

ENDURING: THE EXPERIENCE OF
HOSPITALIZED ELDERLY PATIENTS

by

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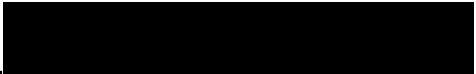
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Enduring: The Experience of Hospitalized Elderly
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Thesis directed by Professor Marilyn L. Stember.

The number of elderly hospitalized patients is increasing dramatically. Yet, the hospitalization experience of the elderly is not well understood. The purpose of this study was to explore the hospitalization process as perceived by elderly patients, family members, and nurses caring for these patients. The design of the study was grounded theory. Data were generated and theory derived from the environmental context of the data. Ethnographic interviews were conducted with eight white, middle-class elderly patients (aged 66 to 83 years), seven family members, ten nurses, and a patient representative in an acute care setting. Other methods of data collection included participant observation and review of medical records. Data analysis included the constant comparative method of systematically collecting and analyzing data until categories were saturated and a core variable emerged.

Substantive theory was developed from the analyses. ENDURING THE EXPERIENCE described the theory that elderly patients engage in a process

that allowed them to "bear it" until they could be dismissed from the hospital. The theory included six categories: (1) Accepting Assistance--describes the willingness of informants to engage in care giving/receiving behaviors; (2) Believing It Will Be OK--describes the informant's thoughts and feelings that someone or something will provide patients with the needed elements; (3) Playing the Game--depicts thoughts and actions of informants to get through the ordeal, with as few disturbances as possible; (4) Protecting--reflects thoughts and actions taken by informants to shield the patients/family members against negative consequences; (5) Remembering--refers to informant's thoughts of past illnesses/hospitalization; and (6) Worrying--describes the frequent distressing thoughts experienced by the informants.

The substantive theory of ENDURING THE EXPERIENCE was depicted by a conceptual model and compared to models of stress/coping. This research provides the groundwork for further formal theory of the elderly person's hospitalization experience. Results of the study may be helpful in the understanding of problems related to the hospitalization experience itself and identifying

interventions that could facilitate this experience
for elderly patients and families.

The form and content of this abstract are approved.
I recommend its publication.

Signed

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CHAPTER I

INTRODUCTION

The majority of elderly people will experience hospitalization at some point in their older years. Admission to a hospital provides people with the technology and skilled care that is not currently available on an outpatient basis. Unfortunately, the hospitalization experience may also create other problems. Illness and hospitalization create a crisis situation for most people regardless of age; however, elderly people are perceived as the least likely to adapt successfully because they have less physiological energy reserve and declining capacity to adapt to unfamiliar environments (Gioiella & Bevil, 1985; Gunter, 1983; Kopac, 1983; Snope, 1989; Warshaw, Moore, Friedman, Currie, Kennie, Kane, & Mears, 1982). Considerable literature depicts the negative effects upon the elderly when changing environments, particularly relocation to a nursing home. Less information is known about the effects of

hospitalization upon the elderly, although several studies have identified mental and physical impairment that results from hospitalization in previously unimpaired elderly people. These studies have begun to identify the unique problems that elderly patients, and the often unprepared health professionals who care for them, must face in an acute care setting.

Little is known about how to intervene in these problems. Some authors have suggested the use of special geriatric units staffed by health care professionals with specialized geriatric knowledge and skills, but no consensus exists on the cost effectiveness, proper staffing, or target patient population of such units (Rowe, 1985).

As noted in the literature relating to hospitalized elderly patients, most researchers have used a quantitative approach and measured specific variables thought to be influenced during hospitalization. However, some of these researchers have recognized that important factors and relationships relating to hospitalized elderly may be overlooked by quantitative approaches. In a quantitative study of stress, hospitalization, and aging, Mezey (1979) emphasized the need for further study of elderly people's subjective response to

hospitalization. Since Mezey's report, only a few researchers have examined the hospitalization process from the perspective of the patient or family members. These researchers reported that many improvements are needed in the hospital care of elderly patients. It seems clear that if improvements are to be made in the care of hospitalized elderly patients, examination of the process of hospitalization from the perspective of those involved should be the first step in this direction.

Purpose of the Study

The overall goal of this investigation was to explore the hospitalization process as perceived by elderly patients, family members, and nurses caring for these patients. Specific aims were as follows:

- (1) To describe the process of hospitalization as perceived by elderly patients, family members, and nurses;
- (2) To identify problems that relate to the hospitalization process of elderly patients; and
- (3) To propose substantive theory grounded in the data that could provide the framework for formal theory.

Definition of Terms

The following terms were defined for clarification of meaning within this study:

Elderly patient. An adult, age 65 years or older, hospitalized in an acute care setting.

Family member. An individual, age 18 or older, identified by the elderly patient as his or her family member.

Nurse. A registered nurse employed by the acute care hospital.

Hospitalization. Voluntary admission to an acute care agency that provides medical and nursing care.

Patient Representative. A person employed by the acute care agency to facilitate patient relations within the hospital system.

Significance of the Study

Approximately 50% of hospitalized patients are elderly (Engle, 1986), yet little attention has been given to the impact of this event on their lives. Several authors emphasized the need for gerontological nursing studies particularly those

involving hospitalized older adults (Burnside, 1984; Engle, 1986; Mezey, 1979; Wolanin, 1983). Compared to younger adult patients, elderly patients present unique clinical problems during hospitalization. Elderly patients tend to be sicker with multiple health problems and tend to be hospitalized longer when compared to the total population (Lueckenotte, 1987).

Several negative effects associated with hospitalization have been observed in elderly patients. One researcher found that one-half of all patient accidents in a large hospital involved elderly patients and the greatest risk occurred within the first week of hospitalization (Catchen, 1983). Others have described the psychological and physiological impairments that occur during hospitalization of elderly patients who were unimpaired prior to the hospitalization. In a sample of 99 hospitalized elderly patients, Chisholm, Deniston, Igrisan, and Barbus (1982) found a daily prevalence rate for confusion of 6%, but 55 out of the 99 patients had acute confusion during their hospitalization (only 5 of the 55 were diagnosed as confused at the time of admission). The average onset of confusion was around the sixth day after admission. Roslaniec and Fitzpatrick

(1979) found that disorientation increased, level of consciousness decreased, and memory improved in elderly patients during four days of hospitalization. However, the authors believed the improvement in memory resulted from instrumentation error.

Gillick, Serrell, and Gillick (1982) found that 30% of 429 patients over age 70 without prior mental impairment demonstrated some confusion from the hospitalization experience itself. They also found that 27% of the 429 patients were incontinent, 16% were not eating, and 5% had fallen with no apparent medical explanation for their symptoms (other than hospitalization). Williams, Campbell, Raynor, Musholt, Mlynarczyk, and Crane (1985) explored the predictors of confusion in elderly hospitalized patients and discovered over 50% of a sample of 170 patients from four hospitals with no prior mental impairment demonstrated some confusion after surgery for a hip fracture. The strongest predictors were pain, narcotics, and mobility.

These studies strongly suggest problems related to hospitalized elderly patients that are not being addressed by health care professionals. One reason for nurses not meeting the needs of the elderly patient may be the lack of gerontological

nursing knowledge (Huckstadt, 1983). Other reasons may include the well documented negative attitude toward the aged and aging of health care professionals and students.

Gerontological nursing practitioners have continued to be concerned by the lack of sensitivity and knowledge of basic human needs by nurses and other health care providers when dealing with the elderly (Lueckenotte, 1987; Phillips, 1987). Bossenmaier (1982) observed 15 registered nurses providing care with elderly patients and evaluated four variables: touch, verbal communication, control, and physical care. She concluded the nursing care was inadequate 20% to 50% of the time.

The number of hospitalized elderly continues to increase and the need for nursing care of these patients is multiplying. Using the Western Interstate Commission for Higher Education (WICHE) model for projecting the supply and requirements of nursing, Oakley (1986) calculated

. . . in 1980 just over 40% of direct care, in-hospital RN FTEs were required to care for people aged 65 and older. By the year 2000, almost one-half, 47%, will be required for care of the elderly; and by the year 2050, the model shows that nearly 80% would be required to care of the elderly. (p. 347)

If nursing is to face the challenge of providing care for these complex patients, more

research is needed in the area of hospitalized elderly patients. This investigation provides one effort in this pursuit. Because every research method has certain bias and presents only a partial view of the total issue, using different methods for the study of hospitalized elderly may allow convergence of information and present a wider perspective. A naturalistic view may shed new light on the troublesome understanding of the hospitalization process of the elderly and may provide a foundation for further studies.

Summary

The purpose of this study was to explore the hospitalization process as perceived by elderly patients, family members, and nurses caring for these patients. Identifying problems related to the hospitalization and developing substantive theory that is grounded in the data were goals of the study.

The following chapters of this dissertation provide the reader with the qualitative research process used in this study, findings, and implications. In Chapter II, the review of literature relating to hospitalized elderly patients is provided. The research design and methods are

identified in Chapter III. A profile of the cases in the study is summarized in Chapter IV. The analysis process is described in Chapter V, and the emerging core variable and linking theoretical constructs are discussed in Chapter VI. A comparative view of stress and coping models with the core variable and constructs is provided in Chapter VII. The dissertation is concluded in Chapter VIII with the implications for nursing practice, education, and research.

CHAPTER II

REVIEW OF LITERATURE

In a qualitative research study such as this one, the review of literature is integrated with the analysis of data. Primarily reflected were quantitative research studies of hospitalized elderly patients with a few qualitative studies reported. In addition to research studies, the review of literature included non-research publications related to hospitalized elderly persons that were found in nursing, medical, and health related publications. These latter publications were primarily written by geriatricians or gerontological nurses who were employed in clinical settings with elderly patients.

Throughout the literature review authors recognized that hospitalization presented special concerns for elderly patients and those caring for them. Cognitive disturbances, physiological changes, psychological dependency, and numerous other hazards were noted for elderly hospitalized

persons. Authors also reflected considerable concern relating to methodological problems in some reported studies and in gerontological research in general. This literature review addresses those issues.

The benefits of hospitalization are rarely addressed in the literature. Positive aspects of hospitalization for elderly persons undoubtedly exist and the reader is cautioned that the literature on this topic reflects primarily the negative aspects of hospitalization.

Cognitive Disturbances

Cognitive disturbances in elderly hospitalized patients have been reported in several studies in both medical and nursing literature, including British publications. The complexity of this condition continues to baffle researchers who are attempting to sort out causal relationships. Regardless of the etiology the problems related to cognitive disturbances can be devastating.

One British medical study by Johnston, Wakeling, Graham, and Stokes (1987) screened all patients (n=204) over age 65 for cognitive impairment and emotional disorder in a general teaching hospital. Three instruments (Clifton

Assessment Procedures for the Elderly-Information and Orientation, CAPE; the Mini-Mental State, MMS; and a scaled version of the General Health Questionnaire, GHQ-28) were used. Those patients scoring in the disordered range were further assessed by psychiatrists. Of 164 patients who were satisfactorily assessed, 22% were cognitively impaired. These patients were found to have significantly longer hospital stays not because they were being treated for the problem but primarily because they could not be discharged due to lack of an appropriate place. While no attempt was made in this study to determine previous cognitive status or other associated variables with the cognitive impairment, a number of studies have further examined the occurrence of cognitive impairment upon or during hospitalization.

In addition to the studies documenting occurrence of confusion in previously alert elderly persons (i.e., Chisholm et al., Gillick et al., Williams et al., and others discussed in Chapter 1), more recent researchers have also found alarming rates of confusion among hospitalized elderly. Foreman (1989) studied the incidence, onset, and variables associated with the onset of confusion in 71 nonsurgical patients over the age of 60 years,

who were admitted to critical care units of a university teaching hospital. Unlike the above study by Johnston et al., patients who were confused upon admission or had a chronic form of cognitive impairment were excluded from Foreman's study.

Foreman found the incidence of confusion in this study's sample to be 38% (n=27). This figure is higher than the 30% reported by Gillick et al., and lower than the 50% found by Williams et al. In Foreman's study the majority of patients exhibiting confusion did so by the second day of hospitalization (19 out of 27 cases) and no further cases of confusion were detected after the sixth day of hospitalization. However, Chisholm et al. found the average onset of confusion to be around the sixth day after admission. No significant differences were found in Foreman's study between the group of confused patients and a nonconfused group with respect to age, sex, race, and admitting medical diagnosis. Depression level and educational preparation were significantly different between the two groups and were treated as covariates in later analysis. A further examination of physical and psychological variables revealed that hypokalemia, hypernatremia, hypoglycemia, hypotension, elevated blood levels of urea nitrogen and creatinine,

receiving more medications, being perceived as confused by nurses, having more orienting objects within the patient's immediate environment, and having fewer interactions with significant others were the variables most associated with confusion.

While Foreman was careful not to identify the above variables as causal variables to confusion, she concluded that these factors were associated variables in her study and necessitate further study. The time of onset of the confusion may also suggest that confusion happening at different times of hospitalization may have different associated factors. Foreman concluded that:

confusion developing rather precipitously after admission to the hospital, as was the case in this study, may indicate that the underlying cause is some combination of stresses related to hospitalization and the associated physical illness. Confusion developing later in the course of hospitalization may indicate the underlying cause to be iatrogenic in nature. (p. 26)

Other attempts to categorize the phenomena of cognitive impairment in elderly hospitalized patients have been reported. Roberts and Lincoln (1988) constructed a theoretical model of cognitive disturbance and tested it with 94 hospitalized and institutionalized elderly persons (65 years old and older). The authors stated:

that [the model] depicted the relationships among cognitive disturbance, neural function, physiological alterations, neural structure, sensory deficits, activity limitations, mental health, drugs, and environmental deficits. (p. 310)

Using path analysis, neural function was found to be the only variable in both the hospitalized and institutionalized groups that was significantly associated with greater cognitive disturbance. Neural function was defined as "the basic functions of the central nervous system required to interpret and respond to the environment in a purposeful manner" (p. 310). The two groups differed in amount of variance explained by the model and also differed in the number and type of significant path coefficients. In the hospitalized group, 39% of the variance in cognitive disturbance was explained by the model with seven significant path coefficients. Neural structural changes and physiological alterations were thought to contribute indirectly to cognitive disturbance by their effects on neural function. Also the "neural function indirectly affected cognitive disturbance through its effects on sensory deficits" (p. 309). The institutionalized group had 49% of the variance explained by the model and four of the path coefficients were significant. Environmental deficits and neural functions were found to be

significantly related to greater cognitive disturbances.

Findings from the Roberts et al. study support the viewpoint that not all cognitive disturbances in hospitalized elderly patients have similar underpinnings but rather are influenced by many factors. The significant differences between groups for the variables included in this study suggest the need to further explore these factors. Roberts et al. suggested that different interventions are needed to reduce cognitive disturbances in these two groups of elderly persons. The sensory deficits found to be associated with cognitive disturbance in the hospitalized group may stem from physiologic changes, and owing to the limited time the elderly person has to adapt to sensory changes in a hospital, may result in cognitive disturbance. Disruptions in the institutionalized elderly person's environment resulted in more cognitive disturbance than in the hospitalized group. The authors suggested this may have resulted because institutionalized elders do not expect changes in their environment which may be perceived as more permanent than a hospital setting. Therefore, interventions for institutionalized elders may need to focus on environmental aspects

(e.g., orienting) while interventions for hospitalized patients may need to focus on physiologic problems and improving sensory function. However, these authors like many in gerontological research, identified measurement problems with this study. For many of the variables, no instruments with estimated reliability and validity were available. These variables were estimated using factors accepted by clinical consensus. The large amount of unexplained variance in the model also suggested the omission of important variables. The authors indicate future studies should focus on the multivariate effects on cognitive disturbance and interventions that may reduce this disturbance.

One nursing study examined interventions directed toward preventing confusion in elderly patients. Nagley (1986) conducted a quasi-experimental study of 60 hospitalized patients who were over age 65 and had met other study admission criteria of English speaking, ability to hear and see, and not confused (scoring four or less on the Short Portable Mental Status Questionnaire, SPMSQ). The experimental group (n=30) received 16 deliberate nursing actions implemented in the patient's daily care aimed at preventing confusion while the control group (n=30) received only routine

care. Each subject's mental status was measured within 24 hours of admission and on day four of their hospitalization using the SPMSQ and CAMS (an investigator designed instrument). A moderate degree of correlation ($r=.63$) was reported between SPMSQ and CAMS scores. No significant difference was found in the mental status scores between the two groups. However, unlike studies by Gillick et al. and others previously described, the majority of subjects in Nagley's study groups did not demonstrate mental confusion on day four of hospitalization. Nagley believed this may be due to excluding patients that may have a tendency to become confused (e.g., those with vision or hearing problems) from this study. Also, the actual implementation of nursing actions lacked control, as well as the control group may have received similar actions. Another difficulty that may have plagued the study included that data were collected only during day hours which was "intentionally selected to avoid a confounding factor referred to as 'sundown syndrome'" (p. 30). This confusional state is thought to occur during nighttime. Also the difficulties of measuring confusion and measurement ending at day four rather than extending data collection over a longer time period were addressed.

Even when research is not the focus, measurement of confusion in a clinical setting is difficult. To determine how well nurses assessed cognitive impairment, Palmateer and McCartney (1985) compared the number of cognitively impaired elderly identified by a mental status exam (Cognitive Capacity Screening Exam, CCSE) with the number of cognitively impaired elderly identified by present nursing assessment techniques (determined by review of nurses' notes). In addition a self-report questionnaire was given to the nurses to determine their perceptions of their assessment techniques. One hundred eighty-two of the 435 patients over 65 who were admitted to one of four general medical/surgical units of a hospital during a six week period of time were given the CCSE. Sixty-five individuals (36%) received a score suggesting cognitive impairment. When nurses' notes were examined for statements recording cognitive impairment, only 18 (28%) of the 65 patients were also identified by the nurses to have cognitive impairment. No documentation of a formal mental status examination was found on any of the 182 charts reviewed. The self-report questionnaire revealed that the majority of nurses in this study believed they were responsible for performing a

mental status examination, but 36% did not feel sufficient time was given to conduct such an assessment upon admission. Concerns about whether the examination results would be used were reflected by the fact that "only 55% of the nurses felt that physicians would believe a nurse's assessment" (p. 11). A knowledge portion of the questionnaire revealed that these questions were answered correctly by some nurses, but "67% incorrectly answered the true-false question regarding the earliest manifestation of dementia, and 47% incorrectly defined disorientation" (p. 11).

Palmateer and McCartney concluded that the nurses' failure to identify patients with cognitive deficits may be due to the nurses': (1) lack of knowledge about formal mental status testing; (2) incompleteness of cognitive assessments; (3) less skill at detecting less overt deficits; and (4) unwillingness to assume cognitive impairment if the patient appears superficially intact. The fourth factor was thought to relate to collaborative statements regarding social interaction and self-care that may have biased the nurses' assessment of mental status.

Palmateer and McCartney reported that their study supported the need for a standardized

assessment tool for mental status that could be used during admission to a hospital. The authors also recognized problems were associated with the use of only the CCSE to determine cognitive deficits in this study. They also indicated that the process by which nurses failed to identify cognitively impaired patients was only speculative and that the agency in which the data were collected may be unique and therefore, not generalizable to other institutions.

In summary of the above studies, cognitive impairment develops in some hospitalized elderly patients. While some studies looked only at the prevalence, others examined the onset and associated factors. The condition also appears to be difficult for researchers to measure and for practitioners to clinically assess. Cognitive impairment is one of the conditions that may occur in hospitalized elderly and may be associated with other conditions. The next section relates to iatrogenic conditions.

Iatrogenic Conditions

A multitude of iatrogenic factors have been reported in hospitalized patients or associated with admission to the hospital for persons of all ages. Steel, Gertman, Crescenzi, and Anderson (1981) found in their study of 815 consecutive patients in a

university hospital that 290 patients (36%) had one or more iatrogenic illnesses. The illnesses were considered life threatening or disability producing in 76 patients (9%) and in 15 patients (2%) believed to have contributed in the patient's death. When the patient's chronological age, drug exposure, and length of stay were examined, each had a positive association with iatrogenic complication ($p < .001$), but the logit model indicated age was secondary.

Researchers indicated that:

older patients were more likely to be admitted to the hospital in fair or critical condition than were younger patients (chi-square, 27.2; $p < 0.0001$ with age in the three categories of under 65 years, 65 to 74, and 75 and over). (p. 640)

This study reflected that iatrogenic conditions occur in elderly patients not because the patients are older, but because they tended to be in more serious condition. Steel et al. pointed out that the benefits of hospitalization may exceed the risks, but the hazards must be examined and efforts must be made to reduce the number and severity.

Drug therapy appeared in many of the publications relating to iatrogenic conditions in persons of all ages. Lakshmanan, Hershey, and Breslau (1986) studied 834 admissions in a public teaching hospital and found 47 iatrogenic events and 45 iatrogenic admissions. These authors believed

59% were avoidable. Drug therapy was primarily the cause. Age, number or type of diagnoses, or number of medications on admission were not found to be correlated with iatrogenic incidence. Colt and Shapiro (1989) found in their study of 244 elderly patients that patient status and number of medications were significantly associated ($p < .005$) with drug-induced illness as a cause for hospital admission.

