patients with multimorbidity, comorbidity, or polypharmacy.<sup>15</sup>

Little research has investigated the views and needs of older patients regarding their (goals of) primary care.<sup>16,17</sup> Moreover, to the authors' knowledge, no research has investigated the views and needs of both patients and their primary health professionals. The current study aimed to explore experiences in the provision and receipt of primary care from the perspective of both primary healthcare professionals and older patients to identify expectations and needs. Other aims of the study were to identify focal areas for improving health care for older patients and to make suggestions for improving the training of the professionals who work in this field.

### METHOD

The study was exploratory because of the paucity of research on this topic. It was decided, therefore, to use focus groups for group interaction purposes to encourage participants to explore and clarify their

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### How this fits in

The world's population is ageing and in recent years primary health care for older people has become increasingly complex. This study sought the views and needs of healthcare professionals with regard to this increasingly complex area of primary care and identified focal areas for improving primary care for older people. One of the most significant results was realising that successful care intervention is an undertaking requiring mutual understanding of the expectations and goals of all the parties involved. The study has also outlined the main requirements of such a system.

views in more depth.<sup>18</sup> To ensure substantial contributions during discussions from each individual participant, group sizes were kept small (three to eight individuals), but large enough to enable discussion and to generate new insights. Participants were grouped with their peers to minimise the impact of power relationships between the interviewees.

Focus group interviews were set up with the following participant groups: residents of elderly care homes (five groups), their GPs (five groups), and their coordinating nurses (five groups) (Table 1). Patients were recruited from five elderly care homes in a small city in the southern part of the Netherlands. The patients were selected with the help of nurses employed at these facilities to ensure a mixed group of older individuals >80 years of age. All coordinating nurses of the five elderly care homes participated in the focus groups, as did GPs from all general practices that had registered patients in the participating care homes. Each focus group interview lasted approximately 90 minutes. All subjects consented to participate and received a guarantee of anonymity and confidentiality. Participants were offered a box of chocolates in appreciation for their contributions.

Patients in elderly care home settings in the Netherlands generally have their own apartments with a combined living/sleeping room, a private bathroom, and small kitchenette. Every apartment has its own front door. The elderly care homes have a common space for dinner or activities. Admission to elderly care homes is limited to individuals with debilitating infirmities. Twice a year a care plan meeting is organised by the coordinating nurse and GPs are invited to these meetings.

Because of the eligibility criteria for

residential elderly care facilities, individual interviews were also conducted with home-dwelling older people to investigate potential differences in important focal areas, and to further develop the areas identified by the focus groups.

Twenty individual interviews were conducted with home-dwelling older participants aged  $\geq 70$  years. These participants were recruited from three GP practices in the same region (Table 1). Patients  $\geq 70$  years old at these three practices were invited during regular consultation visits to participate in the interviews. All patients who were asked to participate agreed to do so and gave written informed consent. These subjects also received a box of chocolates in appreciation for their participation.

### Interviews and data collection

A healthcare manager experienced in conducting professional interviews acted as a moderator for the focus groups. The moderator used an interview guide to direct the discussion and to fulfil the research aims. The interview guide was based on literature and the expert opinions of the supervising committee. Small changes were made after testing in a pilot with five participants. In the individual interviews, every participant was interviewed by two trained research assistants, who used the interview guide for the focus groups and its results as a starting point.

Both the focus group interviews and individual interviews were audiotaped and transcribed verbatim by research assistants. One researcher made field notes and another researcher listened to the tapes to double-check the accuracy of the transcripts, and make any necessary corrections.

