Exploring Older People's Experiences of Urgent and Emergency Care: An Interpretative Phenomenological Study

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ABSTRACT

Background:

Older people are the largest patient user-group of NHS care and yet we know little of their use and experience of urgent and emergency care systems, in particular Emergency Department (ED) provision. Older people are admitted to hospital more frequently, have longer lengths of stay and occupy more bed days than other patient groups

Objectives of Study:

To understand older people's experiences of urgent and emergency care from individuals' perspectives
To identify how the context of care influences older people's experiences of urgent and emergency care

Data Collection Methods:

Qualitative, two stage study with one to one interviews with 10 older people and focus groups with health care professionals from an NHS hospital in the East of England

Analysis:

Data collected was analysed using interpretative phenomenological analysis with older people and thematic analysis with health care professionals.

Results:

Five super-ordinate themes were identified: (1) Conflict with legitimacy; (2) A Need for Safety; (3) Attentiveness to Need; (4) Crisis of Identity and (5) Disempowering self. The findings illustrate the need for validation by staff that older people are legitimate users of urgent and emergency care. Little acts of kindness made them feel cared for and knowing staff being there for them helped participants feel safe in the ED environment. Increased vulnerability exacerbated loss of personal agency and sense of self-worth. Finally, feelings of inferiority, resulted in the relinquishing of control and holding back from being involved in their care. Health care professionals struggled to meet the needs of older people under the organisational constraints and the environment of care in which they work.

Conclusion:

Older people need to be treated as a distinct group within urgent and emergency care services. The role of relational skills and validation cannot be underestimated and facilitates a sense of connectedness and belonging. Health care professionals need time to care to provide patient centred and holistic care they aspire to.

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This PhD is dedicated to my lovely Mum who is my inspiration.

Glossary of Definitions and Abbreviations

Definition of urgent and emergency care:

The current Department of Health definition (2011) for urgent care face-to-face is: "Urgent and emergency care is the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly."

Accident and Emergency (A&E) and Emergency Department (ED)

A&E/ED provides access to high quality nursing and medical care to patients with serious injuries or illnesses 24 hours a day, 365 days a year. A high proportion of patients who attend are also treated for minor injuries. A&E and ED terminology are used interchangeably. For the purposes of the study the ED will be used throughout the study.

Acute Medical Unit (AMU)

The Acute Medical Unit (AMU) diagnoses acutely ill patients referred by their family doctors or A+E department. These patients need rapid specialist diagnoses and a high level of individual care. Some departments call their unit a medical assessment unit (MAU). Therefore, AMU and MAU terminology are used interchangeably and some of the participants in the study will either refer to AMU or AMU.

Older People's Medicine (OPM)

Older People's Medicine (OPM) are based around a multidisciplinary team approach that strives to ensure that patients are cared for holistically. Previously OPM was known as Medicine for the elderly.

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McGee, M (2019) Older people's Experiences of Urgent and Emergency Care *East Anglia Regional Interpretative Phenomenological Analysis Network Meeting March 2019*

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McGee, M; Penhale, B; Campbell, S (2014) Older People's Experiences of Urgent and Emergency Care *University of East Anglia (UEA) PGR Student Conference May 2014*

Chapter 1: Introduction

Introduction and background

Older people comprise the largest patient user-group of NHS care and yet we know little of their use and experiences of urgent and emergency care, in particular emergency department (ED) provision (RCP, 2012, Bridges & Nugus, 2010). Older people are key users of emergency departments and urgent care services (Bridges et al. 2008, BSG, 2012, Cornwell et al. 2012) and use the ED proportionally more than other age groups (Lowthian,2011). Over the next twenty years, the number of people aged 85 and over is set to increase by two-thirds, compared with a 10 per cent growth in the overall population (Banerjee et al. 2013). Recent data reveal an ageing UK population with the number of people aged 85 and over increasing by 22.8% to 1.6 million between 2008 and 2018 (ONS,2018). Hospital episode statistics 2018/2019 indicate that patients over 65 years account for more than 3.5 million attendances in the ED per annum (21% attendances), with the over 75s accounting for the fastest growing element of emergency admissions (NHS Digital, 2019). However, attendance of older people in the ED is associated with adverse outcomes, higher risk of admission, longer length of stay and occupation of more bed days in acute hospital compared to other patient groups who were admitted through this route (Banerjee, 2012, Downing & Wilson 2005, Donatelli et al 2013, Lennox,2019).

The increase in older people's attendance in the ED presents clinical challenges for Health Care Professionals (HCPs) working within these environments (RCP 2012). Assessment of older people can be difficult due to the complexity of their needs, as they tend to present with multiple comorbidities, non-specific presentations such as falls, delirium, immobility and frailty syndromes (Banerjee et al. 2012, RCP 2012, Lowthian, 2017). Moreover, it is apparent from the literature that older people may have complex needs over and above the clinical cause of their attendance in the ED, yet many will be discharged without holistic assessment of their health and social care needs (Bentley & Meyer 2004, Oliver et al. 2014, Conroy & Turpin,2016). Consequently, incomplete assessment of older people's health and social care needs is associated with repeat attendance and adverse outcomes on discharge (Bentley & Meyer 2004, Age UK 2012, Conroy &Turpin,2016) and being discharged from the ED with undiagnosed treatable problems (Schnitker et al. 2011). Thus, traditional models of emergency care have been called into question due to the mismatch between their focus on managing acute emergencies and the nature of the older people's needs (Conroy and Turpin,2016).

Importantly, several high-profile reports highlighted major deficiencies in the care of older people in acute hospitals which include the ED and urgent care services (Health Service Ombudsman 2011, The Francis Report 2013). Furthermore, these reports illuminated the gulf between the values and principles set out in the NHS Constitution (2009) and the felt reality of being an older person in the care of the NHS in England (NHS Ombudsman 2011). Moreover, older patients are not being accorded sufficient dignity or respect and this includes elements of ageism within acute hospital care (Commission for Dignity in Care for Older People, 2012; RCN, 2012, 2013, CQC 2011, Patients Association 2011). These reports underscored that older people are being denied choice, are not involved in decision-making about their own care, and suffer needless indignities around toileting, feeding and privacy. Older people also reported in various studies that they had not been listened to while being assessed, overheard ageist remarks made by staff and that their presenting problems were not been resolved in the ED (Spilsbury et al. 1999, Bridges & Nugus 2010, Schnitker 2011). Significantly, a mixed-method study by Maben et al (2012) suggested that the complex needs and high dependency of the acutely unwell older patient resulted in staff making ongoing compromises in care delivery which often impacted poorly on patient dignity and privacy.

