

# “Why Do We Always Have to Focus on the Bad”: A Strengths-Based Approach to Identify the Positive Aspects of Care From the Perspective of Older Adults Using a Secondary Qualitative Analysis

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## Abstract

Hospitalization is often viewed as a burdensome and stressful period for older adults and their family caregivers; however, little attention has been given to the positive aspects of the care continuum journey. The purpose of this article is to highlight the positive aspects of healthcare from the perspective of Canadian older adults with complex needs and their family caregivers. This study utilized a strengths-based theoretical perspective to conduct a secondary qualitative analysis of interviews with 12 older adults and seven family caregivers. Four themes relating to positive aspects of care were identified, including: (1) looking beyond illness, (2) emotional support from healthcare providers, (3) timely discharge, and (4) upholding independence. Focusing on the positive aspects can help determine areas of care practice that currently work well. These insights will be valuable for current and future initiatives seeking to restructure and optimize healthcare services for older adults.

## Keywords

qualitative, care experiences, integrated care, homecare, hospitalization

## Main Findings:

- Using a strengths-based paradigm, the findings indicated that older adults prefer to be discharged home in a timely manner with appropriate community support.
- Older adults appreciate kind healthcare professionals who look beyond their illness and provide them with emotional support and opportunities to be independent.
- Moving away from a problem-focused approach to studying care experiences can highlight the strengths of the healthcare system and provide a more balanced view of older adults' experiences across care.

## Introduction

Older adults with complex needs (e.g., mixed physical, mental, and financial needs) have become a growing

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concern.<sup>1</sup> Research has shown that in addition to the burden in terms of healthcare resource use<sup>1</sup>, older adults and their family caregivers have reported challenges navigating the healthcare system, which is often poorly integrated and coordinated in providing care.<sup>2</sup> Due to the navigation difficulties, older adults with complex needs frequently experience missed healthcare visits, preventable rehospitalizations, high rates of care provider turnover, unmet needs, and unfulfilled care plans (e.g., lack of delivery of planned supports and services).<sup>3,4</sup> However, more research is needed on how to incorporate patient preferences into the care planning process effectively.<sup>5</sup> Expanding the focus of research to include positive aspects of experiences can help provide further insight into the care continuum that can inform interventions to capitalize on these strengths to better support older adults' care experiences.

Patients' and caregivers' experiences are the common thread across healthcare settings, and improving their experiences during periods of receiving care has been identified as an opportunity for health system improvement.<sup>6</sup> Numerous indicators exist to evaluate high quality patient care for patients with complex care needs including: readmissions, follow-up care, emergency department visits, symptom management, delivery of care, health outcomes, prevention, collaboration/coordination, patient engagement, access to care, and patient safety.<sup>7,8</sup> However, researchers have noted the need to explore quality indicators from the perspective of patients and their caregivers to measure the quality of care.<sup>9</sup> Many researchers have studied older adults' and family caregivers' healthcare experience, particularly as it relates to hospital and community care, and have focused on the negative aspects of care experiences<sup>10–12</sup> by focusing on the challenges they face (e.g., unplanned nature of discharges). However, solely focusing on challenges can overshadow or neglect acknowledgement of the many of the positive aspects of care that may be experienced by older adults.

The emphasis on the deficits of the healthcare system may neglect the positive aspects older adults experience during their healthcare visits that can be used to improve service delivery. Acknowledging positive aspects of experiences may help health systems with limited resources to capitalize on these strengths to better support older adults and their family caregivers throughout the care continuum.<sup>13</sup> Positive aspects of experiences may include clear policies and resources to best support older adults.<sup>13</sup> Thus, this article presents comprehensive insights into the positive aspects of healthcare experiences described by older adults with complex care needs and their caregivers by addressing the following research question: "What are the positive aspects of healthcare from the perspective of older adults with complex care needs and their family caregivers in Ontario?"

