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

Williams A. Patients with comorbidities: perceptions of acute care services. *J Adv Nurs* 2004;**46**:13–22.

Q 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

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Source of funding: no external funding.

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.

Commentary

The study by Williams brings to our attention the perspectives and care experiences of 12 people with multiple chronic illnesses who spent time in an acute care hospital. A chronic illness is one that persists over time, without an easily definable beginning, middle, and end. Although the symptoms that accompany chronic illness may be alleviated to some extent, the illness itself is not curable. Increasingly, people are living with multiple and complex chronic illnesses.

The findings of Williams suggest that acute healthcare systems are not always designed with clients in mind and often do little to assist clients in self care. Often it is a "do as I say" model of care, and the client's role is often passive. This model may work for acute illness, but it doesn't work well for people learning to live with chronic illness for the rest of their lives. Healthcare professionals are still very much in authority, trying to get clients to do what is needed; and the client's job is to be obedient.

This study highlights that most chronic illness care is not provided by nurses, physicians, or other healthcare professionals but by the person who has the illness. On a day to day basis, clients are in charge of their own health, and their daily decisions have an effect on disease outcomes and quality of life. Nurses may know how to manage a wound, or care for diabetes, asthma, or congestive heart failure, but that does not mean they know how clients have learnt to manage illness or symptoms in their everyday lives. Each client is the expert in his or her own life. Nurses, however, can play an important part in a lifelong learning process that can empower clients to be experts in their own self care. Research has shown that effective chronic illness care requires open, equitable communication and a coordinated team approach with the client at the centre.^{1,2} The findings of Williams highlight the complex needs of people with chronic illness. Further research should address the types of approaches nurses can use in the acute care sector when working with people with chronic illness.

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1 Paterson B. Myth of empowerment in chronic illness. *J Adv Nurs* 2001;**34**:574–81.

2 Kralik D. The quest for ordinariness: transition experienced by midlife women living with chronic illness. *J Adv Nurs* 2002;**39**:146–54.