To improve the care of older people and address the gaps in deficiencies in delivering dignified care to older people, a set of best practice guidelines The Silver Book (Banerjee et al.2012) was produced. These focused-on quality standards for the care of older people with urgent and emergency care needs, with specific remits around decreasing variations in care and development of appropriate services across the urgent and emergency care system. Furthermore, it was recognised that better care outcomes could be achieved through holistic models of care, integrated services, and care that was delivered by interdisciplinary teams (Conroy and Turpin,2016). Since the quality standards were introduced, new initiatives and interventions have been introduced such as Common Geriatric Assessment (CGA) and interdisciplinary teams embedding geriatric competencies into their assessment (Conroy and Turpin, 2016). However, there is a limited quality evidence base evaluating these interventions either in terms of improving patient outcomes, quality of care or improving the patient experience (Turner et al.2015).

Why is the older person's experience of urgent and emergency care important?

Improving the patient experience is high on the agenda for transforming urgent and emergency care to drive high quality, patient-focused care (NHS England 2013). Patient experience is now viewed as a dimension of quality, placing the patient at the centre of the health care system (Matthews & Cornwell 2012). The NHS Patient Experience Framework (2018) promotes patient-centred approaches to care and individualised care planning based on the needs of the patients. The NHS Outcomes Framework (NHS 2020) focuses on patients having a positive experience of care, and other initiatives such as the NHS Friends and Family Test, launched in 2013 (NHS 2013) have supported the outcomes framework in a drive to measure patient experience. The ED was one of the first areas targeted to introduce the Friends and Family Test due to the concerns around ED performance and patient experience. However, this initiative has been under scrutiny due to claims that the test is not fit for purpose due to poor methodology, unreliability and unrepresentative results (Reeves et al. 2013). More recently, the quality of care in many of the UK EDs have been found to be failing to meet the quality standards expected, with many patients experiencing unacceptably poor care, long waits and inadequate delays in receiving pain relief, falling well below the standards to protect the safety and welfare of patients (CQC, 2018). However, concerns about an under-resourced NHS, and the growing pressures on EDs point towards a crisis in our healthcare service (Ham, 2015). Thus, the increasing evidence of deficiencies in older people's care and mounting pressure on ED services strongly indicate the need to access reliable data from those individuals who access services in order to drive quality patient care.

Urgent and Emergency Care in the UK

To understand the context of care in which older people experience care, a brief overview of how urgent and emergency care is delivered in the UK is provided.

Traditionally urgent and emergency care in the UK is delivered through acute hospital emergency departments (ED), acute medical assessment, and minor injury units (Conroy and Turpin, 2016, McHugh et al.2019, Ablard et al.2019). In response to the increased demand on emergency services and overcrowded EDs, there has been a drive to reduce acute hospital admissions and to support patients to self-manage their long-term conditions in the community. This has resulted in a redesign in how urgent and emergency care is delivered, with new models of care that aim to treat and manage all age groups (NHS England, 2013). Transforming urgent and emergency care saw the development of services such as urgent care centres, walk-in centres, minor injury units, NHS 111, out-of-hours primary care to improve out of hospital services and deliver care closer to home. The Keogh review (2013) set out a vision for urgent and emergency care services where people could access a range of services that would best suit their health need(s) and more quickly reach the most appropriate service, so those with the more serious or life-threatening illness requiring specialist services could access hospitals and emergency departments. New ways of working reflected in the review required the expertise of these specialist centres to focus on the care of older people, in particular those with frailty, who account for much of the increased demand (NHS England, 2013, Ham, 2015). Oliver et al (2014) argued that a joined-up approach to care for older people supported by best practice was required to relieve the pressures on the NHS.

However, the range of urgent and emergency care services became problematic for many people to navigate, especially those with complex health care needs, with older people falling into this bracket (Pope et al. 2019).Often people found trying to discern which service they required due to their perceived health needs challenging and confusing (Pope et al. 2019, Martin & Manley, 2020). Consequently, people had to identify their health care needs as being ‘urgent’, ‘emergency’, ‘acute’ or ‘primary’, and to choose which services they then felt most appropriate. Adding to this complex navigation system, there was also confusion in defining urgent and emergency care, with terminologies describing care as ‘urgent’, ‘emergency’, ‘scheduled’, ‘unscheduled care’, and conditions described as ‘life-threatening’, ‘serious, but not life-threatening’, ‘not life-threatening’. Not only did this confuse the public, health care professionals also had different perceptions of the definition of urgent and emergency care (Pope et al. 2019). This led to an emphasis on ‘severity of need’ and ‘appropriateness’ by professionals (Pope et al.2019, p.436).

There are very few working definitions of what urgent and emergency care is in policy documents and where it is specified, it is in terms of the speed in which care is required, and thus centres on the individual’s perceived need for healthcare (Martin and Manley, 2020, Conroy and Turpin, 2016). The DH (2011) is the definition most commonly referred to, which aimed to provide clarity to the public and providers of health care:

“Urgent and emergency care is the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly.”

It is evident that the urgent and emergency care system is complex and difficult to navigate, yet it remains a valuable resource to meet older people’s urgent and emergency healthcare needs, and for many ‘*the ED is the main portal of entry to urgent care’* (Conroy and Parker, 2017p.350).

It is therefore important both that services meet the needs of those who will access them, and that older people have positive experiences of care in order to improve health outcomes and meet their individual needs. However, the background information on older people’s experiences of care highlights several major deficiencies in meeting their health care needs. The NHS long-term plan (2019) emphasises the importance of understanding how services are used and experienced by service users, in order to provide care that is streamlined and appropriate to their needs. Listening to the voice of older people will enable services to be shaped around their needs and improve the quality of care provided. Thus, knowledge and understanding of the lived experience can only come from the patients themselves (Sheppard and Hubbert, 2006).

This study will only focus on older people receiving care for their urgent and emergency care needs within an acute hospital setting, with a particular emphasis on the ED, and the DH (2011) will be the working definition of urgent and emergency care. The current pathway of care for people over the age of 80 at the research site will now be described, although it is noted that different Trusts within the UK will formulate different pathways of care depending on their older population needs, and resources.

Pathway of Care for Older People at Research Site

At the time of this study, the pathway of care for older people at the research site (acute hospital) represents the usual care journeys for older people over 80 years who attended urgent and emergency care services (UES) for their acute urgent and emergency care needs. The age of over 80 years for entry onto the older patient pathway was determined at an organisational level and was dependent on specialist older people Consultant availability and resources to support care delivery. All older patients under the age of 80 years accessed the usual care pathway.

