Emergency room referrals to a geriatric outreach team: The analysis of referral reasons.

by

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Abstract

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The purpose of this study was to explore the referrals that were generated from one hospital emergency room to a community outreach team. This study used a specific geriatric program assessment team in Winnipeg, Manitoba, Canada as the community outreach team.

Malcolm Payne's description of Task Centered Casework and Crisis Intervention and Irene Pollin's Medical Crisis Counseling served as the theoretical structure and design to gain an understanding of the reasons geriatric patients were referred to the GPAT on discharge.

This study aimed to answer three research questions:

1) What is the emergency room medical team's main reason for referral to a geriatric outreach team?
2) Are the referrals received from the emergency room medical team clearly identifying psychosocial issues as areas for examination by an outreach team?
3) Are psychosocial issues identified only after an outreach team clinician completed a comprehensive assessment?

This study revealed that out of the 209 referrals to geriatric program assessment team, the highest number of times referred was for functional decline. It revealed that the

emergency room medical team saw functional decline as a valid reason to have the geriatric program assessment team assess the individual in their home settings to ensure that any functional issue be addressed and possible adaptations made in a timely manner to avoid the reverberation that one ailment can set off. The second most common reason for referring to the geriatric program assessment team was for social issues. Forty percent of the referrals identified that there were concerns in relation to social issues which clearly identifies that the emergency room medical team identified psychosocial issues as an area for further examination.

And finally, the findings show psychosocial issues were not identified only after an outreach team clinician completed a comprehensive assessment, but that both appear cognizant of the interplay between medical issues and social issues.

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Contents

Key Words: Older adults; geriatrics; elderly; emergency department/room; acute care; geriatric assessment; outreach teams; geriatric care; alcoholism; social isolation; networks; caregiver burden; abuse; depression; anxiety; social issues; isolation; mood issues; depression; anxiety; dementia; delirium; cognition; cognitive changes.

Chapter I

Introduction

The compounding effects of social issues, physical issues and medical issues are all difficult to consider separately. Those in the health care arena must be cognizant of the interplay between medical, physical, and social issues in the geriatric population. The impact of one problem may set off reverberations that may be reflected in all spheres of the individuals functioning. Without incorporating the psychosocial perspective, diagnosis is likely to be inaccurate, and therefore, intervention is less likely to be effective (Brown et al., 1995).

An Emergency Room Medical Team is the group that may initially encounter geriatric patients at a time of crisis, and it is crucial for the emergency room medical team to understand the interplay of one issue onto another and the effects on a persons overall health and well being. It is these groups of professionals that are valuable in terms of referring geriatric patients for follow up assessments to programs outside the acute care system such as a geriatric outreach team.

While it is known that emergency rooms do refer to outreach teams in the community, little research has been done to examine the nature of content of the referrals. This research will focus on a specific geriatric outreach team in Winnipeg, Manitoba, Canada. What is left to be determined is whether or not there is a full understanding of the extensive role that these outreach teams' play in relation to social contextual issues.

The conceptual framework for this thesis was an eclectic approach. It was rooted in both Malcolm Payne's (2005) description of social work crisis intervention and task-centered theory as well as combined with Irene Pollin's medical crisis counseling model. Together these models focused on an "individualized brief treatment" (Pollin, 1995). These are "clinical processes that are undertaken in a short amount of time that require efficiency and effectiveness in addressing psychosocial problems related to illness in the acute health care setting at a time of crisis" (Pollin, 1995). The crisis intervention and task-centered theory both "reflect a contemporary emphasis on brief, structured forms of therapy and dealing with immediate rather than long term problems" (Payne, 2005, pg. 117).

This combined framework is woven through the literature review and explained in more detail in later chapters. The focus being the gamut of geriatric information and research within the health care arena, particularly within emergency departments, outreach teams, burden on caregivers, the reality of cognitive or memory changes and/or mood issues, the variety of psychosocial issues that elders might be confronted with, and the social supports that they receive, formally or informally.

Chapter II

Research Interest

2.1 Rationale

As the Emergency Room Medical Team is the group that will initially encounter geriatric patients at a time of crisis, it is crucial for the emergency room medical team to understand the interplay of issues and the overall effects on a person's health and well being. Since psychosocial issues are typically co-mingled with issues related to health and lifestyle resources and services, intervention in such cases must involve a sophisticated set of skills for assessment and intervention.

The pursuit of understanding the reasons for referrals to a community geriatric outreach team from the emergency department was my motivation and rationale for my thesis research. In order to achieve a holistic view of systems which have an impact of an individual's whole health and behavior, medical departments, such as an emergency room, must understand and appreciate the impact that psychosocial issues have on overall well being.

2.2 Theoretical Framework

The conceptual framework for this thesis was eclectic in nature. It was grounded in Malcolm Payne's description of social work crisis intervention and a task-centered model and was weaved into Irene Pollin's medical crisis counseling model. Both the crisis intervention model and task-centered model "are in the traditional lineage of social work problem solving, using a conventional social work individualizing relationship with clients who are treated on a medical model with the aim of getting better" (Payne, 1997). Payne's description of crisis intervention model "focuses on

emotional responses to external events and how to control them rationally" (Payne, 1997, pg. 95). Furthermore Payne pointed out that a crisis intervention model, "uses practical tasks to help people readjust, but an important focus is their emotional response to crises and long-term changes in their capacity to manage everyday problems" (Payne, 1997, pg. 97). He goes on to state that according to A. Roberts (2000), "crisis is a period of disorganization. If resolution is unsuccessful, a person will function less well in the future, and be more liable to bad reactions to later hazardous events" (Payne, 2005, pg. 105).

Payne discussed the task-centered approach based on William Reid & Laura Epstein's work. He pointed out that these authors "acknowledge the influence of crisis intervention on the development of task-centered work" (Payne, 1997, pg. 96). He indicated that task centered work "focuses on defined categories of problems" and, "focuses on performance in practical tasks which will resolve particular problems" (Payne, 1997, pg. 97). Reid and Epstein have indicated," the model is addressed to problems of living that the client can, with help, resolve through his own actions" (1978, pg. 2). They identified eight major kinds of problems dealt with in the approach: interpersonal conflict; dissatisfaction in social relations; problems with formal organizations; difficulty in role performance; problems of social transition; reactive emotional distress; inadequate resources; and physiological and behavioral problems not otherwise categorized, but meeting the general definition of problems in the model (Reid & Epstein, 1978, pg. 2-3). Payne described task-centered practice as a "structured short-term model of working with

specific problems, providing good guidance and well supported by research" (Payne, 2005, pg. 117).

It has been my observation as a geriatric clinician that elderly people entering the emergency room and those that agree to a geriatric assessment are dealing with most or all of the issues that Reid & Epstein identify at any one time. Medical crisis counseling is based on an "integrative theoretical approach that focuses on the manner in which chronic illness disrupts normal developmental tasks and trajectories" (Pollin, 1995). Crisis intervention and a task-centered model intertwined in a medical crisis counseling model was suitable for this particular research. Together the focus was on short term intervention techniques, assisting a person to uncover past coping strategies, and assisting them to use those past skills in a time of a medical crisis in a very concrete action plan.

Chronic illness carries with it stressful life changes that in turn can generate considerable emotional distress. When an illness exacerbates, a frequent result is symptoms of psychosocial distress, such as anxiety, depression, and/or family conflict (Koocher & Pollin, 1994). Unfortunately it is these compounding issues that are easily overlooked by medical personnel whose attention is justifiably focused chiefly on the physical illness. The models used in this research are brief interventions used to address psychosocial problems related to chronic illness in the health care setting. More importantly, the focus of these models is the "aim to help patients understand their reactions as normal responses to a stressful circumstance and to help them function better" (Pollin, 1995).

2.3 Research Interest

Health care professionals that work with the geriatric population must have an understanding of the interplay between social issues, physical issues and medical issues. A need for looking beyond what may be directly presented to them could lead to an effective intervention immediately. The impact of one problem may set off after effects that could then be reflected in all spheres of the individuals functioning. All of these compounding issues can easily be overlooked in an emergency department as their attention is understandably focused predominantly on the physical illness. However, for example, if an elderly patient enters the emergency room with physical complaints such as weakness and immobility, it would be important for the emergency room medical team to follow through with exploring possible reasons behind the entrance complaints. Although the presenting issue in the emergency room may be of one form- such as weakness and immobility, it is important for the emergency room medical team to recognize that there may be underlying issues in other life areas- such as a depression, that the elderly patient can not or will not recognize as fundamental causes or issues.

An important question is whether or not an emergency room medical team understands the comprehensiveness of an outreach teams' assessment by which the focus is based on a holistic viewpoint, not just a medicinal ideology. A comprehensive geriatric assessment encompasses all aspects of health and well being in a detailed evaluation of the client's current functioning in their present environment. This assessment includes the evaluation and identification of any issues relating to the persons medical, physical, pharmaceutical, mental, environmental and social functioning. Any risk potentials are then identified and

further examined. For the purpose of this research, the question is if emergency room medical teams recognize the importance of social issues on a person's health and if they refer to geriatric outreach programs for social issues, or predominantly for medically related issues? In order to answer the questions the focus within this research study was on one geriatric outreach team in Winnipeg, Manitoba, Canada- the Geriatric Program Assessment Team. This is a team that operates under the umbrella of the Winnipeg Regional Health Authority in the Geriatrics & Rehabilitation program. The geriatric program assessment team consists of 6 community teams that consist of a two or three person team for designated areas throughout the city limits. The educational backgrounds of these clinicians range from nursing, social work, occupational therapy and physiotherapy. Each team has a consulting Geriatrician to review all cases with and receive direction from. Each team also has a collaborative hospital to work with; Grace Hospital, Victoria General Hospital, Concordia General Hospital, Seven Oaks General Hospital, St. Boniface General Hospital and Health Sciences Centre. These teams attend to the emergency room departments daily to assist the hospital team and assess patients for geriatric services such as community outreach, day hospital, or geriatric rehabilitation inpatient.

This program has an open referral process which means that anyone with a concern for someone over the age of 65 can put in a referral either by telephone or fax through a central intake line. This particular team focuses on an overall function in the home environment. They see people that may have issues such as declining abilities, increase in falls, difficulty with mobility, polypharmacy issues, mood and

depression concerns, declining memory, bladder/bowel incontinence, caregiver burden or social issues. They assess people within the community and therefore this team does not assess any person in a personal care home. The teams may not assess a person with a diagnosis of ALS (Lou Gehrig's disease) or on a Dialysis Program as these clients have specialized service teams available to them. They do not assess anyone under the age of 65 or anyone who lives outside the Winnipeg Regional Health Authority.

This team has been in operation since 1999 and has continued to grow in awareness steadily since its conception. For the purposes of this research, data was collected over a four year fiscal period, April 1, 2003- March 31, 2007. This time frame was chosen, as it was roughly estimated that there are 100 to 120 referrals a year from the emergency room medical team at the Victoria General Hospital to the Riverview geriatric program assessment team. All data for this team had been collected on a central database and all original charts were secured in the Rehab & Geriatric Program's health records at Deer Lodge Centre under the supervision of the Regional Health Information Coordinator. As the researcher, upon exploration into this database, there was an assurance that all data was centrally stored in the computer database and all original charts were filed, therefore there was a level of confidence in that there were accurate accounts of data for a true collection.

2.4 Research Questions to be investigated

The focus was on a qualitative process using a content analysis approach. In order to accomplish this, the research questions addressed in the study were:

4) What is the emergency room medical team's main reason for referral to a geriatric outreach team?

5) Are the referrals received from the emergency room medical team clearly identifying psychosocial issues as areas for examination by an outreach team?
6) Are psychosocial issues identified only after an outreach team clinician completed a comprehensive assessment?

2.5 Delimitations and Limitations of Study

The limitation of this study was that it proved difficult to identify relevant studies in electronic searches. For example, unless a geriatric assessment team or community outreach team referral reason was a primary study outcome, it was not mentioned in the study abstracts and could only be identified by reading the original article.

There were also four projected delimitations of this study. Firstly, the sample size was limited to one acute care hospital emergency room and one outreach team, which then limits the generalizability of any quantitative findings. In light of this, another limitation was that the findings may not be generalized to other groups of medical teams, other acute care hospitals, or other geriatric outreach teams. Furthermore, as the timeline chosen for this research was over a four-year period, it may not be generalized to other years. Finally, as the researcher and the sole coder/writer, it was acknowledged that there would be certain biases brought into the study. Although one sole perspective must be recognized as a possible biases, the final belief was that it lended itself as a strength as much as a limitation.

2.6 Conceptual Definitions

The following terms are major concepts of this thesis and are defined here to assist the reader to identify their contextual meaning for the purpose of clarifying this work. These terms are based on practical experience and are as followed:

i) Caregiver: "Informal Caregivers are persons who provide unpaid assistance to relatives and friends who have health or functional needs" (Weuve et al., 2000). This does not have to be a family member.

ii) Caregiver Burden: Caregiving that causes "physical, psychological, social, and economic distress" (Weuve et al., 2000). Caregiver burden refers to any signs or symptoms that the person involved in caring for the individual is exhibiting, whether direct or indirectly portrayed by that caregiver.

iii) Cognitive changes or memory loss: Cognitive functioning can include "intelligence, learning and memory" (Nathanson et al., 1998, p.134). Intelligence therefore is defined as "the ability to acquire and comprehend information" (Nathanson et al., 1998, pg 134). Learning is defined as "the process by which new information is put into memory" (Nathanson et al., 1998, p.134). Memory is defined as "the process of retrieving or recalling the information stored in the brain when needed" (Hooyman et al., 1999).

iv) Mood: Mood issues of interest to this research study can be defined as mental health issues relating to depression and anxiety. Depression can be defined through its signs and symptoms. These include "a sad mood, loss of appetite, poor sleeping (particularly early morning waking), guilt feelings, irritability, and suicidal thoughts" (Molinari, 1991, p. 24). Anxiety can be defined as "the general

apprehension toward unidentifiable source or uncertain future events" (Wullschleger et al., 1996, p. 4).

v) Social issues: Social Issues are broad and can become topics of research interest on their own. However for the purpose of this research issues will be described in relation to a) alcohol dependence/abuse, b) elder abuse, and the issue of c) social networks.

Alcohol dependence can be defined as " a medical disorder characterized by loss of control, preoccupation with alcohol, continued alcohol use despite adverse consequences, and physiological symptoms such as tolerance and withdrawal" (Zisserson et al., 2004). Elder abuse is defined through types as "definitions of abuse of older persons vary considerably among researchers and state laws" (Wieland, 2000). Diane Wieland describes the types of abuse as: physical, psychological or emotional, financial, neglect, self-neglect, sexual abuse. She goes further to add 'all other types' which would include "violation of rights, medical abuse and abandonment".

Social networks "are generally viewed as the web of social relationships that surround a person, and the characteristics of those social ties" (Berkman, 1983). Berkman further states that characteristics of social networks for the elderly would include the measurement of size, frequency of contact, density, intimacy, durability, geographic dispersion, and reciprocity (p.73-74).

For the purposes of this research the above terms have been chosen as major concepts as they are the psychosocial issues that are outlined on the Geriatric

Program Assessment Team referral form that any emergency room medical team can check off as an issue that needs to be further addressed.

Chapter III

Literature Review

3.1 Geriatrics in the Emergency Room

"Older persons constitute an increasingly important population served by emergency departments, one that is characterized by multiple co-morbid medical conditions, cognitive and functional impairment, and social problems" (McCusker et al., 2006). According to Health Canada, in 2001, one in eight Canadians (3.92 Million) was 65 years of age or over. By 2021, one in four Canadians will be 65 years or older (6.7 Million) (Minister of Public Works and Government Services Canada, 2002).

A study completed by Aminzadeh and Dalziel (2001) focused on the literature of the patterns of usage in emergency departments among the elderly. These authors reviewed articles from 1985 to 2001 and a qualitative approach was used to synthesize the literature found. The discovery was that there was a "general consensus that the current disease-oriented and episodic models of emergency care do not adequately respond to the complex care needs of older patients experiencing multiple and often interrelated medical, functional, and social problems" (p. 244). Aminzadeh and Dalziel eluded to the benefits of community geriatric outreach teams in that they suggested, "follow up interventions may include a referral to the comprehensive geriatric evaluation and management programs or any other specialized geriatric services available in the community to ensure that the patients' medical and psychosocial needs are addressed in an effective and timely fashion" (p. 244).

