

Are Our Hospitals Geriatric Friendly? A Study at a Tertiary Care Centre of Northern India

Shahnawaz Hamid¹, Farooq A Jan², Haroon Rashid³, Susan Jalali⁴, Malik Aubid⁵

ABSTRACT

Introduction: Older adults comprise majority of people receiving hospital services in many regions of our country. The Present Research was carried out to see physical facilities and problems faced by Geriatric patients in a tertiary care hospital.

Material and Methods: It was a prospective type of study undertaken on elderly people based on Questionnaire. Cases were selected by Systematic Random sampling method by picking every 5th patient of the target population after checking the admission files in all wards. A total of 421 cases selected through systematic random sampling were studied. The questionnaire was developed and validated by a pilot study. The study population in the study were elderly (Geriatric) group of people with age = or > 60years as per their medical record. All those patients who do not agree to participate in the study and those patients who were comatose or on ventilator were excluded from the study.

Results: Various parameters studied were Waiting time, availability of wheel chair / stretcher, separate counters at admission, nursing aides; difficulties in locating admission office, in getting the investigations done; 'Respect for age' and privacy, Routine cleanliness, pattern of toilets, Quality/Quantity of food served, Information given at discharge about the management at home.

Conclusion: The study on conclusion establishes that hospitals need to be made Geriatric friendly and Hospital management needs to introduce practicum in order to train and retrain the hospital patient care staff including doctors and nurses to improve their behaviour and skills to deal with the elderly patients so that their stay in the hospital is facilitated.

Key words: Geriatrics, Questionnaire, Friendly Hospitals

public pressure, meeting the challenges of hospitalization for this population is not an easy task for any healthcare organization.¹ As the number of older adults is increasing, acute care hospitals must rethink their views of caring for older adults. The Present Research was carried out to see physical facilities and problems faced by Geriatric patients in a tertiary care hospital.

MATERIAL AND METHODS

The study was carried out in Inpatient department of Sherikashmir Institute of medical Sciences (SKIMS) Srinagar, a 783 bedded tertiary care facility. It was a prospective type of study undertaken on elderly people based on Questionnaire. Cases were selected by Systematic Random sampling method by picking every 5th patient of the target population after checking the admission files in all wards. A total of 421 cases selected through systematic random sampling were studied. The questionnaire was developed and validated by a pilot study. The study was done from 1st January 2013 to 31st December 2013 (i.e for a period of one year) for data collection and observations. The study population in the study were elderly (Geriatric) group of people with age greater than or equal to 60 years (> 60years) as per their medical record. All those patients who do not agree to participate in the study and those patients who were comatose or on ventilator were excluded from the study.

RESULTS

Older adults are admitted to our hospitals through either the Emergency Department or the Preadmission Clinic for preplanned and booked procedures (Routine). Although opportunities to prevent, predict and treat remediable problems exist throughout the hospital stay, the Preadmission Clinic offers an advantage, because once high-risk elders are identified, an opportunity exists to manage their care differently. Managing care differently involves appropriate

INTRODUCTION

Today, healthcare professionals understand that caring for children in hospital is not the same as caring for adults. However, although we recognize that children need to be treated differently, we fail to recognize the same is true for older adults. The failure to recognize this difference is contributing to delayed recovery and poor outcomes.

Current literature is fraught with stories of how risky hospitalization can be for an older adult and demographics in our country indicate that our aging population will mean an increasing number of older adults will be using hospital services in the future- reasons why worrying about older adults in hospital is so important. Even with the best intentions, being in hospital can set up a cascade of events for older adults and their families that result in longer lengths of stay and functional disability.

In a climate of fiscal restraint, competing priorities and

¹Senior Resident, Hospital Administration, SKIMS, ²Additional Professor, Hospital Administration, SKIMS, ³Assistant Professor, Hospital Administration, SKIMS, ⁴Resident Medical Officer, SKIMS, ⁵Medical officer Govt. health services, Kashmir

Corresponding author: Dr. Shahnawaz Hamid, Near Professor Colony, Kanitar, Naseemabad, Sadrabal, Srinagar, J&K, 190006.

How to cite this article: Shahnawaz Hamid, Farooq A Jan, Haroon Rashid, Susan Jalali⁴, Malik Aubid. Are our hospitals geriatric friendly? a study at a tertiary care centre of Northern India. International Journal of Contemporary Medical Research 2018;5(6):F1-F6.