Older people attended either via ambulance, or through their GP, or presented themselves to the ED department. Following assessment of their needs, they were either discharged directly from the ED or if necessary, transferred to the Acute Medical Assessment Unit (AMU). Some went directly from the ED to an Older Person’s Medicine ward (OPM). However, some older people experienced the ED, AMU and OPM in the one care journey. Standard care was delivered by a multidisciplinary team comprising emergency care physicians, advanced ED care practitioners, nurses, physios, occupational therapists, health care assistants, discharge co-ordinators and social workers. In addition, over 80s had access to the older people’s medicine team, comprising geriatricians and advanced care practitioners, specialising in working with older people. Thus, there was an integrated approach between older people’s medicine and emergency medicine through shared clinical assessments and decision-making.

The author notes that a new model of emergency care for older people was established at the research site in January 2017, the older person’s emergency department (OPED), one of the first services of its kind nationally. However, at the time of completion of the PhD thesis, no published research was available to report the impact this service has had on outcomes of care for older people. The OPED is open 9am-5pm, every day except Saturday. None of the participants in this study experienced the new service.

Purpose of the Study

It has been acknowledged that research in the area of the patient experience in the ED has a tendency to focus on measuring the experience, and is dominated by quantitative research and government reports (Nairn et al. 2004, Gordon et al. 2010, DH 2012), and qualitative studies on the 'lived experience' of older people are few (DH,2012). Thereby, valuable insights into the 'lived-experience' older people are experiencing in urgent and emergency care are not captured.

This study aims to research older people's 'lived experience' of urgent and emergency care and health care professionals' (HCPs) perspectives about the care of older people within these care settings. Until now, very little was known about the experiences of older people who access urgent and emergency care from their perspective. Therefore, this study will provide a unique insight into those experiences and what it is like to be an older person who receives care within these settings. The challenges facing older people who access urgent and emergency care are evident and are underpinned by a need to understand the experiences they have, the complexity of the problems associated with caring for this population, and the impact this may have on patient experience. Obtaining the views and opinions of older people and HCPs is fundamental to this study so that the 'voice' of the older person can bring new insights into how services could be built around the needs of older people and improve the quality of their urgent and emergency care experience. Together, gaining the views of the older person and health care professionals will enable this study to contribute to new understandings from both perspectives.

Overview of the Thesis

This thesis provides a detailed account of a two-stage study exploring older people's experiences of accessing urgent and emergency care, with a particular focus on the ED and HCPs' understandings and views of how older people perceive their care. Interpretative phenomenological analysis (IPA) was the methodology used to underpin the research.

Chapter One: The introductory chapter provides the landscape of older people's urgent and emergency care and identifies the current challenges and gaps in acute care practice for this patient population.

Chapter Two: This chapter presents the literature review, which describes the search strategy to identify the relevant literature on older people's experiences of urgent and emergency care. A synthesis of qualitative literature enabled a clearer understanding of some of the key areas which influence older people's care in an acute hospital. It also identified gaps in care and knowledge relating to experiences of urgent and emergency care. Furthermore, the extent of research which focuses on experiences through the perspective of the older person was established, which helped in formulating specific aims and objectives for the study.

Chapter Three: A focus on the methodological approach used provides the rationale to why interpretative phenomenological analysis (IPA) was chosen to meet the aims and objectives of the study. An exploration of phenomenology is discussed to highlight the philosophical orientation of the study.

Chapter Four: A detailed account of the study design and data collection methods are discussed to distinguish the different methods used for the older people interviews and the focus groups with HCPs. The sample, recruitment and design of the study are outlined. Ethical considerations and trustworthiness are also included.

Chapter Five: This chapter presents the findings from the interviews with older people and presents the five themes emerging from the data. The 'voice' of the older person is captured with narrative quotes used to illuminate the themes identified.

Chapter Six: There is a discussion of the main findings in relation to the existing literature and policy which explore key concepts of care which either supported or impeded older people’s positive experiences of care. New insights and knowledge gained are highlighted to demonstrate their unique contribution to how we care for older people.

Chapter 7: presents the findings from the HCPs to gain their perspectives on older people’s experiences of care and their views on caring for older people. The organisational context of care in which HCPs work is explored to see the extent to which it may influence the delivery of patient-centred care to older people.

Chapter 8: provides a synthesis of the older people and HCPs’ findings in relation to similarities and dissimilarities, to appreciate the extent how each view experiences care and how we can learn from both.

Chapter 9: The final chapter begins with reflexivity to recognise and reflect on the role of the researcher at each stage of the research process, and their personal journey. Placing this in the final chapter enabled an explicit focus on the importance of reflexivity as an essential component of the research. The strengths and limitations of the study will be discussed with recommendations for practice, policy and research, that highlight the valuable contribution this study has made to improving the care experience for older people. Importantly, the specific contribution to knowledge will be identified to show how this study has advanced the limited current understandings of older people’s experiences of urgent and emergency care.

Chapter 2: Literature Review

Introduction

The introduction and background in Chapter 1 has provided some contextual insight on the current political and organisational landscape of urgent and emergency care in which older people receive care. These have set the scene, highlighting the current issues and challenges in caring for older people in the emergency department, which draw attention to significant gaps in care, especially around quality and dignity of care. In order to appreciate these challenges and what is already understood about urgent and emergency care for older people, it was pertinent to explore the current evidence available from the perspective of the older person themselves, to illuminate the issues and challenges previously identified in the introduction. Accordingly, this chapter will undertake a literature review of existing qualitative research into what is known about older people's experiences in these settings.

This chapter will begin with a detailed description of how the literature search was conducted, a critical appraisal of the studies included, and a synthesis of the findings will be discussed in relation to the identified themes. This will identify any gaps in caring for older people in urgent and emergency care environments in order to determine the research focus needed for this study.

Literature Search

Research Question

The review question was: *What is known about the experiences of older people who access urgent and emergency care* and w*hat factors influence older people's experiences of care in urgent and emergency care environments?*

Literature search strategy

The main focus of this study was on the experience of older people who access urgent and emergency care from the perspective of the older person themselves, who are often missing from discussions on healthcare (Glasby et al. 2004, Davis,2019), and therefore key to the review. The literature search focused on qualitative papers which have explored older people's experience of care in these settings. The underlying philosophy of this study is that knowledge is created through the ‘lived experience’ of those who have experienced the phenomena which aligns with a qualitative research approach. Thus, qualitative studies were selected as they are the best fit for the review question both to enable insight from the older people who can provide descriptions of their experiences, and to appreciate what those experiences mean to them. It also helps understanding of the extent to which the literature includes the patient perspective (Littlechild et al. 2015). Mixed method papers were also considered, providing there was extractible qualitative data which meet the review aim. Where papers explored both carers and patients’ perspectives or health care professionals and patients' perspectives, the views of the older person were included, only if they could be separated out.