Two older studies (Barnett, Harnett & Bond, 1992; Parboosingh & Larson, 1987) also looked at the patterns of utilization of the emergency department and the frequency as well as appropriateness of ER visits. Barnett et al. (1992) found that the elderly population does not use the emergency department for minor health problems and the usage is appropriate (p.92). Parboosingh & Larsen (1987) discovered that almost one half of their sample was also appropriate users of the ER (p. 1143). Interestingly enough they found that the elderly were in fact more appropriate users of the emergency departments than a younger population (p.1146). Even 10+ years ago, as these two older studies indicated, there is significance to the geriatric outreach short-term intervention techniques as these strategies benefit geriatric patients by moving beyond the confines of the emergency department settings and back into their familiar environment (Barnett et al., 1992).

3.2 Geriatric Assessment

Observing and assessing elderly persons in their own environment is often necessary and can be very beneficial. "Home visits can demonstrate to a client that there is interest in helping, and that the client is not alone. It also offers the opportunity for direct observation of the home itself, the family dynamics and client functioning capacity" (Ivry, 1992).

The literature suggests that the elderly population is the cohort group that utilizes the highest proportion of medical care. Comprehensive geriatric assessment involves the evaluation of the medical, functional, psychosocial, and environmental factors that impact on the well being of older adults that is then created into a comprehensive plan of care that is communicated to the older person's family

physician and if appropriate any other health care professional involved in the care of that person. Important areas of the assessment include the evaluation of activities of daily living (ADL's) such as bathing, toileting, dress/grooming etc.; instrumental activities of daily living (IADL's) such as shopping, meal preparation, laundry, financial management etc.; medical/surgical history; cognition; mood; social supports; elder abuse; power of attorney/advance directives; gait and falls/ balance and mobility; nutrition; sensory impairments; incontinence/constipation; polypharmacy; and pain. It is noted that although these areas are important in the assessment, "perhaps the unique aspect of the comprehensive geriatric assessment is its focus on social and safety issues that are often overlooked in the traditional medical encounter" (Devor et al., 1994).

An article of significance was one (Naleppa & Reid, 2000) that focused on persons 65 years and older living in the catchment area of a particular hospital. It was the beginning of a development of a new case management model for community elderly people. It was similar in the geriatric program assessment team (GPAT) as the case-managers also had access to regular conferences with physicians or other disciplines required. The interesting piece of this article is that they used three different practice concepts and synthesized all into one case management intervention model. One of the concepts utilized was of Reid & Epstein's (1977) task-centered model. This model served as a basis for the intervention process. Naleppa & Reid found that this model "consisted of clearly defined and sequenced activities that were collaboratively carried out by both the practitioner and the client to solve problems that were effective for community work with elderly" (pg.

3). Community outreach teams such as the geriatric program assessment team are essentially case managers. Albeit more of a short-term nature as opposed to the characteristically long-term notion of case management, its focus on planning and decision-making is within a brief limited time frame. These authors explained "the clear structure of the model and its emphasis on client participation making and implementing decisions was considered beneficial for the elderly case management client" (Naleppa et al, 2000, pg. 4). A very important point made within this article that is very relevant within an outreach team role, was of the fact that it is often the case that referral is for one primary client. While many caregivers are involved, more attention is ultimately given to the person with the more obvious and urgent needs. However the important aspect of the community intervention is that the "focus of the work may change after the most significant needs are addressed, and potential problems of the caregiver may need to receive more attention" (Naleppa, 2000, pg. 17). This article suggests a task oriented model can be very effective in assisting clients in the community, and although it originally was adapted from a hospital-based program, it can be adaptable to a wide range of situations that are encountered within the geriatric population in the community.

In addition, another interesting study was initiated to evaluate the effects of both the comprehensive geriatric assessment and the multidisciplinary intervention on elderly patients that were sent home from the emergency department (Caplan et al, 2004). It was over an 18-month period and a control group received usual care and an intervention group received follow up in the community for up to 28 days by an outreach geriatric team who implemented or coordinated recommendations.

Caplan et al. found that the intervention group had a lower rate of hospital admission after the initial emergency department visit. Furthermore, they also found that the intervention group maintained a greater degree of physical and mental functioning. Importantly, these authors determined that a multidisciplinary community outreach team utilizing a comprehensive geriatric assessment intervention "can improve health outcomes of older people at risk of deteriorating health and admission to hospital" (Caplan et al., 2004).

The goals of a geriatric assessment "are to improve diagnostic accuracy, guide the selection of interventions to restore or preserve health, recommend an optimal environment, predict outcomes, and monitor clinical change" (Silliman et al., 1999). Most importantly, a community geriatric outreach team completing comprehensive geriatric assessment targets their assessments "to those persons likely to benefit, especially those who are frail, at critical transition points, or in declining health or function" (Silliman et al., 1999). A community geriatric outreach program "serves as a vital link in the continuum of services for the elderly in the community and matching the appropriate service to the needs of the elderly persons is critical to well being, particularly as this encompasses functional and quality of life- enhancing functional well being is the highest goal for geriatric medicine" (Chan et al, 1996).

3.3 Caregiver Burden

Caregiving is not a new phenomenon. Historically, family members were the primary and often only source of support for an elderly person. What has changed is the number of people involved in the direct caregiving, the length of this caregiving role, and the types of caregiving tasks that are performed. Due to the

"increases in life expectancy and the aging of the population, the shift from acute to chronic diseases and their associated disabilities, changes in healthcare reimbursement, and advances in medical technology, caregiving has become commonplace" (Shultz, 2003). Caregiving typically involves "a significant expenditure of time, energy, and money over potentially long periods of time; it involves tasks that may be unpleasant and uncomfortable and are psychologically stressful and physically exhausting" (Schultz, 2003). Caregiving for an elderly family member can cause significant emotional, medical, social, occupational, and monetary problems, and caregiver burden has been found to be a major factor in the institutionalization of an elderly parent (Fulks, et al., 1995). Furthermore, "caregivers can be so overwhelmed that they forego their own medical needs to attend to the needs of those in their care" (Conway-Giustra, 2002). Studies have repeatedly shown that the best predictor of nursing home placement is the inability of the family to maintain the older person at home, not the actual health or functional status of the elderly person. The family may simply be unable to do all that is necessary, and the elderly person may be subjected to forms of neglect either intentionally or unintentionally. However when the stress is extreme, it may culminate in elder abuse.

A valuable study that lends to a further discussion of 'caregiver burden' examined the predictors of emotional strain between spouse and adult child caregivers using the frameworks of role theory and the stress process model. It included 1,296 completed caregiver interviews that only included unpaid spouses and/or adult child caregivers. The author, Suk-Young Kang (2006) identified "the spousal

relationship dyad and parent-child dyad are substantially different when it comes to emotional strain deriving from the caregiver role" (p.123). The level of caregiver's perceived overload had a significantly greater impact on the sense of emotional strain for the adult child caregiver than for the spouse. Essentially it was also found that the role and demands of the spousal caregivers are different than that of a child caregiver role and expectations- adult child caregivers reported significantly higher levels of family disagreement, and spousal caregivers reported significantly higher need to assist with more activities of daily living tasks and with that, longer hours for caregiving per week. An important point that this author identified was, "because emotional strain can result in negative consequences for the caregiver, understanding what predicts such strain allows those who are assisting the caregiver to first prevent it or to lessen it" (Kang, 2006. p. 126). Regardless of who is doing the caregiving, "many caregivers become socially isolated soon after adopting the caregiver role and this has been found to lead to lower levels of psychological well-being" (Cooke et al., 2001). Social support is likely to be beneficial when helping the caregiver adapt to their new 'caregiving role'.

3.4 Cognition

Cognitive changes or memory loss can be defined as any acute or gradual changes in memory. This would include a dementia or a delirium. However, one must be careful in how they use definitions, "definitions are tools, often weapons, not truth" (Achenbaum & Levine, 1989, used in Ronen et al, 1998). One must be aware of the implications for the elderly population, as "being old is in fact, a definition, which has heavy weapons in it if one thinks of a decrease in skills, health, and abilities" (Ronen, 1998). Defining cognitive impairment is one such definition to be careful

with. It is a difficult term to define as, "memory loss is often a subjective symptom rather than an objective one" (Zarit, 1979).

Two older studies (Lamont et al., 1983; Rahkonen et al., 2001) that were done examined the effects of delirium on hospitalized older patients. It was found that "the prevalence of mental dysfunction during hospital stay was quite high: 45 percent of the 205 charts had references to some degree of patient disorientation" (Lamont et al., 1983, pg. 283). Rahkonen et al. (2001) reported that delirium, even in healthy community dwelling subjects, did in fact indicate a poor prognosis. They noted that delirium is unfortunately a common experience among elderly persons who are hospitalized and "elderly patients with delirium have been shown to have poor prognosis and a great risk for functional decline and institutionalization" (Rahkonen et al., 2001, pg. 38).

A more recent study done in Canada (Ritsuko et al., 2003), also focusing on discharge of elderly patients with delirium was done to determine whether a prevalent delirium was an independent predictor of mortality in older patients seen in emergency departments and discharged home without an admission. It was a prospective study done with 18 months of follow up in two Montreal hospital emergency rooms. Medical charts of the enrolled patients were reviewed at the onset and detailed interviews with patients and caregivers were utilized. The subjects were followed up at 6-month intervals for a total of 18 months. The resulting analysis revealed a significant association between delirium and mortality for the first 6 months of follow-up and they found that the subjects whose delirium was not detected by the emergency department staff had the highest mortality over

6 months. This study was useful in that its results clearly suggest that non-detection of delirium in the emergency department may be associated with increased mortality within 6 months after discharge.

3.5 Mood Issues

Depression is a common problem facing older individuals. Aging can be a time of many losses, i.e. loss of spouse, friends, family, and loss of health, decrease in function, loss of complete independence, and loss of home, possessions. Any of these losses can put stress on the older person at a time where they are least likely able to cope with them. "Symptoms of depression include a sad mood, loss of appetite, poor sleeping (particularly early morning waking), guilt feelings, irritability, and suicidal thoughts. Elderly adults also present with concentration problems, preoccupation with physical symptoms, and memory complaints" (Molinari, 1991).

An interesting study (Burnet & Mui, 1994) worth noting was designed to examine the association between life stressors, psychosocial resources, and depressive symptoms for frail elderly persons living alone. It was based on data from a nationwide experiment initiated by the US Department of Health and Human Services, and the sample consisted of 5, 626 frail older persons. Data was collected on persons over the age of 65 years that had severe impairment in personal and /or instrumental ADL's, inability to independently care for oneself over an extended period of time, a fragile informal support system and/or multiple unmet service needs. Both treatment group and control group received a baseline assessment and a follow up interview was completed. Over half of the frail elderly living on their own were 80 years of age or older, almost 80% were widowed and incomes were

low. The authors found that a majority of the sample reported at least one depressive symptom. The findings showed the life stressors that made significant contribution to depressive symptoms were: 1) decline in medical and functional status, 2) unmet activities of daily living (dressing, bathing, feeding) and, 3) instrumental activities of daily living (banking, driving, shopping) needs. Further noted, the disabling effects of depression on daily performance is "as great as those of chronic medical conditions, and when combined, depression can compound dysfunction that may be associated with a medical problem alone" (Burnette et al., 1994).

A qualitative study (Ron, 2002) that utilized a demographic questionnaire in relation to depression and suicide in community dwelling elderly was completed in Israel. This author sought the answer to one question: Which demographic factors predict suicidal ideation among the elderly? Ron found that females were found to have statistically higher levels of suicidal ideation, depression, and a sense of hopelessness. Historically the woman's role was perceived as the one providing care to family members and as a woman ages this role will ultimately diminish and there is a risk that may lead elderly women to feel useless, hopeless and helpless (pg. 65). Furthermore Ron points out the reality that women live longer than men, which would then mean they would suffer more from widowhood. It is important for health care practitioners to note Pnina Ron's findings with respect to the suggestion that single women may be more vulnerable and at a higher risk for mental health problems and should be given more therapeutic attention.

Anxiety is a mood issue that should also be mentioned, as a large proportion of older individuals have complaints of feeling anxious. “The most common forms of anxiety disorders in the older population are generalized anxiety, phobias, and panic disorders” (Hooyman, 1999, pg. 189). And, as with many disorders that can be masked by physical symptoms, it is important to further evaluate when older individuals complain of pain, insomnia, excessive worry and restlessness. Diagnosing older individuals with anxiety is difficult. Symptoms of anxiety can “mimic symptoms of illness such as heart palpitations, shortness of breath, weakness and appetite changes” (Ferrini & Ferrini, 1993, pg. 243). However one must keep in mind that anxiety can “increase feelings of helplessness and isolation, raise susceptibility to several illnesses, and decrease ability to with stand stress” (Ferrini & Ferrini, 1993, pg. 243). Anxiety about generalized worries is one aspect of this disorder, another is about anxiety about aging itself and this can be described as “worry, concern, or nervousness about the ability to care for oneself as anticipated decline in health and eventual death” (Wullschleger et al., 1996). Health care providers must recognize anxiety as an important medical concern for these elderly individuals. When one is faced with uncertainty within their crisis situation, and further situated in a busy emergency room, any one of us- young or old, would have feelings of anxiousness that might need only reassurance and a kind word to help ease that pain. It is important to consider any therapeutic approach for mood issues in context of that person’s situation and ‘where they are at’. Keeping in mind that “late-life mental illness is so closely associated with functional disability” (Kennedy, 2000), the utilization of a specialist with the

ability to complete a comprehensive geriatric assessment is most likely to lead to optimum treatment for the elderly person in the community.

3.6 Social Issues

This is a wide topic to cover. As mentioned in the definition of terms, for the purpose of this study and with respect to the emergency room referral reasons to an outreach geriatric team, the focus will be on the issues of a) alcohol abuse, b) elder abuse, and c) social support. These issues were chosen as they are prominent concerns that a geriatric program assessment team clinician would face in the community.

3.6 (A) Alcohol Dependency/Abuse

Reasons for alcohol dependency/abuse in the older population are numerous and often complex. Multiple stresses of aging encountered by older adults include retirement, loss of a sense of a perceived productive role, declining health, chronic pain or disability, financial difficulties, lack of social support, and death of a spouse or other loved ones. "Older adults engaging in problem or at-risk use are drinking at a level that either has resulted in, or substantially increases the likelihood of, adverse medical, psychological or social consequences. Individuals engaging in problem or at-risk drinking often do not meet criteria for alcohol dependence" (Zisserson, et al., 2004). Criteria normally used to define alcoholism may not pertain to the elderly population. "The lifestyle disruptions that result from heavy alcohol use are often absent in the elderly. The elderly are less likely to have serious problems with the police and the legal system" and "compared with younger alcoholics, elderly drinkers have fewer signs and symptoms of

alcoholism" (Olsen-Noll et al., 1989). As some of the classic symptoms of dependence such as employment or legal problems are not present, older adults and health care professionals may underestimate the risks of alcohol consumption. "At-risk or problem drinking has been demonstrated to lead to injuries from falls, depression, memory problems, liver disease, cardiovascular disease, cognitive changes and sleep problems" (Zisserson, et al., 2004).

A recent study done in 2003 focused solely on research papers and articles in Pub Med (O'Connell et al., 2003). The papers and articles discovered were specifically related to alcohol use disorders in elderly people and these authors focused on: how common the problem was; possible reasons for under-detection and misdiagnosis; the effects of alcohol use disorders in elderly people; potential health benefits; treatment of alcohol use disorders in elderly people; and how can professionals improve the approach to this problem. They identified 10% of older patients as having current evidence of alcoholism, yet fewer than half of these patients had any mention of alcohol misuse in their medical records (pg. 665). The authors further indicated that elderly people may be less likely to discuss a history of alcohol intake, and the problem is compounded by the fact that healthcare workers have a lower degree of suspicion when assessing older people as workers see alcohol use in older people as being understandable in the context of poor health and changing life circumstances (pg. 665). With respect to the increase of alcohol use and its effects, reported are "more major illnesses, notable poorer self perceived health status, increased visits to the doctor, more depressive symptoms, documented less satisfaction with life, and a smaller social network than non-heavy drinkers or

people who have never used alcohol" (pg. 665). Sadly, the authors found that few studies of treatment for alcohol use have included older people. Their findings have indicated that alcohol use in older people must be redefined if health professionals are to be sensitive to this common but hidden problem.