### Analysis

The focus groups were analysed using constant comparative analysis.<sup>19</sup> Two researchers began by familiarising themselves with the data. They then applied open coding in a process of breaking down, examining, and comparing the data, thereby conceptualising and categorising data (explorative phase). During the subsequent axial coding, data were put back together in new ways after open coding by making connections between categories. This was done with a view to defining the important elements of the information (specification phase). Subsequently, selective coding was used at the highest level of abstraction, in which the core variable guided further relevant coding, and the data were

**Table 1. Demographics of participants, focus groups, and individual interviews**

Variable	GPs (n = 20)	Coordinating nurses (n = 21)	Older care home patients (n = 33)	Home-dwelling patients (n = 20)
Male/female, n	11/9	3/18	12/21	6/14
Mean age, years (range)	48 (32–60)	42 (28–55)	86 (82–94)	79 (70–89)

scrutinised for invalid areas (reduction phase).

The two researchers who analysed the data, discussed the initial coding and consulted a third researcher wherever disagreements or doubts arose about identified themes. The supervising team discussed interpretations of the identified themes. Data collection proceeded until saturation was reached, which in this case, meant that no new themes were identified by the analysis. The individual interviews were analysed with the same technique. Information from the previous focus group discussions was used to feed the discussion of each next focus group. The individual interviews took place after the analysis of the focus groups. At the end of every individual interview the identified themes from the focus groups were discussed and agreed with the participants.

## RESULTS

The 15 focus groups were made up of 33 older residential care patients, 20 GPs, and 21 coordinating nurses, with 20 home-dwelling older patients in the individual interviews (Table 1).

Three major and inter-related themes proved pivotal to understanding the process of primary care provision for older patients from the providers' and recipients' perspectives: 'autonomy and independence', 'organisational barriers', and 'professional expertise'. Although all of the participants mentioned the same themes, the emphasis on issues relating to those areas varied between groups. These themes are presented below in more detail from the perspective of the different groups. Quotations from the participants are included to support the findings, with participants represented by the following abbreviations: CN = coordinating nurse; EP = patient in an elderly care home; HP = home-dwelling patient.

### Autonomy and independence

Although all participants agreed that every discipline has its own role and responsibilities, the expectations of each

group towards the others proved to be largely implicit. Some uncertainty was expressed about the alignment between GPs, patients, and nurses. The GPs, who were used to solitary work, expressed difficulties with the new working method required to handle more complex cases (working together with nurses instead of alone, and being proactive instead of reactive). The GPs were also unaccustomed to working with care plans. Often, they were not present at the care plan meetings held for every patient in their respective care homes:

*'Speaking as a GP, I'd be inclined to say ... let's see, how should I put this? This is like trying to fight too many fires. We just make follow-up appointments – or not, depending on the case. And sometimes, we just agree to get a call if something goes wrong.'* (GP)

*'The thing is, GPs are the generalists that provide care from the cradle to the grave ... Some elderly people function perfectly well and never need any specialised expertise. So, I feel like it's undermining our care provision to draw a line, where the GP's role ends and the specialists are called in.'* (GP)

The coordinating nurses indicated having trouble deciding at times whether to consult a GP. The GPs and coordinating nurses had no format or standard for establishing agreements and setting common goals. All of the professional healthcare providers expressed uncertainty about their degree of autonomy in care provision:

*'You see, a GP might think it's fine for us to make a decision. But we might feel that we can't just take that responsibility without informing the GP of the situation ... And that's when we discuss responsibilities.'* (CN)

Another concern regarding medical care provision in the elderly care homes was the level of patient autonomy. All of the patients were older individuals with infirmities, they mentioned they sometimes lacked an overview of their own cases in terms of, for example, medication use, disease case, or care needed. The GPs and coordinating nurses also sometimes doubted whether the patients were capable of discussing their problems adequately. However, some patients expressed the desire to discuss their problems directly with their GPs without interference from a nurse or relative. Patients also expressed a strong desire to make their own medication arrangements:

*'Patients in elderly care homes have lower levels of independence, overview, and empowerment [than home-dwelling elderly].'* (GP)

*'The minute you enter a nursing home, you give up so much — even if the care is excellent.'* (EP)

*'I take something like 14 or 15 pills a day and that's all well taken care of now. But, it was really hard for me to deal with in the beginning.'* (EP)