Electronic Searches

A search of articles published between 1999 and 2019 in five databases were conducted. These were: Medline, Embase, Cinahl, PsycInfo, and the British Nursing Index. These databases were chosen for their relevance to nursing and health care practice and their wealth of research relating to interdisciplinary research in the field of health, behavioural and social science. Searches were restricted to papers published in the English language and where possible full text publications to increase the likelihood of relevant articles; however, abstracts were also included if they met the inclusion criteria (See Table 1).

Search Strategy

The initial search strategy was conducted using a systematic approach as described by Aveyard et al. (2016) and designed to retrieve as many relevant articles on older people’s experience of urgent and emergency care. There were no limitations on country of study, however, particular attention was given to studies that were undertaken in the United Kingdom due to the similarity to the urgent and emergency care systems attended by the older people in this study. The search focus was limited to between 1999 and 2019: the justification for starting the search from 1999 was because an initial search identified two papers published in 1999 on older people’s perceptions and experiences of care in the ED (Spilsbury et al.1999, Watson et al. 1999), and therefore acted as a baseline. Whilst research from 1999 may seem dated in view of the transformation in healthcare since then, this study is focused on the experiences of healthcare. A structured search (Aveyard et al. 2016) was undertaken in December 2012;

however, the literature was revisited and monitored over the period of the study using the same search strategy in Sept 2015, Oct 2018 and July 2019. A hand search of reference lists was also performed to capture any potential literature that may not have been identified by the database search. These approaches used were to ensure currency, thoroughness and relevance of the literature review.

Specific keywords and index terms related to the research question were compiled for the search, These were: “older”, “aged”, “old”, “frail”, "old* adult*", "old* people" , “elderly”, geriatric*, ‘over 65’, ‘over 75’, ‘over 80’’ together with “accident and emergency”, a+e or a&e, “emergency departments”, “casualty”, “emergency room” “urgent care”, “emergency care”, “amu” together with ‘experiences’, perspective*, experience* ‘satisfaction’ expectation*, together with “lived experience”, ‘phenomenology’.

Separate searches were also made by combining keywords with the Boolean operators ‘AND’ and ‘OR’ and expanders to maximise all variations of the key search terms and limiters to narrow the search. The search strategy was adapted for the requirements of each database (See Table 2). To be eligible, the studies had to include older people over 65 years who had accessed urgent and emergency care. There is no agreed criterion for the definition of ‘older people’ but a cut-off of over 60 or 65 is often used in the developed world (http://www.who.int/healthinfo/survey/ageingdefnolder/en/). The over 75s account for the fastest growing element of emergency admissions (HeS 2014, NHS Digital,2019). The current pathway at the research site for older people’s urgent and emergency care is for those over the age of 80. Therefore, to meet the aims of the study it was important to establish clearly the studies that were eligible only included older people (Shenkin et al.2017). Whilst the study focus is on the over 80 age group, a preliminary search found only 1 qualitative paper that explored older people’s experiences, therefore a pragmatic approach of choosing the over 65 was taken to see what qualitative evidence was already available. Studies were excluded if the older people’s place of residence was a residential nursing home, as their experiences may be different than those who directly attend urgent and emergency care from their own home, or those with cognitive impairment, due to the requirement to be able to be interviewed for approximately 60 minutes and engage in the interview questions. The inclusion and exclusion criteria can be found in Table 1.

Inclusion criteria	Exclusion criteria
Published between1999 and 2019	Not in English
Abstract or full text published in English	Not peer reviewed
Qualitative studies and mixed methods (qualitative elements only)	The focus was not on older people's experiences of urgent and emergency care
Community-dwelling older people who experienced urgent and emergency care	Papers that focused on older people's experiences of care in the ED from residential care
Over 65 years	Papers that focused on people with Dementia or cognitive impairment in the ED

Table 1: Inclusion and exclusion criteria

#	Query	Limiters/Expanders	Last Run Via	Results
S26	S9 AND S17 AND S25	Expanders- Apply related words; Apply equivalent subjects Search modes- Find all my search terms	Interface- EBSCOhost Research Database Search Screen- Advanced Search Database- MEDLINE Complete	193
S25	TI (patient* N3(experience* or perspective* or expectation* or "lived experience*")) or phenomenology*	Expanders- Apply related words; Apply equivalent subjects Search modes- Find all my search terms	Interface- EBSCOhost Research Database Search Screen- Advanced Search Database- MEDLINE Complete	43,335
S24	S9 AND S17 AND S23	Expanders- Apply related words; Apply equivalent subjects	Interface- EBSCOhost Research Database	3,368

		Search modes- Find all my search terms	Search Screen- Advanced Search Database- MEDLINE Complete	
S23	S18 OR S19 OR S20 OR S21 OR S22	Expanders- Apply related words; Apply equivalent subjects Search modes- Find all my search terms	Interface- EBSCOhost Research Database Search Screen- Advanced Search Database- MEDLINE Complete	1,278,630
S22	phenomenology	Expanders- Apply related words; Apply equivalent subjects Search modes- Find all my search terms	Interface- EBSCOhost Research Database Search Screen- Advanced Search Database- MEDLINE Complete	8,442
S21	“lived experience”	Expanders- Apply related words; Apply equivalent subjects Search modes- Find all my search terms	Interface- EBSCOhost Research Database Search Screen- Advanced Search Database- MEDLINE Complete	3,159
S20	Expectation*	Expanders- Apply related words; Apply equivalent subjects Search modes- Find all my search terms	Interface- EBSCOhost Research Database Search Screen- Advanced Search Database- MEDLINE Complete	79,120

Table 2: Search strategy example

Selection of Included Studies

The initial search yielded 427 papers, and these were initially screened for their title, followed by reading of the abstracts. Initially, the abstracts found were either directly or indirectly related to patients or older people in the emergency department or urgent care settings. Further screening reduced the papers to 34, which were selected for full text evaluation. After applying the inclusion/exclusion criteria, 14 papers were identified that directly addressed the criteria for inclusion. Following further reading of the full text articles, papers were excluded which revealed : **(1**) experiences of urgent and emergency care focused on patients of all ages; **(2)** the experiences focused on acute hospital care and therefore the older people would not have followed an urgent and emergency pathway of care; papers that focused on **(3)** health care professionals' experiences/perspectives of caring for older people (for example, Boltz et al.2013, Fry et al.2014; Gallagher et al.2014) as the central focus for this study was on understanding older peoples' experiences. Other papers were excluded as they were **(5)** qualitative and quantitative systematic and literature reviews on patient experience in the ED, acute care settings or scoping reviews on expectations of ED care of patients and relatives (for example, Stuart et al. 2003; Nairn et al.2004; Gordon et al. 2010; Olthius et al. 2014, Shanakar et al.2014). Studies that only used **(6)** quantitative methodologies were also excluded; some of these used surveys and questionnaires on patients' views of their experiences of the ED. Of the 20 papers that were excluded, it was determined that they would be useful for background information, so they were retained for further use.