## Methods

### Research Design

In this qualitative descriptive study<sup>14</sup>, we conducted a secondary analysis of transcript data.<sup>15</sup> Data were collected for a larger study. The primary analysis of the larger study

aimed to evaluate the design, implementation and delivery of a novel patient navigation program and identify opportunities for program improvement.<sup>16,17</sup> The primary analyses of interview transcripts revealed valuable insights into the positive aspects of older adults and their caregivers' care experiences that warranted further in-depth and comprehensive interpretation. As such, a secondary analysis approach was chosen to undertake a more in-depth analysis of the positive aspects of their experiences.<sup>15</sup> Sunnybrook Health Sciences Research Institute provided ethical approval for all study procedures. The Consolidated Criteria for Reporting Qualitative Studies Checklist was used to report the study.<sup>18</sup>

**Sample.** Participants were purposely sampled by gender and degree of complexity. All participants were recruited with assistance from healthcare providers at one large urban hospital in Toronto, Canada. The inclusion criteria were as follows: (a) English speaking and ability to provide informed consent and (b) identified as someone with complex needs as identified by a registered healthcare provider or someone that provided care/support to someone with complex care needs.

In total, 12 older adults with complex needs and seven family caregivers of older adults with complex needs participated in the primary study (see Tables 1 and 2 for participant characteristics).

**Table 1.** Characteristics of Participants.

Characteristics of participants	Older adult participants (n = 12)	Family caregiver participant (n = 7)
<b>Sex</b>		
Female n (%)	7 (58%)	4 (57%)
Male n (%)	5 (42%)	3 (43%)
<b>Age</b>		
Range n (mean, standard deviation)	68–95 (79, 12.18)	50–73 (60, 11)
<b>Marital status</b>		
Widowed n (%)	8 (67%)	1 (14%)
Married n (%)	2 (16.5%)	4 (57%)
Single n (%)	2 (16.5%)	2 (29%)
<b>Race</b>		
Caucasian	9 (75%)	5 (71%)
South-Asian	2 (16.5%)	1 (14.5%)
Biracial	1 (8.5%)	1 (14.5%)
<b>Living arrangement</b>		
Alone n (%)	8 (67%)	1 (14.5%)
<b>Employment status</b>		
Employed n (%)	0	7 (100%)
Unemployed/retired n (%)	12 (100%)	0
<b>Comorbidities (number)</b>		Not applicable
2–3 n (%)	7 (58%)	
4–5 n (%)	2 (16.5%)	
5+ n (%)	3 (25.5%)	
<b>Living with cognitive impairment</b>		
Yes	5 (42%)	
No	7 (58%)	7 (100%)

**Table 2.** Characteristics of Participants.

Characteristics of participants	Older adult participants (n = 12)	Family caregiver participant (n = 7)
<b>Sex</b>		
Female n (%)	7 (58%)	4 (57%)
Male n (%)	5 (42%)	3 (43%)
<b>Age</b>		
Range n (mean, standard deviation)	68–95 (79, 12.18)	50–73 (60, 11)
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2–3 n (%)	7 (58%)	
4–5 n (%)	2 (16.5%)	
5+ n (%)	3 (25.5%)	
<b>Living with cognitive impairment</b>		
Yes	5 (42%)	
No	7 (58%)	7 (100%)

*The Primary Study: Data Collection.* Semistructured individual interviews were conducted as part of a primary study of 12 older adults and seven family caregivers. Interviews occurred approximately two weeks after hospital discharge (i.e., initial interviews) and then again approximately three months later (i.e., follow-up interviews) to determine how their experiences changed over time and while in the community. Six of the 12 older adult participants did not complete a follow-up interview due to health-related reasons (e.g., increased impairment and/or illness symptoms). The first author, a female postdoctoral fellow conducted all interviews in person or on the phone (see Supplemental File A for a sample of the interview guide). Given the aim of the program of research, interview questions targeted the experience of care received in the hospital, experiences of the discharge process and care received at home.

The results from the primary study are reported elsewhere [KMK and HS, SLH (senior author)]. All initial interviews occurred between October 25, 2020, and December 2, 2021. During the study period, stay-at-home restrictions and changes to the normal functioning of healthcare services were in effect due to the COVID-19 pandemic.