Montamat, Cusack, and Vestal (1989) pointed out that regardless of whether age itself is a factor, elderly people experience more adverse drug reactions than younger people. However, Nolan and O'Malley (1988a) reviewed numerous studies of elderly inpatient and outpatient hospital patients and adverse drug reactions. Similar to the findings by Steel et al. in their study of iatrogenic illnesses, Nolan and O'Malley found that adverse drug reactions are more common in elderly patients, but little evidence is available to infer that adverse drug reactions can be attributed to biological aspects of aging. Nolan and O'Malley concluded that "the elderly patient will not experience an adverse reaction simply because of old age" (p. 147). Other variables such as polypharmacy, multiple and severe disease states,

physiological changes, environmental influences, psychological factors, and others may be important contributing factors to adverse drug reactions.

In a later publication, Nolan and O'Malley (1988b) examined literature relating to physicians' drug prescribing patterns for the elderly and concluded that the number of drugs prescribed for patients in the hospital increased with patient age. Specific information regarding appropriateness of such prescribing is not available. Whatever the factors, drugs do appear to predispose elderly person, particularly hospital patients, to adverse drug reactions such as altered drug disposition and drug response.

The result of iatrogenic incidences may manifest themselves in a variety of ways in the elderly person. Halevy, Gunsherowitz, and Rosenfeld (1988) examined severe life-threatening hypokalemia in serum biochemical profiles of patients in a 13 year period at a major university hospital in Israel. Hypokalemic conditions were found in 130 patients (.03%) with 84 being female with a mean age of 64 years. After examination of several factors the authors concluded that this condition commonly resulted from multiple iatrogenic factors such as

administration of intravenous fluids with insufficient or no potassium.

In another physiological study, Snyder, Feigal, and Arieff (1987) examined 15,187 consecutive hospital admissions of patients age 60 and over, in a large teaching hospital. These authors found 162 (1.1%) patients had elevated serum sodium levels. The majority of the patients (57%) became hypernatremic in the hospital while the other patients (43%) were hypernatremic at the time of hospitalization. Snyder et al. concluded that the majority of these cases were iatrogenic and indicated serious related systemic illness.

Elderly persons are at risk for iatrogenic conditions when they come in contact with the health care system. Steel (1984) estimated that 50% of the patients admitted to a large teaching hospital in Boston were 65 years of age or older. However in his review of patient history taking and physical diagnosis in eleven medical textbooks found in most medical libraries in the US and "together account for almost all texts used for teaching of physical diagnosis in the United States" (p. 445), not one mentioned geriatric medicine. Some evidence also exists that elderly patients receive less diagnostic appraisal. In a study by Radecki, Kane, Solomon,

Mendenhall, and Beck (1988), data from a national study of 28,265 ambulatory visits to internists, family and general practitioners were reanalyzed to determine age-related differences in care. While internists used more tests for all age groups than family and general practitioners, results indicated that diagnostic testing occurs significantly less for patients age 75 years or older. These authors stated that this suggests "a pattern that makes little sense based on the known distribution of disease and functional disability in aging populations" (p. 719). These authors acknowledge that the original data were from a 1976 to 1978 time period and that some changes in physician practices may have occurred over the last decade, but they believe until changes in practice are validated that these data should be considered.

Medicine may now have incorporated geriatrics into each medical student's academic curriculum. Even if geriatrics has recently been included in medical education and gerontological nursing has been included in nursing education, the authors of studies relating to iatrogenic illnesses in the elderly report that this cohort remains at risk.

Complications of treatments are the major iatrogenic incidences for the elderly mentioned in the literature. These complications are frequently measured by length of hospital stay, confusion, blood chemistries, prolonged morbidity, mortality, and other quantifiable means. Other iatrogenic complications have not been explored. Patterson (1986) indicated less easily measured factors such as cost to the patient, quality of life, and other less observable factors that may be related to iatrogenic incidences were not found in the Medline search covering the period of 1975 to 1984. These factors per se were also not found for the writer of this paper in several computer and hand searches of medical and nursing literature covering the period of 1984 to 1989. However, the literature reflects some publications relating to perceived stresses, level of satisfaction, and other factors of hospitalized patients that may be associated with iatrogenic complications.

The next section focuses on hospitalization of patients in general, followed by a review of publications relating to elderly patients in particular.

Hospitalization

At a time when an individual's maximum physical and psychological strengths are needed to overcome illness, hospitalization may add another stressor. Ahmadi (1985) examined the level of stress (using the Volicer Hospital Stress Scale), social support, and satisfaction of 100 hospitalized medical patients ranging in age from 33 to 81 years (mean age 58 years). The mean stress score for patients was found to be quite high and higher than scores from earlier studies. Some instrumentation problems were reported in this study and the author urged patient experience to be further investigated using a phenomenological approach.

O'Malley and Menke (1988) examined perceived stress in seven hospitalized patients aged 40 to 70 years, who had suffered a myocardial infarction. Using the Volicer scale, these authors found that missing one's spouse and unfamiliar surroundings were the two factors with the highest percentages of perceived stress.

Perception of stress for elderly hospitalized patients was examined in a British study by Davies and Peters (1983). They interviewed 25 patients, aged 70 to 93 years, who were hospitalized on a short stay geriatric ward, and

their nurses. A 16-item stress scale was used to determine the patient's perceived stresses during the first and third weeks of hospitalization. The most severe stress rated by both nurses and patients during the first testing (first week) and again by patients at the second testing (third week) was "thinking about home." In a comparison of nurses' perceptions of what patients saw as stressful and what patients perceived as stressful, significant differences were revealed. More differences were noted between groups for items relating to the hospital environment and routine such as noise, early morning routines, toileting, and privacy than about physical aspects of illness such as drugs, discharge data, discomfort, and treatments. Patient concerns regarding hospital routines tended to intensify for patients rather than be reduced at the second testing. Nurses, on the other hand, perceived these stresses to be reducing. Davies and Peters suggested that:

the phenomenon of those who work in an institution becoming so accustomed to its aversive aspects that impact on the newcomer is overlooked. This effect may have been operating in the present investigation. (p. 104)

Overall Davies and Peters found a low level of stress reported by the patients. This is opposite of what Ahmadi (described above) found in

her study of a wider age range of patients. While these two studies are dissimilar in many aspects, such as country of setting and instrument used to measure stress, the lower level of stress perceived by elderly hospitalized patients deserves further investigation. Davies and Peters suggested that a possible reason may be that "older patients may have lower expectations of care and find modern hospital conditions exceed their anticipations" (p. 104). These authors also stated the five point rating scale used in this study may have presented problems. In addition, age-related response bias such as denial of difficulties or making light of the situation may have existed.

Satisfaction with some hospital services has been correlated with age. Carmel (1985) found in her study of patient satisfaction and type of service provided in an Israeli hospital that age was a significant predictor of satisfaction with physicians and supportive services, but not with nurses. Carmel was uncertain why age was not a predictor for satisfaction with nurses but stated a possible explanation for patient satisfaction with physicians and supportive services was:

that in western societies, where old age is a disadvantage, older people, in order to avoid frustrations in their social interactions,

expect less and value more the things that they do get. (p. 1247)

Whether elderly people expect less in hospitalization is not known. No additional reports from researchers examining this viewpoint were found. One study's focus was reasons why elderly people refuse hospitalization. Barry, Crescenzi, Radovsky, Kern, and Steel (1988) investigated a group of 35 elderly persons who had refused hospitalization and compared them to a group of 70 elderly patients who had accepted hospitalization in an urban Boston university hospital during an 18-month time period. Common reasons for refusing hospitalization related to a passive acceptance of death or to some negative aspect of hospitalization such as previous negative experience, desire to avoid invasive procedures, fear of hospitals, and a mistrust of the medical system. Those refusing hospitalization were significantly less ill as determined by a clinician at the time hospitalization was recommended, and they did not change in health or functional status at follow-up compared to those elderly accepting hospitalization. The authors concluded that these elderly persons refusing hospitalization, while acutely ill, were stable and may have reasonable outcomes when treated at home.

The negative experiences and mistrust of the medical system expressed by those refusing hospitalization in the above study has been acknowledged by writers in both medical and nursing literature. One medical writer, Falk (1987), vividly depicted the depersonalization of the hospital experience as he described the experiences of an 81 year old man, once the author's teacher and a respected, intelligent, active man, who had been reduced to an object by a hospital system that "bred such behavior lacking in human feeling" (p. 1134). Kruczek (1986) also provided an experiential discussion in the nursing literature with her article entitled, "How Hospitals Hurt Old People." Kruczek stated "it's not unusual for hospital stays to turn functioning old people into helpless dependents" (p. 17). The author described the confusion, the patient's loss of control, and environmental factors which aggravate the negative situation.

One researcher (Lorensen, 1985) explored the self-care activities of 100 elderly patients admitted to a "modern, urban 920-bed hospital" (p. 252) in a Danish community. This author found that patients lacked assistance with walking, personal

hygiene, management of their affairs, and psychological support.

Lueckenotte (1987) echoed that the elderly hospitalized person is highly vulnerable. The normal age-related changes, multiple chronic health problems, negative attitudes toward the aged, and lack of knowledge about how to care for the elderly make the elderly an at risk population when hospitalized.

The attitudes of the elderly themselves toward geriatric medicine was depicted by Salvage, Vetter, and Jones (1988) who examined the attitudes toward hospital care facilities among a random sample of 251 elderly persons living in a British community in South Glamorgan. Subjects were asked their opinion about three in-patient hospital facilities: (1) general medical hospitals; (2) geriatric wards in general hospitals; and (3) geriatric hospitals. Results indicated the elderly subjects would much rather enter a general medical hospital than either a geriatric ward or geriatric hospital. Salvage et al. concluded that results of this study "provides further evidence of public antipathy toward geriatric medicine" (p. 273).

Unfortunately, geriatric medicine was not shown to reduce iatrogenic complications in a study

by Becker, McVey, Saltz, Feussner, and Cohen (1987) who conducted a controlled clinical trial in which 185 patients, aged 75 years or older were randomly assigned to an intervention group (n=92) which received additional geriatric team consultation throughout their hospitalization or a control group (n=93) which received only routine care. The incidence of hospital-acquired complications were measured in both groups. The overall incidence of these complications was 38%, but no significant difference was found between groups. Becker et al. concluded that although the geriatric consultation team was unable to reduce the occurrence of hospital-acquired complications in this study, this is only one function of such a team and other functions of the geriatric consultation team deserve further study.

What elderly patients face when hospitalized is less than pleasant. Their routines may be overturned and even sleep may be dangerously threatened. Berlin (1984) stated that while many hospitalized patients of all ages may have insomnia, age-related changes (e.g., sleep cycle that includes lighter sleep, less total sleep time, more frequent awakenings) may make elderly patients more prone to insomnia. Other factors such as illness,

medications, environmental, psychological, and social factors may intensify the problem of insomnia when hospitalized.

Independence of the elderly person may also be hampered. After examining related studies of elderly patients' dependence upon nurses, Miller (1984) concluded that environmental factors can be as important in an elderly patient's dependency level as the patient's mental or physical condition. Hospital regimes and reinforcement of patient dependent behaviors by nurses appear to be important factors in the patient's dependency role.

Attitudes toward elderly patients often reflect a negative image. Elderly hospitalized persons may be referred to as "revenue losers" under the Medicare hospital reimbursement system (Pawlson, 1988). Several authors have examined staff perceptions of elderly patients. Armstrong-Esther, Sandilands, and Miller (1989) examined nurses' attitudes and behaviors toward hospitalized elderly patients. An investigator-devised questionnaire, including demographic information, frequency of contact with elderly persons, age of parents, preferred working area, and prior courses in geriatrics or gerontology, and Kogan's Old People Scale was completed by 82 subjects (nurses, aides,

and volunteers). Volunteers demonstrated the most positive attitudes, followed secondly by nurses, and lastly by aides. Scores on Kogan's Old People Scale were correlated with preference for working in geriatrics and rehabilitation. Results also revealed that staff who rated basic care as less important to patients than activities such as talking to patients had more positive attitude scores than those who rated basic care higher in importance.

In a second portion of the study by Armstrong-Esther and colleagues, 90 patients (mean age 71.5 years) were observed for a 10 minute period in an acute care setting. These investigators found the majority of patients (74%) spent almost 95% of their time either in bed or sitting in a chair. Activity level was not found related to age nor mental alertness, but mental alertness was related to engaging in constructive activities (e.g., eating, drinking, self-care). Staff assessment of the patient's mental alertness was the strongest related variable to amount of staff-initiated interaction. No interactions with staff were observed for 41% of the patients. Staff had the most staff-initiated interactions with patients they had rated as "slightly confused", an intermediate

amount with patients rated as "alert", and the least amount with patients rated as "confused".

Elderly persons frequently have chronic illnesses that require additional nursing care during hospitalization. Davis (1984) examined staff attitudes toward chronically ill persons. She interviewed nurses caring for 15 patients (aged 24 to 93 years) to explore how nurses perceive caring for these chronically ill patients in an acute care hospital. In this qualitative study Davis concluded that most nurses found providing care to these patients to be a negative experience while some nurses found it to be a positive rewarding and challenging experience.

The outcomes of hospitalization upon elderly patients are beginning to be investigated. Narain, Rubenstein, Wieland, Rosbrook, Strome, Pietruszka, and Morley (1988) examined predictors of immediate and six month outcomes in a study of 396 patients aged 70 years and over admitted to an acute care Veterans Administration hospital during a one year period. Decreased functional status, admitting diagnosis, and decreased mental status were the factors most predictive of 6-month mortality. Functional status was also a strong predictor of length of stay and nursing home placement--even more

than principle admitting diagnosis. Living location, decreased mental status, and decreased functional status were most predictive of nursing home admission. Admitting diagnosis and type of caregiver were significantly related to 6-month rehospitalization. These authors admitted that many predictive variables were not measured in this study, the sample consisted primarily of white males, and the setting had a geriatric evaluation unit that was thought to improve outcomes that may not be seen in other institutions.

Victor and Vetter (1985) also studied the early readmission of elderly persons to the hospital. A random sample ($n=2,711$) of patients over 65 years of age who were originally treated in non-psychiatric hospitals in Wales were followed for three months. Of the subjects still living during the three month time period, 1,930 (81%) responded to the questionnaire. Results indicated that only one factor was significantly related to readmission: the patient's degree of physical disability. Those with chronic disabling conditions were at a higher risk for readmission, and in 77% of the cases the readmitting diagnosis was the same as the initial diagnosis. Factors such as sex, age, length of initial stay, and household composition were not

significant. Interestingly, these authors stated that patients who:

felt they were discharged 'too soon' were more likely to be readmitted than patients who felt they were discharged at about the right time. Thus, when assessing the readiness of patient's for discharge, patients' own assessments seem to be predictive of the need for subsequent readmission. (p. 41)

Methodological Concerns

This review of literature reflects many methodological concerns and difficulties in interpreting results. These do not appear to be uniquely related to the study of hospitalized elderly patients. Numerous authors (Baltes, Reese, & Nesselroade, 1977; Birren & Cunningham, 1985; Botwinick, 1984; Krauss, 1980; Nesselroade & Labouvie, 1985; Schaie & Hertzog, 1985; Schaie & Willis, 1986) reported methodological problems in much of the gerontological research. Most of the authors share concerns that are foundational for all research (i.e., the necessity to clearly define the problem, the theoretical framework in which the problem is to be studied, the design and data collection methodology of the study, and the conclusions which are drawn from the findings). Nesselroade and Labouvie (1985) emphasized the importance of clear distinction in the above areas

and addressed many of the issues related to the researcher's world view and design issues such as threats to internal and external validity. The researcher must clearly identify the theoretical framework used for the study and how terms are defined. Birren and Cunningham (1985) illustrated how the definition of the term "aging" will greatly influence what will be studied and the methodology used. Biological, sociological, and psychological definitions of aging will result in quite different theoretical frameworks and subsequent studies.

Most of the studies reported above have selected a chronological definition of aging (i.e., age 60 or 65). However, wide discrepancy existed in the chronological age of study subjects who are determined as elderly as well as a lack of differentiation of older adults from young and middle-aged adults. This wide range of age, complicated by other methodological problems (e.g., inadequate control groups, failure to identify confounding variables, inadequate sample size for analyses) render some research reports uninterpretable.

The theoretical framework is also crucial for the measurement issues relating to a study of aging phenomena. Mangen, Peterson, and Sanders

(1982) in their book on social gerontology measurements, stated "there is a gross lack of attention to the relevance of substantive theory for measurement issues" (p. 19). These authors stressed the need for theoretical frameworks and attention to measurement biases and associated error. A considerable problem in gerontological research is the uncritical borrowing of instruments and using them for purposes that may not be appropriate. Mangen et al. reminded researchers that "conceptual concerns must dictate the use of instruments" (p. 19). Several authors cited in the literature review referred to measurement errors due to instruments that may not have measured what was expected.

Probably the most frequently mentioned problem in gerontological research relates to a design issue which is critical in identifying what specifically is being measured, age changes or age differences. A number of the researchers attempted to use age as a variable and demonstrate age differences in younger and older groups of subjects. Schaie (1983) argued that no one design has been identified which would accurately yield this type of distinction. He identified the distinction between longitudinal studies in studying intraindividual

changes and cross-sectional studies in studying interindividual differences. In a later publication Schaie and Willis (1986) described the problem of confounding variables associated with the three commonly used designs in gerontology: (1) longitudinal designs confound age and time of measurement; (2) cross-sectional designs confound age and cohort effects; and (3) time lag designs confound time of measurement.

Other authors have also criticized the frequently used designs, specifically cross-sectional and longitudinal designs. Siegler, Nowlin, and Blumenthal (1980) reported two underlying assumptions of cross-sectional designs: "(1) that the younger group will, over time, become like the older group, and (2) that the older group was like the younger group some number of years ago" (p. 602). Both assumptions are faulty. Numerous authors (e.g., Baltes, Reese, & Nesselroade, 1977; Schaie & Hertzog, 1985) reported that both longitudinal and cross-sectional designs are flawed and that this equivalence of subject groups and occasions is the central measurement problem in gerontological research. Krauss (1980) also pointed out the inequity of cross sectional groups and stated that women, lower levels of education, and

more illness are found more frequently in elderly groups than younger groups making these groups uncomparable. Yet the tendency of many gerontological researchers to attribute the results of cross-sectional studies (age differences) to be age changes illustrates the fallacy of the overgeneralization to the elderly population. This group is increasingly recognized as an astonishingly heterogeneous group (i.e., the elderly are not only unlike younger cohorts but also demonstrate very different individual characteristics among their own cohort).

Some effort has been made to address the problematic issue relating to design in gerontological research. Schaie (1983) proposed what he called the "most efficient design" which is a "combination of cross-sectional and longitudinal sequences, created in a systematic way" (p. 28). The extent that this design will be used by researchers is uncertain considering the costs and time involved with such a design.

The multitude of variables and interactions recognized to influence any particular situation need to be considered in future research. Research with the elderly is no exception, but possibly an exemplar for such diversity. In gerontological

nursing, many variables have not been clearly identified in many topics. The grounded theory approach may provide nurse researchers the theory base to further study the identified variables.

Summary

In summary, many concerns for hospitalized elderly patients were reported in the literature. Cognitive impairment, numerous iatrogenic complications, perceptions of stress, and negative viewpoints by staff and patients themselves were identified. Elderly hospitalized patients have been particularly vulnerable for complications resulting from hospitalization. Cognitive disturbances have occurred in previously unimpaired elderly persons. However, this condition has been difficult for researchers to measure and for clinicians to assess.

Numerous iatrogenic complications have been reported in the literature. While the majority of iatrogenic incidences in elderly patients have been attributed to complications of treatments, other less observable iatrogenic complications have not been explored. Factors that may be associated with iatrogenic complications (e.g., perceived stresses, level of patient satisfaction) reveal differences in staff and patient ratings and between younger and

older patients. Older patients were found to have lower stress levels than levels found by another researcher using a younger sample of patients. Older patients were also more satisfied with physicians and supportive services (but not nurses) than younger patients. Authors suggested that older patients may expect less and therefore be more satisfied with the care they do receive. However, negative experiences relating to hospitalization and mistrust of the medical system was reflected by numerous authors in the literature.

Authors have emphasized that elderly persons are frequently afflicted with multiple chronic health problems. The complexity of these health problems coupled with the lack of knowledge and negative attitudes about aging of practitioners put elderly persons at risk when hospitalized.

Outcomes of hospitalization upon elderly patients have recently been investigated by a few researchers. The patient's degree of physical disability and the patient's own perception of discharge readiness were related to readmission. Decreased functional status, admitting diagnosis, and decreased mental status were predictive factors of 6-month mortality.

