Patients with comorbidities perceived that acute care services did not fully acknowledge or accommodate the comprehensive care that they required


How did patients with comorbidities who required an acute hospital stay perceive the quality of acute care services?

**DESIGN**
Qualitative descriptive design informed by Colaizzi’s phenomenological method.

**SETTING**
Metropolitan hospital in Melbourne, Australia.

**PATIENTS**
A purposive sample of 12 patients >18 years of age (age range 34–77 y, 50% women) who had >1 chronic condition (mean 6 chronic conditions) for approximately 5 years, required an acute care stay for >4 days in a large metropolitan private hospital, and understood and spoke English.

**METHODS**
Individual semistructured interviews were done within 14 days of hospital discharge after an acute illness episode. Data collection and analysis were concurrent, and interviews continued until no new major themes emerged. Analysis was done on verbatim transcripts, field notes, and patient medical histories. A template analysis style was used based on Colaizzi’s phenomenological method of theme development. A second, independent data analysis was done to confirm themes. Patients were given a summary of the major findings to verify interpretations.

**MAIN FINDINGS**
3 themes specific to the comorbidity experience emerged. The first theme was poor continuity in the care of comorbidities. In the acute care setting, patients felt that nursing staff managed the acute problem, with little attention to managing comorbid conditions. If comorbidities were particularly troublesome, patients had to seek out additional care. Comorbidities that nurses perceived to be important (eg, diabetes) were closely managed. Patients felt the continuity of care of comorbidities was difficult for acute care nurses to manage because of the complexity of their medical histories. Discharge planning did not include management of comorbidities. In community settings, patients found it difficult to follow up on their various illness episodes. The numerous appointments with physicians were difficult to manage because each disease was treated by different specialists in different clinic locations. A condition could be managed by several different doctors, making it difficult for patients to keep informed of who was in charge of their care. Communication problems were noted between specialists and general practitioners and led to patients receiving conflicting information about their treatments.

The second theme, something always goes wrong in hospital, reflected patients’ feelings that it was inevitable that something would go wrong in acute care settings. Patients were apprehensive of each admission and felt that medical staff ignored the varying requirements associated with their comorbidities. They had concerns about their medications, especially because their complex health states meant that they were on multiple and uncommon drugs, which were often unfamiliar to nurses. Comorbidities were often symptomatic and more troublesome than the acute illness, causing pain and weight fluctuations. Although most patients said they were satisfied with their care, they felt they were gossiped about and neglected, especially when they had long hospital stays or frequent admissions.

The third theme was chronic conditions persist after discharge. Patients felt that their additional health problems and drugs interfered with normal healing processes and their ability to participate in recovery promoting activities. Comorbidities were an additional burden to manage, which was especially difficult with the demands of recovery from an acute illness. All had fatigue after discharge. Ongoing health maintenance had to be carefully planned.

**CONCLUSIONS**
Patients with comorbidities who required an acute hospital stay reflected on the complexity of their health status and highlighted the need for comprehensive discharge planning. They felt that healthcare providers often failed to fully understand and accommodate their complex healthcare needs. They described poor continuity in the care of comorbidities, the inevitability of something going wrong during acute care, and chronic conditions persisting after discharge.
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*Evid Based Nurs* 2005 8: 30
doi: 10.1136/ebn.8.1.30

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