A study done in 1991 by Elizabeth McInnes and Janet Powell showed how easily medical staff did not recognize substance misuse in three hospital settings in Australia. They used a cross sectional design where they had a random sample of 640 hospital inpatients aged 65 and older from three hospitals daily admission lists. Patients were interviewed at their bedside and asked about frequency, quantity and duration of use. The authors also used a piloted questionnaire to randomly sampled medical staff designed to elicit their opinions on problem use among older adults in their care. They had found that "in this study a high percentage of elderly substance users were missed and intervention was unlikely" (McInnes, et al., 1994). What is important to note is that there were several factors that McInnes & Powell found that may hinder identification of misuse in the older population. They identify that "medical staff may perceive their role to be one of diagnosing and treating only conditions related to admission, with long term use of benzodiazepines, alcohol, and tobacco being seen as a matter for general practitioners". Secondly, attitudes were an important factor as, "some staff indicated a belief that to advise older people to give up established habits is inappropriate. Thirdly, "history taking regarding drug use may be less accurate in older people with a multiplicity of health problems and perceptual impairment". And fourthly, "doctors' diagnoses may be influenced by the availability of specialist advice and treatment" (McInnes

et al., 1994). The authors stated that there needs to be a greater awareness of dealing with problems of any substance misuse in the elderly population and that there should be an increased emphasis on medical education with respect the importance of this problem in the elderly.

3.6 (B) Elder Abuse

Elder abuse can be of many forms. It is a serious problem and often overlooked. Professionals must realize that many individuals may not be cognitively able to explain the situation adequately and others may be afraid of caregivers, on whom they are dependent. Definitions of elder abuse are far and wide in the literature and there are many reasons why older people are abused. The most common include "deteriorating family relationships, caregivers who have been abused themselves, social isolation, psychopathology of the abuser, and imbalance of power between abused and abuser" (Bradley, 1996). The reality is that caring for a sick, dependent elderly person is a challenge for even the most capable person. Bradley (1996) points out that when caregivers to older people have little support from within the community they may suffer intolerable strain and this may lead to elder abuse. Potential issues for caregivers that lead to disturbed sleep, having to deal with difficult behavior, and cleaning up after bladder/bowel incontinence can result in severe strain on the caregiver and may potentially set the scene for abuse. "Many caregivers express feelings of frustration, despair, and worry and of not being cared for themselves. They often feel that the situation is beyond their control. Difficult situations are often compounded by strained family relationships where, for instance, a son or daughter feels a duty to care for a parent of whom they have

never been particularly fond or who has treated them badly in the past" (Bradley, 1996). The reality is that as the older population continues to grow, so will the incidences of abuse. Health care professional must be able to assess for and be comfortable with interviewing older persons and their caregivers. "Framing elder abuse as a geriatric syndrome provides a conceptual starting point from which the physician and health care professional can begin to address mistreatment from screening to management" (Bomba, 2006, pg. 111).

A recent, qualitative study was competed in 2006 (Beaulieu et al.) with respect to elder abuse. Sixteen participants that had extensive work experience with an elderly clientele in situations of elder abuse were interviewed. These practitioners were asked to describe their experiences in relation to the interventions for abused older clients and their abusers. They were also asked to express themselves with regards to their practice by using actual cases. The findings showed that the reality for a professional involved in dealing with mistreatment is that there is never an answer to the question- how far do we go? Further these authors identified that health care professionals must be aware of "what mistreatment entails, how it is recognized, how to intervene with the victim, how to work with the abuser, and what legal and social possibilities exist in offering support" (Beaulieu et al., 2006). Elder abuse needs to be looked for, quantified, and treated. Unfortunately, "because of lack of a lack of time, resources, and a general lack of recognition of the problem, many cases may go undetected and untreated, putting elderly at heightened risk of physical and mental harm, and even death" (Lang, 2005).

3.6 (C) Social Networks

Social networks represent an important area of study because, unlike aging or health status, members of a person's intimate circle can develop with relative ease. We can't stop aging, and our capacity to affect our health as we age is limited, but we may be able to build social networks, adjust our living arrangements or otherwise change our behavior to get the care we may need.

A study, based on longitudinal data from the U.S. National Population Health Survey in 1994/95 of senior household residents over a six-year period, Kathryn Wilkins (2003) analyzed results in order to determine whether or not social supports had an impact on seniors' mortality. Wilkins pointed out that among men aged 65 or older, "being married and participating in organizations were each independently predictive of survival". She suggested that women "may be more vulnerable than men to negative aspects of social interactions and may also be more likely to assume the caring tasks in a relationship". Furthermore she added "social interaction may subject women more than men to harmful health effects and although the physiological mechanisms of the relationship between social support and death are not well understood, the findings suggest that older men living in households may benefit from interventions that promote social contact". Indeed her findings of this analysis support the notion that individual components of social support are linked to survival. The size, quality and closeness of people's social networks are arguably among the things that determine whether seniors receive formal care delivered by professionals, rely on informal care provided by family and friends or, indeed, receive no care at all.

An earlier study (Berkman, L., 1983) examined the effects of different relationships, both individually and cumulatively, on mortality. She hypothesized that "lack of these relationships or social connections causes stress in people in such a way as to increase their general vulnerability to disease" (p. 73). Berkman determined that people lacking many social and community ties: were 2.5 times as likely to die in the follow up period as those with many ties; that men and women over the age of 70 were more likely to score low on a social network index; their contacts among friends and relatives did not differ from those of younger people; social isolation does not appear to increase dramatically with age; and social isolation does not seem to predict mortality more strongly in the older age groups than in younger groups. However one must recognize that the evidence that has accumulated over the past two decades indicates "that people with weak social ties are at greater risk of death, even when age, physical limitation and illness, and socio-economic status are taken into" (Wilkins, 2003).

3.7 Summary

The emergency room literature indicates that compared to younger age groups, older persons: receive a more extensive workup, stay longer, be admitted to the hospital, or have repeat visits. An older person receiving emergency medical services is often too sick, frightened and/or confused to give reliable information about his or her health status and medical care. The literature also describes the grim reality that most emergency room personnel have little or no formal training in the special needs of older patients that often present special treatment challenges for the emergency room staff. The independence and quality of life of some seniors can at times be threatened by very complex or multiple health problems.

The literature pertaining to geriatric outreach teams was most useful as this is the primary area of interest in the proposed research. The literature points to a trend that suggests specialized geriatric outreach teams with a more comprehensive focus on overall care is in fact beneficial and an effective way to manage the care of community dwelling seniors. A referral to a more specialized community geriatric service may often help these seniors, their family members, their physicians, and other providers in evaluating and addressing their needs. A common theme in the literature review with these outreach teams is that clinicians from a geriatric outreach program team visit seniors in their own homes and, in partnership with clients and their families, undertake a comprehensive screening assessment which incorporates physical, mental, and functional status, as well as other environmental factors. More in-depth assessment, follow-up, or referral to services most appropriate to client needs may often result from the initial assessment. A prompt, personalized, multidimensional geriatric assessment in a client's own home environment can be instrumental in maintaining his/her independence and quality of life. By accurately assessing a client's abilities and needs, the outreach clinician can possibly ensure that seniors receive the services they need, when they need them.

The caregiver role can be stressful, and identifying this as a health care professional, can provide opportunities to help caregivers cope with the challenges of the caregiver role. As the literature review pointed to, due to caregivers being at an increased risk for depression and anxiety, screening should be done to exclude the presence of either disorder. All literature in this review stated in one form or

another that if there were problems identified, practical counseling about common caregiving stresses and about resources that benefit caregivers would be highly beneficial to the caregiver and the individual requiring the care. It was evident that by helping the caregiver learn strategies for coping with difficulties, it may help reduce some of the stress the caregiver is experiencing.

Depression in late life frequently coexists with other medical illnesses and disabilities. In addition, advancing age is often accompanied by loss of key social support systems due to the death of a spouse or siblings, retirement, and/or relocation of residence. Much of the literature indicated that because of an older person's change in circumstances, and the fact that they're expected to slow down; doctors and family members may miss the diagnosis of depression in an elderly person which ultimately results in delaying effective treatment. As a result, many seniors find themselves having to cope with symptoms that could otherwise be easily treated.

For elderly persons with no support, those that may be isolated, emotional intimacy may be essential to their care and survival. An important theme in the literature review is that one must recognize that some isolated elders may view caregivers in a professional capacity as their own emotional tie. Many of life's transitions are accompanied by anxiety and loss. Caregivers who work with older persons need to be aware of the various defenses people use to protect themselves from hurt and loss and those that inhibit the creation of new intimate attachments. Unfortunately much of the literature suggested that to blunt the effect of lost intimate

relationships or the need for them, elder persons might use alcohol and medications as a coping mechanism.

An apparent reality common in the literature review was the symptoms of alcohol and medication dependence can be different in elderly than in younger people. They often drink at home alone so no one notices the severity of the problem. Many older adults are retired, so they don't have work related problems due to drinking. They drive less, so there's less opportunity to get arrested for driving under the influence. So well hidden, the alcohol problem is sometimes mistaken for depression or other disease. But, over time, it becomes clear that alcohol or drugs are to blame. Older persons are more likely to be taking multiple medications, and if they mix alcohol with medications, this is a potential for significant danger.

Elder abuse is a serious issue which affects the emotional, physical and financial well-being of thousands of older adults each year, it is a largely hidden but growing problem, with serious consequences for the elder person and frequently for his or her family and caregivers. As our population ages and more of our citizens reach the age of 65 or older, the reported cases of elder abuse are likely to rise.

To conclude, the most common theme in the literature review for this thesis was that "a more complete understanding of the acute medical and psychosocial problems, better communication between caretakers and patients, increased coordination and more appropriate use of community agencies and hospital facilities all contribute to improved care" (Shepard et al., 1987) to our elderly population who by nature are a vulnerable population within our health care arena. In the area of specialized geriatric outreach care, the mission is to ensure that the

geriatric care services are not confined within the four walls of the hospital, and to enhance and preserve the health and quality of life of elderly persons in the community through timely assessments and appropriate management.

Chapter IV

Research Procedures

4.1 Research Methodology

This qualitative study was exploratory in nature using content analysis research methodology. The exploratory design was selected due to the modest amount of information in the literature search that was uncovered with respect to referral reasons to geriatric outreach teams from emergency rooms. Royse explains, "Exploratory research design's main value is to generate research questions and hypotheses for additional investigation" (1999, pg. 24), therefore, it is important to continually explore, examine, and evaluate in order to go above the regulatory standards of care that govern all areas of professional practice.

Qualitative content analysis was chosen as it provided a starting point for determining elements of successful practice for geriatric care between the ER and the geriatric program assessment team with respect to prominent referral reasons. Content analysis has traditionally been defined as "a research technique for making replicable and valid inferences from data to their context" (Krippendorff, 1980, pg. 21). According to Krueger & Neuman, content analysis is a "technique of data collection found within quantitative data collection" and is described as a "technique for examining information or content, in written or symbolic nature" (2006, pg. 35). Terms can be implicit as well as explicit. Content analysis enables researchers to sift through large volumes of data with relative ease in an orderly fashion. "It can be a useful technique for allowing us to discover and describe the focus of individual, group, institutional, or social attention" (Weber, 1990).

Qualitative content analysis is one of many to analyze text data. As per Hsieh & Shannon (2005), "research using qualitative content analysis focuses on the characteristics of language as communication with attention to the content or contextual meaning of the text" (pg. 1278). They further go on to state that this type of analysis "goes beyond merely counting words to examining language intensely for the purpose of classifying large amounts of text into an efficient number of categories that represent similar meaning" (pg. 1278).

The goal of this research was not to be conclusive or definitive, but to focus on exploring ideas for further in-depth research. "Content analysis may be considered as a supplement to, not as a substitute for, subjective examination of documents" (Krueger & Neuman, 2006, pg. 305). It would be taken as a guide for future research and /or education endeavors within the acute care hospitals and community based programs that provide care and intervention to the geriatric population. As Krippendorff (1980) posed in his early work, "although a good content analysis will answer some questions, it is also expected to pose new ones, leading to revisions of the procedures for future applications, stimulating new research into the bases for drawing inferences, not to mention suggesting new hypothesis about the phenomena of interest" (pg. 169).

The focus within content analysis was geared towards using a more summative content analysis approach. When planning this research project the desire to use both qualitative and quantitative aspects of research was present. By using summative content analysis a qualitative study was chosen, yet with aspects of quantitative research ingrained. This approach "starts with identifying and

quantifying certain words or content in text with the purpose of understanding the contextual use of the words or content" (Hsieh & Shannon, 2005, pg. 1283). This part of the analysis has a quantitative flavor- a manifest analysis. If one was to leave it at this, it would be a quantitative study focusing on counting the frequency of the words or content. The summative approach allowed for more than just counting to include latent content analysis- the ability to discover underlying meaning within alternative terms that may be used in the referral process.

As the purpose of this study was to determine the predominant referral reasons to the geriatric program assessment team from the emergency room medical team, the focus was on the program process. Once the study was completed the goal was that the program process might then lead to changes in program outcome. It was an exploratory design. The focus of exploring the referrals to the geriatric program assessment team from the emergency room medical team was to determine whether or not the referrals were more focused on the medically related issues, or if the emergency room medical team did in fact identify psychosocial issues as reasons for follow up in the community by a specialist team. For this research the psychosocial issues included the geriatric issues of caregiver burden, mood and social issues. The exploration was geared to benefit both the geriatric program assessment team and the emergency room medical team in so far as it could provide information to both teams for the purposes of improving the care and service to elderly people in the community after a hospital emergency room visit.

4.2 Specific Procedures

As identified in the beginning, the research questions were as follows:

1) What is the emergency room medical team's main reason for referral to a geriatric outreach team?
2) Are the referrals received from the emergency room medical team clearly identifying psychosocial issues as areas for examination by an outreach team?
3) Are psychosocial issues identified only after a geriatric outreach team clinician completed a comprehensive assessment?

In order to answer these questions, past client charts within the Rehab & Geriatric Program files from past four fiscal years were reviewed- from April 1, 2003 to March 31, 2007. The focus was on the charts that were referred directly from the Victoria General Hospital emergency room to one particular Geriatric Program Assessment Team - the Riverview Team, as this was the team that worked within the Victoria General Hospital catchment area. Through the review of the past four years of client charts, each was placed into appropriate pre-identified themes. The themes were well-known geriatric issues and were identified on the geriatric program assessment team referral form. These were: Immobility/falls; Functional Decline; Cognitive changes or Memory loss; Caregiver Burden; Incontinence; Medication; Mood; and Social Issues. These identifiable themes were used as the coding schemes as "the choice of coding system is best made on the basis of information that is relevant to the data to be categorized" (Crano et al., 2002, pg. 245). This allowed for categorization of each referral reason, discovery of which referral reasons were prominent, and whether or not psychosocial issues were directly reported.

Chart numbers were be identified by a designated letter of year: A (April 1, 2003- March 31, 2004), B (April 1, 2004- March 31, 2005), C (April 1, 2005- March 31, 2006), D (April 1, 2006- March 31, 2007); last two digits of referred individual's geriatric program internal health record number, and gender (A-2003/58/Female). Issues one through eight were based on the explicit geriatric issues identified in the conceptual definitions (Table 5.1a).

Once compilation of each of the segmental data was completed, using context analysis, the results identified how many times each theme was present and who identified (geriatric program assessment team or emergency room medical team) as an issue. In its finality, data was presented on tables and graphs (see Contents for locations of tables and graphs). This process was furthered by reviewing every completed assessment by the geriatric clinician to search out if psychosocial issues were identified once a home assessment was completed. This too was recorded as identified in the collection of geriatric issue information.

This information was directly taken from each individual chart collected. Clinician identified was the geriatric program assessment team clinician who completed assessment, year was identified as A (April 1, 2003- March 31, 2004), B (April 1, 2004- March 31, 2005), C (April 1, 2005- March 31, 2006), or D (April 1, 2006- March 31, 2007). Issues were identified as geriatric issues noted above. This coding was performed *blind* to reduce the possibility of any researcher bias. As per Haslam & McGarty (2003), blind refers to "information about the source of data is removed so that it cannot influence coding decisions" (pg, 385).

To complete this research study the permission from the following sources were required: 1) the University of Manitoba Ethics Committee (Appendix B); 2) the Winnipeg Regional Health Authority Ethics Committee (Appendix C); and 3) Deer Lodge Centre Chief Operating Officer (Appendix D).

4.3 Research Population/Sample

The Victoria General Hospital emergency room medical team was chosen. The Rehab & Geriatric programs' historical data was utilized as the ability to decipher the data effectively and efficiently due to familiarity with the referrals and the completed geriatric assessment was important. Furthermore, as the researcher and an integral part of the geriatric program assessment team, it allowed for additional assistance from the geriatric program and the emergency room medical team at the Victoria Hospital in relation to a better understanding of how to serve the elderly population at risk in the community.