Methodological problems have plagued some of the gerontological research reviewed. Unclear theoretical frameworks and large age ranges have made results difficult to interpret. In addition, elderly subjects have been compared to highly unlikely comparison groups, and the elderly person's characteristics have been measured with instruments that may or may not be appropriate because many have been designed and tested on younger subjects. Differences found in these studies may have resulted from sample bias, instrument bias, or other methodological flaws.

In response to some of the methodological concerns in previous gerontological research, several researchers have asserted the need to examine hospitalization of elderly patients through a qualitative approach. In the next chapter, the design and methods of this study are described.

CHAPTER III

DESIGN AND METHODS

Design

The design of this study was a grounded theory approach. Grounded theory is an inductive method developed by Glaser and Strauss (1967) from the symbolic interactionist view of human behavior that suggests humans act and interact on the basis of symbols that have meaning for them. Blumer (1972) explained that symbolic interaction was uniquely human behavior when he defined the term as

the peculiar and distinctive character of interaction as it takes place between human beings. The peculiarity consists in the fact that human beings interpret or "define" each other's actions instead of merely reacting to each other's actions. Their "response" is not made directly to the actions of one another but instead is based on the meaning which they attach to such actions. Thus, human interaction is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of another's action. This mediation is equivalent to inserting a process of interpretation between stimulus and response in the case of human behavior. (p. 145)

While variations (e.g., Chicago and Iowa Schools) do exist in the interpretation and use of

symbolic interactionism (Meltzer & Petras, 1972), most authors agreed that George Herbert Mead was the foremost developer of the theory. There is also ample evidence that the theory has greatly influenced scholars of human behavior for some time. Rose (1962) summarized the assumptions of symbolic interaction theory that have permeated numerous authors' views of human behavior as follows:

- [1] Man lives in a symbolic environment as well as a physical environment and can be "stimulated" to act by symbols [that have learned meanings and values] as well as by physical stimuli. (p. 5)
- [2] Through symbols, man has the capacity to stimulate others [e.g., role-taking] in ways other than those in which he is himself stimulated. (p. 7)
- [3] Through communication of symbols man can learn huge numbers of meanings and values--and hence ways of acting--from other men. (p. 9)
- [4] The symbols--and meanings and values to which they refer--do not occur only in isolated bits, but often in clusters, sometimes large and complex [clusters refer to "roles" or "structures" such as those in social settings]. (p. 10)
- [5] Thinking is the process by which possible symbolic solutions and other future courses of action are examined, assessed for their relative advantages and disadvantages in terms of the values of the individual, and one of them chosen for action. (p. 12)

Symbolic interactionism has provided the framework for various research approaches. Grounded theory is one of the congruent approaches that has been used in a variety of disciplines including nursing to discover and conceptualize interactional processes (Benoliel, 1967; Chenitz, 1983; Chenitz &

Swanson, 1986; Hutchinson, 1986; Stern, 1985; Wilson, 1986). Nursing authors (e.g., Field & Morse, 1985) have advocated the use of grounded theory in theory development prior to the use of quantitative methods. These authors believe that without prior use of grounded theory, quantitative methods may be prematurely applied without the foundational understanding that is offered by this inductive method grounded in the data. Grounded theory differs from other qualitative methods such as phenomenology in the use of selected literature review during analysis and in the assumption of the existence of a process (Omery, 1983). Wolanin (1983) stated that problems in geriatric clinical nursing are not well understood and the grounded theory method is well suited to exploring these problems. In this study the grounded theory method was used to describe the process of hospitalization in elderly patients from the perspective of the informants (i.e., patients, family members, nurses).

Setting

Data were gathered from patients, family, and nursing staff at a 300-bed acute care hospital in a large western metropolitan area. The hospital was selected on the basis of availability of elderly patients, family members, nursing staff, and

agreement to participate in the study. Four units were selected for data collection which provided ample opportunity for interviews and observations. The four units consisted of two medical and two surgical units and provided a wide range of medical diagnoses. Data were collected on both day and evening shifts.

All patients chose to be interviewed in their own hospital rooms and most chose to be interviewed immediately or shortly after consent forms were signed. Family members were not usually available immediately after the patient interviews; therefore, arrangements were made for later interviews. All family members chose to be interviewed at the hospital either in a conference room, another empty patient room, or in the patient's room. Nurses chose to be interviewed in empty conference rooms or unoccupied offices. All nurses chose to be interviewed at work during their shift and were able to arrange a convenient time when other staff would cover their patients. Unit supervisors were agreeable to the interviews taking place during work hours.

Sample

White, middle-class patients, aged 65 or older, were selected for participation in the study

from a patient census listing with the assistance of nursing staff. This ethnic and socioeconomic group was reflective of the hospital's elderly patient population. Only patients who were alert and in no severe pain were asked to participate in the study. Family members of the patients selected were also requested to participate. Unlike quantitative studies in which probability sampling is used, a specific sample size was not predetermined for this grounded theory approach. However, men and women with various medical/surgical diagnoses and varying hospitalization days at the time of the interview were included. Information from all data sources (i.e., patients, family members, nurses, observations, records) were collected until categories of data were saturated. Data were collected over a seven-month time period.

Eight patients ranging in age from 66 to 83 (mean age 73.5) with varying medical/surgical diagnoses participated in the study. (See Table 1 for Description of Patient Cases). Four males and four females comprised the sample of patients. All patients who were identified through purposive sampling for the study agreed to participate.

Seven family members participated in the study. Five spouses and two children were selected

Table 1

Description of Patient Cases

CASE NUMBER	AGE	SEX	DIAGNOSIS
1	67	F	Fractured Hip
2	66	M	Thymectomy
3	72	F	CHF, Diabetes
4	80	M	Cancer
5	83	F	Fractured Hip
6	74	M	Acute Confusion
7	77	F	V. Tachycardia
8	69	M	Pacemaker Implant

by the patients to participate in the study. None of the family members who were approached refused to participate in the study. One patient did not have a family member available for interview.

Ten nurses who were providing nursing care to the elderly patients in this study agreed to participate. As with the other informant groups, none of the nurses who were requested to participate refused participation. In two of the eight patient cases, two nurses who were assigned to the patient, or had been assigned to the patient recently, agreed to participate. Eight of the nurses were regular staff members on the unit, and two were "float" nurses who were assigned to the unit only temporarily. No effort was made to select nurses that had requested assignment to elderly patients or had any particular views toward the elderly or aging in general. Efforts were made to interview nurses in a naturalistic setting which would provide a broader perspective of nurses' perceptions as well as a means of confirming and elaborating information received from patient and family member interviews.

In addition to the above groups, a patient representative from the agency agreed to be interviewed as a part of the study. The representative offered her perspective as it related

to comments she had received in general from hospitalized patients. The patient representative and all members of the above informant groups were white, spoke English, and agreed to be taped recorded during the interviews.

Procedures

Bracketing of prior knowledge and attitudes (i.e., bringing biases into the awareness level) outside of the data generated from the informants was performed throughout this study. A weekly journal was maintained by the investigator to assist with this awareness. Examples of the biases of the investigator included prior background experience in surgical intensive care where some elderly patients did not recover from their surgery, and previous teaching and research knowledge and experiences.

After identification of patients meeting the selected criteria, each was contacted and the purpose of the study explained. Those providing signed informed consent were interviewed. Demographic data and nursing/medical notes relating to the special gerontological problems were obtained from the medical records. Available family members and nurses caring for the elderly patients were included using the same informed consent procedure. Any harmful conditions that were exposed via

interviews or other sources were to be reported to the head nurse of the unit where the data were collected.

Ethnographic interviews (Hammersley & Atkinson, 1983; Spradley, 1979) of patients and family members occurred in the patient's room or other convenient location preferred by the informant within the hospital. Every attempt was made not to disrupt the daily routine of the patients or hospital staff.

Interviews used an unstructured format and each was expected to take approximately 30 to 60 minutes. A broad opening statement such as, "Tell me what your (or your family member's) hospitalization experience is like. . ." was used to elicit the informant's perceptions. Additional prompting was used to elicit further information as needed. The informant (interviewee) was considered the teacher and the investigator the learner. At any point the informant could choose to postpone or withdraw from the study.

All interviews were tape recorded with the written consent of informants. The patient interviews ranged from approximately 20 to 75 minutes. One patient chose to take rest breaks during the interview while the remainder chose to

talk until they were tired or had nothing else to say. Those who were tired were given the option to continue the interview later or not at all. The family member interviews ranged from 25 to 55 minutes.

Interviews with the nurses were also unstructured and began with a broad directive such as "Tell me what it is like to care for an elderly patient (or this specific elderly patient). . ." It was anticipated that these interviews would also last approximately 30 to 60 minutes. The interviews lasted from approximately 15 to 45 minutes.

The interview with the patient representative was conducted midway through the data collection. This interview served as a means to validate some data categories as well as to obtain additional data concerning comments that patients or family members might have expressed to her about their hospitalization experience.

Beyond the broad opening statements for all informants, additional directives or questions stemmed from previous comments or observations. At the end of each interview each participant was provided with additional time to add any further information that he or she would like. At the conclusion of the interviews informants were thanked

and were reminded that the investigator may contact them again to clarify information if needed.

Interviews were identified by code numbers and transcribed by a secretary trained in transcription. All transcripts were subsequently read by the investigator for accuracy, and nonverbal observations noted during the interview were added. Transcripts were coded by categories prior to the next interview to the extent possible.

Field notes were used to record nonverbal information and analytical information during or after each interview. Personal impressions were also recorded at the completion of interviews. Participant observation with field notes occurred as elderly patients were receiving care during hospitalization. These observations included environmental arrangements, traffic to and from the patients' rooms, noise levels, location and activity of patients and visitors, and other unit activity.

Data Analysis

The constant comparative method of coding and analysis to generate theory was employed for all data within this study. All information from the different perspectives of patients, family members, nursing staff, investigator observation, and medical

records was entered into an information pool for coding. Considerations given included: patient's medical diagnosis and special gerontological problems, length of hospital stay at the time of the interview, demographic factors such as gender and age of the informant, relationship of the family member to the patient, and work experience of the nurse with elderly patients and the selected patient(s). These factors were considered as each informant's perceptions of the hospitalization experience was analyzed.

A microcomputer program, The Ethnograph (Seidel, Kjolseth, & Clark, 1985), was used to sort and organize investigator coded data. All codes were compared against each other and additional data collected until mutually exclusive categories began to emerge for this study. As categories were analyzed a connection among the categories emerged. Reduction of categories, selective sampling of literature for the concepts of interest, and selective sampling of the additional informants was necessary to identify the central connective process called the core of the emerging theory (Glaser & Strauss, 1967). Through this analytical process a grounded theory was identified for the elderly hospitalization experience. Through theoretical

coding and memoing a substantive theory was described. This theory is specific to the data in this study and precedes developed formal theory. The analysis conducted throughout the entire process continued through the writing of the report.

Informed Consent

The Human Subjects Committee for the University of Colorado Health Sciences Center reviewed and approved the proposal for this study prior to data collection. Permission to interview patients and family members, review medical records for demographic and health information, and make a follow-up call (if needed) was obtained from the patient. Permission to interview the family member, including a follow-up call (if needed) was also obtained from the family member. (See attached informed consent forms for patients and family members, Appendix A and B, respectively.) Similar informed consent procedures were used with nurses who were caring for the selected elderly patients. (See attached informed consent form for nurses, Appendix C.)

No risks to participants were expected in this study. Efforts were made to maintain the health and strength of all informants especially the

elderly patients. All interviews were kept as brief as possible.

Confidentiality of information was maintained by assigning a number to each transcript and erasure of tape recordings after transcription. All consent forms, transcripts, and written notes are to be maintained by the investigator for a period of not less than three years.

Reliability and Validity

Reliability and validity are important considerations of any research study. While better understood by most in quantitative research, the rigor of qualitative research can be assessed using the following criteria of truth value, applicability, consistency, and neutrality described by Lincoln and Guba (1985) and discussed in the nursing literature by Sandelowski (1986).

Truth value, often referred to as the management of threats to internal validity in quantitative studies, is referred to as credibility in qualitative studies. Applicability, called control of threats to external validity in quantitative research, is evaluated by the "fittingness" of qualitative information. Credibility and fittingness was increased in this

study by evaluating the representativeness of the data, coding and categorizing data, verifying typical elements, and deliberately trying to discount conclusions by further data collection and analyses.

Credibility was enhanced by triangulation or multiple methods of data collection (interviews, observations, and record review) and multiple informants (patients, family members, nurses, patient representative). Congruence among these multiple methods and informants was examined. In addition categories emerging from the data were validated by checking with informants. Using this technique, perceptions of the investigator were compared with those of the informants who were living the experience. Thus, the reality was defined by the informant rather than the investigator.

Fittingness was enhanced by the collection of data in a naturalistic setting with few controlling variables. While the sample of this study was not representative of a population in the quantitative sense, the data should be representative of the informants. If the findings can fit into similar contexts outside of this study and if readers view the findings as meaningful and

applicable based on their own experiences, the study can be considered fitting.

Consistency, or reliability in quantitative studies, is called auditability in qualitative studies. This aspect requires that a detailed description and justification of the procedure of data collection, analyses, and interpretation is provided. The degree of auditability is determined if someone else can follow the "decision trail" (Lincoln & Guba, 1985; Sandelowski, 1986) and come to a similar decision. In this study faculty with expertise in qualitative research consulted with the investigator and confirmed the "decision trail."

Neutrality, or objectivity in quantitative research, is referred to as confirmability in qualitative research. Confirmability occurs when credibility, fittingness and auditability are established.

The above aspects of rigor were attempted within this study. Further evaluation will occur as others read the study report and seek to use the information for further studies.

Summary

A qualitative, grounded theory design was used to explore the perceptions of the

hospitalization experience by eight white, middle-class elderly patients, seven family members, ten nurses, and one patient representative. Approval for the study was obtained from the University Human Subjects Committee prior to the implementation. Permission to participate in the study was obtained through signed informed consent. Data were collected over a seven-month time period, and patients/family members/nurses from four separate hospital units were included. Sources of data included interviews, participant observation, and review of medical records. Data were transcribed and coded using The Ethnograph (Seidel et al., 1985). The constant comparative method of coding and analysis to generate theory was used for all data within the study. Data were collected until saturation of categories occurred. Through this analytical process a grounded theory was identified for the hospitalization experience of elderly patients. Efforts of qualitative research rigor including credibility, fittingness, and auditability were attempted throughout the study. A profile of each case in the study is provided in the next chapter.

CHAPTER IV

PROFILE OF CASES

The patients, family members, nurses, and patient representative who participated in this study did so knowing about no direct benefits to them. Their decision to participate was based on a willingness to share what each was experiencing. Some expressed concern that "they didn't know much," but each was assured there were no right or wrong answers and only their perceptions of the experience were being requested. The informant's perceptions were emphasized as the focus and important aspect of this study. The investigator became the learner and the informants became the teachers in this context.

Deliberate attempts were made to make the informants feel at ease. Arranging seating, decreasing noise levels and providing privacy by closing the door, making sure the informant could see and hear, and increasing comfort by providing drinks of water and position changes were all employed to facilitate communication.

The majority of informants appeared to speak easily. In fact, a feeling of respect and trust seemed to pervade the interviews. When additional interview times were needed, the investigator was always recognized and greeted warmly. Continual efforts were made by the investigator to assure the informants that their perceptions were valuable and there were no "expected responses."

As interviews were conducted, additional notes were taken including nonverbal communication, physical arrangements of the room, and other notations that would serve as "memory joggers." These notes in addition to the other sources of data collection provided the information for the following synopsis of cases. The following brief descriptions of case profiles further provide the context in which informants shared their perceptions. (See Table 2, Summary of Cases, for case information that includes a fictitious patient name, diagnosis, the number of hospitalization days when first interviewed, the family member interviewed, and the number of nurses interviewed.)

Case 1

Case 1 included Mrs. Adams, a 67-year-old white female hospitalized for repair of a fractured

Table 2

Summary of Cases

Case Number	Patient	Diagnosis	Hospital Days	Family Member	Number of Nurses
1	Mrs. Adams	Fractured Hip	6	Step-daughter	1
2	Mr. Brown	Thymectomy	1	Son	1
3	Mrs. Clark	CHF, Diabetes	2	Husband	1
4	Mr. Deeds	Cancer	33	Wife	1
5	Mrs. Everett	Fractured Hip	16	None	2
6	Mr. Franks	Acute Confusion	6	Wife	1
7	Mrs. George	Ventricular Tachycardia	30	Husband	1
8	Mr. Hays	Pacemaker Implant	4	Wife	2

hip. She was initially interviewed on the sixth hospitalization day (five days postoperatively) and again visited on the seventh hospitalization day. Lying in bed with a cast and traction, she was able to adjust her position slightly through the aid of an overhead bar. Mrs. Adams was amazing articulate and appeared determined to share her experiences as she spoke. She discussed her current hospitalization experience and previous, albeit negative, experiences with the health care system. She spoke of other life experiences and many friends and family members who provided her support. Her room was filled with flowers, cards, and food. She had received so many flowers that she stated she had began giving some to other patients. The interviews had to be scheduled when she was not preoccupied with friends and family in her room or talking on the telephone.

Throughout the interview she continued to refer to past experiences surrounding her husband's illness, hospitalization, and subsequent death. She also referred to her mother's negative experience with medications and the lack of awareness on the part of health care staff to intervene in the situation. As she spoke she appeared determined that she would not allow herself to be the victim of

such circumstances. She referred to religious beliefs, years of "getting along on her own," and her own parents' reliance on her to be the "advice giver" which made her strong. She stated she "was liberated long before they even thought of that word" and found it hard to ask for help. She expressed concern how she was going to recuperate at home since she knew she would need assistance.

A stepdaughter was selected by Mrs. Adams and the investigator for the family interview. The stepdaughter was referred to as a daughter by Mrs. Adams and the her admiration of the stepdaughter was evident. The stepdaughter was a middle-aged business woman who confirmed much of what the patient had stated. In addition, she freely expressed her anger at how her father had been treated during hospitalization, as well as how she, a family member, was treated and is still treated on the nursing unit. The stepdaughter indicated that she was frequently ignored and left standing for long periods of time when she approached staff at the nursing station for anything. The stepdaughter also expressed concern about her stepmother's rehabilitation and was perturbed that efforts, such as crutch training and nutrition, were not initiated prior to surgery.

The interview with the nurse and review of the medical records validated the patient's medical condition. The nurse expressed some concern that the patient would need to gain mastery of crutch-walking before discharge. The nurse also discussed adjustment she believed nurses must make in caring for elderly patients such as slowing the pace in providing care to accommodate these patients. In addition, the nurse indicated that elderly hospitalized patients often are afraid, particularly in their ability to recuperate and be self-sufficient. She emphasized that some elderly patients "lose a lot of . . . the integrity of their personality." She concluded that nurses have a difficult time in helping these patients remain strong and to "keep them feeling good about themselves."

Case 2

Case 2 included Mr. Brown, a 66 year-old white male who was interviewed during his first day of hospitalization. He had been admitted for a thymectomy in an effort to decrease complications resulting from myasthenia gravis. He did not speak as easily as the patient in the previous case. It may be that he had fewer things to say due to fewer

experiences because he had just been admitted that day. Mr. Brown did, however, strongly express concern that a previous error in treatment would not be repeated during this hospitalization.

His room contained no flowers, just a few magazines that he brought with him. He sat in a chair at the foot of the bed during the interview. He was polite but appeared to be a man of fewer words, as well as concerned about his impending surgery. He indicated he had confidence that everything was going "to turn out alright" and he "would just have to get through it." He had surgery the next day and was transferred to the Surgical Intensive Care Unit (SICU). In SICU, the nurses stated his condition was stable and he would probably be transferred back to his room the next day. When visited in SICU Mr. Brown recognized the investigator and stated he was so relieved that the surgery turned out okay. He was transferred back to his room and was sitting on the side of the bed when the investigator visited him. He was smiling and stated he was to be discharged the following day. He proudly stated that he was being discharged earlier than most younger patients.

The interview with the family member, a son, was an expression of relief that the surgery had

gone well. The son validated that his father had almost died because of a wrong anesthetic administered in a previous hospitalization. He also indicated that while he did not expect his father's recovery to be much trouble, his father would be living with him and his brothers. His mother had recently left the family and his father had sold his house to the sons. He would now be living with them. The son did not know any specifics about the care of his father upon discharge other than "keeping an eye on him." No discharge information had been received at this time by the family.

The interview with the nurse validated the medical condition and surgery. Numerous comments by the nurse related to frustration, sadness, and lack of preparation in working with elderly patients in general. She also spoke of the "demeaning" hospital environment for elderly patients. The aging process of the nurse's own parents seemed to be reflected in her comments about the care of hospitalized elderly patients. She stated Mr. Brown appeared younger to her than her parents and agreed he was doing well. No discharge information to the patient or family was discussed.