The selection process for the resultant papers is illustrated in the PRISMA diagram (Fig. 1) and a summary of the selected studies in Appendix A. The papers listed in Appendix A were analysed for quality using the CASP (2006) appraisal tool (See Appendix B).

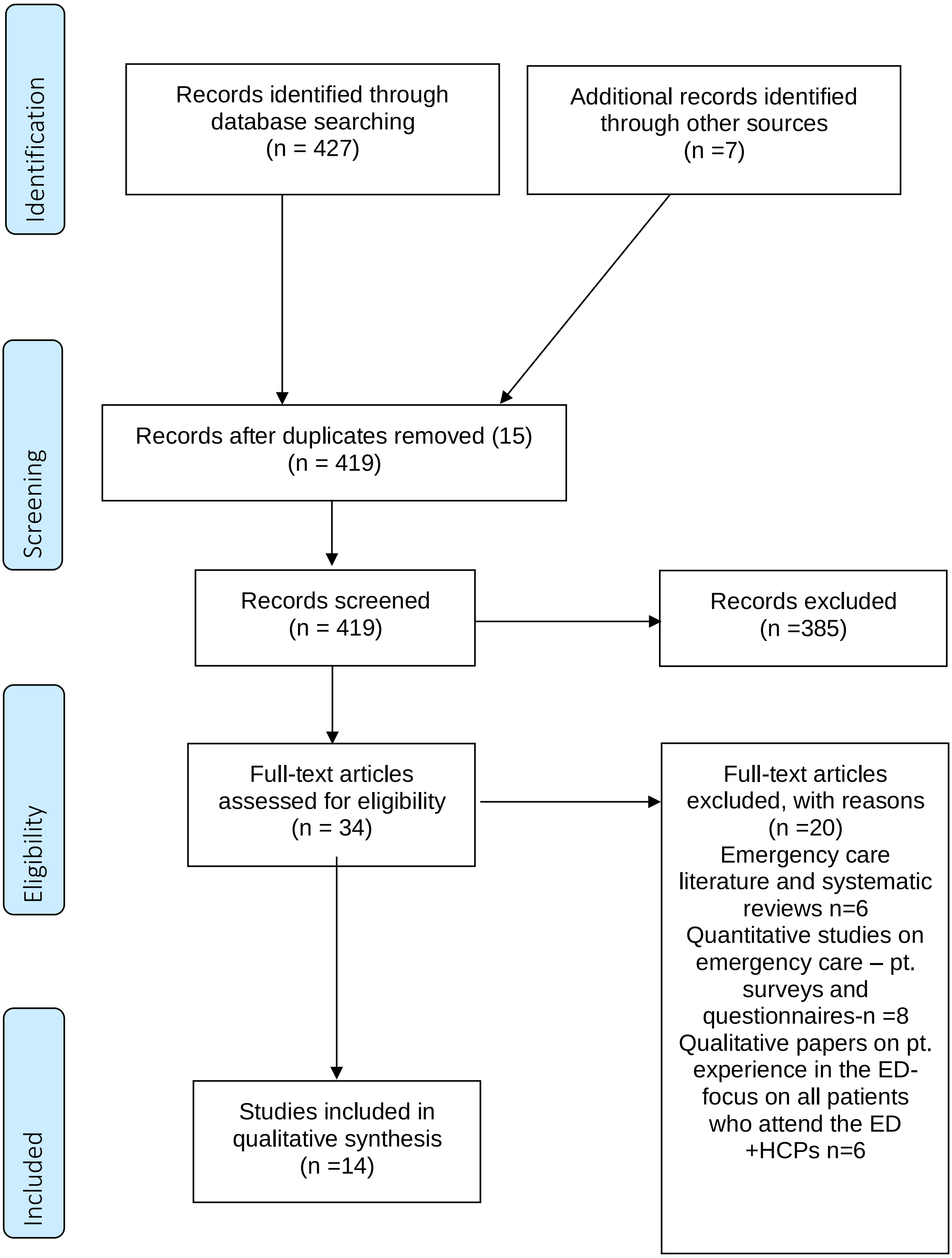


Figure 1 Literature search selection process: PRISMA flow diagram (Moher et al.2009)

The Review Process

Despite a significant drive in the UK on patient experience research from both policy and practice contexts (NHS Improvement, 2018), the review identified only 14 qualitative studies that fully met the inclusion criteria and were included for the review synthesis (See Appendix A). These all contained the elements of exploring older people's urgent and emergency presentations and admissions. Two studies had samples comprising a mix of older people and relatives (Bridges, 2008 and Bridges and Nugus, 2010), and two studies sampled older people and staff (Maben et al.2012, Glasby et al.2016).

Summary of the methodologies for the included studies:

Five qualitative descriptive design using semi-structured interviews, one qualitative interpretative, two phenomenology, one grounded theory, two used narrative methodology, two mixed methods (quantitative and qualitative approaches and one mixed qualitative method (focus groups and interviews) were identified for the included studies.

Five studies were of a qualitative descriptive design, using semi-structured interviews with older people (Spilsbury et al. 1999, Watson et al.1999, Lawrie and Battye, 2012, Lyons and Paterson, 2009, Considine et al.2010). Lawrie and Battye (2012) undertook a primary research study for AGE UK, exploring both emergency admission and readmission. Considine et al (2010) focused on older people's experience of accessing emergency care. This paper was included as it forms part of the whole experience of emergency care. One study used a qualitative interpretative approach (Stein-Parbury,2015) to explore older people's experience of the ED. Two used a phenomenological methodology (Nyden et al.2003 and Olofsson et al.2012). Nyden et al. (2003) study used an interpretative lifeworld approach, whereas Olofsson et al (2012) employed descriptive phenomenology. One grounded theory paper by Kihlgren (2004) was included to describe the conditions older people experienced while waiting in the ED. One study by Bridges (2008), used narrative methodology (discovery interview technique) to explore older people's and their relatives' urgent care experiences. A further study by Bridges and Nugus (2010), was derived from the same study by Bridges (2008) and used the same methodology and population, however it had a different emphasis on dignity and significance in urgent care than the original study. Two studies used a mixed methods approach (Maben et al.2012 and Richardson et al.2007). Maben et al (2012) employed surveys with staff and patients, observations and interviews with older people and their relatives in a 'Medicines for Older People' service. This paper was included as this setting can be part of the urgent and emergency care pathway following ED admission. Qualitative data about older people's experiences of care was collected through one-to-one semi-structured interviews with older people and their relatives and from informal conversations held during observational fieldwork. Therefore, the qualitative data is of relevance to the review question. Richardson et al (2007) used a quantitative approach in the form of an audit to enable a degree of statistical analysis on demographic and process factors. The qualitative component employed followed a descriptive design, using open semi-structured interviews with older people to explore their experiences of the ED and discharge. Finally, Glasby et al (2016), in a two-year NIHR funded research study used mixed qualitative methods, including telephone interviews and focus groups with staff and semi-structured interviews with older people to explore their emergency admissions to gain older people's insights about how to prevent avoidable hospital emergency admissions. It is evident from the studies identified that a variety of methodological approaches were used to gather the patient perspective of using urgent and emergency care services.