The time frame of four fiscal years that was chosen was defined as from April 1, 2003- March 31, 2007. The program began in 1999 and the reality was that the geriatric program assessment team's role would not be seen as a new one after four years and therefore it would have had the opportunity to grow and become known within the community prior to this time frame. This indicated that there was a high certainty that this program was accepted within the health care arena and furthermore, hospital emergency rooms would have been successfully educated about the program before 2003. Furthermore, an important reality for choosing this time frame is that the program was centralized by this time and therefore all client charts/data have since been stored centrally. This allowed for examination and exploration of all charts in one central location without having to try relocating

older information within that catchment area. An important note as well was that the referral form itself has been consistent over the years in the identification of geriatric issues. Although the form itself may have changed over the years, the referral reasons (geriatric issues) remained the same.

The population sample was of community dwelling, male and female elderly clients aged 65 and older, referred by the Victoria General Hospital emergency room medical team and seen by a geriatric program assessment team clinician in the Riverview catchment area of the city of Winnipeg. Each case examined in this research process was for one individual only. If a referral identified concerns for an elderly couple, they were immediately divided into two separate cases. This sample did not discriminate against education level, cognitive or functional ability or disability, marital status, economic status, or ethnicity. The only three requirements for this population sample in this study was that the person was 65 years of age and older, resided in the community (as opposed to Personal Care Home), and resided in the catchment area of the particular hospital/geriatric program assessment team.

4.4 Data Collection

A stratified sampling technique was chosen. All referrals from the collected four-year time frame were divided into the first *strata*- the Victoria General Hospital ER referrals to the catchment area geriatric program assessment team (Riverview Health Centre Team- RHC). Separation from this first stratum of referral populations into *sub-strata's* oriented to the identified eight geriatric issues categories (Figure 4.4A) then occurred. The contents of each of these sub-strata's was examined and explored in order to answer the identified research questions. As per Robert Weber (1990), "to make valid inferences from the text, it is important

that the classification procedure be reliable in the sense of being consistent: different people should code the same text in the same way" (p. 12).

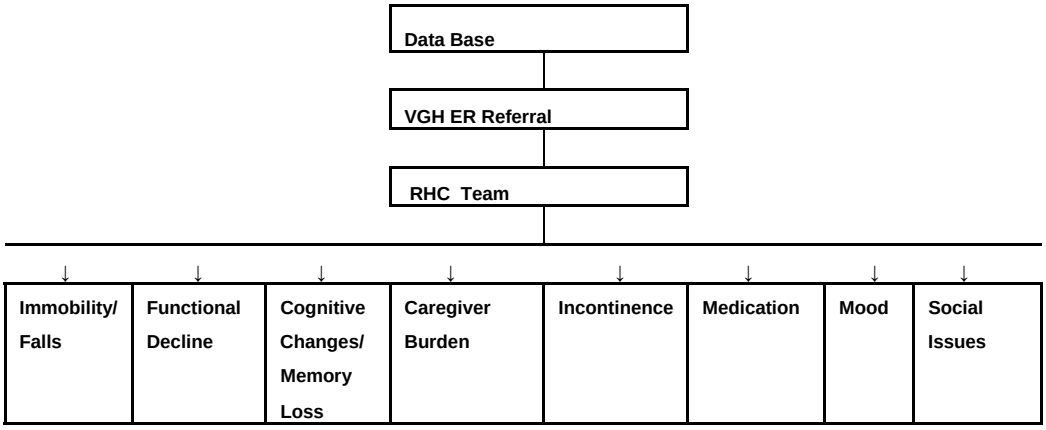


Figure 4.4A

Weber further noted, "Reliability problems usually grow out of the ambiguity of word meanings, category definitions, or other coding rules" (p. 15). In order to avoid this, one of the most critical steps in content analysis involved developing a set of explicit recording instructions that would determine the level of implication that allowed me as the researcher to code not only for the explicit words but for the implicit words that imply the same.

Both manifest coding and latent coding from Krueger & Neuman's (2006) viewpoint were used to assist in arrangement of the data. Coding was based on the identified eight geriatric issues on the referral form and flexible coding was allowed so as important material was incorporated into the coding process. Manifest coding is "coding the visible, surface content in a text…it lists terms or actions that are then located in text" (Krueger & Neuman, 2002, pg. 307). Latent coding is the "underlying, implicit meaning in the content of a text" (pg. 308). Krueger & Neuman identified that the validity of latent coding "can exceed that of manifest coding because people communicate meaning in implicit ways that

depend on context, not just in specific words" (pg. 308). Furthermore, they stated that if both the manifest and latent coding approaches agree the final result is strengthened (pg. 308). Content analysis extends far beyond simple word counts. What makes the technique particularly rich and meaningful is its reliance on coding and categorizing of the data. The basics of categorizing can be summed up in Robert Weber's quote: "A category is a group of words with similar meaning or connotations" (Weber, 1990, p. 37). The focus within the coding was on frequency, as the number of times themes were found in the text very well might have been more indicative of importance.

After data was obtained, coded, categorized, stratified, the compiled data was analyzed retrospectively. Tables and bar graphs were constructed to show frequency of identified referral reasons found within the initial referral form from the Victoria General Hospital emergency room medical team and the results of the geriatric program assessment teams assessment using the same components. The data for these graphs were results that were obtained from the categorized and coded data. Comparison of the resulting data was done by using content validity. Content validity, according to Krueger & Neuman (2006) "addresses the question – is the full content of a definition represented in a measure" (pg. 181). They indicated that the measures should represent all of the ideas within the conceptual space. By using manifest and latent coding schemes this was accomplished and this form of data analysis was of no way intrusive and was able to accommodate for the large amounts of data that was involved.

Krippendorff (1980) distinguished among three approaches to reliability that has been historically used in content analysis research. The reliability of a content analysis study refers to its stability, reproducibility, and accuracy. He suggested that stability was the weakest form of reliability and accuracy was the strongest form. Krippendorff (1980) put forward that "a reliable procedure should yield the same results from the same set of phenomena regardless of the circumstances of application" (pg. 129). He went further to state that "to test validity, on the other hand, the results of a procedure must match with what is known to be 'true' or assumed to be already valid" (pg. 129). The generalizability of the conclusions was very dependent on how the researcher determined conceptual categories, as well as how reliable those categories were. It was imperative that the categories were defined accurately to measure the themes and/or categories that were caught to measure.

4.5 Treatment of Data

During the data collection from the chart review, a research codebook was created to ensure that there was accurate documentation of the cases that were reviewed using identification numbers to ensure confidentiality as well as to have available if they were required any point throughout research process. The year letter, last two digits of referred individual's geriatric program internal health record number and their gender was used to identify each chart. The geriatric program assessment team clinician was identifiable by their initials. Only the original data base could identify the clinician.

Original Chart Particulars

Chart Number	Gender	Initial & Full Name	Assigned Identification	Clinician Initials	Clinician Identification

A direct-entry method was used by using a personal laptop computer in where documentation, on Microsoft Excel, of the frequency of the themes- both the direct and indirect (manifest and latent coding) and the presence of identified themes on both original referral as well as the geriatric program assessment team clinician's findings on the requested assessment.

Original Referral Information/Referral Reasons

Chart #	Seen	Not Seen	Issue #1	Issue #2	Issue #3	Issue #4	Issue #5	Issue #6	Issue #7	Issue #8

Issues Identified in Final GPAT Report

Clinician	Year	Issue #1	Issue #2	Issue #3	Issue #4	Issue #5	Issue #6	Issue #7	Issue #8

All original archived charts were in a locked room within Deer Lodge Centre. Once the data was collected from this secure site, it was stored on a SanDisk memory stick in a locked office within Riverview Health Centre Day Hospital site. This office was locked at all times and after hours was monitored by security.

Chapter V

Collection & Analysis of Data

5.1 Arranging Data

The sample population was that of past client charts within the Rehab & Geriatric Program files from four fiscal years- from April 1, 2003 to March 31, 2007. The focus was on the charts that were referred directly from the Victoria General Hospital emergency room to one particular Geriatric Program Assessment Team - the Riverview Team. Within these referrals to the Riverview geriatric program assessment team, the referrals for inpatient requests were discarded and only community requests were kept for the purposes of useable data. These were the final charts to be reviewed and analyzed (Figure 5A).

There were a total of 209 charts reviewed. The first step that was taken was data entry of all the identifiable information pertaining to the charts that were determined to be appropriate. A data entry form (Table 5.1a) was devised that could compile all initial entries. It was the guideline for coding all client/chart information. It contained information pertaining to original Rehab & Geriatric Program health record number; gender; name and initials; assigned identification code; clinicians initials and there full name. All coding was done manually. Once this information was collected it was entered into the computer and stored on a password protected removable memory stick. This data entry form had all original chart numbers; an alphabet letter assigned pertaining to year assessed; the clients name and gender; and the geriatric program assessment team clinician assigned. This was the official hard copy in case there was a need to return to the original

chart for review once data was collected. There were three separate classification coding forms; original referral information; geriatric program assessment team findings information; and a data base of a compilation of both Victoria General Hospital requests and geriatric program assessment teams findings. To achieve scientific respectability, Crano & Brewer (2002), identified that research procedures must be logical and efficient. They identify that one of the main ways of "introducing systematization to this area is through the use of a pre-specified classification system in the coding of content" (pg.253).

5.2 Coding Unit

Collection of data had to begin with coding. Crano & Brewster (2002) informed their readers that the choice of coding system was best made on the basis of information that was relevant to the data to be categorized. In the case of a content analysis, this means that as the researcher, before decided on the appropriate coding scheme, the need to be thoroughly familiar with the general body of content under consideration was important. Crano & Brewer reported that "only then is the investigator in a position to make an informed and reasoned decision regarding the most appropriate classificatory system" (2002, pg. 254).

As Crano & M. Brewer (2002) pointed put, "the content analyst is particularly interested in the what and the how of the process, that is, with the particular content of a message and the particular manner in which this content is delivered or expressed (pg. 245).

This research was more than a single word investigation. The check boxes on the referral form did not constitute the whole of this content analysis research and therefore the other common coding units used in this research were 'theme' units.

Being of greater complexity than a single word, these 'theme' units provided just as much if not more information than originally suspected. Crano & Brewer (2002) also stated that "making use of both themes and words as coding units, generally provided more information than analyses based on words alone" (P. 249). The combination of words and themes as coding units in this study enabled a more accurate analysis than that afforded by the use of the more simple word unit alone. During the data collection diligent notes were kept on other words/statements that were identified on a referral form. These notes were then categorized onto a separate data sheet under the 8 geriatric issue themes.

5.3 Strata

According to Michael Patton (2002), "developing some manageable classification or coding scheme is the first step of analysis" (pg. 463). As this as the basis for beginning the content analysis, a stratified sampling technique was chosen.

The first set of strata allowed for the recording of information from the 209 original referral from the hospital to the Riverview geriatric program assessment team (Table 5.1b). The original coded client information was utilized; if the client was seen by the geriatric program assessment team or not; the eight geriatric issues; and a space for indirect social definitions that may have been put on the original referral form. Although the referral form itself (Appendix A) has check off boxes to identify concerns within the eight geriatric issues, it was not always utilized and therefore at times there are statements written either alone or with the boxes checked off.

To further the strata, another data entry form (Table 5.1c) was devised in order for the collection of data regarding the geriatric program assessment teams finding.

Again, the documentation consisted of the chart number; the clinician involved; the year clinician involved; and the eight specific geriatric issues. There was also a space for social definitions that the geriatric program assessment team may have used in their writing as well as recommendations that they made. The data entry was based on the 209 appropriate referrals.

A final sub stratum was done to document the summary of identified issues (Table 5. 1d). This data base was similar in the others in that it identified chart number; the eight geriatric issues and a space to document 'other'. This 'other' space was used as a space that could easily identify who was seen and who was not and why, as well as identify what the hospital professional put directly on the referral form. For each time Victoria General Hospital identified an issue it was labeled with a 'v' and each time the geriatric program assessment team identified an issue it was labeled with a 'g'. If neither identified the issue it was left blank and if they both identified an issue it was labeled with a 'b'.

5.4 Manifest and Latent Coding

With this in mind, both manifest coding and latent coding were used to assist in the arrangement of the data. Manifest coding is "coding the visible, surface content in a text…it lists terms or actions that are then located in text" (Krueger & Newman, pg. 307). With manifest content, the content elements are fairly significant and distinct. The coder is required to recognize certain content elements and record their presence- in this case, the geriatric issues checked off on the original referral source. Latent coding is the "underlying, implicit meaning in the content of a text" (Krueger & Newman, pg. 308). The coding of latent content is much more complex because as a coder, meaning must be constructed rather than simply match it to a

list that was followed. Clearly, the coding of latent content requires much more mental effort as a coder as judgments are made on what is acceptable to code. What makes the coding of manifest content typically so efficient and reliable is that it is an automatic process.

5.5 Trustworthiness

Research findings should be as trustworthy as possible and every research study must be evaluated in relation to the procedures used to generate the findings (Graneheim & Lundman, 2003, pg 109). Credibility deals with the focus of the research and refers to confidence in how well data and processes of analysis address that focus. Hsieh & Shannon (2005) document that "as evidence of trustworthiness, this type of study relies on credibility" and "a mechanism to demonstrate credibility or internal consistency is to show that the textual evidence is consistent with the interpretation" (pg. 1285). To achieve this, there was thorough examination of each chart twice at each session. At each session period 25 charts were chosen to complete data collection at a time. As Salahu-Din (2003) recommends, "developing a codebook soon after data collection begins to make working with your coding scheme easier" (pg.231). She furthered this recommendation by saying "the process of looking for meaning units, connecting the meaning units to themes, and then categorizing them continues until you feel that adding new themes and categories will yield no new information" (pg.231). The manifest coding was entered on the data entry sheets simply with a mark as they were identified in a check box on the original referral form. Each chart was reviewed and latent coding was then completed. All words or statements that were also written on referral form were documented and further categorized them into

themes that correlated with the eight geriatric issues (Table 5.2). At the end of each session all charts were reviewed again to ensure accurate coding was accomplished according to the process originally devised.

Graneheim & Lundman (2003) reported that one important way to prove credibility is by "choosing participants with various experiences as it increases the possibility of shedding light on the research question from a variety of aspects" (110). Although there was one sole researcher in this project, the perspective that came from being a direct geriatric clinician and a practicing medical social worker for several years, speaks to the not only how this research idea came to fruition, but to the credibility as well.

It was apparent that selecting the most appropriate method for data collection and the amount of data; the appropriate coding agenda; and how well categories and themes cover the data, are all important in establishing credibility within this research. As stated, a schematic design was used in order uncover the appropriate referrals that in its finality, led to the identified charts to review. Only a small amount of charts were reviewed at any one time to ensure that the ability to judge the similarities within and differences between categories was present without the sense of being inundated with information. This also enabled for completion of the data entry details and the coding agenda.

To further address trustworthiness, three sets of data collection techniques were employed. Three different, yet similar data collection methods were deliberately included rather than just one or two (Table 5b-d). The intention was to generate three layers of data from each referral. This technique, while not meeting the

technical definition of "triangulation", nonetheless provided a richer, more multilayered and more credible data set than one data entry system would have generated.

Another aspect of trustworthiness was dependability. Dependability is the "degree to which data change over time and alterations made in the researcher's decisions during the analysis process" (Graneheim & Lundman, 2003, pg. 110). When data is extensive and the collection extends over time, there is a risk of inconsistency. This was not an issue as there was one researcher and the time line was over a three month period.

Trustworthiness also includes the question of transferability. Graneheim & Lundman (2003) pointed out that the authors of any research can give suggestions about transferability, but it is the reader's decision whether or not the findings are transferable to another context. There is no single approved meaning or universal application of any research findings, but only the most believable meaning from any one particular perspective.

Chapter VI

Findings & Interpretation of the data

Graneheim & Lundman (2003) claim that, "trustworthiness will increase if the findings are presented in a way that allows the reader to look for alternative interpretations" (pg. 111). This project become a reality when the desire to explore how the emergency rooms were assessing and managing the care of geriatric patients and whether or not they could see beyond the physical ailments. The question was if the emergency room medical team could recognize that although presentation might have been physical/medical, the likelihood that there were psychosocial issues exasperating the situation was great. The three questions proposed within this research project were:

1) What is the emergency room medical team's main reason for referral to a geriatric outreach team?
2) Are the referrals received from the emergency room medical team clearly identifying psychosocial issues as areas for examination by an outreach team?
3) Are psychosocial issues identified only after an outreach team clinician completed a comprehensive assessment?