All interviews were digitally recorded and professionally transcribed. Interviews lasted 30–45 minutes for the older adults and 60–80 minutes for the caregivers. Interviews continued until preliminary data analysis suggested sufficient

data were obtained to answer the research question and thus, theoretical saturation was believed to be reached.<sup>19</sup>

*Data Analysis.* A secondary thematic analysis was conducted. First, the transcribed data were inputted into NVivo software to support data analysis.<sup>20</sup> The first and second authors (KMK and HS) reexamined all of the transcripts to identify data pertaining to the positive aspects of participants' care experiences during their hospital-to-home transition. Next, the two authors (KMK and HS) independently inductively coded six transcripts (three initial interviews and three follow-up interviews) to identify new codes relating to the research question. A codebook was created based on this initial review, which was applied by the senior author to all transcripts. The coded data were then reanalyzed using a deductive approach theoretically informed by the strengths-based approach<sup>21</sup> by having the two authors recode aspects of the coded data with the codes "opportunity," "strength," "area for improvement," and "overall positive experience." All coded data were then compared, and any discrepancies were discussed. The two authors (KMK and HS) discussed patterns and nuances in the coded data through a series of weekly meetings. The distinguished responsible author (SLH) also reviewed a subset of the transcripts and the coded data to ensure that all relevant concepts were identified. Preliminary themes that arose from this process were discussed with all members of the research team. Through a series of discussions, final themes were given titles.

### Rigor

Rigor was achieved by employing multiple individuals during the analysis process and maintaining regular team meetings (triangulation). We also adhered to practicing reflexivity. Reflexivity involved open discussions and documentation of the study team's experiences that could potentially impact the interpretation of data.

### Results

Four themes were identified through the analysis: (1) looking beyond illness, (2) emotional support from healthcare providers, (3) timely discharge, and (4) upholding independence. Illustrative quotations are embedded in each of the themes and are sourced using the participant group (i.e., older adult or caregiver), sex and study identifier.

#### Looking Beyond Illness

Participants discussed various medical issues affecting their health, including the presence of comorbidities and increased complications from previous treatments. Participants shared descriptions of situations where they felt heard and treated as individuals rather than having their care providers simply focus on their illness. For instance, one person commented that a positive aspect of care she received related to

staff interactions, wherein staff did not focus on her age, gender, or health status: *“they never say it’s because I am old or because I am a woman, they just cared for me as a person, not as a sick person. I am not just a sick old woman to them”* (Older Adult, Female, ID#6). Similarly, other participants reported that healthcare providers empathized with the older adult participants, particularly those with cognitive impairments, with one sharing: *“they [providers] never talked to me like I was stupid just because sometimes I stumble on my words”* (Older Adult, Female, ID#12). In the context of caregiving, family caregivers described a positive aspect of care was that staff were empathetic to their concerns about their family member’s care: *“I just felt like they were sad my mom was there, and I couldn’t be.”* (Family Caregiver, Female, ID#3). Overall, participants felt that interactions were humanistic, personable, and caring.

### Emotional Support From Healthcare Providers

Almost all participants mentioned feeling overwhelmed during hospital discharge processes. However, participants frequently cited positive feelings associated with hospital and community providers reassuring and helping them feel emotionally supported and safe during their healthcare experience. Participants also highlighted that all their healthcare providers validated their concerns related to COVID-19 and *“did not dismiss them”* (Family Caregiver, Male, ID#6). Participants used various positive phrases to describe healthcare providers, including “caring,” “professional,” “going above and beyond,” and “kind.” One participant shared: *“Why do we have to focus on the negative? What makes the healthcare system so great for you? The follow-up. [Primary care physician] is very good at that.”* (Older Adult, Male, ID#13).

Older adult participants described feeling a sense of helplessness due to their high level of physical and psychological needs. However, participants shared that members of their care team frequently reminded them that *“it was their job to help”* (Older Adult, Male, ID#1).