Case 3

Case 3 included Mrs. Clark, a small-framed 72 year-old woman eager to talk. She had been admitted to the hospital for congestive heart failure exacerbation and had recently been transferred from the Intensive Care Unit (ICU) to her current room. She had a long history of medical problems, including chronic obstructive pulmonary disease, severe osteoporosis with compression fracture, myocardial infarction, and diet controlled diabetes.

When approached for inclusion in this study, Mrs. Clark had been hospitalized for two days and was lying in bed, connected to a halter monitor and oxygen tubing. A few personal belongings surrounded her in her room. Her husband was present and he seemed to be getting her things and making her more comfortable. She had been intubated during her ICU stay but denied a sore throat or difficulty in talking. She did complain of a sore nostril from the oxygen tube. When the nurse stated she would get a lubricant, Mrs. Clark stated she already had tried that and the nurse responded that she did not think much could be done about it.

Another interaction between Mrs. Clark and a staff member was observed in which the lunch tray

was picked up and Mrs. Clark wanted to keep her diet soda. The staff member was hesitant to let her keep it but eventually let her do so.

Mrs. Clark seemed close to her husband and stated he visited often. Watching them interact they seemed protective of one another and frequently "kidded" each other in a playful way. They indicated they had been married for 25 years, this being her second husband. They had many grandchildren and great-grandchildren. During the interview prior negative hospitalization experiences were dominant in her discussion. Too early discharge had been a problem and issues relating to independence and dependence were revealed. She expressed feelings that people in general expected too much in a hospital and that if you did not do things for yourself you would get weak. On the other hand protecting oneself from becoming too tired was a concern as well as what to do with all the empty time.

The family interview with the husband revealed his main concerns relating to his wife's premature discharge at the prior hospitalization and his inability to care for her at home. He was very forceful in expressing his beliefs and did not want to lose his "train of thought" relating to this.

The interview with Mrs. Clark's nurse focused on adjustments in care that were necessary for elderly patients. She seemed to know what was ideal for patients but little of what was stated had been done for Mrs. Clark and her family. However, Mrs. Clark had been only recently transferred to this unit.

The investigator listened to the report of this nurse to another oncoming shift nurse regarding Mrs. Clark. The nurse mentioned the oxygen tube, called her a "sweet lady" and stated she had been transferred from ICU. The report lasted approximately thirty seconds.

Case 4

Case 4 included Mr. Deeds, a 80 year-old white male with recurrent bladder cancer who had recently undergone pelvic exenteration. He had been hospitalized for approximately one month in ICU and was transferred to the current room three days ago. When approached for the interview, he was lying in bed using the trapeze to shift himself in bed. The room was cluttered with chairs and equipment. Some plants were placed on the radiator along the wall. His wife and daughter were with him. Both Mr. Deeds and his wife wanted to be interviewed together.

This was arranged as it seemed evident that he needed the support from his wife. As soon as the interview started Mr. Deeds stated the experience has "been hell for me" and began crying. His wife took over and explained what her husband had been through (i.e., cancer, surgeries). Mr. Deeds regained composure and demonstrated efforts to be independent (e.g., what he would tolerate in behavior from an allied health therapist). He also expressed anger at the noise level in the ICU and the difficulties entailed in being transferred from room to room. As the interview continued both Mr. Deeds and his wife evaluated his condition against a patient who was "worse off" (a young burn patient with double leg amputation). Both demonstrated optimism and confidence in the surgery and physicians, with even more in the nurses.

The interview with the nurse acknowledged the medical condition of the patient. It also surfaced her feelings of disagreement with the medical procedure that was performed on Mr. Deeds, indicating that the outcome was not good for such an elderly man. Although the family was not known to the nurse, she also expressed concern that the patient was not exhibiting enough self-care

necessary for discharge. Other frustrations in caring for elderly patients were also revealed.

The medical record of Mr. Deeds confirmed his and his wife's account. The history indicated a once very active man who was now very dependent and had suffered a great deal of pain. In addition the family was from out of town and had to travel many miles to visit.

Case 5

Case 5 included Mrs. Everett, an 83 year-old white female, admitted for a fractured hip revision. She was alone and from out-of-town. No family had visited and she had been hospitalized approximately sixteen days. Prior to the interview with her, the nursing staff stated that she was confused at times with one nurse stating she thought she was "early organic." When approached Mrs. Everett was lying in bed alone. The television was not on, nor were any reading materials evident. No cards or flowers were present, other than a few drawn pictures with the name of the hospital and a hand drawn train on a small bulletin board. A wound isolation sign hung on the door and gloves were located on a cart outside the room. A second bed in the room was vacant. Few personal possessions were observed.

After ascertaining that Mrs. Everett was currently oriented and the consent form was signed and witnessed by the nurse, Mrs. Everett discussed being from out-of-town and her desire to arrange an airplane ride back home when she was dismissed from the hospital. As the interview progressed she seemed to know she did not remember certain things. She also exhibited demanding behavior that seemed to drive people away from her. Confrontations between her and the nurses occurred, usually with the nurses leaving the room.

No family members were available for interview for this case. Interviews were conducted with two nurses who had cared for Mrs. Everett. The first nurse focused on what adjustments were needed in the nursing care of elderly patients, especially in Mrs. Everett's case. She acknowledged the patient's fears and the need for extra care. The second nurse was extremely frustrated with the patient. The nurse was a "float nurse" to the unit and stated she had not received any information about Mrs. Everett. She repeated she was frustrated with this "complaining old woman." The nurse stated she had not received any gerontological content in her nursing curriculum but stated that "most of the

patients I've taken care of from nursing school till now have been elderly."

Case 6

Case 6 included Mr. Franks, a 74 year-old white male who had been a paraplegic for 32 years as a result of a traffic accident. He was currently admitted for acute confusion. On the day of the interview (sixth day of hospitalization), he was alert which was verified by the nurses and the patient's wife.

When approached for the interview, Mr. Franks was in a supine position in bed. He had a foley catheter and received oxygen per nasal cannula. His room was rather empty. No flowers were present and his meal tray was on the stand beside the bed. Mr. Franks agreed to participate in the study but requested that he wait until he had received a breathing treatment from respiratory therapy.

His medical records revealed both congestive heart failure and chronic obstructive pulmonary disease. He had been previously hospitalized a number of times, most recently one month ago. During that hospitalization for pneumonia, Mr. Franks was placed on 80 mg. of Prednisone and

remained on the medication after discharge. His wife reported that since this medication had been given, Mr. Franks had been agitated, confused, suicidal, and homicidal. During the current hospitalization, the amount of Prednisone had been gradually reduced until it was discontinued. The medical record did not provide an explanation for the confusional state even after several diagnostic procedures, including a spinal tap, CT scans to rule out a stroke, a psychiatric consultation, and others. The progress notes did show a steady improvement in the patient's mental state.

The interview with Mr. Franks focused primarily on his life experiences and how they related to his current hospitalization. He believed his will to survive the traffic accident 32 years ago had made him strong. He did not remember much about the previous days other than being upset about the procedures that he had to undergo. He also expressed remorse if he had threatened his wife in any way. He pointed out some of the difficulties in being hospitalized such as his concern for his wife who has cardiac problems and now must be alone. He also stated the difficulties in his wife traveling by herself to visit him. Other difficulties arose from what to do with the time he was in the

hospital. Being an outdoor type he found little to occupy his time in the hospital but to lie and wait.

The interview with Mr. Franks' wife emphasized that she knew her husband's behavior was a side effect of the medication. She expressed frustration that no one seemed to take her seriously. She stated that she had cared for her husband all these years and knew him better than anyone else. She expressed love for her husband and the desire to continue caring for him when discharged. She did not know what her husband did all day but thought "he lays here and worries."

The interview with the nurse echoed the frustration in caring for elderly patients heard by other nurses. She did not know why Mr. Franks had been confused, but knew that "sometimes he is like totally with it and other times he gets real confused." She could not understand why he acted that way but thought that he was acting better now because he wanted to go home. The nurse was unaware what medications Mr. Franks was taking but knew he had been on some medications. She had not administered any medications to him yet and this was the first day she had cared for him. She did not know what Mr. Franks did to fill his time. She did state that he had the television on earlier in the

morning but turned it off because he did not want to be charged for it.

Case 7

Case 7 included Mrs. George, a 77 year-old thin white female admitted for ventricular tachyarrythmias and drug studies. When approached, this lady was sitting in a chair reading. Her room had several vases of flowers and cards were placed on her bedside table and night stand. Her voice was clear and her speech very deliberate. She was dressed in a long robe and sat very straight in her chair. Her face seemed to light up when her name was called.

During the interview she stated she had been hospitalized for approximately one month and was currently being tested with the third cardiac medication. The previous medications failed to control the arrhythmias. Her frustrations became more apparent as she talked. Prior heart surgery had removed approximately one third of her heart and her condition had continued to degenerate over the years. The last medication that had been tried looked very promising. However, when she was about to be discharged she went into cardiogenic shock and nearly died. She stated she had been through a near

death experience. She believed she had been brought back to life for some purpose. Her commitment to her family seemed very evident. She also stated a desire to help her roommate who was much younger than she and had suffered cardiac damage due to drug abuse. Mrs. George attributed her religious beliefs and her life experiences in making her strong. She had cared for her daughter during her fatal struggle with cancer and held her family together during her husband's battle with alcoholism.

Although evidently a strong woman, this hospitalization brought severe stressors for her and her husband. Her home was over 300 miles away and her husband traveled by car several times to visit her. The length of her hospital stay appeared to weigh heavily on both her and her husband. Her voice and facial expressions related her fear and frustration due to the uncertainty that a drug could be found that would control her arrhythmias.

Her husband voiced similar concerns. The tiresome travel and his concern for his wife seemed unending and made this experience a difficult one that they never before had to face.

The interview with the nurse and medical records validated Mrs. George's account of her illness. The nurse believed Mrs. George just

"wanted to get it over with." The procedure that the patient had to undergo for evaluation of each new drug was extensive. Frequently, Mrs. George was alone since her husband returned home to work. Prior to the cardiogenic shock experience, the nurse believe the patient was very optimistic. Since that time the nurse felt Mrs. George had understandably lost some of this optimism.

Several days after these interviews, Mrs. George was discharged and returned home. The investigator does not know if her medication has maintained its effectiveness.

Case 8

Case 8 included Mr. Hays, a 69 year-old male from out-of-state hospitalized for pacemaker implant. The patient was interviewed on the fourth day of hospitalization. His room was a semi-private room, with a vacant bed on one side of the room. His room still contained the intravenous equipment that had recently been discontinued. No cards or flowers were evident. The window blinds were open revealing a picturesque view that Mr. Hays said he enjoyed.

When interviewed Mr. Hays was alone in his room and was resting in a supine position in bed

with telemetry intact. He stated he had been very sick with nausea all night after undergoing six hours of surgery in which a pacemaker had been implanted and then had to be returned to surgery after a loose lead on the implant was discovered. His wife had stayed all night with him and had left early in the morning to rest. While somewhat still tired from the surgery he indicated the most troublesome problem for him and his wife had been getting admitted to the hospital. He had been referred to a physician at the hospital by an out-of-state physician and through miscommunication, many details had to be worked out before his admission. He expressed fear, fatigue, and exasperation after traveling so many miles by automobile to face more waiting and anxiety just to get admitted. Mr. Hays also indicated the anxieties relating to the uncertainties surrounding the pacemaker. He did not know if he was a candidate for this procedure and the fears associated with this unknown had taken its toll on him.

The interview with Mr. Hays' wife occurred the next day. She validated and expanded on the difficulties relating to admission. In addition she shared many concerns relating to the care of her husband after surgery. For example, she could not

understand why her husband had been served potato chips (along with a cold sandwich) for the first meal after his surgery. She did not believe she should question the staff since she believed they should know best. However, now as she looked back she believed she should have questioned a number of aspects relating to his care. She believed the food had partially contributed to her husband becoming so ill the first evening after surgery. She also expressed concern that the staff would view her as a "meddler" when she provided care for her husband. Both she and her husband in their interviews voiced amazement at the size and all the unknowns related to the hospital. Being transferred from a smaller hospital both were unsure of "rules or regulations."

The interviews with two of Mr. Hays' nurses acknowledged the patient's fears about his surgery and his lack of knowledge relating to aspects of his care. Neither nurse was aware of the problems related to admission but one nurse stated that Mr. Hays seemed to be "sarcastic at times." The sarcasm seemed to relate to his fears about dying. The other nurse described Mr. Hays as "extremely cautious and compliant with his care." Discharge education had been initiated for both Mr. and Mrs. Hays by the cardiac team educators. These two

nurses expressed frustrations relating to caring for elderly patients. The nurses described adjustments that nurses needed to make in caring for these patients and one nurse emphasized the need of the nurse to be an "advocate" for the elderly patient.

The nurse's report to oncoming shift members reflected a brief summary of the history, diagnosis, vital signs, and current physical and psychological state. She addressed the Mr. Hays' apprehension and his difficulty with nausea the preceding night that may make him reluctant to eat.

The medical records revealed a man who had been in excellent health until four months ago when he began experiencing increasing fatigue, shortness of breath, and other cardiac symptoms. He had been hospitalized out-of-state for three days to rule out a myocardial infarction and now was referred for pacemaker evaluation. Problems relating to positioning leads in the pacemaker validated the need for the repositioning described by Mr. Hays.

Patient Representative

In addition to the above eight cases an interview with the patient representative was arranged in an effort to add another perspective that may yield different information. The interview

with the patient representative occurred in her office within the hospital. The representative had been employed by the hospital for a period of eight years. The majority of comments received by the representative resulted from patients and/or their families coming into her office. Lack of staffing did not permit visiting each patient on the floors other than volunteers from the volunteer department who provided a range of functions. Therefore, the comments received by the patient representative are only one segment of the comments that patients may have during or after their hospitalization. Efforts were made to identify common comments made by elderly patients and their families. Commonalities and differences in comments between elderly patients and younger patients were explored. Both positive and negative comment areas were addressed. Efforts being made by the hospital that may minimize the negative aspects for all patients were discussed.

For all content areas, the representative stated that younger patients were more likely to complain. Billing complaints, problems relating to communication, cleanliness of rooms, and other complaints appeared to be made more frequently by younger patients. The patient representative also emphasized that some comments may be very complex

and not reveal until later (if ever) the actual complaint the patient and/or family may have.

The patient representative stated that in general, elderly patients may be more hesitant to complain due to fear of retaliation by staff. Some elderly patients that have made comments have added conditional agreements such as "I don't want to complain about . . . until I go home. Don't tell anybody I'm mad because I don't want . . . to get mad at me." The patient representative also added that when elderly patients are asked specifically, most are happy with their care and believe the hospital is very good.

Summary

The profile of cases has provided an overview of contextual data used in this study. While each case provided uniqueness in its contribution, similarities in the hospital experience were evident for all cases.

All of the patients shared the current hospitalization status as well as previous experience with the health care system. Four patients were male, four were female. Patients differed in age and diagnoses with the exception of two patients with fractured hips. They differed in

physical stature, level of health, and functional abilities. Most had one or more chronic illnesses. Some were recuperating with few physical complications, two had life-threatening illnesses with guarded prognosis. They differed in the number and type of medical diagnostic and treatment procedures they had undergone and that were expected to continue after discharge.

Patients shared the perception that hospitalization was necessary for them and the hope that they would recover and be able to go home. Mobility varied within the sample of patients. Some were ambulatory, others required assistance with ambulation, and others were confined to beds with limited time in a chair. One patient was paraplegic, and one had wound isolation precautions.

Patients differed in the hospital length of stay. Duration of stay ranged from recent admission to 33 days. Patients differed in the number of times they were transferred to different rooms or units. Some patients remained in one room, while others had been transferred from Intensive Care Units or other rooms.

Patients varied in the physical evidence of support (e.g., visitors, flowers, cards). All patients but one had a family member or members that

visited them. The selected family members for interview included one stepdaughter and one son, and the remainder were spouses. The family members varied in age and how much time they spent with the patient. Some family members were from out-of-town and others lived in nearby communities. Family members expressed varying levels in their own health status.

Nurses involved in each of the eight cases were female and varied in age, educational preparation, and experience with elderly patients. They expressed varying levels of desire in working with elderly patients. All nurses shared frustrations in working with elderly patients with few nurses expressing positive comments.

Eight cases were included in this study. Each case was an attempt to theoretical sample until categories were saturated. In Chapter V the analyses of these data are described.

CHAPTER V

THE ANALYSIS PROCESS

Data collection and data analysis were interwoven phases in the grounded theory approach used in this study. As such, analysis occurred with each new piece of information and prior to the collection of any additional data. Each interview was coded and initial analysis performed which then fostered purposive sampling and stimulated the next interview.

Initial coding (Level I) was an effort to break the data into small pieces and attach a word or words to pieces that were similar or exact words of the informants. Each line of transcript, field note, and record information was read and reread, in an effort to identify leads or issues. Words in the codings that were redundant were collapsed (e.g., immobility concerns and mobility concerns were combined) until 35 codes remained. (See Table 3 for Initial Codings.) Many lines of transcript were coded with more than one coding. Each

Table 3

Initial Codings

Level I Analysis	
Adjustment	Nurse Sadness
Anger	Nursing Education
Changes	Nursing Frustration
Confusion	Optimism
Difficult Time	Pain
Discharge Concerns	Patient Prognosis
Errors	Patient Teaching
Family Treatment	Perceptions of Medical Care
Fear/Anxiety	Perceptions of Nursing Care
Filling Time	Perceptions of Other Care
Independence/ Dependence	Personality
Kindness/Unkindness	Sensory
Loneliness	Sleep
Loss	Staffing
Medications	Tiring
Mobility/Immobility	Translocation
Noise	Uncertainty
	Unpleasant Memories

patient/family member/nurse case was compared not only to itself but also to other cases. The computer program, The Ethnograph, facilitated this procedure. (See Appendix D, E, and F for Example of Numbered Segment, Coded Segment, and Sorted Segment, respectively.) Codings were examined from all existing cases to determine the need for additional data. If questions remained unanswered additional data were generated. For example, the need to know what elderly patients do when family members are not available to "fill their time" could only be answered by patients who were alone without family members for prolonged time periods during their hospitalization. Therefore, patients who were completely alone or alone for extended periods were included in the sample.

As data collection and analysis occurred, initial codes were reevaluated and further condensed into categories (Level II codes). At this level Hutchinson (1986) stated that "... some data may be discarded if they seem irrelevant" (p. 120) only after very careful consideration. Decisions about categories are made by asking "What does this incident indicate?" Each incident is again compared with all other incidents. Eight categories emerged as analyses continued. (See Table 4 for Emerging

Table 4

Emerging Categories

Level 2 Analysis

Patient/Family Concerns**Filling Time****Independence/Dependence Struggle****Memories****Optimism****Perceived Threats****Perceptions of Care****Nurse Adjustment/Frustration**

Categories.) The following discussion describes each category and provides examples from the generated data.

Patient/Family Concerns

The Patient/Family Concerns category emerged from Level I codes of Changes, Difficult Time, and Discharge Concerns. Concerns about family members by the patient and concerns about the patient by family members were voiced.

All of the patients who had family members expressed concern about difficulties encountered by their family while they were hospitalized. These concerns were especially pronounced if the patient was discussing a spouse. Concern surrounded travel to and from the hospital for visits, bad driving conditions, and fear of spouse being alone. The patients' spouses often were elderly persons with many health problems themselves who were now faced with making sole decisions, maneuvering new environments, and spending exhausting hours in the hospital setting to be with their spouses. Mr. Franks described his concerns for his wife in the following passage:

The only thing I'd be afraid of is sending her home by herself and you know and her not being well either and storms and stuff like that. (Case 6)

Mr. Franks' wife also believed that her husband's biggest concern was that something would happen to her while he was hospitalized. Families that had to travel greater distances felt an added burden. Mrs. George's husband stated that prior hospitalizations of his wife that were closer to home were not as bad but the current hospitalization was more difficult:

When I lived only 40 miles away that was entirely different than 350 I had an incident when I went back about two weeks ago after a snow storm and a little stretch was not very comfortable. (Case 7)

Some patients expressed concern that they did not know how the family would manage their care upon dismissal. Their concerns were echoed by their family members as in the following case:

They do a very, very poor job of educating people how to take care of themselves, how to prepare and get themselves into good health prior to a situation like this. [She] should have been doing exercises to build her arm strength prior to coming into the hospital. She was not. She should have been talked about in terms of a nutritional sense. I feel like the kinds of meals that they provide and the counseling they provide people in terms of how they should be eating when they go home is extremely poor. (Stepdaughter, Case 1)

This family member continued to express her doubts and reasons why she did not believe her family member (Mrs. Adams) was ready for discharge. She was unsure how the family could care for her and what would be done.

Other patients were concerned that family members would worry about them. Some patients appeared to be more concerned that they would worry their relatives than concern for themselves. Mrs. George expressed concern for her husband and the ordeal that he was going through during her illness and hospitalization:

After this last session that I had, he [husband] happened to be present, he is not a strong person emotionally to watch. He said how many times are you going to do this to me? (Case 7)

All family members that were interviewed expressed concern for their related patient. While most family members believed the patient would receive adequate care, they remained worried that things would not go right.