6.1 Strata I Victoria General Hospital

To begin, the first set of strata was "Original referral reason". There were 209 charts used as a sampling population and therefore for this data entry collection there were 209 entries. Identifiers were: each coded chart number; if the individual was seen by geriatric program assessment team or not; the eight geriatric issues;

and a space for ‘other’. This ‘other’ was for documenting the words that may have been located directly on the referral form. Although there are identifiable check boxes for referral sources to check off on the original referral form, they are not always used, or they are but with additional comments.

Out of the 209 referrals Victoria General Hospital (VGH) referred to the geriatric program assessment team for the following issues (Figure 6a):

- **Immobility/Falls: 77 times referred/ 36.8% of VGH referrals were for mobility concerns**
- **Functional Decline: 92 times referred/ 44% of VGH referrals were for functional concerns**
- **Cognitive Decline/Memory Loss: 58 times referred/ 27.8% of VGH referrals were for cognitive concerns**
- **Caregiver Burden: 36 times referred/ 17.2% of VGH referrals were for caregiver burden concerns**
- **Incontinence: 5 times referred/ 2.4% of VGH referrals were for incontinence concerns**
- **Medications: 20 times referred/ 9.6% of VGH referrals were for medication concerns**
- **Mood: 20 times referred/ 9.6% of VGH referrals were for concerns of Mood**
- **Social Issues: 84 times referred/ 40.2% of VGH referrals were for Social Issues**

Out of the above Victoria General Hospital referrals, the number of issues identified per referral was between one issue and six issues and the average number of issues per referrals was three to four.

This data set answers question #1 of the research questions: What is the emergency room medical team’s main reason for referral to a geriatric outreach team?

It is apparent through this data collection that out of the 209 referrals to geriatric program assessment team, the main reason, or highest number of times referred, was for functional decline. For older persons, bathing, dressing, grooming and the ability to get around their living environment are all considered essential activities for maintaining independence in the community. Any disability that affects the function of an older person living in the community should be considered an acute reversible event, more similar to falls and delirium than to progressive disorders such as a dementia. It is apparent that the emergency room medical team, to some degree, sees functional decline as a valid reason to have an outreach team, geriatric program assessment team, assess the individual in their home settings to ensure that any functional issue be addressed and possible adaptations made in a timely manner.

Are the referrals received from the emergency room medical team clearly identifying psychosocial issues as areas for examination by an outreach team is the second research question? The data from the Victoria General Hospital referrals also identified that the second most common reason for referring to the geriatric program assessment team was for social issues. Forty percent of the referrals identified that there concerns in relation to social issues. Out of the 209 Victoria General Hospital referrals, 153 had identified in a statement or a sentence the reason for referral. These statements were either alone on the referral form or accompanied a mark in one of boxes positioned beside each listed geriatric issue (see Appendix A). Some examples of these were:

"Assess ability to live alone"

"Lives alone please follow up"

"Is she managing emotionally and physically?"

"Safety at home as caregiver"

"Arguing and fighting with spouse"

"Frequent ER visits- afraid to be alone"

While biological factors are necessary to the understanding of illness and its relationship with aging, they are not by themselves sufficient. Social and psychological factors also need to be taken into account so as to explain the unpredictability in the way people respond. This is important in order to provide the proper intervention for a person with possible limited social supports, limited finances, and/or history of poor coping strategies or problem solving ability. The key in examination and assessment in the emergency room would be to rule all out medical issues and have team continue evaluation using a task centered approach with respect to adequate functioning in the community.

6.2 Strata II Geriatric Program Assessment Team

Out of the 209 referrals from Victoria General Hospital to the geriatric program assessment team (GPAT) 113 were seen and assessed- this is the second strata set. Out of these 113 seen referrals, the following issues were identified (Figure 6b.):

- **Immobility/Falls: 75 times identified/ 66.3% of total GPAT findings**
- **Functional Decline: 51 times identified/ 45.1% of total GPAT findings**
- **Cognitive Decline/Memory Loss: 64 times identified/ 56.6% of total GPAT findings**
- **Caregiver Burden: 28 times identified/ 24.8% of total GPAT findings**
- **Incontinence: 6 times identified/ 5.3% of total GPAT findings**
- **Medications: 57 times identified/ 50.4% of total GPAT findings**
- **Mood: 29 times identified/ 25.7% of total GPAT findings**

- **Social Issues: 56 times identified/ 49.6% of total GPAT findings**

To better view the differences the results are portrayed in percentages of either number of Victoria General Hospital referrals or the percentage of the geriatric program assessment team findings due to the difference in number of referrals. Although the Victoria General Hospital sent 209 appropriate referrals, the geriatric program assessment team assessed 113 of them. A graph (Figure 6c) showing comparisons in their respective numbers has been provided. Figure 6d shows the results based on only the 113 referrals seen.

As Figure 6c and 6d show, the geriatric program assessment team found more medication issues once in the home. This could be as the emergency room medical team is unable to assess the management of this specific task while someone is in an emergency room. There is the obvious length of stay as a factor, as many people are not admitted to the ER and if they are not discharged home, they are transferred to another unit. Another factor along with the length of stay is the ability to safely monitor self medication in such a fast paced, very busy environment and therefore it is not done. A person is discharged and if there are no blatant issues that would impede on this task, it may simply be overlooked. Furthermore, once the geriatric program assessment team is in the home, they are able to look closely at the medication regime and the medications themselves. On many occasions as the results show, the geriatric program assessment team will see pills on the floor, missed days in blister packs, incorrect dosette and/or wrong count in an original pill bottle.

To further these findings, it is also evident that there was an increase in both mood and cognitive concerns present upon the geriatric program assessment team assessment as compared to the original referral reason(s). Again this may be due to the length of stay and if the patient was deemed medically stable he/she may or may not have seen the team for complete assessments (i.e. Occupational therapy for cognitive screen).

Are psychosocial issues identified only after an outreach team clinician completed a comprehensive assessment is the last research question. As the findings showed, this is not the case. Although the geriatric program assessment team identified social issues 49.6% of the time and Victoria General Hospital identified 40.2% of the time, it is not a significant difference. What it does show is that both appear cognizant of the interplay between medical issues and social issues.

As there were 209 original referrals and the geriatric program assessment team saw 113 of them, it is important to identify the reasons that the clinician did not see and these reasons were noted on the reviewed charts. A brief synopsis of these reasons is shown on Figure 6A. More detailed reasons were as followed:

- **Redirected to Palliative Care Program**
- **Redirected to the Geriatric Mental Health Team**
- **Redirected to WRHA Home Care Program**
- **Patient declined GPAT assessment**
- **Family declined GPAT assessment**
- **Redirected to Geriatric Rehabilitation**
- **Redirected to Acute Care Hospital**
- **Readmitted to Acute Care Hospital**
- **Redirected to Specialist**

- **Redirected to Outpatient Psychiatry**
- **Redirected to Geriatric Psychiatry**
- **Not appropriate- for Panel to PCH/admit to PCH**
- **Not appropriate- open to Day Hospital**
- **Redirected to Family Medical Doctor**

6.3 Strata III Compilation

The third and final strata set focused on identifying who found what issue. Each category remained the same as did the availability of an "other" box to identify any important notes. Victoria General Hospital (VGH) was identified as "v"; geriatric program assessment team (GPAT) as "g"; both as a "b" and if neither identified as an issue, it was left blank. This set of strata identified if the geriatric program assessment team did not see client, however this was noted in the "other" box. The information pertaining to results for this set of strata is not separated as is the other two sets of data. This data is based on 209 referrals regardless if the geriatric program assessment team saw or not.

- **Immobility/Falls: VGH 42 /GPAT 41/Both 34/Neither 92**
- **Functional Decline: VGH 65/GPAT 22/Both 27/Neither 95**
- **Cog Changes/Mem Loss: VGH 29/GPAT 33/ Both 28/Neither 119**
- **Caregiver Burden: VGH 25/GPAT 20/Both 10/Neither 154**
- **Incontinence: VGH 3/GPAT 4/Both 2/Neither 200**
- **Medication: VGH 14/GPAT 42/Both 7/Neither 146**
- **Mood: VGH 17/GPAT 24/Both 4/Neither 164**
- **Social Issues: VGH 57/GPAT 25/Both 23/Neither 104**

Victoria General Hospital referred to the geriatric program assessment team for the following reasons in order of highest number of referrals to the lowest:

1. **Functional Decline**
2. **Social Issues**

3. **Immobility/falls**
4. **Cognitive changes/Memory Loss**
5. **Caregiver Burden**
6. **Medications** } **Both were tied**
7. **Mood** } **at 20 times/9.6%**
8. **Incontinence**

As these results have shown, it is apparent that both functional decline (44%) and social issues (40.2%) accounted for a majority of the 209 referral reasons to the geriatric program assessment team.

The geriatric program assessment team findings indicated that out of the 113 referrals that they saw the identified order of findings from highest to lowest:

1. **Immobility/Falls**
2. **Cognitive Changes/Memory Loss**
3. **Medications**
4. **Social Issues**
5. **Functional Decline**
6. **Mood**
7. **Caregiver Burden**
8. **Incontinence**

These results show that both immobility (66.3%) and cognitive changes (56.6%) were the most identified issues and accounted for a majority of the 113 referrals that the geriatric program assessment team did see.

And finally, both Victoria General Hospital and the geriatric program assessment team identified the same geriatric issue(s) as followed:

1. **Immobility/Falls- both identified in 34 referrals**
2. **Cognitive Changes/Memory Loss- both identified in 28 referrals**
3. **Functional Decline- both identified in 27 referrals**

4. **Social Issues- both identified in 23 referrals**
5. **Caregiver Burden- both identified in 10 referrals**
6. **Medications- both identified in 7 referrals**
7. **Mood- both identified in 4 referrals**
8. **Incontinence- both identified in 2 referrals**

Immobility and falls were the number one issue that both the Victoria General Hospital and the geriatric program assessment team identified as a concern. This can be due the simply reality that it is easily identified. However, one must be able to mobilize within their living environment to safely live independent. An environmental assessment is paramount if an individual displays difficulty with mobilizing. Immobility and/or falls can be a result of an underlying medical disorder, a loss of senses (i.e. vision problems), cognitive impairment, mood, etc. A fall can be the outcome of so many different precipitating factors.

Cognitive changes and/or memory loss was the next identified issue that both Victoria General Hospital and the geriatric program assessment team identified together. One of the most important health care issues facing today's elderly population is cognitive impairment and its implications. Cognitive changes inevitably affect all aspects of ones life and those around them. It effects the ability to perform tasks which then effects the functional ability which can relate to activities of daily living (bathing, dressing, taking medications, etc.) and instrumental activities of daily living (i.e. banking/finances, driving, shopping, etc). Cognitive impairment reverberates through all aspects of life.

The top four issues found by both are immobility and falls, cognitive changes and/or memory changes, functional decline and social issues. The results have shown that regardless of whether it was the Victoria General Hospital or the geriatric program assessment team that identified a concern they are not being downplayed nor ignored, they are addressed.

Chapter VII

Conclusion

7.1 Generalizations from research results to theoretical framework

Crisis intervention and task centered models were developed out of a need to provide brief methods of intervention. Although they are theoretically separate, they are inter linked for the purposes of this research project. William Reid "acknowledges the influence of crisis intervention on the development of task centered work" (Payne, 2005, pg. 97). Malcolm Payne illustrated, "both try to improve people's capacity to deal with their problems in living" (2005, pg. 100). Crisis intervention uses practical tasks to help people readjust, but an important focus is their emotional response to crisis and long term changes in their capacity to manage everyday problems. Task centered work focuses on performance in practical tasks which will resolve particular problems.

The medical crisis counseling model is also a short term therapy protocol. The overall objective of this model is not to resolve the issues completely, but to help patients internalize an adjustment process that will help them in further adaptation. Irene Pollin (1995) discussed eight expectable issues with respect to chronic illness that should be dealt with in sequence. These were: loss of control, change in self image, dependency, and stigma of the illness, fear of abandonment, anger, social isolation and death. She posited that normal living is replaced by conditional living- the realization that one cannot go on with one's life as planned (Pollin, 1984). Mechanisms that people had used successfully in the past to cope with life's problems will not necessarily be helpful under severe stress in relation to a medical

crisis. The medical crisis counseling model has three goals that are identified as 1) to reiterate the physician's message; 2) to help with specific anger and fears as well as the practical aspects of adjusting to the medical situation; and 3) coordinate better communication between health care staff, patient, and family.

Older adults, like anyone else in the general population, sometimes need help coping with the emotional and physical effects of chronic conditions or disease. This includes learning to manage such aspects as dealing with medications, need for home care services, loss of independence, and the emotions that arise for that individual and their family/friends. People make sense of their lives in whichever way helps them cope, a diagnosis or exasperation of an illness, can send a person spiraling into a crisis, especially if they are not understanding the full concept of what the physician may have explained to them. They may require crisis counseling for this reason alone- a need to comprehend what they are about to face. Illness is upsetting in that it is usually experienced as a threat to the order and meaning of how people do make sense of their lives. An illness frequently alters a person's relationship with those surrounding them. A person who was traditionally independent, may suddenly have to depend on family for physical, emotional, and even financial support. This may compound the stressors that they are already facing with the illness and be unable to commit to long term counseling when they are feeling their world collapse. They need to focus on the tasks at hand and how to cope with the changes.

As noted in the beginning of this research report, it is important for the health care professional or team to recognize and respond to a patient within the sphere of bio-

psycho-social context. This perspective would enable the practitioner to consider an individual patient's situation within their crisis as a dynamic compilation of both medical and psychosocial factors. If trained to portray elderly patients in a more holistic human being view instead of as 'bed-blockers', health care professionals have a much better chance of helping find the means to improving the crisis situation for that person which could result in a successful discharge plan. If we continue to focus on a patient's deficit, we are likely to perpetuate the situation rather than exploring task centered approaches to manage the issues that are present in a positive way. Focusing within a task centered approach during a crisis may allow for identifying any immediate specific services, programs, devices, and/or retraining that would assist that patient with a desired outcome without having the sense of being overwhelmed and out of control.

7.2 Limitations of the study

This study is not without limitations. As there was one researcher for this study there is the obvious issue of coder reliability. There may have been a subjective component to the coding since the referrals, charts and the domain template were coded by a single investigator, thus significantly limiting reliability.

It is also important to consider that the use of the domain template that identified the eight geriatric issues to quantify the frequency to which the referrals issue was for, may not accurately reflect the value that was placed on the originating concerns. Although there is space below the check boxes, for sake of time or possibly a referral after the person was discharged, the emergency room medical team may have identified a social issue via the check box but not clearly portray the trepidation of allowing the person to return home to the community.

Sampling for this study was restricted to older persons referred to one of the geriatric teams and from one hospital. Although this study can be broadened to include other teams and hospitals, the results are limited in that they are only portraying one part of the population of referrals. Replication in future studies is needed to validate the generalizability of these findings to other populations.

7. 3 Serendipitous Findings

Through data collection, there was a constant reminder of how easy it was to place certain words into different categories which meant that there had to be a system that ensured the data was checked and rechecked several times and that t were placed in the category that was originally planned for. There were a few words or statements that easily could have been placed into separate categories and still would have been valid. These were diet and nutrition. The decision was to place these in the functional decline category as for the majority of findings; these were documented as issue in relation to inability to complete the task due to the decline in function. However, it was questionable if those particular referrals also included cognitive decline intertwined with nutrition and/or diet identified as issues. Does the person have trouble cooking or remembering to eat because of cognitive decline or inability to complete the task due to function deficits? The decision was to remain steadfast and include these in function regardless of what the other issues were for.

Another finding was in relation to driving. There was not a clear definition of why driving was the issue at hand and therefore the referral reason. The question was: is it cognition that is impairing the ability or is it the physical inability to have the proper reflexes and range of motion to safely navigate? Is it the fear of driving and

having an accident or getting disoriented at night and therefore a fear of getting lost? Any documented driving concerns were therefore placed in the category of social issues as it was decided that this ambiguity could be rectified by placing it in a category that was open ended in nature.

A surprising finding was that of the medications. Although these assessments are done by me on a regular basis, I would not have assumed they constituted as much of an issue as these results have portrayed. Of the geriatric program assessment teams findings, 50.4% were with respect to medication issues. I understand that as a clinician, that it is much easier and less threatening to that person to review medications in the comforts of their home, however, I was surprised at the results nonetheless.