DOI: <http://dx.doi.org/10.21276/ijcmr.2018.5.6.15>

Admission	Specialty	Waiting time to reach Ward							
		1-2 days;		2-4 days		5-6 days		4> 1 week	
		n	%	n	%	n	%	n	%
Emergency	Medical	16	13	38	30	71	56	1	1
	Surgical	15	18.30	43	52.44	23	28.05	1	1.3
P-Value		< 0.0001							

Table-1: Waiting time of Elderly to reach ward from Emergency viz a viz specialties

Admission	Specialty	Availability of Wheel Chair/Stretcher		Availability of Separate counter for elderly at admission		Availability of nursing aid to accompany to ward	
		Yes	No	Yes	No	Yes	No
		Emergency	Medical	107 (84.92%)	10 (15.08%)	-	126 (100%)
	Surgical	77 (93.9%)	5 (6.1%)	-	82 (100%)	-	82 (100%)
Routine	Medical	113 (79.57%)	29 (20.43%)	-	142 (100%)	-	142 (100%)
	Surgical	51 (71.83%)	20 (28.17%)	-	71 (100%)	-	71 (100%)
P-Value		0.002					

Table-2: Availability of various facilities to elderly after admission viz a viz specialties

Admission	Specialty	Difficulty faced in locating admission office						Difficulty faced in locating wards					
		With no difficulty		With some difficulty		With much difficulty		With no difficulty		With some difficulty		With much difficulty	
		n	%	n	%	n	%	n	%	n	%	n	%
Emergency	Medical	50	39.7	66	52.3	10	8.0	62	49.2	50	39.7	14	11.1
	Surgical	26	31.7	47	57.3	9	11.0	32	39.02	44	53.7	6	7.31
Routine	Medical	64	45.0	70	49.3	8	5.7	64	45.0	70	49.3	8	5.7
	Surgical	39	55.0	30	42.3	2	2.8	40	56.3	28	39.5	3	4.2
P-Value		0.04						0.20					

Table-3: Difficulty faced by elderly in locating various areas of hospital viz a viz specialties

Admission	Specialty	Difficulty faced in locating bed in ward		Difficulty faced in investigations		Did Doctor/Nurse Involved you in decisions		Did Hospital Staff did everything to control your pain	
		Yes	No	Yes	No	Yes	No	Yes	No
		Emergency	Medical	49 (38.89%)	77 (61.11%)	69 (54.76%)	57 (45.24%)	52 (41.27%)	74 (58.73%)
	Surgical	38 (46.34%)	44 (53.66%)	46 (56.10%)	36 (43.90%)	24 (29.27%)	58 (70.73%)	34 (41.46%)	48 (58.54%)
Routine	Medical	48 (33.80%)	94 (66.20%)	66 (46.48%)	76 (53.52%)	65 (45.77%)	77 (54.23%)	85 (59.86%)	57 (40.14%)
	Surgical	22 (30.90%)	49 (69.01%)	32 (45.07%)	39 (54.93%)	33 (46.48%)	38 (53.52%)	41 (57.75%)	30 (42.25%)
P-Value		0.05		0.05		0.04		0.02	

Table-4: Difficulty faced by elderly in wards and behaviour of staff towards elderly viz a viz specialties

Admission	Specialty	Explanation of management of Ailment by Doctor/Nurse					
		Poor		Average		Good	
		N	%	N	%	N	%
Emergency	Medical	26	20.6	49	38.9	51	40.5
	Surgical	13	15.9	45	54.8	24	29.3
Routine	Medical	20	14.09	62	43.66	60	42.25
	Surgical	11	15.5	26	36.6	34	47.9
P- Value		0.17					