No one wants to be in the hospital. Let alone during a pandemic when all we hear is that people are sicker. But they made it clear that my uncle could stay as long as needed and that they were going to help, despite anything else going on. That reassured me because I knew he needed help. (Family Caregiver, Male, 5)

### Timely Discharge

All older adult participants reported wanting to be discharged from the hospital as quickly as possible. Participants frequently spoke about the importance of a timely diagnosis and treatment, with one commenting: *“I just want to be home. [...] I don’t even care if I am ready or not”* (Older Adult, Female, ID#9). Participants often shared their desire to remain home for as long as possible. Despite some feelings

unprepared to leave the hospital, many participants in this study indicated they were happy to do so whenever possible. Participants emphasized that if healthcare providers felt they were ready for discharge, they trusted providers’ opinions, trusting that they were provided with the necessary care and supports to manage their care at home. Trust in providers’ opinions made them feel more confident in their own ability to manage their care at home. Many of the participants described knowing that they could always return to the hospital if their symptoms returned, even if not explicitly mentioned by hospital staff, which lessened their fear of being discharged: *“Maybe I wasn’t ready to go home. But who cares. I got to come home and take care of myself. I don’t want the hospital fuss anyways. If it happens again, I go back, big deal. They’re nice.”* (Older Adult, Male, ID#10).

### Upholding Independence

Participants described feeling powerless from the time that the older adult became ill to when they received treatment in the hospital.

I was just powerless, losing my sight. I thought I was having a heart attack. I could do absolutely nothing but call 911. And I hated that because then I needed to depend on doctors. Luckily, once I go there, they let me at least walk around or have a say about surgery. (Older Adult, Female, ID#2)

As noted above, when staff were able to help older adults better manage their symptoms, older adults reported increased confidence in their ability for self-care. Relatedly, this assistance also fostered a greater sense of regained independence. Participants described that independence over their care, or the care of their care recipient was important to them. Individuals who were involved in their care plan expressed gratitude for being able to do so. Some participants described being assertive over their need to provide some degree of care for themselves. For example, one older adult shared: *“it’s not like the olden days where [hospital staff] fret over you. I was able to take myself to the bathroom. They didn’t think I just couldn’t. They made me take my own pills. And I prefer that.”* (Older Adult, Male, ID#1). Participants described that their independence was heightened when the older adult returned home: *“At first it was all in their [hospital staff]’s hands. Now I’m able to go back to helping her, which is what I want. Plus she likes that she can care for herself”* (Family Caregiver, Female, ID#4).

### Discussion

We conducted a secondary analysis of existing qualitative data, informed by the strengths-based paradigm, to explore some of the positive aspects experienced by older adults and their family caregivers across the healthcare continuum. A positive approach to understanding healthcare experiences

**Table 3.** Practice Recommendations: Positive Aspects of Care to Continue.

Theme	Practice recommendations: Positive aspects of care to continue
Looking beyond illness	<ul style="list-style-type: none"> <li>• Person-centered care in hospitals and community care to help promote the wishes of older adults</li> <li>• Ensure communication with older adults and caregivers is person-centered rather than solely focusing on their illness (e.g., ask patients for their preferences)</li> </ul>
Emotional support from healthcare providers	<ul style="list-style-type: none"> <li>• Check-in with older adults and caregivers to ensure they feel heard and emotionally supported</li> <li>• Provide equitable care regardless of patient age or sex/gender</li> <li>• Empathize with older adults and their caregivers</li> </ul>
Timely discharge	<ul style="list-style-type: none"> <li>• Provide updates regarding your patients' diagnosis and discharge needs in a timely fashion</li> <li>• Where appropriate, consider early discharge with suitable community supports</li> <li>• Inform older adults/caregivers that they can return to the hospital if they are experiencing worsening symptoms after hospital discharge</li> <li>• When older adults and/or their caregivers desire an earlier but nonrecommended discharge, provide appropriate education about why a longer length of stay is required</li> </ul>
Upholding independence	<ul style="list-style-type: none"> <li>• Ensure older adults and caregivers feel included in the direction of their care and discharge plans</li> <li>• Provide opportunities for older adults to maximize their independence in self-care activities</li> </ul>

can help identify aspects of care that may most appropriately support older adults and their family caregivers. This study involved older adults with multiple care needs, who are often most reliant on healthcare services.<sup>22</sup> Combined, our findings suggest that even older adults with heightened vulnerabilities<sup>23</sup> can have positive aspects of care based upon meaningful relationships. A positive approach to understanding healthcare experiences can help identify aspects of care that may most appropriately support older adults and their family caregivers. Table 3 provides a summary of the potential practice areas as a result of this work. We synthesize the recommendations for healthcare providers in Figure 1. Through utilizing these suggestions, providers can adopt their interactions with patients to yield more positive patient care experiences.