7.4 Implications for further research and practice

Further longitudinal research is needed to determine if there is a causal order within these eight geriatric issues- for example, would health counseling in the home help geriatric clients avoid unplanned use of acute health care services? As greater emphasis is placed upon care in the home, the accurate identification of an at-risk client is paramount to targeted efforts to ensure health and autonomy for the elderly population. A geriatric assessment can be completed to identify risk factors; however when there is little community in- home resources, many recommendations can be futile and clients will still end up in the hospital.

Furthermore, this study focused on the main referral reasons from an emergency room medical team to the geriatric program assessment team. As the results showed, many of the issues identified were in fact for social issues. With this in mind, a more in-depth qualitative study examining these social issues may assist in

providing a task centered plan of action using the crisis model of intervention. Focus groups with families and personal interviews with clients may further provide information on what 'social issues' are and how to better assist in a crisis. This focus may help professionals in providing the guidance elderly patients and their families may need in obtaining new coping strategies to better deal with the social issues that are present in their lives.

As this study was limited in its focus on past charts, further investigation would be beneficial with respect to the understanding of what the emergency room medical team and the geriatric program assessment team defines as 'social issues'. Throughout data collection, it was questioned what it was that the emergency room medical team were referring for when it was not medically related (i.e. medications, falls, etc). The geriatric program assessment team findings were also questioned when social issues were not listed. Many of the reports would identify cognition whether there were reported concerns or not, however the information pertaining to social and environmental was minimal.

The results of this study have noteworthy implications for social work and social work intervention. First there is repeated talk in the literature that social workers must continue to provide the vital role of being responsible for the coordination and linkage of elderly to necessary community resources. However, with having said this, one must be cognizant that social workers are not normally available in the hospital emergency room setting at all times. There is normally no coverage in the evenings and on weekends. Social work is in great demand within the realm of the ER. As so many elderly clients enter the hospital via the emergency room, with

more than physical issues/complaints, the hospital social work department could consider a care plan binder that would allow other professionals to direct patients and their families to outside resources when needed, regardless of time or day. It would be important for them to study, evaluate, research and devise a task centered approach to assisting geriatric patients after hours. One that can easily direct a professional to possibly retain a geriatric patient until further assessment can be done or evaluate on terms of psychosocial ability to safely return home. To better understand how to work within such complex situations that geriatric patients undoubtedly present to the ER with, a more careful study needs to be made of elderly use of the emergency room and the social work intervention provided.

The findings of this study point to competencies that social workers already possess. Social Workers are sensitive to the special needs and vulnerabilities of geriatric patients and therefore they recognize the important role played by the social system in the all encompassing health of a geriatric patient. Throughout the literature on geriatric evaluation and assessments, a comprehensive multidisciplinary approach to assessment and recommendations is emphasized. Social work is considered a core profession within the Geriatric Program.

As it has been stressed throughout this study, entrance complaints can be triggered by a medical problem. Upon investigation other areas of concern can and usually do emerge. Assessment is an essential aspect of all social work practice. This study pointed out that due to the complexity of factors which influence functioning in the older person, education regarding the multidimensional geriatric assessment would provide social workers with the requisite knowledge and skills needed to work

within this field of social work. Learning the various domains of a geriatric assessment is vital to the knowledge of where bio-psychosocial areas enhance and which impede functional capacity in an elderly client. The goal of any social work assessment is to gain an accurate picture of the client's current functioning in order to help with an individualized care plan and can be seen as the catalyst for action and/or change. For social workers interested in the realm of geriatric care, to experience a geriatric assessment in the full sense of the statement is to be able to focus on the multidisciplinary facets so that the true intricacies of the assessment process are best learned.

Social workers have a special role among health care providers, considering not just one aspect of care but devising plans to meet the multivariate needs of older adults and their families, including medical care, mental health care, social needs, and other aspects of the person's welfare. This is the key to social work's unique perspective, allowing the proper coordination of care for clients. Yet despite a growing demographic need for these services, not enough social work students are specializing in gerontology or receiving the training needed to become a skilled geriatric practitioner. This study showed that psychosocial issues are prevalent for most of the geriatric patients and unfortunately may not be fully addressed either due to lack of understanding, lack of assessment skills or medical/physical/functional issues dominate the immediate care needs. This study showed that a major contribution to the social work profession would be to have possible Pre-Master Social Work students be placed with a geriatric program assessment team Social Work Clinician during a designated block of time. One

barrier that appears to discourage many students from choosing gerontology is the fact that many geriatric field placements occur in nursing homes, giving students a distorted experience with older clients. If the geriatric program hosted a student placement, students would be working along a continuum of care that they typically don't see. This study and its finding in relation to the social issues prevalent in community living geriatric population, show that many students might leave the program far more knowledgeable about the field of gerontology by utilizing the multidimensional objective approach to the assessment process.

References

Adams, W.L., Magruder-Habib, K., Trued, S., & Broome, H.L. (1992). Alcohol abuse in elderly emergency department patients. *Journal of the American Geriatric Society*, 40(12), 1236-1240.

Addictions Foundation of Manitoba (1995). *Seniors and Addiction, the Challenge to Professionals: Aging Without Addiction*. Winnipeg: Addictions Foundation of Manitoba.

Addiction Research Foundation (1993a). *The Older Adult and Alcohol*. Toronto: Addiction Research Foundation.

Addiction Research Foundation (1993b). *The Older Adult and Sleeping Pills, Tranquillizers and Pain Medication*. Toronto: Addiction Research Foundation.

Aminzadeh, F., & Dalziel, W. B. (2002). Older adults in the emergency department: A systematic review of patterns of use, adverse outcomes, and effectiveness of interventions. *Annals of Emergency Medicine, 39*(3), 238-247.

Babbie, E. (1995). The practice of social research (7th Ed.). Wadsworth Publishing Company.

Barnea, Z., & Teichman, M. (1994). Substance abuse and misuse among the elderly: Implications for social work intervention. *Journal of Gerontological Social Work, 21*(3/4), 133-148.

Barnett, L., Harnett, P., & Bond, A. (1992). Patterns of emergency department use by geriatric patients. *Journal of Gerontological Social Work, 19*(1), 77-98.

Beaulieu, M., & Leclerc, N. (2006). Ethical and psychosocial issues raised by the practice in cases of mistreatment of older adults. *Journal of Gerontological Social Work, 46*(3/4), 161-186.

Berg-Weger, M., Rubio, D. M., & Tebb, S. S. (2000). Depression as a mediator: Viewing caregiver well-being and strain in a different light. *Families in Society, 81*(2), 162-173.

Berkman, L. (1983). The assessment of social networks and social support in the elderly. *Journal of the American Geriatrics Society, 31*(12), 743-749.

Bomba, P. A. (2006). Use of a single page elder abuse assessment and management tool: A practical clinician's approach to identifying elder mistreatment. *Journal of Gerontological Social Work, 46*(3/4), 103-122.

Bradley, M. (1996). Elder abuse: Caring for older people, part 8. *British Medical Journal, 313, 7056,* 548- 550.

Breakwell, G., Hammond, S., Fife-Schaw, C., & Smith, J. (2006). Research methods in psychology. (3rd Ed.). London: Sage Publications.

Burnette, D., & Mui, A. C. (1994). Determinants of self-reported depressive symptoms for frail elderly persons living alone. *Journal of Gerontological Social Work, 22*(1/2), 3-19.

Canadian Coalition on Medication Use and the Elderly (1992). Ask/Demandez. Ottawa: Canadian Coalition on Medication Use and the Elderly.

Caplan, G. A., Williams, A. J., Daly, B., & Abraham, K. (2004). A randomized, controlled trial of comprehensive geriatric assessment and multidisciplinary intervention after discharge of elderly from the emergency department--the DEED II study. *Journal of the American Geriatrics Society, 52*(9), 1417-1423.

Chan, H., & Wong, C. (1996). New frontiers in geriatric service-The community geriatric assessment teams. *Journal of the Hong Kong Geriatrics Society, 7(4),* 9-13.

Clark, N. M., & Becker, M. H. (1998). Theoretical models and strategies for improving adherence and disease management. In S. A. Shumaker & E. B. Schron (Eds.), *The handbook of health behavior change (2nd ed.; pp. 5–32)*. New York: Springer.

Conway-Giustra, F., Crowley, A., & Gorin, S. (2002). Crisis in caregiving: A call to action. *Health and Social Work, 27*(4), 307-311.

Crano, W., & Brewer, M. (2002). Principles and methods of social research. (2nd Ed.). New Jersey: Lawrence Erlbaum Associates.

Creswell, J. & Plano Clark, V. (2007). Designing and conducting mixed methods research. Sage Publications.

Devons, C. (2002). Comprehensive geriatric assessment: making the most of the aging years. *Current Opinion in Clinical Nutrition and Metabolic Care, 2002, 5: 19-24.*

Devor, M., Wang, A., Renvall, M., & Feigal, D. (1994). Compliance with social and safety recommendations in an outpatient comprehensive geriatric assessment program. *Journals of Gerontology, 49*(4), M168-M173.

Ferry, J., & Abramson, J. (2005). Toward understanding the clinical aspects of geriatric case management. *Social Work in Health Care, Vol. 42 (1), 2005.*

Fiksenbaum, L., Greenglass, E., & Eaton, J. (2006). Perceived social support, hassles, and coping among the elderly. *The Journal of Applied Gerontology, Vol. 25, No. 1, February* 2006, 17-30.

Fulks, J. S., & Molinari, V. (1995). The young-old and the old-old: Issues of well-being, the family, and social support. *Journal of geriatric psychiatry, 28*, 197-218.

Graneheim, U. H., & Lundman, B. (2003). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today (2004) 24,* 105–112.

Haslam S. A., & Mc Garty, C. (2003). Research methods and statistics in psychology. London: Sage Publications.

Hsiu-Fang H., & Shannon, S. (2005). Three approaches to qualitative content analysis. *Qualitative health research v15, n9, November*, 1277-1288.

Hightower, J., Smith, M.J., & Hightower, H. (2006). Hearing the voices of abused older women. *Journal of Gerontological Social Work, Vol. 46, No3/4, 2006,* 205-227.

Holsti, O.R. (1969). Content Analysis for the social sciences and humanities. Philippines: Addison-Wesley.

Huston, P. (1990). Family care of the elderly and caregiver stress. *American Family Physician, 42, 3, September,* 671-677.

Ivry, J. (1992). Teaching geriatric assessment. *Geriatric Social Work Intervention.* New York: The Haworth Press.

Kakuma, R., Galbaud Du Fort, G., Arsenault, L., Perrault, A., Plat, R., Monette, J., Moride, Y., & Wolfson, C. (2003). Delirium in older emergency department patients discharged home: Effect on survival. *Journal of the American Geriatrics Society, 51 (4),* 443-450.

Kakuma, R., Galbaud du Fort, G., Arsenault, L., Perrault, A., Platt, R. W., Monette, J., Moride, Y., & Wolfson, C. (2003). Delirium in Older Emergency Department Patients Discharged Home: Effect on Survival. *Journal of the American Geriatrics Society 51 (4),* 443–450.

Kanel, K. (2003). A guide to crisis intervention. (2nd ed.). Thomson Learning Inc.

Kauh B., Polak, T., Hazelett, S., Hua, K., & Allen, K. (2005). A Pilot Study: Post-Acute geriatric rehabilitation versus usual care in skilled nursing facilities. *American Medical Directors Association.*

Kennedy, G.J. (2000). Geriatric mental health care: A treatment guide for health professionals. New York, NY: The Guilford Press.

Koocher, G. P., & Pollin, I. (1994). Medical crisis counseling: A new service delivery model. *Journal of Psychology in Medical Settings, 1, (4),* 291-299.

Koocher, G. P., Pollin, I., & Patton, K. (2001). Medical crisis counseling in a health maintenance organization: preventive intervention. *Professional Psychology: Research and Practice, 2001, Vol. 32, No. 1,* 52-58.

Krueger, L. W., & Neuman, W. L. (2006). Social work research methods: Qualitative and quantitative applications. New York: Pearson Education Inc.

Krippendorff, K. (1980). Content Analysis: An Introduction to Its Methodology. Newbury Park, CA: Sage.

Lamont, C., Sampson, S., Matthias, R., & Kane, R. (1983). The outcome of hospitalization for acute illness in the elderly. *Journal of the American Geriatrics Society, 31*(5), 282-288.

Lang, S. S. (2005). Elder abuse cited as urgent problem. (BRIEF REPORTS). *Cornell University, Human Ecology, March.*

Lindsey, A., & Hughes, E. (1981). Social support and alternatives to institutionalization for the at-risk elderly. *Journal of the American Geriatrics Society, 29*(7), 308-315.

Linzer, N. (2002). An ethical dilemma in home care. J*ournal of Gerontological Social*

Work, *37*, 23-34.

Mailick, M. (1982). Understanding illness and aging. *Journal of Gerontological Social Work, 5*(1/2), 113-126.

McCusker, J., & Verdon, J. (2006). Do geriatric interventions reduce emergency department visits? A systematic review. *Journals of Gerontology Series A-Biological Sciences & Medical Sciences, 61*(1), 53-62.

McInnes, E., & Powell, J. (1994). Drug and alcohol referrals: Are elderly substance abuse diagnoses and referrals being missed? *British Medical Journal, 308,* 444-446.

Miles, M, B., & Huberman A. M. (1994). Qualitative data analysis: an expanded sourcebook (2nd ed.). Sage Publications.

Minister of Public Works and Government Services Canada (2002). Canada's aging population: A report by Health Canada in collaboration with the

interdepartmental committee on aging and seniors issues. Division of aging and seniors. Health Canada: Ottawa, Ontario. Website: www.statscan.ca

Molinari, V. A. (1991). Mental health issues in the elderly. *Physical and Occupational Therapy in Geriatrics, 9*(3/4), 23-30.

Naleppa, M., & Reid, W. (2002). Integrating case management and brief-treatment strategies: A hospital-based geriatric program. *Social work in health care, 31*(4), 1-23.

Nathanson, I., & Tirrito, T. (1998). Gerontological social work: Theory into practice. New York, NY: Springer Publishing Company.

O'Connell, H., Chin, A., Cunningham, C., & Lawlor, B. (2003). Alcohol use disorders in elderly people- Redefining an age old problem in old age. (Clinical review) *British Medical Journal, 327,* 664-667.

Olsen-Noll, C. G., & Bosworth, M. F. (1989). American family physician; Alcohol abuse in the elderly. *American Academy of Family Physicians, 39*(4), 173-180.

Onwuegbuzie, A. J., & Johnson, B. R. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33, 7,* 14–26.

Onwuegbuzie, A. J., & Leech, N. L. (2005). Taking the "Q" out of research: Teaching research methodology courses without the divide between quantitative and qualitative paradigms. *Quality & Quantity: International Journal of Methodology*, *39, 3,* 267-295.

Paddock, K., & Hirdes, J. P. (2003). Acute health care service use among elderly home care clients. *Home health care services quarterly, 22*(1), 75-85.

Parboosingh, E., & Larsen, D. (1987). Factors influencing frequency and appropriateness of utilization of the emergency room by the elderly. *Medical Care, 25 (12),* 1139-1147.

Patton, M. Q. (1990). Qualitative evaluation and research methods (2nd Ed.). Newbury Park, CA: Sage Publications.

Patton, M. Q. (2002). Qualitative research and evaluation methods (3rd Ed.). Newbury Park, CA: Sage Publications

Payne, M. (1997). Modern Social Work Theory (2nd Ed.; pp. 95-113). Chicago Illinois: Lyceum Books Inc.

Payne, M. (2005). Modern Social Work Theory (3rd Ed.; pp. 98-117). Chicago Illinois: Lyceum Books Inc.

Podnieks, E. (2006). Social inclusion: interplay of the determinants of health-new insights into elder abuse. *Journal of Gerontological Social Work, Vol. 46, No. ¾,* 57-79.

Pollin, I. (1984). The task-interrupted dimension: Understanding the emotional components of a traumatic medical diagnosis. *American Journal of Hospice and Palliative Medicine, 1984; 1; 28;* 28-31.

Pollin, Irene. (1995). Medical crisis counseling: Short-term treatment for long term illness. Evanston, IL: Norton.

Powell, W. (1988). The "ties that bind": Relationships in life transitions. *Social Casework, 69*(9), 556-562.

Pyper, W. (2006). Balancing career and caring. *Perspectives on Labor and Income, 7, 11, November 2006,* 5-15.