Table-5: Explanation of management of illness to elderly viz a viz specialties

Admission	Specialty	Respect for Age			Respect for Privacy			Response to Call	
		Never	Some-times	Usually Always	Never	Some-times	Usually Always	Poor	Good
Emergency	Medical	29 (23.01%)	51 (40.48%)	46 (36.51%)	79 (62.70%)	2 (1.59%)	45 (35.71%)	35 (27.7%)	91 (72.23%)
	Surgical	22 (26.8%)	42 (51.3%)	18 (21.9%)	49 (59.76%)	3 (3.66%)	30 (36.58%)	24 (29.26%)	58 (70.74%)
Routine	Medical	22 (15.49%)	67 (47.18%)	53 (37.33%)	85 (59.86%)	1 (0.71%)	56 (39.43%)	29 (20.42%)	113 (79.58%)
	Surgical	15 (21.12%)	30 (42.26%)	26 (36.62%)	47 (66.20%)	0 (0.0%)	24 (33.80%)	18 (23.35%)	53 (74.65%)
P-Value		0.14			0.24			0.13	

Table-6: Degree of respect to elderly viz a viz specialties

Admission	Specialty	Routine Cleanliness of ward/room/bed			Cleanliness of Toilets and Bathrooms used		
		Poor	Average	Good	Poor	Average	Good
Emergency	Medical	18 (14.29%)	50 (39.68%)	58 (46.03%)	49 (38.89%)	51 (40.48%)	26 (20.63%)
	Surgical	11 (13.41%)	38 (46.34%)	33 (40.25%)	33 (40.25%)	38 (46.34%)	11 (13.41%)
Routine	Medical	20 (14.08%)	57 (40.14%)	65 (45.78%)	65 (45.78%)	48 (33.8%)	29 (20.42%)
	Surgical	11 (15.49%)	27 (38.03%)	33 (46.48%)	31 (43.66%)	27 (38.03%)	13 (18.31%)
P-Value		0.83			0.25		

Table-7: Satisfaction of elderly in relation to cleanliness viz a viz specialties

Admission	Specialty	Did Pattern of Toilets Suit Your Age	
		Yes	No
Emergency	Medical	0	126 (100%)
	Surgical	0	82 (100%)
Routine	Medical	0	142 (100%)
	Surgical	0	71 (100%)

Table-8: Satisfaction of Elderly in relation to pattern of toilets viz a viz specialties

Admission	Specialty	Quality/Quantity of food Served						Temperature of Hot meals					
		Average		Good		Poor		Average		Good		Poor	
		n	%	n	%	n	%	n	%	n	%	n	%
Emergency	Medical	31	24.6	95	75.4	0	0.0	20	15.9	104	82.5	2	1.6
	Surgical	11	13.4	71	86.6	0	0.0	9	11.0	70	85.4	3	3.6
Routine	Medical	40	28.1	102	71.9	0	0.0	31	21.8	109	76.8	2	1.4
	Surgical	21	29.5	48	67.6	2	2.9	13	18.3	57	80.2	1	1.5
P-Value		0.04						0.09					

Table-9: Satisfaction of Elderly in relation to meals viz a viz specialties

and timely consultations with geriatricians, patient and family education, and patient-centered interdisciplinary team process units that anticipate potential problems and intervene appropriately.

Waiting time of elderly subjects constituted the time taken by elderly patients admitted through emergency department to reach their respective medical /surgical specialty. Observation for waiting time to reach ward' (as shown in Table 1) revealed that majority of geriatric patients (56%) admitted through emergency from medical side reached to

their wards in '5-6 days' while majority of patients (52.4%) from surgical side reached to wards in '2-4 days'.

Studying the physical facilities available for geriatric patients observations revealed that regarding availability of wheel chair / stretcher (as shown in Table 2) among patients admitted through Emergency, majority 84.9% in medical side and 93.9% in surgical side said that wheel chair / stretcher was available to them when needed.

Regarding availability of separate counters for elderly at admission (as shown in Table 2) revealed that all Geriatric

Admission	Specialty	Did you need to complain		How would you rate the way complaint was handled		
		Yes	No	Poor	Good	Excellent
Emergency	Medical	48 (38.09%)	78 (61.91%)	73 (57.93%)	41 (32.53%)	12 (9.54%)
	Surgical	33 (40.24%)	49 (59.76%)	46 (56.10%)	30 (36.58%)	6 (7.32%)
Routine	Medical	52 (36.61%)	90 (63.39%)	78 (54.93%)	54 (38.03%)	10 (7.04%)
	Surgical	20 (28.17%)	51 (71.83%)	39 (54.93%)	30 (42.25%)	2 (2.82%)
P-Value		0.27		0.21		

Table-10: Responsiveness to elderly complaints viz a viz specialties

Admission	Specialty	Information given at discharge about the management at home		
		Poor	Average	Good
Emergency	Medical	4 (3.17%)	53 (42.06%)	69 (54.77%)
	Surgical	1 (1.22%)	45 (54.88%)	36 (43.90%)
Routine	Medical	1 (0.70%)	55 (38.73%)	86 (60.57%)
	Surgical	2 (2.82%)	28 (39.44%)	41 (57.74%)
P-Value		0.16		

Table-11: Information given to elderly regarding discharge viz a viz specialties

patients who were admitted through Emergency and routine found non-availability of separate counter for Elderly at admission office.