The selected papers represent work undertaken in the UK (7), USA (1), New Zealand (1), Australia (2) and Sweden (3). The overall timeframe of the studies ranged from 1999 to 2016. Considering the time span of over 17 years, there appears to be comparatively little data specifically exploring older people's experiences of urgent and emergency care. Given that older people are the highest users of these services, especially for individuals over 80 years (Downing and Wilson,2004), it highlights the limited attention to patient experience in this important area of healthcare practice. Whilst improving personal experience of healthcare has emerged as a major policy driver over recent years (Bridges, 2008, DH,2012), this has not necessarily translated into research to understand how services need to respond to and be shaped by patient experiences, specifically from the perspective of older people.

Assessment of study quality

Consideration of the findings in relation to the quality and limitations of the studies included is important to ensure 'quality assurance' in qualitative research (Sandelowski and Barroso,2002), and study quality was assessed using the CASP checklist (CASP, 2006, 2018). CASP is a widely used, validated checklist for evaluating distinct components of each stage of the research process. However, Long and Godfrey (2004, p.189) argue that checklist tools should not just be seen as a list of methodological questions to consider for a qualitative study, but to aid the researcher to make an informed judgement of the potential quality and contribution the study may have on illuminating a phenomenon. For rigour, CASP was combined with a scoring checklist developed by Kmet et al (2004) for assessing the quality of qualitative studies. This tool incorporated a quality score and therefore was used in conjunction with CASP to provide an overall impression of the quality of each individual paper (See Appendix B and C). Kmet et al (2004, p.3) acknowledge that due to the subjective nature of checklists and the limitations of such tools in the absence of a "gold standard" for comparison, evaluating the quality of qualitative research is a matter of considerable debate". However, checklists may assist the researcher in the synthesis and interpretation of the research findings (Kmet et al.2004). Regardless of the quality, (the included studies ranged from high to low) (See Appendix B), although no study was excluded on the grounds of poor methodology, potential limitations were noted. Sandelowski and Barroso (2007) recommend that all findings should be included to avoid the risk of excluding studies that provide perspectives on the phenomenon to be explored.

Quality of included studies

The appraisal of the included papers using CASP and Kmet quality scoring tool identified a range of quality studies from low to high (See Appendix B). This was based on the scoring approach adapted from Kmet et al. (2004)(See Appendix C) for which the suggested cut off point for quality is 75%. The overall quality scores of the included studies were high (range 75% to 100%), with the exception of two studies (Wayne et al. 1999) (55%) and (Lawrie and Battye, 2012) (60%). This suggests that overall the studies were of sufficiently robust quality to have confidence in the value of the evidence.

All papers had clear aims and objectives and used appropriate qualitative methods to answer their research question. Recruitment strategy of participants were absent in two studies (Watson et al.1999 and Maben et al.2012) and not fully described in Lawrie and Battye (2012). All other studies provided a clear account of their recruitment strategies using stakeholders to identify eligible participants at the research site. Of those studies that described their sampling, participants were obtained through purposive sampling and therefore recruitment strategies were appropriate to the aims of the studies. However, in eight studies the relationship between the researcher and the participants was not apparent (Spilsbury et al. 1999, Watson et al.1999, Nyden et al.2003, Lyons and Paterson,2009, Lawrie and Battye, 2012, Maben et al.2012, Stein-Parbury et al.2015, Glasby et al.2016). The author(s) reflexivity should be disclosed in how they considered their position in relation to their influence in all areas of the research process to demonstrate the transparency and trustworthiness of the study (Mason 2002).

Only one study, Lawrie and Battye (2012) was not clear in their data collection techniques, whereas all other studies were clearly stated and comprised mostly of open-ended interview questions. All studies carried out semi-structured interviews to obtain rich data concerning the subjective experiences of older people's experiences of urgent and emergency care. Triangulation of data was also poorly represented within some of the studies. with the majority collecting one source of data through interviews. However, Spilsbury, 1999, Kihlgren, et al.2004, Considine et al 2010, used observations in the ED as well as interviews with older people to capture different dimensions of the same phenomenon. Richardson et al. 2007, Maben et al. 2012, Glasby et al.2012 used mixed methods. In keeping with qualitative studies, most of the sample sizes were small, and were representative of the qualitative methods used, with the exception of Bridges, (2008) and Bridges and Nugus, 2010 (same study – same sample population and methods) and Glasby et al (2016), whose studies had large sample sizes since they were multi-centre research sites to explore the phenomenon. With the exception of (Watson et al. 1999), all studies sufficiently considered ethical issues due to the sensitive nature of the research and the potential vulnerability of the population being studied.

Watson's (1999) paper was the weakest in quality, without evidence of the research design being fully described, ethical issues unidentified, recruitment strategy not described, data analysis not fully described, nor was the relationship between the participants and the researcher identified. In contrast, Kihlgren et al

(2004) study met all areas of the inclusion and reporting of the CASP quality criteria represented in (Appendix B) to reveal a high-quality study.

In summary, the majority of the qualitative studies explored aspects of older people experiences accessing urgent and emergency care, either from their experiences of accessing the ED, their experience of being in the ED or experienced an older people’s medicine ward as part of ED care. There were numerous strengths identified regarding the quality of the majority of the studies regarding methodological stance, trustworthiness and ethical considerations, however there were limitations in many of the studies regarding the position of the researcher within the research process. Many of the studies had good methodological design and even those with a weak design (due to lack of detail in the research process and design) still provided sufficient patient experiences to inform further understandings in this area of practice.