Filling Time

The Filling Time category included the initial coding of the same name. Issues surrounding what to do during hospitalized time was expressed by all patients. Mrs. Everett expressed that she had been so sick all that could be done was "to lay here like a half-dead calf" (Case 5). Others stated they read, with many stating they did not have anything to read and were unaware of any hospital library that would provide reading materials for them.

Family members and the patients' nurses also recognized the problem of patients' waiting and worrying without constructive activities to fill their time. In response to a question by the investigator about what Mr. Franks does all day when you are not here, the family member replied, "I don't know but I think he lays here and worries" (Wife, Case 6).

Mr. Franks replied to the question of what he did to fill his time as follows:

Well [I] try to figure out some way to pass the time away. I'm not much of a TV person. Anyway that's bad when you're in the hospital and bad when you have no company but that's about it. (Case 6)

Independence/Dependence Struggle

The Independence/Dependence Struggle category drew from initial codings of Independence/Dependence, Mobility/Immobility, and Patient Teaching. Comments relating to independency and dependency were expressed by all patients and many family members voiced concerns not only regarding the patient's independency/dependency but also their own in relation to the hospital system. Informants perceived that the less mobile the patient was the more the patient was dependent.

Patient teaching was viewed by nurses and family members as a means to increase independence.

Other expressions of independence related to the family. One family member described her need to become more assertive in order to protect her husband (Mr. Hays) and his care when she stated "I didn't question it [his care] at the time but I wish I had later" (Case 8).

Other patients recognized that their concerns regarding their independence were not over at discharge. As Mrs. Adams' stated:

This [current hospitalization] is difficult, yet it's the 8 weeks at home that are going to be difficult It's very hard for me, if, one of kids said to me, now when you come home from the hospital don't be ashamed to ask anybody to help you, you know, you're a caring person and you give but you never want to ask and that's true. I don't. And I do anything to avoid asking somebody to do something for me It's being helpless and dependent on other people. That I think is the most important thing. That's the thing, that, that's the thing that gets to me. I'm not used to that.
(Case 1)

The problem was also stated by many of the nurses as in the following description:

The problem isn't just physical things. It's probably their independence too. When you lose your, you know when they lose their independence, well everybody loses their independence when they come into the hospital. When you lose your independence, um, your planning ability, I wonder if that's part of it too. It's a very demeaning experience to be hospitalized.
(Case 2)

Others expressed an acceptance of their dependent role such as described in Mr. Brown's following passage:

. . . like I told the doctor I'm not going to worry about it. I, you know your business or you wouldn't be here. So, he said you've got any questions, I said no. I figure that you know what you're doing and what you've got to do with me and I have confidence in you. (Case 2)

Later Mr. Brown expressed frustrations relating to other aspects of his hospitalization such as the following passage describing his dependency in just being confined in a hospital room:

I would rather do things myself. Really. Yeah. I don't like to be laying down. That's why I'm sitting up instead of over there. I don't like to be down too long. I like to be able to get up and move around. Sometimes you can't do that. So you have to do what you have to do. (Case 2)

Other patients and their family members described examples of their attempts to exert some control over what was happening to them such as in the passage below:

Today when . . . came to see him [Mr. Deeds] and they wanted him to wait, they wanted to see him first before he took his bath and showered. We were just getting him ready to go and he [the patient] said no. He said you can come back later. I think he's just learned from, you know from his stay here, that after a while it gets to be real inconvenient for him if he always adjusts for everybody else. (Case 4)

Mr. Franks also reflected his effort in independence when he stated, "I just told my doctor this morning,

I said I will refuse another test like that" (Case 6).

Memories

The Memories categories included initial codings of Loss and Unpleasant Memories. Past experiences with illnesses and hospitalization appeared to heavily influence every patient's and most family members' perceptions of the current hospitalization. The degree to which this occurred seemed to be related to whether the past experience was perceived as a negative or positive experience. The more negative the past experience the more the patient and family members referred to it. Not surprisingly, patients and family members were determined not to allow similar negative happenings to occur again during this hospitalization.

The following are excerpts from patients' transcripts relating to past experiences. Some memories of the patients reflected experiences with other ill persons and hospitalization experiences of others such as Mrs. Adams' following comments:

You know one of the worst experiences I had, and I think, and I know this from when my mother was so very sick and she was in the hospital, she had a stroke and she was in for a long, long time, they are not patient with older people. The nurses aren't patient. And I think there are some that are still not patient

I think about it [taking care of her mom] all the time [while in the hospital]. (Case 1)

Mrs. Adams also had memories of her husband's hospitalization, discharge, readmission, and subsequent death:

My husband died in this hospital three years ago. He was here for months. And the first time he was in this room on [another] floor. . . . I thought a lot about how he suffered I seem to go back to experiencing what he must have felt [Later the patient described her husband's discharge from the hospital.] This [name of doctor] comes in and tells me to go home. I said how can you send him home. That opening is in there and he had to irrigate it. I can't do that. I'm not a nurse. That takes a nurse They sent me home with so much stuff all this, you know, to irrigate and all this stuff. After he (husband) died I donated that and you know what kind of a donation they gave me? \$750 worth of equipment I come home to this horrible hospital atmosphere at home which is worse than going there and leaving him. I don't know why they did that. [After discussion with another physician the patient's husband was readmitted after three days at home and died in the hospital shortly after readmission.] They were the most frightening three days I ever went through. First thing he was on oxygen. I, what do I know about oxygen. It was making bubbles in there and I thought for sure that I was going to kill him because they were air bubbles and they were going to go to his heart. (Case 1)

She also remembered her own hospitalization experiences now that she was rehospitalized:

. . . I remembered about that last surgery was that I had a general anesthetic on that first one, and I was terrified, I woke up, I must have, they must have brought me to in the recovery room. I didn't remember being woke up but subconsciously I must have because all of a sudden I was, it was like I'm coming out of this blackness and I feel like I'm going to throw up

which is to me awful. I hate that worse than anything. And I said oh, oh, oh, nurse, nurse, bring me a pan I'm going to throw up. So I knew where I was without knowing, and I guess the girl in the next bed, there was somebody in the next bed, she called. That nurse came in and what I do remember of that is that she was so unkind and said, well, couldn't you have waited. What is the matter with you? Look now you've messed up this whole bed and I have to do it all over again. And she was absolutely terribly nasty . . . this time . . . I wanted a private nurse when I came out of it that would take care of that so that I wouldn't have that. (Case 1)

Other patients stated their current hospitalization also brought back unhappy memories both of their previous hospitalization(s) and the illness and hospitalization of loved ones:

They gave me the wrong anesthesia over there. I told everybody but nobody paid attention and they gave me the wrong one. I almost died. (Mr. Brown, Case 2)

I hadn't been home 72 hours until I filled up with water and I couldn't breathe and he [husband] almost broke a glass window down, this hospital's window, what do you call it their, their emergency room, because there was nobody answering to us. And we got in there and why they just, they said we just can't put her in, they won't let us. And finally this one doctor, he worked with me all night long, and finally he put me in. (Mrs. Clark, Case 3)

. . . the death of our daughter who was 30 years old and had died of cancer and I took care of her for a year before she died . . . Yesterday was a very depressing day because it was ten years ago yesterday she died and I was with her. Of course I closed her eyes . . . (Mrs. George, Case 7)

Family members related similiar experiences with the majority being negative. Like patients,

these experiences seem to influence the perceptions of the current hospitalization. The following are excerpts from family members' transcripts relating to past experiences:

So I can't even begin to tell you the anger I still feel about the way they treated my father and I'm sure that one of [patient's name] determinations to get well is in some related to the deterioration we both watched happen to him. (Stepdaughter, Case 1)

. . . right after they gave him the anesthesia he quit breathing because his throat collapsed. Apparently you lose all muscle control in your throat and they were trying to jam it, they couldn't get the tube down the throat. They screwed that up. The whole bit. And then they kept him in the hospital just a couple of days. Really didn't do much. I didn't like that hospital at all. I will never go there. And they let him loose and he just steadily got worse and worse and three weeks later we had to rush him down here. (Son, Case 2)

So they told me that it was either one of two things, they were going to run the show or I was going to get her out of intensive care. We took her out of intensive care. We put her in her own room. Then they ceased to be the boss anymore. (Husband, Case 7)

Optimism

The Optimism category emerged from the initial coding of the same name. Patients and family members, regardless of the patient's current physical state, reported feelings that things would work out in their situations. Some comments referred to confidence in hospital staff, while others indicated that prior events had made them

strong. Belief in God and an acceptance of his "purpose" were expressed by several patients. The following excerpts from patients' transcripts illustrate a sense of optimism:

I have, I have all the confidence in the world in these people over here so I'm not going to worry about it I realize anything can happen at any time, I understand that, but as far as their ability and everything to take care of me I think they have it. (Mr. Brown, Case 2)

I won't be as weak this time I don't think and I feel better because I think maybe they're getting to the base of my problem I don't know whether it can be cured or not, but it can be kept under control and I feel confident that they are doing all they can to do it. (Mrs. Clark, Case 3)

I don't really think I'm frightened. I know there is a power greater than me up taking care me I do feel that there is something left for me to do on this earth or I would have been gone. I don't know what it is but maybe in time we'll know. I do think, without a halo over my head or sprouting wings, that I do a great deal in keeping our whole family together. (Mrs. George, Case 7)

Family members expressed optimism but it was usually coupled with concern such as in the following excerpt:

I'm sure that she's in professionally good hands, but on the other hand there are a lot of things that I know that she wants and she doesn't have to ask me for it. (Husband, Case 7)

While most nurses expressed frustration in taking care of elderly patients and some doubted that the elderly patients would do well especially after discharge. However, a few nurses expressed

optimism for their patients such as in the following passage:

And I believe that if people have the will to live, have a reason to live, and have the will and think that they are going to live, that chances are that they probably will One time I saw this little old man, he was 101 years old and he was on his death bed you know. We knew he wasn't going out. He left. He walked out of the place like about three weeks later. (Case 6)

The optimism described by patients and family often had stronger moments and weaker moments. Nurses also reflected the patients' changing optimistic state such as the following case:

She [Mrs. George] was really upset this morning. She is a little bit more cheerful now but still not herself. She was real cheerful before this whole incident happened and you know optimistic and she felt good but she's not so much anymore. (Case 7)

Perceived Threats

The Perceived Threats category included initial codings of Errors, Fear/Anxiety, Loneliness, Medications, Pain, Patient Prognosis, Sensory, Sleep, Tiring, Translocation, and Uncertainty.

Fear of what was happening to the patients and their family members tended to be referred to more often than optimistic comments. Numerous comments were made from every case relating to problems relating the hospitalization, concerns

about tiring procedures that depleted their energy, sleep disturbances, noise levels, pain, loneliness, side effects of medications, problems relating to being transferred to other rooms, and food that was not perceived as appropriate for hospitalized patients.

Errors that had been made were of particular concern to some patients and family members such as the mistake that was made in discarding blood that Mrs. Adams had given over a five-week period prior to surgery (Case 1), and a problem with transferring from an out-of-state hospital that resulted in many hours of confusion and exhaustion for Mr. Hays and his family before admission to the current hospital finally occurred (Case 8). However, as fearful statements were made, some patients would add optimistic comments or indicate a willingness to put up with the situation. The following excerpts relate to comments of fear expressed by patients:

[Patient describing that she must take medication at night.] At night to sleep because it is so uncomfortable. You know what happens when you can't move around and every little pain at night and you're not sleeping and every minute becomes an hour. (Mrs. Adams, Case 1)

I know what it's like because I had a lot of tests and boy it takes a lot of time Yeah it does get tiring because you don't always, it's rough on me sometimes if they take me through my meal time because I eat right on the dot. I vary an hour. I've got an hour's variation for breakfast, lunch, and dinner. But

if I don't eat between that time I get a little bit sick to my stomach. [Patient is a diet controlled diabetic.] (Mrs. Clark, Case 3)

Some patients expressed fears that the situation was overwhelming to them and they feared a lack of energy to deal with it as described in the following passages:

It's just, it's been hell for me [patient cries] [Later the patient refers to the noise in the intensive care unit that he had just been transferred out of to the current unit.] The boiler room [referring to ICU]. Oh I never got any sleep Very little. A little cat nap now and then. (Mr. Deeds, Case 4)

This has been a very depressing thing. I want very much to go home and this morning when my husband left I wondered if all of this was worth it. (Mrs. George, Case 7)

You know the nervous waiting waiting for all the tests and it got on your nerves and the whole family too. (Mr. Hays, Case 8)

[Referring to too early discharge.] This business . . . they are scared to death that you'll stay one day too late If something isn't done about that, they're killing people. (Mrs. Adams, Case 1)

Family members' comments also reflected the fears of patients and themselves as the following excerpts from transcripts demonstrate:

He [Mr. Franks] does get scared once in a while. And especially the tests There is a lot of medication that goes against him and he does, it worries him. (Wife, Case 6)

He [Mr. Hays] was feeling very badly and we were frightened I just can't imagine letting him go alone [being hospitalized] if you want to know the truth. [Later this family member described her own exhaustion.] I mean mentally as well as physically because we did not know

what the problem was but we knew it was, it needed immediate attention. (Wife, Case 8)

Family members were also afraid they would not be able to handle the care of the patients at times, particularly at discharge:

[Family member describing his wife's condition.] Yes, sure it is [scary]. It makes you stop and wonder. And I think okay now we pull out of the hospital here maybe next Wednesday morning or something like that, and there are some stretches of road between here and [name of town] that there is nobody there. Fifty to sixty miles and there is no help. (Case 7)

Nurses voiced numerous threats that they believed elderly patients in general experienced, as well as specific examples of the patients included in this study. The following excerpts are a few of the nurses' comments relating to elderly patients in general:

. . . at first I think they [elderly patients] like knowing that somebody is around and they are scared. (Case 4)

They [elderly patients] have, you know, a lot of fears and concerns about their well-being. (Case 5)

Older people sometimes are a little more fearful. I think they are worried about falling. They are worried about, and I think in the back of their mind what they are actually expressing to you with all these minor complaints is just that basic fear of you know will I be self-sufficient or how will I take care of myself when I go home. (Case 1)

Nurses also discussed their perceptions of the fears of the patients in this study:

Yeah I think she's [Mrs. Everett] frightened and I think she's lonesome. And she really doesn't have much faith that she's going to be able to walk again. (Case 5)

But he [Mr. Franks] gets real wierd about his catheter and his breathing treatments. He's just fixated on both of those He gets uptight real easily. (Case 6)

He [Mr. Hays] comes out with real sarcastic remarks about death and if you go in and look at him he'll ask you are you just checking to see if I'm dead or alive I think he's afraid of what's going on and afraid of what the future holds for him, if he has one. (Case 8)

And I have seen a change in her [Mrs. George], her affect. She is a little more depressed and down about the whole situation and she is tired of the situation. She wants to get it over with It upsets her a lot that it happened and she just, she really wants this to be over. This morning she even told me that she would rather just die than to keep on trying, to keep trying the medications and keep going through all of this trouble. She thinks it will be less trouble just to die. [During the interview with Mrs. George, she indicated she did not want to die, but she was just tired of exhausting procedures and wanted it to be over with so that she could return home]. (Case 7)

Patients reflected changing states in their perception of threats as well as their reaction to the threats. In some cases this changing patient behavior was not understood by nurses:

Sometimes he [Mr. Franks] is like totally with it and other times he gets real confused. He starts talking off the wall and I just don't know what's going on with him. I don't even understand why he's acting that way. (Case 6)

Perceptions of Care

The Perceptions of Care category is linked to Level I codings of Perceptions of Medical Care, Perceptions of Nursing Care, Perceptions of Other Care, Anger, and Kindness/Unkindness. Perceptions of care by patients and family members frequently revealed ambivalence. On one hand, patients and family members were grateful to the staff and were willing to be compliant with their medical regime.

When asked specifically about medical and nursing staff, both patients and family members indicated tremendous confidence in the care they had received from individuals. On the other hand, these informants expressed confusion and sometimes anger that they or their family members had to go through needless mental anguish as well as physical suffering. In some cases these latter perceptions tended to be from previous hospitalization experiences but heavily impacted their current perceptions. Patients and family members may be more reluctant to express negative perceptions about staff while they were currently under their care. Conversely, elderly patients and their family members may have been genuinely pleased with their care. Positive comments about nurses and physicians

are typified in the following comments from patients' and family transcripts:

I think the nurses are much, much better trained to take care of . . . patients here than they were in [name of hospital] at that time. They are able, for instance, when it comes to turning you they know where it's going to hurt and they know how to get you in bed and how to get you out. (Mrs. Adams, Case 1)

Well, most of them [staff] have been really, really good. The nurse has been good. The doctors have been real good and I have been well satisfied . . . (Mr. Brown, Case 2)

. . . they were basically watching him and they were, everything they were doing, they were keeping a real good eye on him. Real good care . . . They are real courteous and everything. (Son, Case 2)

. . . for a man who hates doctors, or thought he just didn't need doctors, when he really needed one we were just very, very reassured and he got wonderful care. I've been concerned for years that maybe someday we really would need one and what in the world would we do and we feel like we certainly lucked out. (Wife, Case 8)

Some patients and family members stated that they had made friends while in the hospital. Mrs. George indicated that she developed a close friendship with one of the nurse's aides and had many friends among the nursing staff. As the following passage indicates, her husband acknowledged these friendships and indicated he, too, had made friends with some of the nurses and perceived these nurses to be capable in providing care for his wife:

And she's [Mrs. George] made some real good friends here. The nurse that comes in and checks her vital signs, she put her arms around me when I came in today . . . I'm sure that they [nurses] have to be extroverts in order to handle some of the kind of patients that they find themselves saddled with and these girls that I have seen around here almost every one of them is an extrovert type. I have, obviously I have seen nothing but evidence of capability. (Case 7)

However, patients often expressed ambivalence in their perceptions of care. The majority perceived the care as good, but often described situations when they perceived the care as not being satisfactory. Informants in these statements often categorized certain individuals as "good" or "bad", or behavior as "kind" or "unkind". Mr. Brown stated he had been satisfied with his care ". . . outside of this one episode when people didn't pay any attention to what they were told" (Case 2). When he was asked how he thought elderly patients would like to be treated during hospitalization, the patient replied, "Well just like a human being" (Case 2). Mr. Brown also described two nurses who he perceived as "bad nurses" and his reaction to their perceived behavior is described in the following statements:

Actually I ran into two nurses here that was really mean, but they wasn't that mean . . . Oh, they were just kind of snotty type, you know. Well I get that way back with them and they settle down a little bit. I won't tell you what I tell them. (Case 2)

Some patients and family members more strongly voiced their anger of how staff had treated them as people. Mr. Deeds remarked angrily that "Some of them [staff] just try to tell you what to do instead of helping" (Case 4). Mrs. Everett (Case 5) stated that she did not feel like anyone ever came into her room just to talk to her.

Observations of staff and the interview with her assigned nurse supported her perception of being avoided. Not surprisingly, Mrs. Everett reacted by increasing her demands of the staff, and a cycle of demands and avoidance was apparent.

Family members similarly expressed anger in how they or the patients were treated during hospitalization. One family member (wife of Mr. Franks) could not convince the physicians that she knew her husband's condition was a side effect of medication:

I have told the doctors and I have a hard time convincing them here that I've had him over to the emergency room and I couldn't convince them that it was the medication. And I knew it was . . . And I know him . . . I knew he wasn't right but I knew it was the medicine that was doing it but I couldn't convince the doctors. (Case 6)

The most vocal in her resentment of the staff was one family member who was primarily reflecting back on her father's previous hospitalization, but indicated her perceptions had

not changed now that her stepmother (Mrs. Adams) was hospitalized. The following statements reflected her anger:

And this stupid . . . egotistical doctor, excuse me, but I have not a high regard for surgeons as human beings . . . orthopedic surgeons only relate to bone, any soft tissue is of no meaning to them at all. And, but I, I have not gotten over my feelings of anger at the way in which my father was treated. And that the attitude on part of many of the nursing staff and the part of the physicians that he was being stubborn . . . You know he'd gone so low before they started taking any steps. (Case 1)

Frequently, patients and family members would justify behavior of staff, particularly nurses, as not being ideal because of the patients' own behavior or extenuating circumstances. Mrs. Clark stated that patients can expect nurses to treat them similarly to how they treat nurses. She illustrated with the following statements:

Now if you go into a hospital and yap at the nurse and lip back at her, I don't blame her, I wouldn't bend over backwards either. They have to have respect as well as anybody else does. (Case 3)

Mrs. Clark added that she thought people expected too much of hospital staff. She stated that staff, including physicians, are "humans the same as I am, and they can't always be right" (Case 3). Mr. Brown also stated that "Of course now some patients can make nurses mean and I don't go along with that" (Case 2). He indicated that patients'

unpleasantness would, in turn, make nurses unpleasant. Other justifications of staff's behaviors included shortage of nurses in the hospital and difficulty of care that the patient required. One family member expressed:

A person like him [Mr. Franks] takes a lot of care. And they are so short of nurses part time that they cannot give him the care that he needs. As far as being good to him, yes, they are good but they can't be with him as much as they should on account of the shortage (Wife, Case 6).