All Geriatric patients admitted via Emergency and OPD (Routine) admitted that there was no nursing aide available for them to accompany them to ward.

Comparing difficulties in locating admission office and wards (as shown in Table 3) it was seen that majority of patients admitted through Emergency (52.3% on medical side and 57.3% on surgical side) faced 'some difficulty' in locating admission office while in routine Geriatric admissions majority from medical side (49.3%) and surgical side (55.0%) faced 'some difficulty' and 'no difficulty' respectively in locating admission office.

Overall the statistics showed that around 40-50% of Geriatric patients from over all selected cases faced 'Some difficulty' in locating wards.

Upon arrival in the ward assessment of difficulties faced by geriatrics in many areas was made. Observations (as shown in Table 4) revealed that majority of patients admitted through Emergency (61.1% on Medical side and 53.66% on surgical side) and Routine (66.20% on Medical side and 69.01% on surgical side) faced no difficulty in locating bed in ward while as largest group among overall geriatric patients which faced difficulty were admitted through Emergency and belonged to surgical and allied specialties (46.34%).

Majority of Geriatric patients admitted through Emergency (54.76% from medical side and 56.10% from surgical side) faced 'difficulty' in getting the investigations done while majority of patients admitted through Routine (53.52%

from medical side and 54.93% from surgical side) faced 'no difficulty' in investigations.

Comparing Decision involvement of Geriatric patients regarding their ailment by Doctor / Nurse revealed that majority of old patients admitted through Emergency (58.73% on medical side and 70.73% on surgical side) and Routine patients (54.23% on medical side and 53.52% on surgical side) were 'not involved'. (as shown in table 4)

Likewise majority of geriatric patients who were admitted through Emergency and belonged to medical side (53.17%) said that 'hospital staff did everything to control their pain' while majority from surgical Emergency side (58.54%) revealed that hospital staff 'was not able to control their pain' to their satisfaction. Among routine admitted patients majority (59.86% from medical side and 57.75% from surgical side) said that everything was done by staff to control their pain.

Explanation of management of ailment by Doctor/Nurse among Geriatric patients (as shown in Table 5) showed that in majority (40.5%) of patients admitted through Emergency belonging to Medical category agreed that explanation of management of ailment was 'Good' while as it was 'average' (54.8%) among surgical patients admitted through Emergency.

15-20% of patients from both categories (Emergency and Routine) revealed that management of ailment was 'poorly' explained to them.

Comparing 'Respect for age' (as shown in Table 6) by ward staff revealed that majority of old age patients admitted through Emergency (40.48% from medical side 51.3% from Surgical side) were 'sometimes respected' for age while 36.5% from medical and 21.9% from surgical side belonging to same emergency group were 'always respected' for age.

A significant Percentage of patients were seen in both Emergency (23.1% on medical side and 26.8% on surgical side) and routine (15.49% on medical side and 21.12% on surgical side) stated that they were never respected for age. (as shown in table 6)

Respect for privacy (as shown in Table 6) was assessed viz a viz Geriatric patients which showed that Majority of patients admitted through Emergency (62.70% from medical side and 59.76% from Surgical side) and through Routine (59.86% from Medical side and 66.2% from Surgical side) were shown 'no respect' for privacy.

Comparing response to call revealed that majority (70-80%) of patients from emergency and routine side of both specialties were given 'good' response to their call.

Geriatric patients were enquired about Routine cleanliness of ward/room/bed they were in (as shown in Table 7) and it showed that majority of patients admitted through emergency who belonged to medical side (46.03%) said that cleanliness was 'good' while majority of Surgical Emergency patients (46.34%) revealed that cleanliness of their ward and bed area was 'average'. Similarly in Routine admissions majority of medical (45.78%) and Surgical (46.48%) admissions admitted that cleanliness of ward/bed they were in was 'good'.