Synthesis of included studies

Following selection of the papers, a thematic analytical framework was developed and used to bring together and organise the findings of the multiple studies into themes (Thomas and Harden, 2008, Silverman et al.2010). Using Thomas and Harden (2008) framework for synthesis of qualitative studies which uses a three -stage approach to guide the analysis. First a free line-by -line coding of the findings of 14 studies revealed free text codes. This is noted as one of the key tasks in the synthesis of qualitative research to enable the translation of key concepts from one study to the next (Fisher et al.2006). Similarities and dissimilarities are then reviewed between the codes to enable the grouping of the initial codes. The free text codes were then organised into emerging descriptive themes. Seven descriptive themes were generated, following this process, for example the free text code, ‘*Fear of burdening services and using NHS resources’* was grouped into the descriptive theme of ‘seeking help’ due to how feeling a burden and utilising scarce NHS resources influenced help seeking behavior of the older person. Finally, further analytical work generated five overarching themes (See themes: Table 3) representing the most prominent features of the experiences of older people who accessed urgent and emergency care from the studies adopted for this review. This stage of the synthesis requires a level of interpretation by the reviewer. Using the descriptive themes, the analytical process inferred the barriers and facilitators from the perspective of the older people what impeded or promoted positive experiences of care was the most prominent across all descriptive themes. Thus, using the previous example provided, the descriptive theme 'seeking help' was interpreted to capture the prominent meaning of the general reluctance of older people to seek emergency care. Therefore, through the analytical interpretation, the overarching theme was 'reluctance to seek emergency care'. However, Thomas and Harden (2008) emphasise the challenges and difficulties involved in this stage of the synthesis in order to reach the analytical interpretations and is potentially the most controversial as it is dependent on the judgements and insights of the reviewer. A draft of the findings was discussed with my supervisors to discuss my approach and interpretations to support their credibility.

Themes

Using the thematic framework described in the synthesis of studies, five overarching themes relating to the experiences of older people using urgent and emergency care services were identified: 1. **Reluctance to seek emergency care; 2. Variations in caring experience; 3. Lack of comprehensive assessment of older people's needs; 4. Desire for information and involvement in care; and 5. Environment of care not attuned to meet older people's needs.** Key to all of these themes was the lack of patient-centred care that meets the individual needs of the older person in an urgent or emergency care environment.

Table 3: Coding and Analytical Framework

Overarching Themes	Descriptive Themes	Codes
Reluctance to seek emergency care	Seeking Help	• Reluctance to access ED care and seek help • Frequent use of ED does not mean inappropriate use • Exacerbation of symptoms a reason for seeking help from the emergency services • Fear of burdening services and using NHS resources prevents seeking help • Most feel their admission to the ED was appropriate
Variations in caring experience	Caring	• General satisfaction and gratitude about care received from urgent and emergency care services • Long waits and barriers to patient satisfaction • Comfort and physical needs not met

		• High personal tolerance when care expectations were not met by ED staff • Care focus was on meeting technical and medical needs over relational care • Want to be treated with respect and dignity • Want to be seen as appropriate users of emergency care • Valued personalised and continuity care • Family members/carers have a very influential role when accompanying older people in the ED • Relinquish control to the system • Reluctance to criticise or question process or procedures they experienced • Do not have high expectations of healthcare • Variations in experience is significantly influenced by interactions with staff • Inattentive attitude and indifference contribute to feeling neglected and ignored
	Maintaining Autonomy/sense of worth	• Diminished sense of significance whilst in receipt of services • A sense of significance is enhanced or diminished by staff
Lack of comprehensive assessment	Assessment	• Lack of comprehensive assessment (did not take account of physical and sensory problems) • No understanding by staff of pre-admission circumstances or concern for future care issues • Assessment brief and focused on physical components of health • Focus on presenting complaint- failed to recognise multiple pathology • Lack of understanding of staff about older people's health conditions • Following attendance at the ED, did not feel their problems were solved
Desire for information and involvement in care	Shared Decision and Information giving	• Lack of involvement in care and information giving • Not always given the opportunity to fully explain their situation to staff • Want to have more say about their care • Received very little information about their admission

		- Need to understand specific care and treatment processes and what was happening to them - Failure by staff to listen contributes to disappointment and frustration
Environment of care not attuned to meet older people's needs	Environment	- Lack of physically attuned facilities for older people's needs - Particular sensitivity to the physical environment of the ED - Environment provoked fear and anxiety
	Feeling Safe	- Reliance on staff to make them feel safe - Trust in staff's judgement and to know what they were doing

Table 3 Synthesis of the included literature with identification of overarching themes

Reluctance to Seek Emergency Care

Delays in seeking help and reluctance to access emergency care by older people was reported in six studies (Nyden et al. 2003, Lyons and Paterson, 2009, Considine et al. 2010, Lawrie and Battye, 2012, Stein-Parbury et al. 2015, Glasby et al.2016). Glasby et al (2016) mixed methods qualitative research study conducted in the UK specifically explored older people over the age of 65, experiences of utilising emergency care in order to understand and prevent avoidable hospital admissions. They found that older people delay seeking help and only access care when it is necessary. Similar findings were reported in Stein-Parbury et al (2015) Australian qualitative-interpretative study, using semi structured interviews with older people over the age of 65, however the authors highlighted that the consequences of such delay in seeking help resulted in many older people presenting to the ED in a crisis. This was due to older people experiencing severe and potentially life-threatening symptoms for several days prior to their ED admission and thus, hospital admission becomes their only option. Therefore, these findings suggest that older people must believe that their escalating symptoms pose a significant threat to their lives before they seek help (Considine et al 2010, Stein-Parbury et al.2015). Similarly, using an interpretative phenomenological approach, to explore older people's experiences of meeting their care needs in the ED, Nyden et al (2003) Swedish study also found that older people tend to use the ED only in an emergency, although they are less likely to use it for minor complaints. Significantly, reluctance to seek help resulted in the likelihood of increased admission rates of older ED patients because they presented on arrival with greater clinical urgency and complexity of illnesses (Considine et al.2010).

‘*I didn't have any hesitation. I didn't feel well enough because nothing has changed and it didn't get any better’* (Stein-Parbury et al.2015, p.478).

In two studies, conducted in the UK and Australia, factors reported as contributing to delays in seeking help were older people’s fears of being perceived as a burden to the health services and using up scarce NHS resources (Glasby et al.2016, Considine et al. 2010).

‘*But I did feel as well – I know having [a] heart problem, whatever, I thought if I’d have had that x-ray and they detected it wasn’t a heart attack, I could have come home… Instead of taking beds up’* (Glasby et al.2016, p.32).