In general, patients and family members had fewer negative than positive perceptions of care. However, there were negative comments expressed by all informants but most were qualified that these situations were understandable. These informants seemed to accept the care the patients and family members received even though they realized in some cases it could be better. Informants that expressed particularly angry comments indicated reluctance to accept such unsatisfactory care and identified methods to circumvent around it because they realized the situation was not likely to change.

Nurse Adjustment/Frustration

This category captured the additional data provided by the nursing staff and is linked to Level I codings of Personality, Confusion, Nursing

Education, Nursing Frustration, Nurse Sadness, and Staffing.

All the nurses interviewed expressed frustration as they discussed caring for these elderly patients and older patients in general. Lack of preparation to care for gerontological patients was voiced as well as difficulties in dealing with the complexities of multiple conditions (many being chronic). All nurses stated they had taken care of elderly patients prior to this time although some had not received preparation in their educational curriculum.

The nurses expressed concern for the patients and their family members and many identified adjustments that were needed in the care of these patients/family members as compared to younger patients. Many of the nurses voiced problems with confusion of elderly patients. One nurse stated, "They [elderly patients] are confused, you know, for the most part or disoriented" (Case 5). Other nurses indicated the hospital environment and/or treatments tended to cause elderly patients to become confused. The following excerpts typify this change in cognition:

Some elderly people when they are hospitalized they really lose a lot of the shall we say the integrity of their personality. They kind of fragment a little bit. (Case 1)

. . . people that have never been confused before in their lives they will get confused when they are in the hospital. Probably a reaction to medications and strange surroundings. Strange noises. Lights on at night, you know. It is a very disturbing environment I think. (Case 2)

Nurses did not readily identify interventions for the confusion, but rather the problems it presented for them. Most nurses indicated that they had not received preparation in caring for elderly patients while in nursing school. Yet, the majority of nurses reported that many of their patients had been elderly persons since the nurses had graduated from nursing school.

Nurses varied in their perceptions about elderly patients. The majority viewed them as requiring complex and time-consuming care that often drained the nurses' energy. A nurse's comment that elderly patients are ". . . a more difficult type of patient to take care of" (Case 5) was echoed by nurses throughout the study. Most nurses indicated the frustrations with their care exceeded the rewards. Few nurses expressed enjoyment in caring for elderly patients. One nurse stated that "pretty much I, I have good feelings about taking care of elderly people" (Case 4). This nurse believed elderly patients are more polite but did find them more time consuming. Another nurse seemed to enjoy

the challenge of helping the elderly person regain independence even though adjustments had to be made in their care. The following excerpt describes this nurse's view:

Yeah, I think with elderly people everything moves just a little bit slower. You have to be a little bit more patient and you have to speak more slowly, sometimes more loudly You kind of have to gear down a little when you're caring for them. I mean you just can't be flying about. You have to be prepared to take a little more time and listen You kind of have to constantly be reassuring them You know you don't want to go to this back to the cradle type thing where you start treating them like babies. You just, you have to constantly kind of be after them I think to be independent and to make these decisions for themselves. And if it is at all physically possible, which it is for most of these people. I think a lot of this is mind over matter. It is just all a state of mind when you get to a certain age as to you know what you're going to be able to do for yourself. (Case 1)

Another nurse seemed to enjoy elderly patients' dependency as the following excerpt describes:

. . . a lot of times they [elderly patients] are a lot of fun, especially the confused ones. I enjoy them. They are always funny. They always say funny little things and it just makes your day. They are like little babies. They are like taking care of babies, only they are bigger. But they are fun. (Case 6)

A few other nurses made comments to elderly patients' similarity with "babies" but cautioned that elderly patients should not be treated as "babies" (as described above in Case 1). All nurses expressed comments relating to the patients'

independency or dependency. Most nurses expressed desire to foster independency in their elderly patients; however, most were uncertain how independency could be achieved.

The frustrations of the nurses were more pronounced in the majority of the comments than the excerpts of the previous two nurses. The frustrations that nurses experienced when caring for elderly patients often related to perceptions about aging in general. One nurse indicated elderly patients reminded her of her own aging parents. In addition, this nurse believed she had "a skewed view of what elderly patients are like and what they are. I've never really seen too many healthy ones" (Case 2). Some nurses may not have experiences with well elderly persons and may view all elderly patients as in a state of decline. Other nurses expressed the time needed to get to know elderly patients and their inability to gather information in time to plan the care. The following excerpts describe nurses' frustrations:

So, it's frustrating for me because I don't know, you know, that much about her [Mrs. Everett]. And I don't have a chance to really you know find anything out about her until the end of the shift when I get to sit down and look at her history and physical and maybe find out some more information about her. So it's frustrating. (Case 5)

If you are staffed adequately then it's not a problem, but if you are staffed like you might be staffed to take care of five 40 year old patients, not five 80 year old patients, then it can be very time consuming and very frustrating. (Case 8)

The following excerpt seemed to summarize the nurses' perceptions of the complexity of care with elderly patients and possibly why nurses were frustrated:

. . . they [elderly patients] are usually chronically ill so you um, they tend to be more discouraged about their care. More, they're, they also tend to be, have a lower baseline of good health. Um, they tend to, they tend to be poor, be poor nutritionally so they have susceptibility to hospital created infections, skin breakdowns. They also don't tend to tolerate changes as easily as say somebody that is younger and that can cause a problem with just the hospital routine because the hospital routine is constantly changing They need a lot more emotional support than say sometimes a younger one because they are a lot of times lonely or affection starved to begin with I found a lot more elderly people have stronger religious views than some of the younger people and I think that tends to get ignored a lot when people are in the hospital. (Case 3)

The complexity of care for elderly patients is reflected in the above comments. The chronicity in some elderly patients' conditions may be discouraging to nurses. One nurse stated that her some of her frustration came from the feeling "you can't cure them" (Case 2). She also voiced what many nurses alluded to in their statements about frustrations, when she stated nurses' inability to

deal with elderly patients "it's because it reminds us that we are going to be this way some day" (Case 2).

Summary

Level I initial codings reflected the process of arranging the data into small pieces and attaching words that were similar or exactly like words of the informants. Thirty-five codes were identified for this level.

Level II reevaluated initial codings as data collection and analysis continued. Through this process the initial codes were further condensed into categories. The following eight categories emerged: (1) Patient/Family Concerns--describes the difficulties that both the patients and family members encountered because a family member was hospitalized; (2) Filling Time--refers to problems that patients, as well as family members, had in finding constructive activities to occupy their time; (3) Independence/Dependence Struggle--depicts the patients' and family members' level of ability to be responsible for and to actively participate in their (the patients') care; (4) Memories--captures the experiences of patients and family members with previous illnesses and hospitalizations of

themselves or loved ones; (5) Optimism--describes the feelings of informants that things would work out in their situations; (6) Perceived Threats--relays the fears that informants expressed regarding hospitalization; (7) Perceptions of Care--describes the patients' and family members' views of hospital staff and the care they were receiving; and (8) Nurse Adjustment/Frustration--provides the information related to the nursing staff's difficulties in caring for elderly patients.

Examples of data directly from informants were provided for each of the eight emerging categories. While informants responded somewhat differently within each of the categories, all informants shared the commonality of the emerging categories. In the next chapter, the core variable is discussed.

CHAPTER VI

THE CORE VARIABLE

The final level of analysis (Level III theoretical constructs) resulted from the previous analyses and continual reflection of the data. Six constructs emerged with one overriding core variable. Data from each of the cases were then reread to validate the constructs and additional interviews were conducted with study participants.

The hospitalization experience for elderly patients, family members, and the nurses providing care for these patients appeared to be one of surviving the experience. Hospitalization was not an experience that one enjoyed but an experience that must be tolerated. Informants hoped the hospitalization would result in an improvement of the patient's medical condition. However, informants expressed difficulties involved in the experience. The experience was perceived to contain obstacles that required varying amounts of energy to manage. Yet, all informants perceived the

hospitalization to be necessary and therefore, one would have to make the best of the situation. This experience was expressed by the core variable, ENDURING.

Webster's Ninth New Collegiate Dictionary (Mish, 1988) defined the verbs endure, endured, and enduring as follows: "(1) to continue in the same state: LAST; (2) to remain firm under suffering or misfortune without yielding" (p. 412). The word endure was further defined as: "(1) to undergo (as a hardship) esp. without giving in: SUFFER; (2) TOLERATE, PERMIT" (p. 412). The synonyms provided by Webster's Dictionary are "BEAR, CONTINUE" (p. 412).

The substantive theory developed from the analysis in this study indicated that elderly patients engage in a process that is aimed at ENDURING THE EXPERIENCE so they can hopefully go home. Considerable energy was required to maintain this posture. The expenditure of energy had to be balanced with the receipt of energy usually from the assistance and support of family and hospital staff, and self-determination. ENDURING was evidenced by not only patients but also family members and the nurses caring for the patients.

The concerns expressed by family members and nurses for the elderly patients also related to getting the patient through this experience. For the nurses the task was assisting patients toward healthier states, but if that was not possible shielding them against the negative consequences of the hospitalization experience.

ENDURING seemed also to reflect the personal experience of most of the nurses interviewed while caring for elderly patients. The numerous frustrations voiced by every nurse seem to be laden with trying to get through the ordeal themselves. The few positive comments reflected by nurses were overshadowed by the expressed frustrations in caring for elderly patients.

Theoretical Constructs

ENDURING incorporated six theoretical constructs and linked the constructs together in a circular manner. The constructs were relational but not mutually exclusive. No linear components were identified, but rather a continual, dynamic relationship of constructs.

All informants perceived the hospitalization to be a temporary event, one that was necessary to get through so that the patients might return to the

former or a better health state. The six theoretical constructs that were linked by the core variable were as follows: (1) Accepting Assistance; (2) Believing It Will Be OK; (3) Playing the Game; (4) Protecting; (5) Remembering; and (6) Worrying.

Accepting Assistance

Accepting Assistance was the first theoretical construct and described the willingness of informants to engage in care giving/receiving behaviors. This construct encompassed Level II categories of Independence/Dependence Struggle and partially Nursing Adjustment/Frustration. The assistance was usually from family members and/or hospital staff and was perceived as helpful or not helpful. Informants varied as to the type, amount, and situations in which the assistance was helpful. They expressed that a delicate balance existed between fostering independence and promoting dependence. Informants cautioned about the hazards of becoming too dependent and the detrimental effect that may have on patients. Lack of assistance was also recognized to be detrimental. All of the informants acknowledged the need to be hospitalized and considered the hospital to be the appropriate place for them. However, numerous comments related to needs that were not being met within the current

hospitalization. Some unmet needs related to physiological conditions that were continuing to deteriorate; others related to a lack of knowledge and/or skills in how to help themselves. Patients in some cases did not know how to get assistance and from whom. Within the Level II category of Filling Time was one example of an unmet need in that patients and family members did not know whom to ask for assistance. The majority of patients and family members were not aware of hospital resources that were available. Many patients and/or family members expressed boredom but perceived the boredom to be an inevitable part of the hospitalization experience.

Believing It Will Be OK

Believing It Will Be OK was the second theoretical construct and reflected the informants' thoughts and feelings that someone or something will take care of the patients. This construct is directly related to the Level II category of Optimism, and partially related to the category of Perceptions of Care. For some informants these perceptions appeared to add strength to the enduring process. For others it appeared to be the only option available to them. Some believed nothing could be done about the situation so they resigned themselves to being in the situation without the

power to do anything about it. Some perceptions were internally related such as those reflecting an inner strength that the individual possessed from their years (frequently from prior hardships) of trusting themselves. Other perceptions were externally related such as those that placed their fate in the hands of hospital staff or God. Most of the patients and family members seemed to have a combination of both inner and outer strength during the hospitalization.

Playing the Game

The third theoretical construct that evolved was Playing the Game. This construct is most directly related to Level II categories of Independence/Dependence Struggle, Filling Time, and Perceptions of Care. Playing the Game became evident as the informants described what was needed to get through the experience. The construct was also evident in informants who did not know the system well. Those that knew the system appeared to have plans about what and how they would get through the hospitalization. Those new to the system and those overwhelmed by it voiced related anxieties. Most expressed compliant behavior and for some even when they perceived it not to be in the patient's or family member's best interest. Many expressed

concerns about how the system worked so they could better adapt to it and not offend anyone. This seemed especially evident for family members, particularly spouses who were unsure of their exact role. Most wanted to provide some aspects of care for their spouses that they believed would be beneficial to the patient. They were unsure however, if it was "allowed" and did not want to appear as overstepping the "rules" or "get in the way." Nurses appeared to quickly evaluate patients and the family members in regard to whether they were complying with the system or not.

Protecting

Protecting was the fourth theoretical construct that emerged from Level II categories of Memories, Patient/Family Concerns, Perceived Threats, and Nursing Adjustment/Frustration. Informants acknowledged what they had to do to prevent some of the negative consequences of hospitalization. Patients and family members expressed actions and thoughts that they used to protect themselves or to make the experience more bearable, for example, to prevent oneself from becoming too weak. The patients, family members, and nurses identified adjustments that had to be made so that endurance was possible.

Remembering

The fifth theoretical construct, Remembering, referred to thoughts and past illnesses/hospitalizations of informants and was supported by numerous comments from the informants. This construct encompassed the Level II category of Memories and influenced perceptions throughout the entire experience. Remembering appeared to play both positive and negative roles on the process of enduring. On one hand, remembering how they had endured previous experiences seemed to provide strength for many of the informants. On the other hand, remembering negative prior experiences seemed to cloud the current experience. Patients, family members, and nurses alike expressed angers and frustrations that resulted from prior experiences which were now resurfacing when similar circumstances were being faced.

Worrying

The sixth theoretical construct, Worrying, was linked to Level II categories of Nursing Adjustment/Frustration, Filling Time, Memories, Patient/Family Concerns, Perceived Threats, and Perceptions of Care. Worrying described the frequent distressing thoughts of informants that seemed to keep the enduring process continuing. All

informants were concerned about what was happening to the patients and family members and would they be able to get through it. The fear of the unknown was prevalent. Worries regarding pain, safety of both patients and family members, discharge, and others continued the enduring process. Nurses recognized the complexity of care required for elderly patients and family members, but frequently expressed helplessness in assisting them. Inadequacies in staffing, lack of time and knowledge, and negative attitudes toward elderly patients were frequently voiced as reasons for nurses' frustrations. Yet, nurses expressed a desire that these elderly patients get better and maintain functional levels to maintain independence.

Model

A model for the core variable and theoretical constructs is depicted in Figure 1. This model illustrates a star which reflects the process of hospitalization for the elderly person. ENDURING becomes the center of the star and describes the star's existence. The six theoretical constructs surround the star with a broken line representing a dynamic, open system. The circular pattern depicts the non-linear relationship among

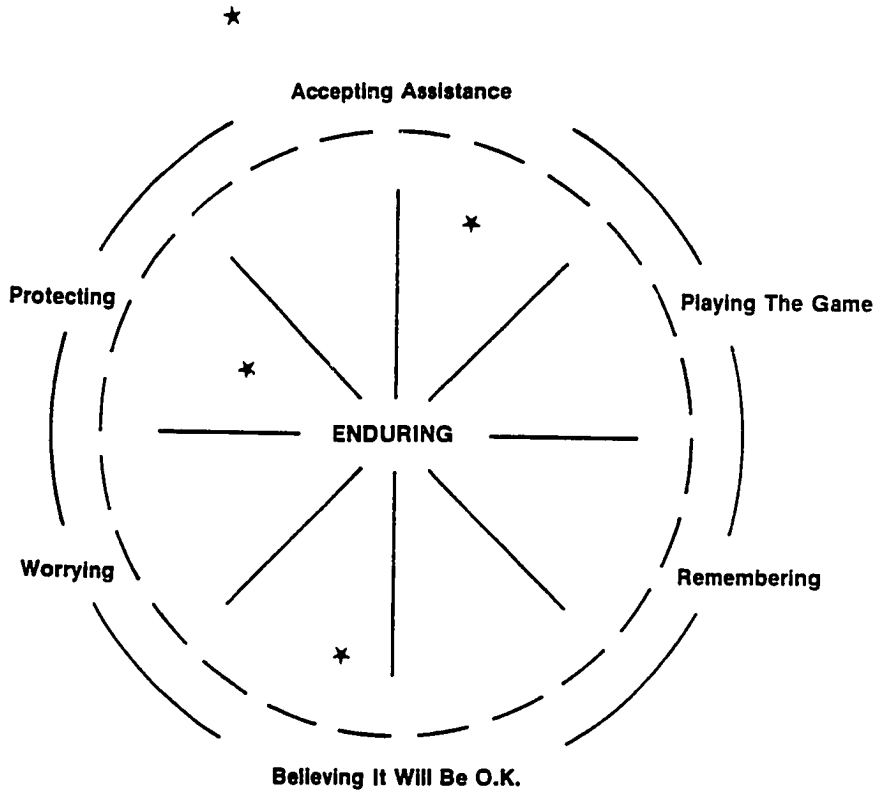


Figure 1. A Theoretical Model for the Hospitalization Experience of Elderly Patients, Family Members, and Nurses: **ENDURING THE EXPERIENCE**

constructs. In addition, constructs are relational but not mutually exclusive. Interrelationships exist among constructs such as the influence that Remembering has on Believing It Will Be OK, Protecting, and other constructs. Several constructs may also be present for the same individual at any one time. Informants in the study demonstrated the complexity of their experience through the multiplicity of constructs occurring at one time: Protecting of some aspects of their experience (e.g., protecting against becoming too tired), Believing It Will Be OK (e.g., the physicians will find out what is wrong with me), Playing the Game (e.g., assuming a "good patient" role), Accepting Assistance (e.g., receiving help with bathing, walking), Remembering (e.g., comparing past hospitalization with present one), and Worrying (e.g., how is my family doing without me at home).

The variability of ENDURING among individuals and within the same individual is analogous to the brightness of a star. This light intensity, or magnitude, of the star can wane or grow brighter depending on obstacles or paths that are placed in front of it. Like stars being viewed during the daytime, endurance can be difficult to see and like some stars may disappear forever.

Scientists identify a regular evolutionary pattern for stars. Stars gather material (particles and gases) toward themselves and as they become hotter and hotter, they radiate energy into space. This process allows the stars to endure. Over periods of time (probably millions or billions of years) stars will grow cooler and fainter. Astronomers do not know if stars stop shining and cease to be stars or if they begin to attract particles and once again become stars. Nevertheless, stars are considered to be variable; they differ greatly in brightness, size, and color. As they gain interstellar particles and release energy, stars may become brilliant or they may explode as a nova and lose many of the particles they have gathered (Sentman, 1970).

Like the stars, the enduring process of hospitalization is one of gathering and emitting strength (energy). Each theoretical construct adds to or subtracts from the enduring process. Five of the six constructs, Accepting Assistance, Believing It Will Be OK, Playing the Game, Protecting, and Remembering, may intensify the endurance if the activity contains the "particles" the patient needs at the time. But the sixth construct, Worrying, or inappropriate activity relating to any of the other five constructs decreases the endurance by weakening

the self-strength. Elderly patients' energy reserves may not be as plentiful as in the past. Therefore, if the patient continues to exert increasing amounts of energy without gathering additional strength, he or she, like the stars, may begin to fade. If this downward process continues long enough to exceed the reserves and abilities to gain further strength, the patient may lose his/her life.

While all patients demonstrated the enduring process with the six linking theoretical constructs, the amount of strength that it required to endure the hospitalization seemed variable among patients and even within the same patient at various times. All patients referred to the hospitalization as something they had to get through, and for some the amount of assistance received appeared relatively adequate. Through their own strength and that provided by hospital staff and family their endurance was maintained. Other patients seemed to wane, just as the brightness of stars diminish, and for a few, the experience seemed to overwhelm their ability to endure at times. Patients whose physical conditions did not rapidly improve voiced considerably more expressions that questioned if they had the needed strength to want to continue

enduring. However, even in these patients the enduring process appeared to be quite dynamic rather than a static state.

Summary

The emerging core variable of ENDURING with its six theoretical constructs resulted from indepth analyses of data. The variable was validated with informants and each transcript was reread for supporting evidence of the overall variable and each construct.

The six constructs were as follows:

- (1) Accepting Assistance--describes the willingness of informants to engage in care giving/receiving behaviors;
- (2) Believing It Will Be OK--describes the informant's thoughts and feelings that someone or something will take care of the patients;
- (3) Playing the Game--depicts thoughts and actions of informants to get through the ordeal with as few disturbances as possible;
- (4) Protecting--reflects thoughts and actions taken by informants to shield the patients/family members against negative consequences;
- (5) Remembering--refers to thoughts of past illnesses/hospitalizations of informants; and
- (5) Worrying--describes the frequent distressing thoughts experienced by informants.