*'Yes, and if all you get is half of them, that's really upsetting.'* (EP)

The home-dwelling older participants placed great importance on maintaining control of their own medical affairs, and thus remaining autonomous. They expressed the wish to discuss their medical needs with their GPs, and if necessary, with their relatives. All patients felt it was important to have conversations with their GPs and nurses about the meaning of life and what was important to them; their global healthcare goals and their standards and values, or even more existential questions. This was summarised as conversations about the meaning of life):

*'I think this is lacking. I really do. Good discussions ... it's because the doctor ... hardly has time anymore.'* (EP)

*'As long as I can manage, I want to do things myself ... My children and husband know what I want. If we reach the point where we can't handle things, then our children can take over with our GP.'* (HP)

All participants — doctors, nurses, and patients alike — expressed difficulty in determining their own individual independence and autonomy. This was a result of the need for collaboration between all parties, which arises as cases increase in complexity.

### **Organisational barriers**

All participants expressed concerns about the practical workings of care protocols in the elderly care homes. Care provision in these facilities was described as deficient in its coordination and clarity regarding the distribution of tasks and responsibilities. The consensus was that the care homes lacked formal agreements concerning the assignment of responsibilities to patients, their coordinating nurses, and their GPs. All participants felt that longitudinal

continuity (continuity of care by the same professional) was vital to good quality care. However, most participants felt that this continuity was threatened by the constant changes in attending nurses and GPs. It was noted that the frequent unavailability of coordinating nurses to discuss questions and planning undermines, among other things, the longitudinal continuity of care in patient health check visitations at these elderly care homes. Typically, during visitations the GPs dealt with their patients' acute problems, but were unaccustomed to recording their treatment plans in patients' care logs. The nurses expected the GPs to note their findings, but never explicitly requested that. As a result, an excellent platform for building common care goals was neglected. Another barrier appeared to be a lack of acquaintance with each other. Often, the GPs and coordinating nurses did not know each other very well, hampering good communication and continuity. Moreover, GPs and nurses adhere to their own sets of professional standards, which proved to lack common alignment. This was further complicated by the absence of any collective digital patient records:

*'And then they run into 20 GPs, while we deal with at least 30 care workers.'* (GP)

*'I think the biggest problem is the number of care workers involved in a patient's care ... as well as confusion and miscommunication between the staff.'* (GP)

Time is another important organisational barrier. Patients in elderly care homes often ask their coordinating nurses to contact their GPs, which can prove very time consuming for the nurses:

*'Calling takes up enormous amounts of time. It's hard to get in touch with the doctor. You have to keep calling back, and waiting on hold. You lose so much time in the process. They're hard to access; they're really hard to access.'* (CN)

Both the home-dwelling patients and the resident patients in elderly care homes wanted more time with their GPs. The patients in elderly care homes complained about frequent changes in attending nurses. For home-dwelling patients, long telephone waiting times and all the questions asked by medical assistants were an extra barrier. These patients wanted to be able to make appointments at short notice with their own GPs:

*'We keep getting different caregivers. One shows up in the morning to help with the elastic stockings. Then there's another one for the medicines.'* (EP)

*'Whenever you need to call, you get this recording: "there are 11 callers ahead of you." And then they ask you all kinds of questions and decide for you whether you get an appointment with the doctor.'* (HP)

*'He just never seems to have time. If you ask about a second problem, he tells you to come back ... Whenever my husband can't take me, I have to go on my own by bike, but that's getting harder these days.'* (HP)

### **Professional expertise**

GPs acknowledged that their training was disease-oriented, and that they sometimes felt overwhelmed by the complexity of problems presented by older patients with infirmities. They also admitted that their knowledge of multimorbidity, polypharmacy, and care plans for older people was insufficient:

*'Some time ago, I prescribed quite a number [of medications], but I really don't feel very comfortable with that. I think I would benefit from some extra training in this area because I feel like patients are getting far too much medication.'* (GP)