Rahkonen, T., Eloniemi, S. U., Paanila, S., Halonen, P., Sivenius, J., & Sulkava, R. (2001). Systematic intervention for supporting community care of elderly people after a delirium episode. *International Psychogeriatrics, 13*(1), 37-49.

Reid, L., & Epstein, W. (1977). Task-centered practice. New York : Columbia University Press.

Rock, B., & Auerbach, C. (1994). A study of hospitalized elderly patients no longer acutely ill. *Journal of Social Service Research, Vol. 20 (1/2),* 1994.

Ron, P. (2002). Depression and suicide among community elderly. *Journal of Gerontological Social Work, 38*(3), 53-71.

Ronen, T., & Dowd, T. (1998). A constructive model for working with depressed elders. *Journal of Gerontological Social Work, 30*(3/4), 83-99.

Salahu-Din, S. (2003). Social work research: An applied approach. New York: Pearson Education Inc.

Shepard, P., Mayer, J., & Ryback, R. (1987). Improving emergency care for the elderly: Social work intervention. *Journal of Gerontological Social Work, 10*(3/4), 123-140.

Sorocco, K., & Ferrell, S. (2006). Alcohol use among older adults. *The Journal of General Psychology, 2006, 133(4),* 453-467.

Suk-Young Kang. (2006). Predictors of emotional strain among spouse and adult child caregivers. *Journal of Gerontological Social Work, 47*(1/2), 107-131.

Tutty, L.M., Rothery, M.A., & Grinnell, Jr., R.M. (1996). Qualitative research for social workers. Allyn and Bacon.

Templeton, V. (2005). Dementia care: An outpatient, community- based, multi-disciplinary approach. *NC Medical Journal, 66 (1),* 66-68.

Vernon, M., & Bennett, G. (1995). Age and ageing; 'elder abuse': The case for greater involvement of geriatricians. *Age and Ageing, 24(3),* 177- 180.

Vogt, W., P. (2007). Quantitative research methods for professionals. New York: Pearson Education Inc.

Weber, R. P. (1990). *Basic Content Analysis*, 2nd ed. Newbury Park, CA: Sage Publications.

Weuve, J., Boult, C., & Morishita, L. (2000). The effects of outpatient geriatric evaluation and management on caregiver burden. *The Gerontologist, 40 (4),* 429-436.

Wieland, D. (2000). Holistic nursing practice; abuse of older persons: An overview (statistical data included). *Holistic Nursing Practice, 14*(4), 40-50.

Wilkin, K. (2003). Social support and mortality in seniors. In *Statistics Canada Health Statistics Division Health Reports, 14, 3, May 2003.* Ministry of Industry. Ottawa.

Williams, J., & Koocher, G. P. (1998). Addressing loss of control in chronic illness: Theory and practice. *Psychotherapy, 35,* 325–335.

Wright, H., N. (1993). A practical guide for pastors, counselors and friends: crisis counseling. Here's Life Publishers, Inc: San Bernardino, California.

Wullschleger, K. S., Lund, D. A., Caserta, M. S., & Wright, S. D. (1996). Anxiety about aging: A neglected dimension of caregivers' experiences. *Journal of Gerontological Social Work, 26*(3/4), 3-18.

Zisserson, R. N., & Oslin, D. W. (2004). Alcoholism and at-risk drinking in the older population. *Psychiatric Times* (Feb 1, 2004): 50. *Health Reference Center Academic.* Thomson Gale. University of Manitoba. January 30, 2007.

Diagrams

Diagram A

General Terms used for Social Issues on Referral Forms

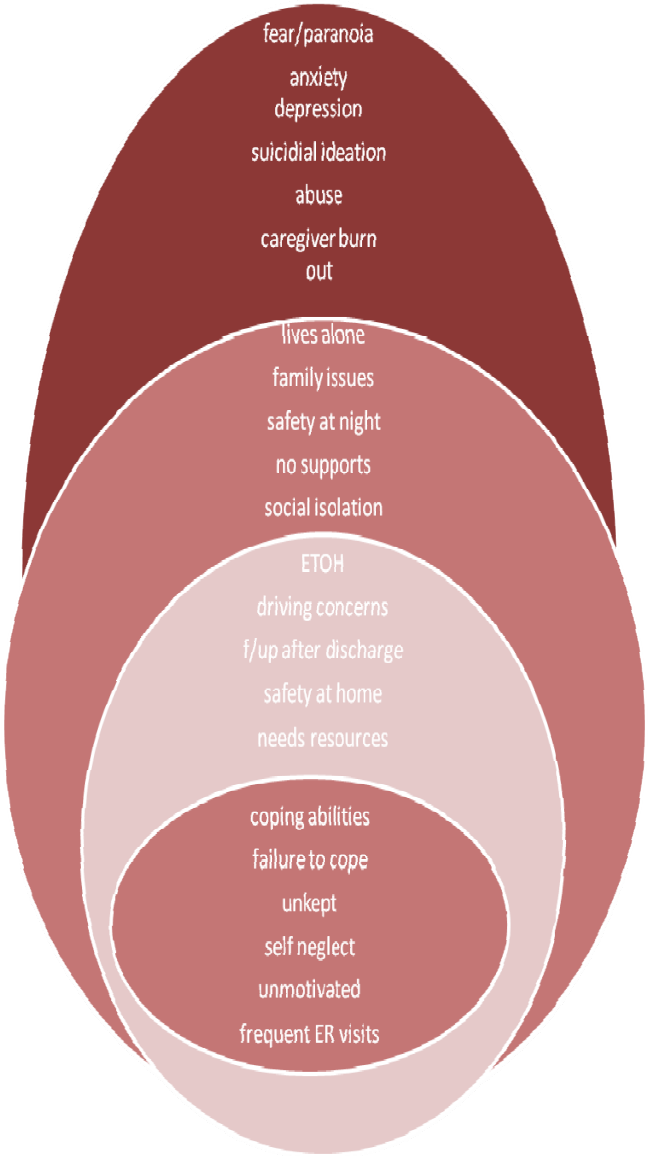


Diagram B

Social Issues not Identified

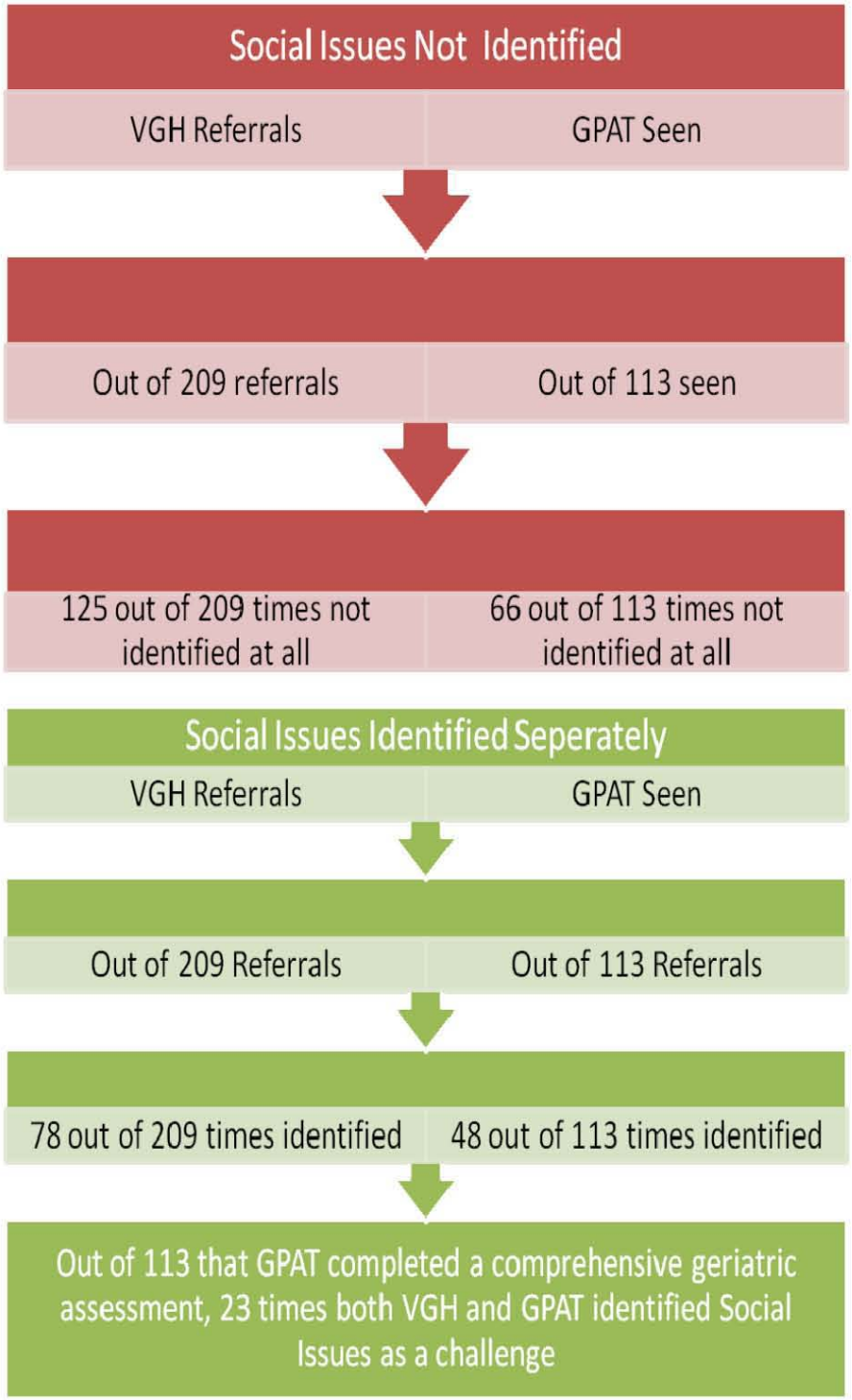


Diagram C

Reasons Identified for GPAT Not to See in Community

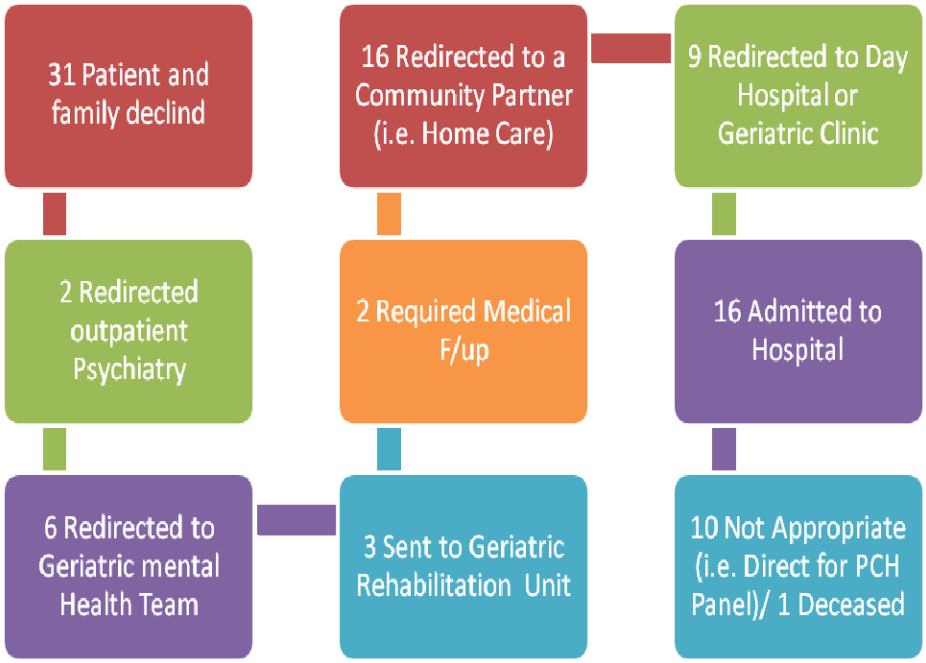
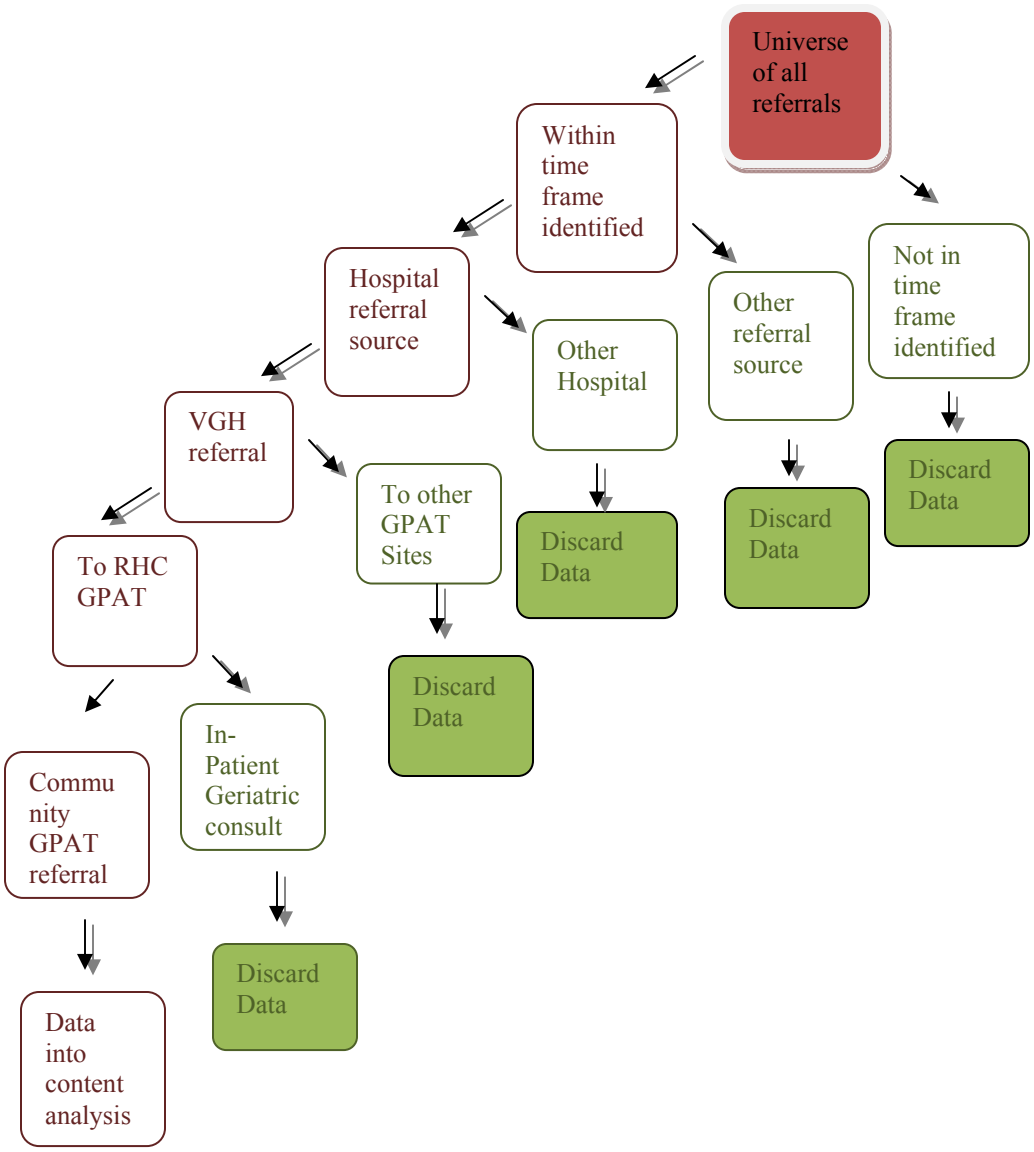


Diagram D - Schematic Design of Decisions Made in Content Sampling from a Universe of Referrals.