The findings of these analyses reflected coping of individuals to a perceived unpleasant experience; therefore, in the next chapter the enduring model is compared to selected existing models of stress and coping.

CHAPTER VII

COMPARISON OF CORE VARIABLE WITH RELATED VIEWS OF STRESS AND COPING

Through the emerging core variable, ENDURING, and the linking theoretical constructs of this study, a process was described that seemed to be related to stress and coping. Therefore, in this chapter selected stress and coping views are examined and compared to the findings of this study.

Early Views

Stress and coping have been viewed in a variety of ways since the early work of Hans Selye (1956) who through animal studies identified stress as "the state manifested by the specific syndrome which consists of all the nonspecifically induced changes within a biological system" (p. 54). Selye's nonspecific response called the "General Adaptation Syndrome" (GAS) identified the following three responses to stress: (1) "alarm reaction", (2) "stage of resistance", and (3) "stage of exhaustion."

Other researchers such as Seligman (1974) deduced primarily from animal studies that the response to stress was a learned response (i.e., a learned helplessness). Others such as Weiss (1970, 1971a, 1971b) demonstrated in experiments with rats that the stress response was lessened if the stressor was predictable. But basic points relating to stress and coping (i.e., helplessness) were agreed to be the following: (1) a powerful psychological force exists; (2) both behavioral and biochemical factors are present; and (3) the person's coping ability determines how much damage stress entails (Colligan, 1975).

More Recent Views

More recent stress and coping theories include the individual's cognitive appraisal of the stressor and the selection of a coping strategy (or strategies). Pearlin and Schooler (1978) emphasized the individual's roles in life as a major component of their stress and coping model. To these authors, social stratification "causes" stressors which then "causes" stress responses. Improving living conditions and life roles would decrease stressors. Coping was defined as "any response to external life-strains that serves to prevent, avoid, or

control emotional distress" (p. 3). These responses are further categorized as: (1) those that modify the situation; (2) those that control the meaning of the problem; and (3) those that manage the emotional distress. In their cross sectional study of the efficacy of the coping modes to strains in marriage, parenting, household economics, and occupation, Pearlin and Schooler found that "the style and content of coping do make a difference to the emotional well-being of people" (p. 18). With close interpersonal role areas such as marriage and parenting, the individuals' coping interventions are most effective while they are the least effective when dealing with the more interpersonal problems such as those found in occupation. However, with impersonal strains (economical or occupational) behaviors which distance the individual from the problem were found to be the most effective, while mechanisms which bring the individuals together (committed and engaged) are most effective for close interpersonal roles. These authors concluded that intraindividual and interindividual differences existed in the coping successes for the various role areas. However, the authors emphasized that effective coping modes are unequally distributed in the American society, usually with men, the

educated, and the affluent making greater use of modes that deal with the problem rather than emotion-focused responses.

Lazarus and Folkman (1984) offered a cognitive appraisal or perception component to their stress and coping model. Two cognitive processes were identified in the perception of stressors: (1) primary appraisal, in which a person decides whether or not a situation is potentially threatening; and (2) secondary appraisal, in which the individual assessed the resources available for coping with the threat. If resources are available, less stress is experienced than if the person perceives inadequate resources. The process in which a person cognitively evaluates the situation is contextual, continual, and influenced by the person's past history and experience. Perceived threatening situations evokes the GAS (as described earlier by Selye). The extent to which the physiological response occurs is dependant upon how threatening the stressor is perceived by the individual. Lazarus and Folkman found that "emotion-focused" coping techniques were likely to be used when a person perceives the situation as one that cannot be changed, and the coping task is defined in terms of needing to accept and adjust to

the situation. Lazarus and Folkman emphasized the need to further explore coping using longitudinal designs to capture the intraindividual differences that characterize coping.

Paterson and Neufeld (1987) examined existing literature relating to stress and coping and concluded that the individuality of appraisal of threat related to numerous factors. These authors examined the following three factors and found these factors to have particular relevance to an individual's assessment of a threat (anticipatory stress): (1) severity of the threat; (2) imminence of the threat; and (3) probability of the event occurring. The authors also acknowledged other factors, such as ambiguity about the imminence (predictability) and the availability of control, to have "well established effects" (p. 413). Control, as it relates to secondary appraisal described by Lazarus and Folkman, was determined to have considerable supporting literature. Paterson and Neufeld concluded that "control appears to moderate the effects of stress by allowing the individual to alter or avert the threatened event" (p. 413).

Maintaining personal control during hospitalization presents problems, particularly for elderly patients. Taylor (1979) described the

hospital patient role as a situation where individuals relinquish control over their daily existence. This author suggested that "good patients" may actually be very stressed patients suffering from helplessness and "bad patients" may be angry patients reacting to the loss of control. This lack of control may have a further impact on elderly patients. Rodin's (1986) review of the literature revealed that a sense of control has:

special relevance for older people either because experiences related to control increase markedly in old age or because these experiences have different social meaning. (p. 1271)

Rodin stated that both variability in perception of control and desirability for control increase as one ages. Also the association between health and control in elderly persons is strongly linked (e.g., immunological suppression and lack of control). The author further emphasized that assistance provided to elderly persons, such as that found in dependency promoting health care, can undermine the elderly person's sense of control.

In addition to the published work on individual stress and coping, authors have begun to view stress and coping as a family concept. Rather than family members experiencing their own separate stress from other family members, McCubbin and McCubbin (1987) addressed the interconnectiveness

among family members in their family stress model. These authors' model is based on the following assumptions: (1) families will inevitably face hardships and changes throughout life; (2) families develop strengths and abilities to foster growth and protect the family from major disruptions resulting from family transitions and change; (3) families develop strengths and abilities to protect the family unit from unanticipated stressors and strains and to foster adaptation by the family following a crisis; and (4) families benefit from community relationships and resources during family stress and crisis, as well as contributing to the process.

Phenomenological View

Nursing and health professionals have used the theoretical frameworks from Pearlin and Schooler (1978) and Lazarus and Folkman (1984) for numerous studies relating to stress and coping. Some of these researchers have recognized the complexity of the stress and coping phenomenon and have called for better ways of viewing and researching the phenomenon. Panzarine (1985) challenged researchers to develop ways to examine stress/coping that include the multidimensionality and contextuality of the phenomenon.

Recently, two nursing authors have added a phenomenological perspective to stress and coping.

Benner and Wrubel (1989) have identified stress as the disruption of meanings, understandings, and smooth functioning so that harm, loss or challenge are experienced and sorrow, interpretation, or new skill acquisition is required. (p. 412)

Coping was further defined by these authors as

What people do when personal meanings are disrupted and smooth functioning breaks down. Since the goal of coping is the restoration of meaning, coping is not a series of strategies that people choose from a list of unlimited options. Coping is always bounded by the meanings and issues inherent in what counts as stressful. (p. 408)

Benner and Wrubel described coping to be more than a conscious, cognitive process. Coping may involve a "nonconscious" knowing that the authors identified as "embodied intelligence." This component "refers to the body itself as a knower and interpreter" (p. 409). Embodied intelligence is thought to include innate capacities and rapid interpretations of the situation that are largely "nonconscious." These authors stated that when this type of intelligence is working well, no one seems to notice and only when it breaks down does one notice. Embodied intelligence and conscious appraisals of hospitalization are intricately tied to the person's past history. Benner and Wrubel stated that "in the phenomenological view of the

person, there is no way to step outside of one's own history. The person both constitutes and is constituted by his or her experience" (p. 61).

Within the phenomenological view of stress and coping, nursing has been identified as having unique intervention capabilities. Benner and Wrubel (1989) stated the following:

Nurses are in a unique position of being able to understand both the disease experience and the meanings that the patient brings to that experience. As a result, nurses can help shape the illness experience for the patient by guiding, interpreting, and coaching. (p. 62)

Nurses may assist patients in using individualized coping strategies but Benner and Wrubel also stated that nurses:

establish a healing relationship by helping the patient mobilize hope and embrace recovery by appropriating available social, emotional, and spiritual resources. (p. 62)

Further support for the phenomenological approach to stress and coping in nursing care is given additional support from nursing theorists. An early nurse theorist, Travelbee (1966), defined nursing as:

an interpersonal process whereby the professional nurse practitioner assists an individual or family to prevent, or cope with, the experience of illness and suffering and, if necessary, assists the individual or family to find meaning in these experiences. (pp. 5-6)

Travelbee further stated that:

the function of the professional nurse practitioner is to assist the individual in coping with and bearing the stress of illness and suffering when he does encounter these experiences. The process of nursing, i.e. everything the nurse does for and with the patient, is designed to help the individual or family in coping with or bearing the stress of illness and suffering in the event the individual or family encounters these experiences. (p. 8)

Travelbee emphasized that the only way the nurse can assist the patient and family in this coping is to find out the patient's perceptions of his or her illness.

Comparison: Core Variable to Other Views

Comparing the core variable, ENDURING, that emerged in this study to the published views of stress and coping facilitates the expansion and advancement of substantive theory. The ENDURING process, as described in the previous chapter, is thought to be a coping activity that hospitalized elderly patients and their families engaged in during the experience. The effectiveness of the coping activity was not evaluated by the investigator this study, but rather the meaning of the experience of the informants was explored.

As Lazarus and Folkman described in their two stage appraisal process, individuals in this study appeared to perceive hospitalization as a

stressor and they compared their strengths with what they had to do to get through the experience. Their prior experiences heavily influenced how they perceived the situation. Consistent with Benner and Wrubel's findings, this study's informants did not seem to have a list of unlimited options from which they selected a strategy for coping. Rather the informants seemed bounded by their past experiences and what meaning this current hospitalization had for them. While an overall process of ENDURING and linking theoretical constructs was identified for all informants, intraindividual differences existed. Each informant appeared to be engaging in and interpreting the ENDURING process in a unique manner. This was not surprising since each had uniquely different physiological conditions, sociological circumstances, and past experiences. All informants were undergoing a common experience yet, the meaning of the experience was uniquely their own.

If the stress of hospitalization was only a physiological stress, researchers project that when the resources of the person were exceeded, the individual would no longer be able to ENDURE, and exhaustion and death as described by Selye would occur. In the review of literature (see Chapter

III), incidents of "overloading" the elderly person's physiological system were described (e.g., medication and other treatment miscalculations, resulting iatrogenic complications, including death). The range of the elderly patients' physiological capabilities for enduring is rather narrow because they are more likely to be physiologically compromised upon entering the hospital than younger patients. Patients and their elderly spouses in this study were found to have multiple health problems. Some patients had life-threatening conditions that required invasive procedures that taxed their energy levels. Informants expressed uncertainty relating to how much more the patient could tolerate. Some informants perceived that death was imminent for two of the eight patients. In addition, nurses expressed concern relating to the survival of elderly hospitalized patients in general. These nurses perceived elderly persons less likely to be able to tolerate the many stressors that patients may have to encounter. But unlike the early theories of stress and coping, informants appeared to holistically view stress and coping. It was more than physiological, but included other factors. Worrying was viewed by the informants in this study

as an ineffective activity in relieving stress and resulted in decreasing energy even further.

The literature also reflected that numerous factors contributing to iatrogenic complications of hospitalization elderly patients were unknown. Foreman (1989) concluded that confusion occurring in elderly patients soon after hospitalization was thought to result from stresses associated with hospitalization as well as physiological illnesses. Other stresses examined have included pain, mobility, medications, and other quantifiable measures; however, many authors echoed that the negative effects of hospitalization for elderly persons was not solely related to physiological stressors.

The separation of physiological from psychological aspects and the objectification of data found in earlier work relating to stress and coping ". . . decontextualizes and removes any 'interpretive' element from the data" (Benner & Wrubel, 1989, p. 99). In this study the subjective, contextual interpretations of informants were gathered and analyzed. Physiological, sociological, and psychological components were considered as connected from the perspective of the informants who did not view these components as being separate.

This connectiveness was reflected in the core variable, ENDURING, and each of the theoretical constructs. For example, the theoretical construct in which the patient is accepting of assistance includes not only assistance in meeting physiological needs but includes sociological and psychological components. This construct includes a cognitive-behavioral aspect in which the person makes a decision to accept assistance. There may also be a component that included "embodied intelligence" as described by Benner and Wrubel (1989). The extent that the informants in this study consciously analyzed their situation and how much was "nonconscious" is not known. But it does seem possible that persons are knowers beyond the typical cognitive appraisals. At the time of hospitalization, patients are experiencing changes in numerous aspects of their lives. It seems unreasonable that they would be consciously evaluating every aspect but rather that their innate knowing would also be in play. Also, it may be that this embodied intelligence is hampered due to the number and extent of stressors elderly patients (and family members) are experiencing during hospitalization. This disrupted knowledge may interfere with the person's ability to find the

meaning of the situation. The lack of meaning constitutes a stressful situation for the person.

Additionally, congruent with the phenomenological view, the informants of this study revealed an interaction between the person seeking the help and those rendering the help. The past experiences of all involved persons influenced the meaning of this interaction. The person was active, rather than passive, in creating the meaning (i.e., rather than solely responding to the stress of hospitalization, the person was actively engaged in the interaction).

Theoretical constructs were also connected to one another. Worrying, Protecting, Believing It Will Be OK, and Playing the Game are also interwoven into the Accepting Assistance construct. Findings revealed that patients were not the only informants to undergo the ENDURING process. Family members and the nurses caring for the elderly patients were also undergoing the process. The linking theoretical constructs reflected the process of family members and nurses as well as the patients. In this study the patient and family member (when present) appeared to be a unit experiencing the hospitalization. However, attempts at protecting one another were not always realized but were

sometimes thwarted by hospital routines, inability to be with each other, and other factors.

For nurses ENDURING appeared to be reflective of the frustrations perceived by the nurse in caring for elderly patients. The nurse's past history appeared to influence her meaning of the experience as much as the past histories of patients and family members. Nurses varied in their involvement of the other linking theoretical constructs but all nurses exhibited the ENDURING process.

Summary

In this chapter, previous views of stress and coping were explored and compared with the emerging core variable and theoretical constructs found in this study. The findings of this study indirectly reflected aspects of physiological stress and response described by early stress researchers. The findings of this study also revealed cognitive-behavioral appraisal and response to the stressor of hospitalization. Even more important, the findings disclosed the connectivity and complexity of informants' perceptions to the experience. Benner and Wrubel's phenomenological approach to stress and coping was the view most

congruent with the findings of this study. The similarities of this study's findings and the phenomenological perspective and symbolic interaction theory, foundational to this grounded theory study, are recognized. Findings of this study reflected that the meaning of the experience for the involved individuals influenced their perceptions of hospitalization and how each uniquely engaged in the process with others.

The comparison of views provides groundwork for advancing the substantive theory of this study toward a more formal theory about hospitalization of elderly patients. In the final chapter implications for nursing practice, education, and further research are addressed.

CHAPTER VIII

NURSING IMPLICATIONS

A substantive theory of the hospitalization experience of elderly patients, family members, and nurses caring for those patients was identified in this grounded theory study. Within the theory various problems relating to the hospitalization experience were identified. In this chapter, the significance of the theory to nursing practice, education, and further research directions is explored.

Nursing Practice

From the findings of this study and comparative views of stress and coping, stress for elderly hospitalized patients and families is inevitable. Therefore, the nurse's role is not only to minimize stressors but also to help patients and their families to endure stress. Benner and Wrubel (1989) exemplified the findings of this study when they stated that "nurses do not cure stress, but

they help patients survive it" (p. 62).

Hospitalization is likely to remain a stressful event as perceived by most patients, family members, and even nurses. All persons involved in the experience interact on the basis of symbols that have meaning for them. The meaning that each individual attaches to the event is unique.

However, informants in this study exhibited a common ENDURING process. Implications for nursing practice are discussed for each of the six theoretical constructs that link together to form the ENDURING process.

Accepting Assistance

Findings revealed a complex balance between the patient/family member's decision to accept assistance or to reject assistance. Even within decisions to accept assistance, concerns were voiced that the assistance would in some way decrease the patient's independence. Based on these findings, better ways are needed to foster independence and decrease dependence in elderly patients. Nursing implications include the recognition that patients, family members, and nurses alike are actively involved in the development of the experience, rather than passive receptors of what is going on around them. This shift from viewing the

hospitalized elderly patient as only a recipient of care to one that acknowledges all participants as interactional would provide a framework for fostering perceived control and coping with the stressors that each will encounter in the experience. This recognition coupled with the implications that are identified in other following theoretical constructs will aid in the fostering of perceived control and coping.

Believing It Will Be OK

The patients and family members in this study indicated they perceived certain aspects of their care were in their favor. The informants identified these beliefs as stemming from internal and/or external sources. However, these optimistic perceptions seemed to relate to specific and individualized aspects of their care. In addition, these perceptions often reflected change as additional threats were encountered.

Implications for nursing practice relate to the dynamic nature of the patients' and family members' optimism. Nurses need to continually assess the perceptions of patients and family members, and not assume that optimism with care relates to all aspects nor that optimism is a static state. Nurses should explore with patients and

family members sources of optimism that are meaningful for specific aspects of care and for specific times. Activities that provide insight into optimism may include life reviews with focus on sources of strength in other experiences. Spiritual opportunities, support from family and friends, and educational sessions with the health care team may also provide optimism for the patient. In addition, implications identified in other theoretical constructs (e.g., fostering self-management) may also enhance optimism.

Playing the Game

Patients and family members recognized that they were involved in an organized structure that required certain behaviors. Generally, they wanted to know how the system worked so they could better adapt to it and not offend anyone. The only preparation for the role that the patients in this study had was previous experiences. Nursing care would be more beneficial if nurses understood what meaning the hospitalization held for patients. In addition, patients and family members would benefit from clear expectations of the role. Because all informants were involved in a large organized system, it seems logical that each must comply with certain aspects in order to survive. Nurses are in

unique positions to explore compliant behaviors that facilitate the patient's recovery and those that do not. Patients and nurses can then foster those patient behaviors that enhance recovery.

Family members, as well as patients, may benefit from the family member's involvement in the patient's care. Family members expressed a desire to help patients but often did not know how or they perceived that hospital staff would not be supportive of their efforts. To encourage family involvement with care, family members could spend time in learning about the patient's care through appropriate learning modalities.

A variety of activities related to filling time. Not all patients and family members need help in filling time. However, those that do may lack knowledge about the resources that the hospital provides (e.g., reading materials). Because informants spent considerable time looking at the walls and ceilings, attention to the quality and location of visual materials (e.g., artwork) may be beneficial to patients and family members who must spend long periods of time in the same environment. Additional resources such as audiotapes and videotapes may also provide patients and family

members with enjoyable and educational opportunities.

In addition to the implications for the physical environment, findings of this study also suggest that changes are needed in the social environment. As perceived control is increased (as described in other theoretical constructs) the patient and family may not believe they must adhere to a certain role that is determined by the hospital system. Instead patients and families may actively participate with the health care team in identifying their roles as they plan, implement, and evaluate their care. Less energy will be directed toward playing a game that is often not productive in recovery.

Protecting

Informants in all groups (patients, family members, and nurses) identified numerous threats that were encountered by hospitalized elderly patients and families. The threats encountered by the hospitalized elderly patients presented additional stressors for them. If already compromised due to illness these threats can jeopardize recovery. Efforts to identify and minimize threats with patients and family members may provide them with the needed energy to recover.

Provided that hospitalization is not an emergency, these efforts should include prehospitalization activities such as a functional assessment with appropriate educational preparation (e.g., what to expect during and after hospitalization), and physical preparation (e.g., crutch training and strengthening exercises if applicable; visual and auditory adjustments to demonstrated deficiencies; improvement in nutritional status if necessary; donation and storage of patient's own blood if needed; adjustments to current medications and other medical treatments). These efforts will require assessment and referral to other health professionals as appropriate.

In-hospital efforts should promote continuity of care for elderly patients and their families. Specific efforts should be made to minimize room changes; decrease noise levels; eliminate unnecessary and unexplained changes in routines; avoid disrupted sleep, pain, and immobility. Attention should be directed to improving and maintaining a nutritional status and exercise regime that promote recovery. Patients and families members should receive individually designed discharge education that is developed with

the elderly patient and family (prior to hospitalization if possible) and reinforced throughout the hospital stay.

Of paramount importance is the respect and dignity that should be the basis for all care with elderly patients and families. Elderly patients deserve to be treated as adults rather than as "babies" as described by one nurse in this study. The respectful treatment of elderly patients should include a thorough examination of difficulties encountered by the patient and family with specific interventions for dealing with these problems. In direct opposition with the above compliance in the Playing The Game construct, elderly patients may not comply with aspects of the care regime for valid reasons that may not be apparent to the nursing and medical staff. It is most appropriate that nurses explore non-compliant behavior with an openness and belief that the patient has "insider information." All effort should be made to maintain the elderly patient's and family's sense of control.

Other in-hospital efforts should include the careful appraisal of all procedures and treatments. Determination of the benefit/risk ratio of procedures and treatments should be evaluated by the patient, family, and involved health care staff.