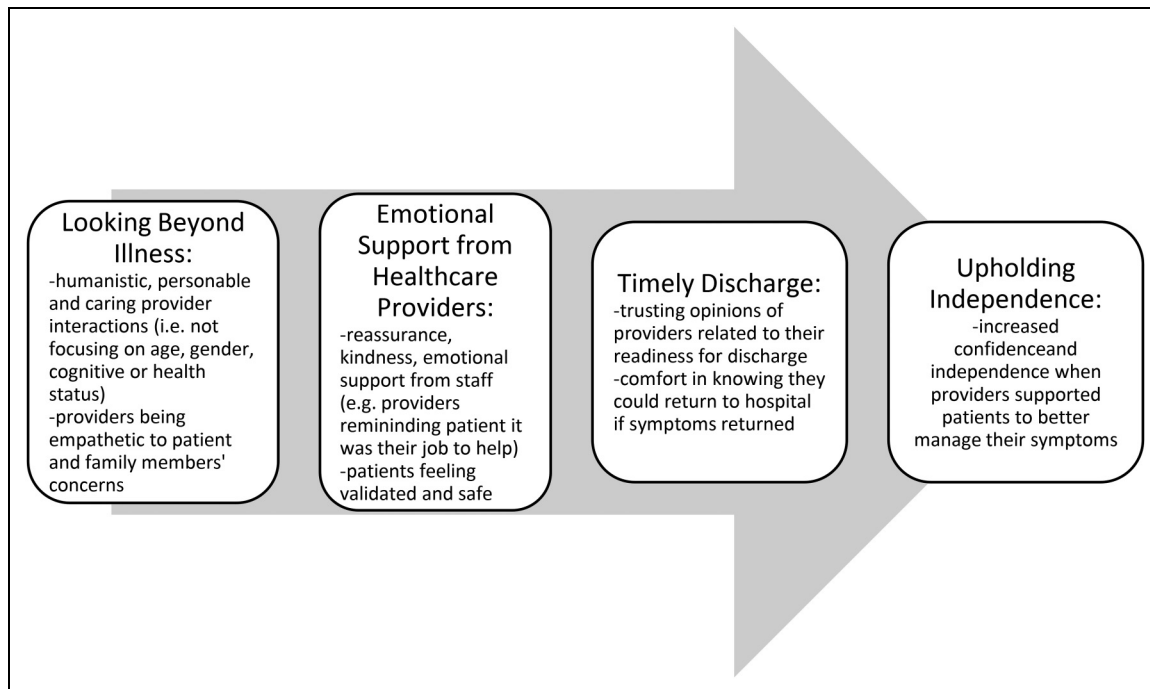
### Timely Discharge by Leveraging Community Supports and Resources

There is insufficient evidence supporting the effectiveness of quick discharge for older adults.<sup>24</sup> In fact, research on the experiences of older adults who transition from hospital to home has reported that a shortened hospital stay could increase readmission rates and adverse medical events.<sup>25</sup> Additionally, the decreased length of stay in the hospital has increased the need for family members to undertake a caregiving role, even if they do not feel ready.<sup>2</sup> As such, providers must carefully and cautiously consider the potential positive aspects of rapid discharges reported by older adults and caregivers in our study to avoid the risk of discharging older adults before they are deemed clinically ready to do so. Using the strengths-based approach, our study has identified several opportunities to capitalize on new and existing resources, such as improved community support to help sustain positive aspects of care. Given the risks with transitions, providers may need to educate older adults and caregivers on the benefits of longer hospital stays. In addition,