Tables & Figures

Table 5.1a

Original Confidential Data Collection

Chart Number	Gender	Initial & Full Name	Assigned Identification	Clinician Initials	Clinician Identification

Table 5.1b

Original Referral Information Data Collection

Chart #	Seen	Not Seen	Imm/ Falls	Fxn Decline	Cog/ Mem	Care Burd	Incont	Med	Mood	Social

Table 5.1c

GPAT Findings

Chart #	Clin ician	Year	Imm/ Falls	Fxn Decline	Cog/ Mem	Care Burd	Incont	Med	Mood	Social	Social Issues Definition

Table 5.1d

Strata Data Collection

Data Base

VGH ER Referral

RHC Team

	↓	↓	↓	↓	↓	↓	↓	↓	
Chart #	Immo bility/ Falls	Func tional Decline	Cog nitive Changes/ Mem ory Loss	Care giver Burden	Incont	Med ication	Mood	Social Issues	Other

Identified:

B= Both
G= GPAT

V= VGH

Table 5.2

Qualitative Coding Schematic

Imm/Fall	Fxn Decline	Cog Changes/ Mem Loss	Caregiver Burden	Incontinence	Medication	Mood	Social Issues
Chronic leg pain	Home management	Forgetful	Burn out	Odor	Polypharmacy	Personality	Home crisis
Knees buckling	Need for service	Inappropriate behavior	Wife burned out	Diapers	Trouble with pills	Anxiety	ETOH
Decreased tolerance	Family assisting	Wander risk	Family can't cope	Pad use	Memory pill	Anxious at night	No MD
Short of breath	No home care/? Home care	Delusion	Caregiver frustrated	Product	Increase meds	Angry	New MB resident
Needs walker/cane	Decrease ROM	Fluctuating memory	Difficult managing	Bowel issues	Decrease meds	Scared to be alone	Resources/future planning
Falling	? ADL fxn	Decline in memory	Stressed	Bladder issues	Sleeping pill	Unmotivated	Not coping/ failure to cope
Fallen	Decrease tolerance	Paranoid behaviors	Caregiver cognition		Blister pack	Depressed	? coping/ ?managing
Fear of falling	Not bathing	Change in behavior	Too reliant on caregivers		dosette	Sad	Abuse/ neglect
Needs equip	? Home fxn	Stove safety	Family dynamics		Old prescriptions	Self neglect	Cluttered environment
Difficult transfers	Not groomed	Burned pots	Poor family relationships		Medication abuse	Remains in bed	Home in disrepair
Hx of falls	Unkept	Poor MMSE score	Caregiver unable to leave			Lonely	Minimal/No supports
Tripped	Self neglect	Safety alone	? Respite care			Grief	POA/will
Near miss	Not eating	Combative/Aggression	Fighting with Spouse			Stopped activities	Isolated
Unable/diff to move	Loss of weight	Safety at home both have dementia	Family issues			Argumentative	Frequent ER/Failed discharge
Handicap parking/Handi transit	Nutrition	? Early signs of dementia	No supports for caregiver			Decreased Confidence	Alternative living

Weakness	Assess environment	Left against medical advice	Caregiver sick/Caregiver in hospital	Suicidal ideation	Driving
Geri Rehab	Requires assistance at home		? Safety for both		Discharge follow up
Pain	Assess current fxn		Dtr concerned		Lives alone
	Augment services		Pt asking for companion		?PCH Placement
	Assess pt and husband for services				Financial
	?Pt requires support				
	Assess management in home				

Figure 6a

209 VGH Referrals to GPAT- # of Times as Referral Reason

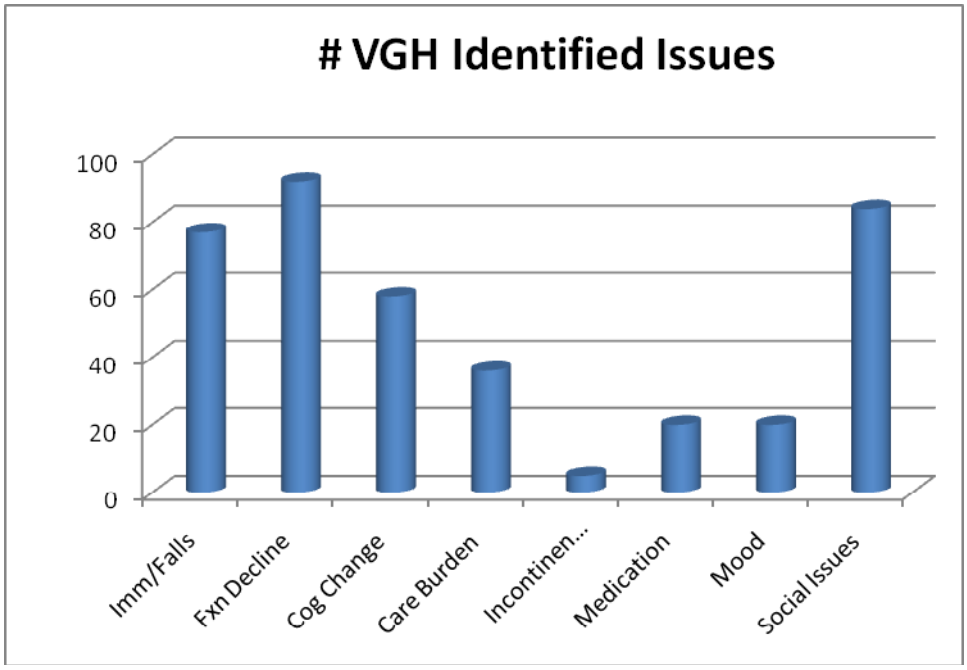


Figure 6b

113 Seen Referrals- GPAT Findings

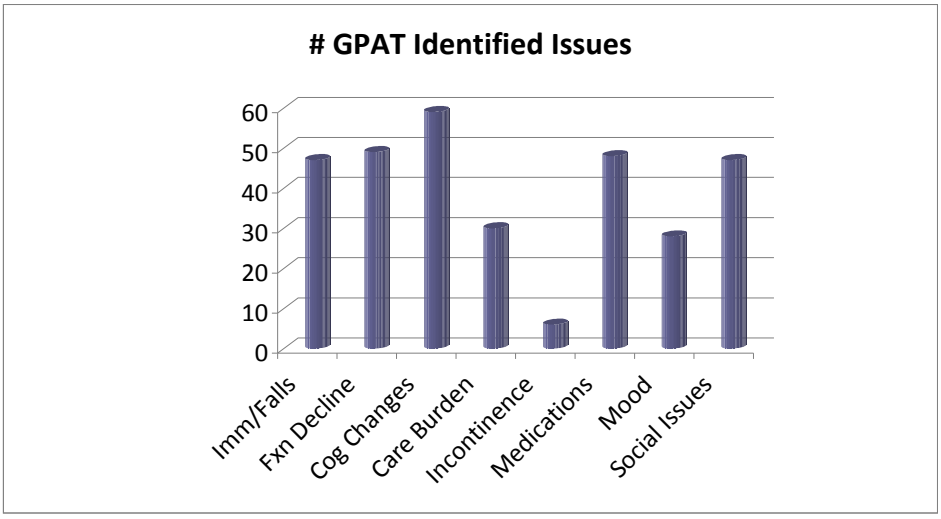


Figure 6c

Total % of 209 Referrals & the Findings Based on 113 Seen Referrals

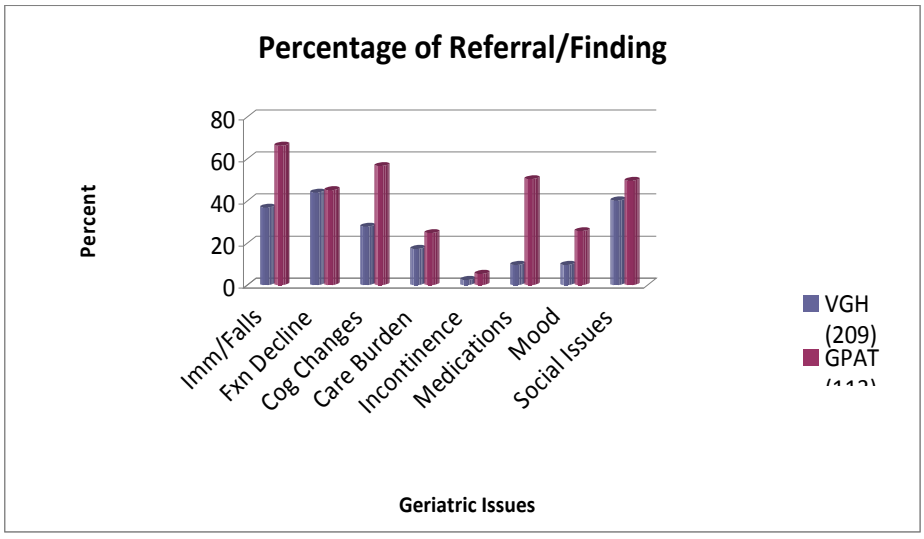


Figure 6d

Results of Referrals & GPAT Findings Based on 113 Seen Referrals

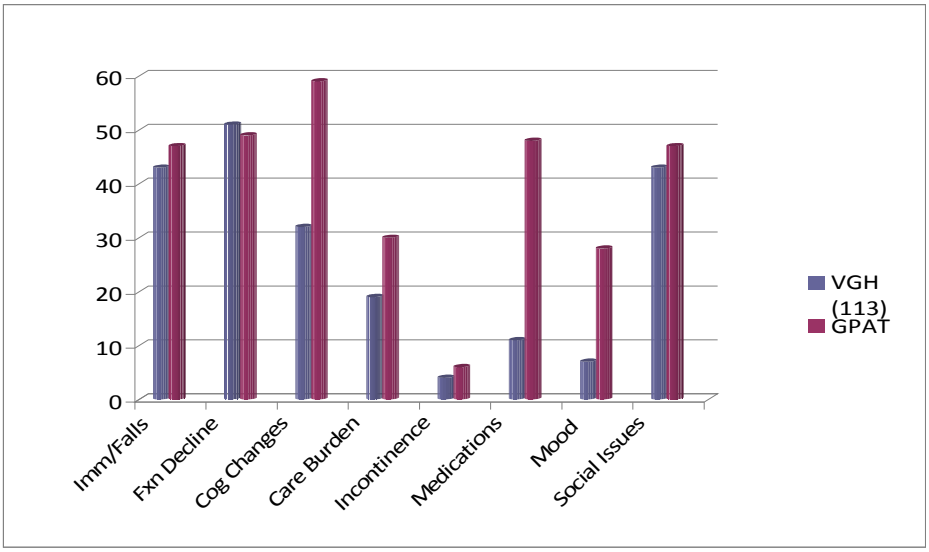
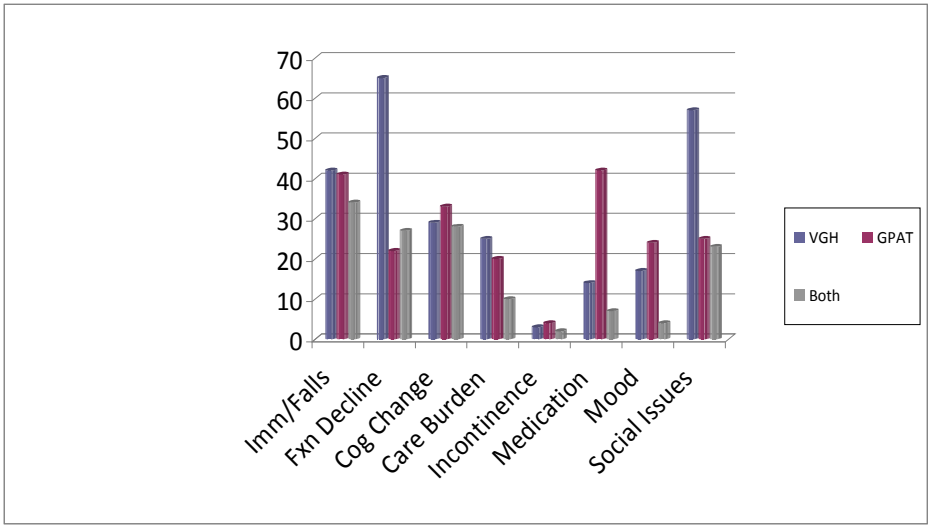


Figure 6e

Total Compilation of (209) Referrals and Who Identified as a Geriatric Issue.



Appendix A

Winnipeg Regio Health Authorit, Caring for Health À l'écoute de notre santé

Geriatric Program Assessment Team

PH#: (204) 982-0140; FAX#: (204) 982-0144

ASSIGNED TO: ☐ **CGH** ☐ **DLC** ☐ **HSC**
☐ **SBGH** ☐ **SOGH** ☐ **RHC**

☐ **DATE OF REFERRAL:** _____ **HIGH SAFETY RISK TO SELF OR OTHERS**

CLIENT'S NAME: _____ (M / F) PHONE #: _____

ADDRESS _____ Postal Code: _____

MHSC#: _____ PHIN#: _____

DATE OF BIRTH: _____ Age: _____ Languages spoken: _____

RESIDES WITH: ☐ Spouse ☐ Alone ☐ Other _____

AGENCIES INVOLVED:

Day Hospital _____; Mental Health _____; GPAT _____; R & G Clinician _____

Home Care Co-ordinator _____ Phone: _____ Fax: _____

Family Physician: _____ _____ Phone: _____ Fax: _____

Address: _____ Postal Code: _____

Is Physician aware of concerns? ☐ YES ☐ NO _____

☐ ☐
TO ARRANGE APPOINTMENT, CALL: **CLIENT, or** **CONTACT (S).**
Primary Contact: _____ Relationship: _____ Phone: _____
Alternate Contact: _____ Relationship: _____ Phone: _____
Has client been advised of referral? ☐ YES ☐ NO Are contacts aware of referral? ☐ YES ☐ NO

GERIATRIC ISSUES: ☐ Immobility / falls ☐ Functional Decline ☐ Cognitive changes or Memory Loss
☐ Caregiver Burden ☐ Incontinence ☐ Medication ☐ Mood ☐ Social Issues

DESCRIBE SITUATION (Include CURRENT and PAST MEDICAL HISTORY / MEDICATIONS / LABS / DIAGNOSITCS):_____

_____

_____

Date and location of last hospital admission or ER visit:_____

EXPECTATION (QUESTION) FOR THE TEAM: _____

_____

_____

REFERRED BY: _____**AGENCY:** _____**Ph.#:** _____

Print Message

From: Bruce Tefft Block Sender | Block Domain
Date: 2008/04/23 Wed PM 02:02:10 CDT
To:
CC: Margaret Bowman
Subject: Re: Ethical review

Dear Ms. Kliewer:

I have now reviewed the attached description of your research proposal. Based on this description, it appears that you plan to conduct a strictly archival (secondary) analysis of medical records, with each patient identified by number only (i.e., no personal identifiers will be recorded by you or reported in your findings). In this circumstance, it is the policy of the Psychology/Sociology Research Ethics Board that no application to the Board for ethics approval is necessary. Good luck with your research.

Sincerely,
Bruce Tefft, Chair
P/SREB

At Fri, 11 Apr 2008 9:27:05 -0500, skliewer wrote:

> Hi Dr. Tefft,
>
> Thank you for your voice message. I am attaching a letter for you to
> review. If you have any questions please do not hesitate to contact
> me either via email or telephone during the day
>
> Thank you for all of your assistance.
>
> Sande Kliewer
>

--
Dr. Bruce Tefft, C.Psych.
Associate Professor, Department of Psychology
Director, Psychological Service Centre
Chair, Psychology/Sociology Research Ethics Board
University of Manitoba
Winnipeg, Manitoba
R3T 2N2

Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé

January 9, 2008

Sande Kliewer

Dear Sande,

Re: Emergency Room Referrals to a Geriatric Outreach Team: The Analysis of Referral Reasons
WRHA Reference No: 2007-055

On behalf of Dr. Mike Moffatt, Chair of the WRHA Research Review Committee, thank you for sending the above-named proposal for our consideration.

Upon reviewing your application and in light of our subsequent correspondence, we have deemed that the Deer Lodge Research Committee would be better suited to handle your request. For your information, the application for research access at Deer Lodge can be found at the following URL: http://www.deerlodge.mb.ca/programs_services/research_info.asp.

We extend best wishes for successful completion of your project.

Sincerely,

David A. Hultin, MA
Coordinator, Research Review Committee
Winnipeg Regional Health Authority

cc. Chair, Deer Lodge Research Committee

Appendix D

Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé

DEER LODGE CENTRE
Making lives better

March 4, 2008

Sande Kliewer
University of Manitoba
Faculty of Social Work

Dear Sandy:

Re: Request for Research Access:
Emergency room referrals to a geriatric outreach team: the analysis of referral reasons.

Please find enclosed the approved "Request for Research Access" form for the project: "Emergency room referrals to a geriatric team: the analysis of referral reasons."

Harriet Maynard, Manager of Patient Care will be the temporary site facilitator for this project. Please contact Ms. Maynard at or through email: for any assistance or information you may require. When you have finished this study, please forward a copy of the project results to Michael Kaan in the Operational Stress Injury Clinic.

We are pleased to support this project and wish you every success in completing it.

Sincerely,

Real J. Cloutier
Chief Operating Officer