Eliminating or minimizing interventions that carry too much risk will decrease the number of iatrogenic complications that elderly patients experience during hospitalization. Exploration of less threatening procedures and treatments may provide alternatives that minimize the energy drain on the elderly patient.

Assisting family members with perceived threats may require additional effort by nurses. Generally, family members in this study indicated they did not want to impose on hospital staff for problems that related to their own needs. Similarly, nurses did not know about specific problems that family members were encountering. In many cases the family members were also older persons with one or more chronic illnesses. These family members described the exhaustion they experienced traveling to and from the hospital, long hours staying with the patient, and missing their family member after leaving the hospital. In some cases sleeping accommodations (usually a reclining chair) were provided to family members who wanted to spend the night with the patient. Such actions on the part of nurses were greatly appreciated but family members indicated these were not restful nights. "Roll-away" beds for family members in the

patient's room would provide closeness to the patient while allowing the family member to recline when rest was needed. Findings in this study revealed that family members often were the first to recognized threats to the patients and often were instrumental in protecting the patient from further harm. Family should be considered as valuable participants in the experience. Rather than being made to believe they are a nuisance, family members should be recognized as having the ability to provide care and support to the patient, support that hospital staff are not able to provide due to short staffing and/or unfamiliarity with the patient.

When "rooming-in" with the patient is not possible or desired by either the patient or family member, nurses need to explore with family members other means to reduce threats. Resources such as a close place to stay (similar to Ronald MacDonald House for parents of hospitalized children) may decrease the stress relating to travel and being too far away from the patient. Other ways to minimize hospitalization threats and to increase the support between patient and family members include "passes" for patients to leave the hospital during intervals when acute care is not needed and the patient is

physically able. Patients could return for hospital care as needed. Other actions include more self-management and family management of medications, meals, and other activities that the patient and family desires. Patient and family education would be necessary to assure knowledge and skills in the implementation and evaluation of activities.

All efforts should be made to prevent the "too early" discharge from the hospital feared by so many of informants in this study. As mentioned earlier, the discharge education that is initiated prior to hospitalization and continued throughout the hospitalization would help to return elderly patients to their previous residences at the earliest date. Follow-up contact with the health care system through the use of telephone calls, visiting nurses, and other means may decrease considerable patient and family anxiety as well as providing needed care that is not required in an acute care setting.

Remembering

The memories that each informant shared influenced the current hospitalization. For some informants the memories were more dramatic than others. Every patient expressed memories relating

to past illnesses and hospitalizations of themselves or loved ones. The majority of the memories were perceived as negative ones in that the health care system had failed them in some way. Informants may have had other positive experiences that were not shared. Regardless, these experiences shared conveyed the impact that contact with the health care system had on these persons. While past experiences cannot be changed, nurses can seek to understand patients' and family members' behaviors in relation to their past experiences. The use of reminiscence or a more in-depth life review may help to achieve the understanding that hospitalization and its symbolism has for the elderly patient and family member. In addition, nurses can provide care that could make the current hospitalization one that will be remembered as a positive experience. To a large extent this can be accomplished by reducing the threats that have been previously described in the Protecting construct.

Worrying

Informants varied in the amount and source of their worries. Some patients were described as worrying when they did not have anything to occupy their time. Patients and family members expressed worry when they were uncertain about diagnoses or

treatments, as well as other threats previously discussed.

Nurses can assist patients and family members to minimize worrying through interventions that eliminate or decrease threats. Worrying that can be focused toward constructive ways to decrease threats may thwart unproductive energy draining behavior. In some cases counseling may be necessary to assist patients and family members to direct energy in a manner that facilitates recovery.

Summary

All six of the theoretical constructs can positively or negatively influence ENDURING. The nurse's role is to minimize stressors and to help patients and their families (as well as the nurse) to understand the meaning of this hospitalization experience thereby fostering the ENDURING abilities. Nurses are encouraged to minimize threats associated with hospitalization and to explore with elderly patients and family members what the hospitalization experience means to them. What past histories do patients, family, and nurses bring with them into this experience? What symbolic meanings does the experience include for each individual? The process of ENDURING can be fostered or hampered by the meaning perceived. Nurses cannot erase past

histories nor perceived meanings but can assist patients "to bear" the stress that is involved in illness and hospitalization. In addition, nurses can be instrumental in minimizing the iatrogenic complications that jeopardize recovery for elderly patients.

However, the nursing practice implications addressed will present challenges for the entire health care system. Rather than viewing the hospitalization episode as an isolated event in the lives of elderly persons, the entire continuum of care will need activation. In order for prehospitalization care and posthospitalization care to occur, elderly persons will need assistance from a health care system that focuses on preventive care and avoidance of hospitalization if possible. In the event hospitalization is needed, the prehospitalization plans previously addressed will benefit not only the elderly patient and family, but also the health care system in general by minimizing hospitalization days (and costs) and potential iatrogenic complications from hospitalization. Furthermore, the multitude and complexity of care that is needed in the implications for nursing practice will require a multidisciplinary approach to the continuum of care for elderly patients and

families. Involvement of physical therapists, social workers, nutritionists, and others will complement the traditional nurse-physician dyad as prehospital, in-hospital, and posthospital care is planned with patients and families.

Nursing Education

Findings from this study have implications for nursing education. The ENDURING process for nurses primarily related to their frustrations in caring for elderly patients and families. Most nurses voiced a lack of gerontological nursing preparation, yet many of the nurses stated that they had been assigned to care for numerous elderly patients since graduation from their nursing programs. For most nurses the reality of caring for the elderly patients resulted in frustration from inadequate knowledge of how to best assist these patients and families. These frustrations were intensified by the limited amount of time that nurses were able to spend with patients and the limited numbers of staff available on the unit. The nurses conveyed frustration that many of the elderly patients would continue to decline in health. Nursing education can prepare nurses to minimize the

negative aspects of hospitalization for elderly persons and their families.

Patients and family members had definite expectations about nurses and the care that patients should receive. The role of the nurse was perceived to be more clearly defined than the roles of the patient or family member. Although these expectations did not exceed what most nurses would consider "good" nursing behavior, the nurses' inability to provide the assistance because of lack of knowledge, limited time, or inadequate staffing no doubt added to their feelings of frustration.

With few exceptions nurses tended to view elderly patients as a homogenous group that shared similar problems. However, in the last few years gerontological education efforts have focused on the individuality of elderly persons, including physiological changes involved in the aging process. Educational efforts for nurses such as those in this study should include hospital in-service programs that provide specific content relating to hospitalized elderly patients and family. This content should include not only commonly occurring disease processes that hospital nurses will encounter with elderly patients, but also emphasize

individuality of older persons including physiological aging.

In addition, educational efforts for nurses should include interventions that would assist elderly patients and their families to explore what hospitalization means to them. If hospitalization is viewed as the stressful event that the patients and family members in this study described, nurses can assist them in understanding the meaning of the experience and assist them in coping with the situation. The importance of elderly person's and family member's perception of the hospitalization has been supported throughout this study. What memories the patient and family member bring with them to the current hospitalization heavily influences their current perceptions. Nurses can assist patients and family members in making each hospitalization a more bearable experience. Nursing activities which foster the patient's and family's sense of control are thought to minimize the appraisal of the threat. These efforts are likely to enhance patients' and families' ENDURING abilities. This educational effort suggests that nurses should be provided a phenomenological framework in which nursing care can be rendered.

From the findings of this study attitudes toward aging and the elderly will need to change. The sadness and despair expressed by some nurses reflected negative views of aging. These nurses may not experience elderly persons in a healthy state. They may not have elderly family members or friends who are well and functioning independently. Educational experiences with well elderly can provide opportunities for nurses to develop more positive attitudes toward elderly persons and aging.

In addition, the contributions to nursing education of nurses such as those in this study should be recognized. Some nurses expressed constructive approaches in their care of elderly patients (e.g., independence fostering activities) that may be beneficial within educational programs. These nurses could work with nursing educators to develop programs that are based in practice.

The implications for nursing education have been grounded in the data primarily from nurse informants with additional data from patient and family informants relating to their perception of nurses and nursing care. Findings suggest the need for developing educational programs that would assist these nurses who are struggling with the

realities of caring for elderly patients and families.

Nursing Research

The complexity of elderly persons coupled with the multidimensionality of stress/coping presents profound challenges for nursing research. Numerous methodological problems in previous gerontological research have been addressed. Limitations of this study included a small sample of men and women (mean age 73.5 years) from similar ethnic and economic backgrounds who were interviewed during only one hospitalization in the same setting. Individual differences among the elderly and individual differences in one's coping at various times make single group data difficult to interpret. For this reason research designs that incorporate intraindividual and interindividual contextual aspects will undoubtedly shed more light in the understanding of the hospitalization experience.

Findings from this study revealed some beginning direction for further research in this area. However, considerable research is required to advance knowledge about hospitalized elderly and families. White, middle-class informants from one hospital setting were included in this study.

Different ethnic, economic, and geographically located groups are likely to have varying perspectives of the meaning of this experience. In addition, the patients in this study ranged in age from 66 to 83 years. Older patients may have different meanings for the experience. Persons over age 85 are usually considered more frail and may experience additional stress during hospitalization. In addition, younger adult patients (age 65 or younger) may also perceive the experience quite differently. These younger patients may have fewer memories of past hospitalizations and illnesses and may vary remarkably in the degree and extent that they ENDURE. The substantive theory identified in this study can be expanded through the inclusion of such groups of people experiencing hospitalization.

Therefore, evolution of the substantive theory to formal theory will require a research plan that includes additional groups that are similar and vary in ethnic origin, economic status, age, diagnoses, and hospital setting. As groups are added, the relationships among theoretical constructs and to the core variable can be further examined. Findings from this study revealed an interrelationship of constructs that enhanced or hampered ENDURING. Testing of these relationships

is required to determine further direction and strength. Further research questions can be posed from the findings of this study (e.g., What is the relationship between patients' level of optimism and their willingness to accept assistance for a specific aspect of care?). However, instrumentation may not be currently available for studying such questions. As discussed in the review of literature, researchers are faced with a paucity of instruments available for use with elderly patients. Therefore, preliminary work will require psychometric studies for the development of instruments. As these instruments are developed and available for research, quantitative designs using multivariate analyses will assist in the examination of the relationships among constructs and with the core variable.

The substantive theory may also be expanded toward formal theory by sampling elderly persons experiencing other stressful events, including events that do not have as definite time parameters as hospitalization. Informants frequently related other experiences that required enormous amounts of strength. The ENDURING process could potentially apply to other life experiences (e.g., widowhood, entry into a nursing home, discovery and living with

an illness). Through the sampling of additional groups and additional comparisons of literature, the substantive theory may be clarified and modified as other stressful experiences are considered.

Findings from this study also presented various problem areas for further exploration. Specific nursing interventions would require further testing prior to implementation. Research questions relating to nursing interventions (e.g., those that may minimize the perceived threats) expressed in this study could be formulated. Using appropriate instrumentation (that may require prior psychometric studies), interventions could be tested with a variety of outcome measures (e.g., patient satisfaction, stress adaptation, hospital duration, cost, discharge readiness, 3-month mortality). These studies would use experimental or quasi-experimental research designs.

Further exploration of the nurse's ENDURING process is needed. Nurses in this study faced a difficult situation in attempting to provide care to complex patients who may have exceeded the nurse's educational preparation. These elderly patients may have also elicited negative responses in the nurse as a result of the nurse's own experiences with elderly persons. Educational research questions

(e.g., What teaching methods increase nurses' understanding of gerontological nursing skills and improve attitudes toward the elderly and aging? Will an increase in gerontological nursing knowledge produce positive changes in practice?) will need to be answered before educational programs are instituted.

Through a triangulation of data sources and research methods, the knowledge about hospitalization of elderly patients and families will evolve. This study included one method, grounded theory, that provided a substantive theory. This substantive theory provides the framework upon which future research can be based.

Summary

In this chapter, implications for nursing practice, education, and research were addressed. Implications for nursing practice were identified within each of the six theoretical constructs. These implications primarily related to activities that foster the ENDURING abilities of patients and families while minimizing the threats that drain their energies and hamper ENDURING.

Implications for nursing education directly related to the frustrations and adjustments in nursing care of elderly patients expressed by

nurses. Educational programs developed in conjunction with nursing educators and nurses in these practice areas warrant further examination.

Implications for nursing research included a research plan designed for expansion of the substantive theory in this study toward formal theory. Further sampling of similar and comparison groups was described. Comparisons to other stressful experiences of elderly persons and comparison to additional literature were suggested. Further research efforts that addressed specific nursing problems that were identified in the data were discussed. Through these efforts that included a triangulation of sources and methods, the body of knowledge relating to the hospitalization experience of elderly patients can be expanded.

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APPENDIX A

SUBJECT CONSENT FORM FOR PARTICIPATION IN CLINICAL INVESTIGATION PROJECT UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER

Project Title: Hospitalization of Elderly Patients

Project Description: You are being asked to participate in a study exploring elderly patients', family members', and nursing staff's perceptions of the hospitalization experience.

The results of this study will allow us to better understand what hospitalization means to elderly patients and may help us to improve nursing care for future elderly patients.

You were selected to participate in this study because you are age 65 or older and are currently hospitalized.

If you agree to participate you will be interviewed by me. The purpose of the interview is to obtain your perceptions about your current hospitalization experience.

The interview will last approximately 30 to 60 minutes and will be arranged at a time and place that is convenient for you. If agreeable with you, the interview will be tape recorded. During the interview you will be asked questions such as, "What is your hospitalization experience like?" After the interview I would like permission to call you if I need to clarify any of the information. In addition to the interview, I would like permission to review your medical record in order to obtain demographic and health information. I am also requesting to interview any available family member that is agreeable to participate in the study.

There are no risks to you involved in this study. There are also no expected benefits to you for participating in the study.

You may postpone or withdraw from the study at any time. If you choose not to participate or withdraw from the study, this will not affect your hospital care in any way.

Funding for this study is provided through a Public Health Service Individual National Research Service Award.

There will be no cost to you for participating in the study.

You are encouraged to ask any questions that you may have about the study. I will answer any questions that you may have about the study now or, if you have questions later you may call me at [REDACTED]

All interview and record information will be strictly confidential. After the interview, your information will be assigned a number and your name will not be used. After the information is typed from the tape recording (if used), the tape will be erased. Information obtained from this study may be published in professional journals, but your identity will not be revealed.

Authorization: I have read the above and understand the discomforts, inconveniences and risks of this study. I understand that, if I refuse to participate or withdraw at any time, my treatment will not be affected in any way.

Signed: _____

Witnesses:

Date _____

APPENDIX B

SUBJECT CONSENT FORM FOR PARTICIPATION IN CLINICAL INVESTIGATION PROJECT UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER

Project Title: Hospitalization of Elderly Patients

Project Description: You are being asked to participate in a study exploring elderly patients', family members', and nursing staff's perceptions of the hospitalization experience.

The results of this study will allow us to better understand what hospitalization means to elderly patients and may help us to improve nursing care for future elderly patients.

You were selected to participate in this study because you have an elderly family member who is currently hospitalized.

If you agree to participate you will be interviewed by me. The purpose of the interview is to obtain your perceptions about your family member's current hospitalization experience.

The interview will last approximately 30 to 60 minutes, and will be arranged at a time and place that is convenient for you. If agreeable with you, the interview will be tape recorded. During the interview you will be asked questions such as, "What is your family member's hospitalization experience like?" After the interview I would like permission to call you if I need to clarify any of the information.

There are no risks to you involved in this study. There are also no expected benefits to you for participating in the study.

You may postpone or withdraw from the study at any time. If you choose not to participate or withdraw from the study, this will not affect you or your family member's hospital care in any way.

Funding for this study is provided through a Public Health Service Individual National Research Service Award.

There will be no cost to you for participating in the study.

You are encouraged to ask any questions that you may have about the study. I will answer any questions that you may have about the study now or, if you have questions later you may call me at [REDACTED]

All interview and record information will be strictly confidential. After the interview, your information will be assigned a number and your name will not be used. After the information is typed from the tape recording (if used), the tape will be erased. Information obtained from this study may be published in professional journals, but your identity will not be revealed.

Authorization: I have read the above and understand the discomforts, inconveniences and risks of this study. I understand that, if I refuse to participate or withdraw at any time, my family member's treatment will not be affected in any way.

Signed: _____

Witnesses:

Date _____

APPENDIX C

SUBJECT CONSENT FORM FOR PARTICIPATION IN CLINICAL INVESTIGATION PROJECT UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER

Project Title: Hospitalization of Elderly Patients

Project Description: You are being asked to participate in a study exploring elderly patients', family members', and nursing staff's perceptions of the hospitalization experience.

The results of this study will allow us to better understand what hospitalization means to elderly patients and may help us to improve nursing care for future elderly patients.

You were selected to participate in this study because you are currently providing nursing care for an elderly patient.

If you agree to participate you will be interviewed by me. The purpose of the interview is to obtain your perceptions about your experience with an elderly hospitalized patient.

The interview will last approximately 30 to 60 minutes, and will be arranged at a time and place that is convenient for you. If agreeable with you, the interview will be tape recorded. During the interview you will be asked questions such as, "What is it like to care for an elderly patient?" After the interview I would like permission to call you if I need to clarify any of the information.

There are no risks to you involved in this study. There are also no expected benefits to you for participating in the study.

You may postpone an interview or withdraw from the study at any time. If you choose not to participate in the study, this will not affect your employment at the hospital in any way.

Funding for this study is provided through a Public Health Service Individual National Research Service Award.

There will be no cost to you for participating in the study.

You are encouraged to ask any questions that you may have about the study. I will answer any questions that you may have about the study now or, if you have questions later you may call me at [REDACTED]

All interview and record information will be strictly confidential. After the interview, your information will be assigned a number and your name will not be used. After the information is typed from the tape recording (if used), the tape will be erased. Information obtained from this study may be published in professional journals, but your identity will not be revealed.

Authorization: I have read the above and understand the discomforts, inconveniences and risks of this study. I understand that, if I refuse to participate or withdraw at any time, my employment will not be affected in any way.

Signed: _____

Witnesses:

Date _____

APPENDIX D

THE ETHNOGRAPH

Example of Numbered SegmentCase X Patient

AH:	What I would like for you to do is just	12
	tell me what it's been like for you to	13
	be hospitalized, particularly coming	14
	from out-of-state and being transferred	15
	in here.	16
PT:	Well it's quite an experience to come	18
	into a large hospital from a small one	19
	and didn't know the rules or regulations	20
	and had trouble getting admitted.	21
AH:	Is that right?	23
PT:	Well we didn't know how to do it.	25
AH:	Uh huh.	27
PT:	We were referred up here by our doctor	29
	and he said he'd make an appointment	30
	with (name of physician). We got here	31
	well some foul up, he didn't know we were	32
	coming so we had to go through admittance	33
	and another doctor saw us and so it was a	34
	foul up on one end or the other.	35

APPENDIX E

THE ETHNOGRAPH

Example of Coded SegmentCase X Patient

PT:	The depressing part of course	81] DIFFICULT TIME
	is that nothing seems to have	82	
	been accomplished so far.	83	
	But I should have realized it	84	
	is trial and error and needs	85	
	patience.	86	
AH:	Are you having a lot of	88	
	effects from the medications?	89	
PT:	Oh yes, I did have. I had a	91] MEDICATIONS
	very serious problem Saturday	92	
	and I guess I kind of left the	93	
	world for a little bit and	94	
	then they had to put me in	95	
	intensive care and I just came	96	
	out of intensive care yester-	97	
	day afternoon. That was	98	
	probably the most serious	99	
	side effect Saturday. They	100	
	were to release me to go home	101] ERRORS
	within two hours and just	102	
	before the release I didn't	103	
	feel very well and it kept	104	
	getting worse and worse and	105	
	finally one of the nurses	106	
	from the lab caught on that	107	
	something was wrong and she	108	
	immediately called in the	109	
	staff and they started	110	
	working. My condition	111] DISCHARGE CONCERNS
	deteriorated very quickly.	112	

APPENDIX F

THE ETHNOGRAPH

Example of Sorted Segment
(Sorted by Code Errors)Case X Family Member

SC: ERRORS

#-MEDICATION #-ERRORS #-CONFUSION

:	FAM:	Um hum. They did. And they put	41	-#
:		him on it in (name of hospital),	42	#
:		not here, in (name of hospital).	43	#
:		And the next time well it was	44	#
:		stormy and the next time I went	45	#
:		over to see him he was a complete	46	#
:		changed man. His attitude,	47	#
:		everything, was completely	48	#
:		changed. And the longer that	49	#
:		he would take it, the more he had	50	#
:		changed. And it just got to	51	#
:		where he was out of his head more	52	#
:		than he knew. And I would notice	53	#
:		it in the morning he would be	54	#
:		pretty good and then when he	55	#
:		would take this Prednisone it	56	#
:		wouldn't be an hour till he'd	57	#
:		be back just like he was.	58	#
:		He didn't, it was just awful.	59	#
:		And he imagined a lot of things.	60	-#