Likewise cleanliness of toilets and bathrooms was compared viz a viz medically and surgically admitted Geriatric patients (as shown in Table 7) where it was seen that majority of those admitted from emergency (40.48% from medical side and 46.34% from surgical side) revealed that cleanliness of toilets and bathrooms was average while majority of old aged patients from routine admissions (45.78% from medical side and 43.66% from surgical side) said that cleanliness of toilets and bathrooms was poor.

When geriatric patients were asked about pattern of toilets in their wards (as shown in Table 8) and all (100%) of them said that pattern of toilets does not suit their age.

Regarding Quality/Quantity of food served to Geriatric patients (as shown in Table 9), it was seen that majority of patients admitted through emergency and routine had no complaint regarding food served. They were satisfied with the Quality and Quantity of food served to them.

Similarly majority of Geriatric patients admitted through emergency and routine revealed that temperature of meals was 'good'.

Upon asking Geriatric cases that did they need to complain regarding any problem (as shown in Table 10), majority of Geriatric patients admitted from emergency (61.91% from medical side and 59.76% from surgical side) said that there was no need for them to complain while significant portion of emergency patients belonging to surgical side (40.24%) revealed that they 'complained' about their problems.

Majority of Geriatric patients admitted through emergency (57.93% from medical side and 56.10% from surgical side) and routine (54.93% from medical side and same 54.93% from surgical side) revealed that their complaint was 'poorly' handled and they were totally not satisfied.

Information given at discharge to Geriatric patients about the management at home (as shown in Table 11) was assessed viz a viz medical and surgical specialties, it was seen that majority of patients admitted through emergency belonging to medical side (54.77%) and routine admissions (60.57% from medical side and 57.74% from surgical side) were of the opinion that information given to them at discharge was 'good' while majority of patients admitted through emergency and belonging to surgical side (54.88%) revealed that information given at discharge was 'average'.

Finally suggestions were sought from Geriatric patients regarding improvement of Geriatric set up in SKIMS.

These suggestions were sought irrespective of specialty the patients were in. The following were the suggestions given by Geriatric patients for health care set up at SKIMS.

All Geriatric patients (100%) suggested that there should be a separate ward for elderly people.

Majority of Geriatric patients suggested that there should be more man power to support geriatric care, more wheel chairs for their benefit, special architecture like high toilet seats, railings in Beds and bathrooms, non-slippery floors.

Majority of Geriatric patients (65%) suggested that there is need of social workers for Geriatric patients particularly for those who are unknown or unattended.

94.5% of Geriatric patients suggested that there should be a separate prayer room for them.

All Geriatric patients suggested that there should be a separate admission counter, Drug counter and investigation counter for their age.

88% geriatric patients suggested that medicines and investigations should not be charged for their age.

Majority of Geriatric patients (90%) said that there should be Government financing for their health expenditure.

Majority of Geriatric patients suggested that there should be a separate facility for Geriatric people and that facility should be disabled friendly, should maintain confidentiality and there should be an easy access to other specialties for their age group.

DISCUSSION

Traditionally, hospital care has specifically focused on the primary reason for admission, the presenting diagnosis. This is important in dealing with a biological crisis when the primary goal is to save the patient's life. However, older adults come to hospital with all of their complex health concerns and social circumstances. It is therefore necessary to move beyond the traditional assessment and treatment plan to include all the unique needs of the population.

The objective of the study was to find out the problems faced by geriatric inpatients from Admission in a hospital to discharge.

Comparing the results with a multicenter Cross-Sectional Survey by Yonathan Freund, MD et al² revealed that in the multivariate analysis, age greater than 75 years was independently associated with an exceeded target waiting time.

The study 'Satisfaction Survey of Accident and Emergency Department in a Tertiary Care Hospital of SKIMS' conducted by asmat et al³ revealed that in patients admitted in A/E 58% responded positive for availability of trolley, wheel chair of patients to and fro from A/E department.

Results of study by Wissendorff Ekdahl, et al⁴ revealed that elderly patients complained that they were less informed regarding their treatment than was their preference. Another study by Taimur Saleem et al⁵ conducted at a tertiary care hospital in Pakistan revealed that 79.2% respondents ranked discussing treatment options and letting patient make final decisions as a very important expectation.