participants trusted that providers would only discharge them when they were ready to regain independence over their recovery at home. While similar findings have been reported in other patient populations<sup>26,27</sup>, our findings extend the existing literature by focusing on older adults to provide more clarity of practice recommendations for older adults with complex care needs. Hospital-at-home services that enable older people to be cared for more effectively in the community may help avoid costly readmissions.<sup>28</sup> More studies are needed to consider the cost-effectiveness of hospital-at-home services, as well as older adults' experiences with them. We also encourage further research to explore the development of interdisciplinary interventions that support the early and safe discharge of older adults with complex needs while reducing readmissions and adverse medical events. For example, successful early discharge planning should involve addressing older adults' and their caregivers' concerns while in the hospital so they are more prepared and empowered for community care.<sup>29</sup> Interventions must also address and acknowledge the heterogeneous needs of older adults transitioning home after a hospital stay, including those who do not have family caregivers and those from diverse and understudied communities. Therefore, there is a need for hospital-to-home and hospital-at-home interventions to be tailored to the linguistic, cultural, and personal preferences of patients and caregivers.<sup>30</sup>

### Considerations for Positive Staff Interactions

Participants spoke about being cared for by competent, empathetic healthcare providers who considered their individuality and capabilities during their relationship. Seminal research concurs that older adults desire expressions of humanity when receiving care.<sup>31</sup> Expanding person-centered care in hospitals and community care can help promote the



**Figure 1.** Conceptual framework: Recommendations for health providers based on positive aspects of care identified by Canadian older adults with complex care needs and family members.

wishes of older adults by addressing psychosocial and biomedical needs.<sup>32</sup> However, there are concerns about the feasibility and operationalization of person-centered care for older adults in some healthcare settings.<sup>33</sup> For instance, some concerns include structural constraints of care imposed by providers' work environments (e.g., time constraints and staffing shortages).<sup>33</sup> As such, health systems are encouraged to promote people-centered relationships, by offering appropriate solutions to their organizational needs (e.g., appropriate staffing mixes). Despite these concerns, the promotion of person-centered care respects the preference of older adults to be independent while minimizing strain on healthcare practitioners. Healthcare practitioners should continue to assist older adults and caregivers in identifying what aspects of care they can provide and encouraging them to take an active role in managing their well-being in alliance with their preferences. However, a caveat and caution of using the strengths-based approach in such research is the necessity to ensure that it will not exploit the ability of older adults and caregivers to manage their care beyond their capabilities or desires.

### Considering Patient Values of Independence

Our findings are emblematic of the importance of relationships and independence in care. However, it is important to note that many of our participants were not the most complex patient populations (e.g., those with five or more commodities<sup>34</sup>) who may require more assistance. As a

result, they may have had fewer care needs and required relatively less medical intervention than complex patient populations. Another consideration is that the participants included in this study were primarily English-speaking and White, and all participants were from one area of Ontario, Canada. English-speaking individuals may have found it easier to understand medical instructions and communicate with healthcare providers as this communication tends to occur in English. However, these experiences may also not resonate with individuals from different ethnicities. One area for future research is to explore the systemic barriers that influence care experiences (e.g., racial bias<sup>35</sup>) in promoting relational care and independence for diverse patient populations, including those who are recent immigrants or non-English speakers.

### Limitations

A limitation of the study was the small number of caregiver participants, which limits the transferability of these findings. Future research should consider focusing on the experiences of diverse groups of caregivers (e.g., different relationships to the care recipient) and older adults (e.g., non-English speaking) to get a more fulsome understanding of experiences of care experiences. A methodological limitation to consider is that due to the study design, which was a secondary analysis, we were not able to probe some of the topics of interest. In addition, participants spoke of their experiences in retrospect (i.e., none of the participants were interviewed during their hospital stay). As such, participants may have recalled

their care experience differently following hospital discharge. Lastly, not all older adults could complete the follow-up interviews, limiting the depth of our analysis posthospital discharge.

## Conclusion

Healthcare experiences involve both positive and negative aspects. Traditionally, research has focused on improving the discharge process to alleviate the negative aspects. Our study indicates that older adults value individualized care that goes beyond addressing their illness, prefer to be self-sufficient in managing their health, and desire prompt hospital discharge. These findings can inform person-centered care interventions aimed at maximizing the positive aspects of healthcare. Adopting a positive approach can assist policymakers and healthcare providers in leveraging available resources to promote independence and timely discharges.

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## Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Ethical Statement

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