GPs were concerned that the nurses had insufficient knowledge and expertise, and that these shortcomings hindered them from gaining an overall medical picture. Coordinating nurses acknowledged that not all attending caregivers were capable of providing adequate medical information, such as blood pressure, pulse, or temperature to the GPs, and that they had no standard format for communicating patients' medical status to GPs. The coordinating nurses also felt that GPs underestimate their ability to determine whether a GP visit is necessary, and said they often feel caught in a difficult position between patients and GPs:

*'I still think that this is mainly an issue of knowledge ... The problems we're seeing in elderly care homes are more complex than they were, say, 15 or 20 years ago. And I just think what's needed is the expertise [in nurses] to deal with it.'* (GP)

*'To top it all, some of our staff members call the doctor for every band-aid. As a result, the doctor doesn't take any of us seriously ... And we also have some who don't record*

*all the necessary information before they call the GP.'* (CN)

*'Doctors often feel that the difference in levels of expertise [of the different nurses] is too great.'* (CN)

Most patients agreed that their coordinating nurses and GPs were highly qualified caregivers. Both patient groups asserted, however, that their GPs sometimes had difficulties in judging the complexity of their conditions. The patients viewed their GPs as having sufficient knowledge about different diseases, but felt they lacked an overall understanding of how individuals with multiple conditions suffer. Moreover, some of the patients in elderly care homes mentioned that not all of the nurses were sufficiently knowledgeable to assess their medical conditions and doubted their ability to pass on their questions accurately to their GPs:

*'I trust him. I think he [the GP] is a nice person, and I'm comfortable with any treatment he administers. Common sense also tells me I should be comfortable since he's known me for so long.'* (EP)

*'I think they [the doctors] underestimate things sometimes. There's too quick a tendency to advise people to focus on what they still can do, rather than what they can't any more. But that makes me feel like these GPs and specialists know everything about diseases, yet have no clue what it's like to have several of them together ... I feel like this should be handled better.'* (HP)

## **DISCUSSION**

### **Summary**

This study explored the experiences and needs of primary healthcare professionals and older patients. Participants agreed about the need for primary care for older patients with infirmities, and also showed sympathy with one another's perspectives. However, they did note a number of obstacles that hinder good healthcare provision. The following focal areas for improvement were identified based on their observations: 'autonomy and independence', 'organisational barriers', and 'professional expertise'. Moreover, the participants gave some suggestions for the training of professionals working in the field of older peoples' care.

### **Strengths and limitations**

This study included all of the three

groups involved in primary care for older people: GPs, nurses, and older patients themselves. Inclusion of these three groups enables a multidisciplinary perspective from which to draw more solid conclusions about primary care for older people. All of the coordinating nurses at the five participating elderly care homes took part in the study. The patients living in the elderly care homes were recruited through the coordinating nurses, thus ensuring a mixed group of patients. GPs from all the general practices that had registered patients in the participating elderly care homes also took part. The study was novel and used focus group methods and individual interviews to obtain the views of patients and primary care givers for further research. A pragmatic approach to recruitment resulted in an appropriate number of participants. However, given the voluntary nature of the participation, it is possible that the participants were more motivated than may have been the case otherwise. Considering that a caregiver-patient hierarchy had the potential to limit or alter contributions from patients, heterogeneous groups were used to minimise the impact of power relationships between the interviewees.

The data were analysed by two researchers. The high level of agreement between the focal areas identified by the two independent researchers and the fact that the focal areas were recognised and agreed by the participants increase confidence in the results. Focus group and individual interviews were conducted in Dutch. For the purposes of this article, the quotations included to illustrate the interview findings were translated from Dutch into English. The translation was done by a native English speaker with extensive qualifications as a medical translator to preserve, as closely as possible, the nuances of the interviewees' responses.