Another study "Elderly patient satisfaction with quality of

pain management” by Raftopoulos et al⁶ revealed that the vast majority of elderly patients were totally satisfied with their pain management (92.8%), with the way doctors managed their pain (96.3%) and the way nurses managed their pain (92.1%).

Study conducted by Gromulska L et al⁷ revealed that over 80% of patients felt that medical staff responded to their requests and concerns. High percentage of patients assessed positively the cleanliness of linen (89%), followed by the general indoor room appearance, cleanliness of hospital room, toilet, showers and bathtubs, and availability of soap (40-50%).

When geriatric patients were asked about pattern of toilets in their wards and all (100%) of them said that pattern of toilets does not suit their age. All the cases from medical and surgical side had same opinion. There was not a single Geriatric patient who said that pattern of toilets is suiting their age. Comparing it with survey of hospital toilet facilities conducted by A F Travers et al in 1992⁸ where it was revealed that although the quality of toilet facilities varied, none met the standards recommended by the British Standards Institution.

Research by Ajaz Mustafa et al⁹ revealed that overall satisfaction with all the aspects of the food served was satisfactory (69.85% rated food services “Good”). The effect of patient demographic characteristics and the type of diet served did not have considerable effect on the overall satisfaction levels.

Research by Anne Wissendorff Ekdahl et al¹⁰ revealed that the discharge information was often given in an indirect way as if other, albeit absent, people were responsible for the decision.

CONCLUSION

The study on conclusion establishes that hospitals need to be made Geriatric friendly in the form of availability of separate admission counters, medical social workers for assistance and making delivery of care free of charges for elderly patients. Hospital management needs to introduce practicum in order to train and retrain the hospital patient care staff including doctors and nurses to improve their behaviour and skills to deal with the elderly patients so that their stay in the hospital is facilitated.

REFERENCES

1. Definition of Geriatrics Wikipedia <http://en.wikipedia.org/wiki/Geriatrics>
2. Y Freund, C Vincent-Cassy, B Bloom, B Riou, P Ray. Association between age older than 75 years and exceeded target waiting times in the Emergency Department: a multicenter cross-sectional survey in the Paris metropolitan area, France. *Annals of emergency medicine*. 62 (5): 449-456.
3. Asmat, Haroon Rashid, Shahnawaz Hamid, Muneer A Bhat, Arshad Pandit. Satisfaction Survey of Accident and Emergency Department in a Tertiary Care Hospital of SKIMS. *International Journal of Health Sciences and Research* 2014;4; 223-227.

4. Wisendorff Ekdahl et al. The challenge of participation in medical decision making. Linköping University Medical Dissertations No. 1297, 2012; Department of Social and Welfare Studies Faculty of Health Sciences Linköping University, Sweden www.liu.se
5. Taimur saleem, Umar Khalid, Waris Qidwai. Geriatric patients expectations of their physicians, findings from a tertiary care hospital in Pakistan. *BMC health services research* 2009; 9: 205.
6. Raftopoulos V. et al Pain, satisfaction with quality of pain management and depressive symptoms in elderly hospitalized patients. *ICUs and Nursing Web Journal*. 2005; 21(68).
7. Gromulska L, Supranowicz P, Wysocki MJ. Responsiveness to the hospital patient needs in Poland. *Rocz Panstw Zakl Hig*. 2014;65:155-64.
8. A F Travers, E Burns, N D Penn, S C Mitchell, G P Mulley. A survey of hospital toilet facilities. *BMJ*. 1992; 304: 878-879.
9. Ajaz Mustafa, Haroon Rashid, Dara Singh, G.J. Qadri. Dietary Services viz-a-viz Patient Satisfaction at a Tertiary Care Hospital. *JK-Practitioner* 2008;15(Suppl. 2): S13-S15.
10. Anne Wissendorff Ekdahl, Märit Linderholm, I Hellström, Lars Andersson, Maria Friedrichsen. Geriatric medicine ‘Are decisions about discharge of elderly hospital patients mainly about freeing blocked beds?’ A qualitative observational study. *BMJ Open* 2012;2:e 002027

Source of Support: Nil; **Conflict of Interest:** None

Submitted: 23-05-2018; **Accepted:** 25-06-2018; **Published:** 06-07-2018