An important merit of this study is that, to the authors' knowledge, it is the first qualitative study aimed at identifying focal areas for improving the provision and receipt of primary care from the perspectives of both primary healthcare professionals and older patients. The patient group was representative of the Netherlands' older population, as both home-dwelling older people and residents of elderly care homes were interviewed. The focal areas for improvement that were identified based on the focus group and interview findings were the same for both patient groups. One of the most significant results — and the greatest value this study

offers — was the finding that clarifying the differences in perspectives on good care between patients and caregivers is vitally important. GPs and nurses adhere to their professional perspective and are more medically oriented, while, for most patients the perspectives of their wellbeing and mutual understanding or personalised communication are more important than their actual medical condition.

### Comparison with existing literature

The focal areas identified in the study are supported in part by earlier research on specific areas of health care for older people. A 2013 study,<sup>20</sup> which reviewed the perspectives of older patients regarding their health and healthcare needs, supported the finding that older patients residing at home and care facilities alike have problems with caregivers not understanding their desire for meaning in their lives, or their struggle for autonomy and independence. However, that study was limited to older patients and did not cover the perspectives of doctors or nurses.<sup>20</sup> Another study confirmed the finding that nurses often feel caught in a difficult position between patients and doctors.<sup>17</sup> In addition, a review on quality improvement in care homes, which focused on the management of specific physical health needs, argued that structured interventions in shared planning are necessary.<sup>21</sup> The current study reveals a picture of varying quality in care. Frustration was also observed among the participating care professionals, who, despite their best intentions, do not formalise methods for collaboration or express mutual expectations. These findings confirm the importance of creating protocols, where mutual expectations are clarified and common goals are established. From earlier studies, it is known that shared goal setting is still in its infancy.<sup>16,22</sup>

The current study's findings on the main organisational barriers for patients are supported by those of two qualitative studies on patient perceptions of (chronic) care.<sup>23,24</sup> All patients want more time with their GPs and nurses. GPs frequently interact with older patients with infirmities, and are ideally positioned to give tailored, patient-centred care.<sup>23,25</sup> However, as the current study shows, time pressures, the increased complexity of cases, and lack of specific expertise may complicate the process of providing such tailored, patient-centred care. All of the GPs and nurses interviewed want more knowledge to deal with complex order persons' care and to better support their patients.

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### Funding

None.

### Ethical approval

Dutch legislation does not require the approval of an ethics committee for interviews of healthcare professionals and patients regarding their beliefs. The study design was approved by the research committee of the elderly care organisation De Zorggroep.

### Provenance

Freely submitted; externally peer reviewed.

### Competing interests

The authors have declared no competing interests.

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### Implications for research and practice

The current study found conflicting expectations between patients' and caregivers' views on good primary care. The current focus of primary care for older people is two-fold: to deliver innovative initiatives for cost-effective, community-based care;<sup>13,26,27</sup> and to prevent disability.<sup>28</sup> The findings clearly show that realising successful care intervention is an undertaking that requires mutual understanding of the expectations and goals of all the parties involved. Recognition of expectations and goal setting is still in its infancy and the main challenge facing caregivers and patients is to create a system that carries out these tasks as standard procedure. This study has also outlined the main requirements of a system like this. On a short-term interim basis, practical measures for strengthening care coordination would likely improve primary care for older people. In the longer term,

a digitally accessible system of care plans, where patient information is recorded, could further improve the system. GPs and nurses lacked knowledge and expertise on how to cope with cases of complex care and multimorbidity, emphasising the need for specialist training for nurses and GPs in these areas. Caregivers as well as patients expressed difficulties in determining their autonomy and discussing goals. These findings underline the need for training on how to discuss topics, such as autonomy, goals, and shared care.<sup>4,16,29,30</sup> The number of older patients with multiple problems calls urgently for well-organised health care at local and regional levels that takes special account of patients' views and priorities to stimulate patient empowerment and patient-centredness. Further improvement is needed in health care for older people and research should focus on these requirements.

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