Notably, a major concern for older people in Considine et al (2010) Australian study was the need to feel certain they had legitimate reasons before calling the emergency services, and not wanting to bother the paramedics. Once in the ED, Nyden’s et al (2003) Swedish study also identified this concern of not wanting to bother the (ED) staff continued once in the ED (Nyden et al.2003).

‘*I don’t like to call them and have them runout for nothing, so I waited a couple of hours’* (Considine et al.2010, p.64).

According to Glasby et al (2016), older people were more likely to seek help if they lived with someone, more notably a spouse, or had been prompted by a family member. Significant others either helped the older person make the decision to attend the ED or were more likely to call the 999-emergency service, due to their own perceived emergency of the situation. Older people also relied on their GP and other HCPs to make the decision for them to attend the ED for their complaint (Considine et al. 2010, Glasby et al. 2016). These findings demonstrate the significance of seeking ‘permission’ to call an ambulance or attend the ED from family members and HCPs and the role others have in validating the appropriateness of that need.

Attendance at the ED centred on identifying the problem, and having their condition fully assessed in order to confirm a diagnosis (Lyons and Paterson, 2009, Stein-Parbury et al. 2015). Concern that older people would not be seen as an appropriate attendee in the ED was reported in three studies (Nyden et al.2003, Considine et al.2010, Glasby et al. 2016). Significantly, many of the older people in Glasby et al (2016) study felt their admission to the ED was appropriate. The complexity and ongoing health care concerns often triggered the need to access emergency services. The majority of older people presented to the ED because of an exacerbation of symptoms, with many having multiple existing long-term conditions, or falls, and heart conditions (Considine et al, 2010, Stein-Parbury et al. 2015, Glasby et al, 2016) and most were unplanned (Lawrie and Battye, 2012). Considine et al (2010) study noted that frequent use of the ED by older people does not mean inappropriate use, and asserted the evidence already reported that older people only seek emergency care when they are seriously ill and are less likely to seek help for minor complaints. Glasby et al (2016) findings suggest that older people felt there was nothing they could have done to prevent their admission. However, the older people did state that the following services might have been beneficial in preventing their admission: easier access to their GP or other community services, or review of their medications. Others felt their condition(s) should have been managed more effectively by the medical teams they were under or by their GP. However, there was also evidence that older people felt previous admissions to the ED had failed to diagnose their problem, which then saw them return to the ED with the same problems (Glasby et al.2016).

Variations in caring experience

In general, many of the studies reported that older people were satisfied and grateful for the care they received and mindful of the busy environment (Bridges, 2008, Kihlgren et al.2004, Lyons and Paterson,2009, Maben et al.2012). However, this gratitude stemmed from older people’s perception that they were receiving care from overworked and busy staff (Bridges and Nugus, 2010, Lyons and Paterson,2009, Stein–Parbury et al. 2015). Overall, older people demonstrated considerable understanding and acceptance of the pressures which staff had to work under (Lyons and Paterson,2009). Consequently, many older people demonstrated a stoic acceptance of care, despite having to wait long periods to be seen by a professional, or for support with their physical comfort and privacy needs (Kihlgren et al.2004, Richardson et al.2007). Furthermore, Stein-Parbury et al (2015, p.480) and Maben et al (2012, p.87) drew attention to the adoption of the ‘good patient’ role by the older person, who would demonstrate their appreciation of staff by not wanting to bother them or cause a fuss. Bridges and Nugus (2010) UK multi-centre study using qualitative discovery interviews with older people over 75 reported that under this ED culture of busyness and high workload, older people had a tendency to downplay their symptoms in their reluctance to ask for assistance with their needs.

In addition, several studies described the high personal tolerance levels shown by older people when staff did not meet their care expectations (Watson et al.1999, Nyden et al.2003, Richardson et al, 2007, Bridges and Nugus, 2010, Lyons and Paterson, 2009, Lawrie and Battye, 2012), despite many of them being frustrated and dissatisfied with the care they received (Nyden et al.2003, Considine et al.2010). According to Lyons and Paterson (2009), grounded theory study with older people over the age of 65, in the UK found that concern for overworked staff resulted in a strong desire by older people not to blame them. It was apparent in many of these studies that there was a general reluctance for older people to criticise or question poor care experiences. Instead they were more likely to direct blame onto the organisational processes of care, the managers and politicians for their lack of care, than to staff (Nyden et al. 2003, Kihlgren et al.2004, Richardson et al.2007, Bridges,2008, Lyons and Paterson, 2009, Considine et al.2010). Other plausible explanations for older people’s reluctance to complain highlighted in the studies were related to their low expectations of care, fear of becoming an unpopular patient, or being seen as a nuisance (Spilsbury et al.1999, Nyden et al.2003, Bridges,2008, Considine et al.2010, Maben et al.2012).

Notably, several studies reported not only personal tolerance of suboptimal care due to concern for staff workload, but that older people also demonstrated a deep understanding for the needs of other patients in the ED. They viewed their problems as less significant than other patients and appreciated that nurses might need to spend time with more urgent patients (Watson et al.1999, Nyden et al.2003, Bridges, 2008 Bridges and Nugus,2010).

‘You can’t rush things when everybody else is having problems’ (Watson et al, 1999, p.90).

'They (hospital staff) have so many people now that they haven't really got time for you' (Lawrie and Battye,2012, p.1).

Personalised care was emphasised in many studies as highly valued and appreciated by older people (Spilsbury et al al.1999, Bridges,2008, Lyons and Paterson, 2009). The 'little things', that resulted in more positive experiences of care was a dominant feature in studies by Spilsbury et al (1999, p.25) and Maben et al (2012, p.90); these specifically related to meeting older people's personal care needs around privacy, personal hygiene, physical comfort and safety. Meaningful relationships with staff and their role in the provision of the 'little things' heightened the older people's sense of being cared for (Maben et al.2012, Lyons and Paterson, 2009). Staff who were friendly, kind, thoughtful, attentive and were able to anticipate need were met with gratitude by the older people, resulting in positive experiences of care (Nyden et al.2003, Kihlgren et al.2004, Bridges, 2008). Importantly, those professionals who took time to listen to older people were highly appreciated and facilitated autonomy (Kihlgren et al.2004, Olofsson et al.2012). These efforts to treat the older person with respect and dignity were widely recognised in several of the studies as making a difference to older people's perceptions of care (Bridges,2008, Lyons and Paterson, 2009, Bridges and Nugus, 2010, Oloffsson et al.2012). Oloffsson et al (2012) suggest that empathetic approaches and a commitment to older people's care from ED staff are the foundation of caring encounters in the ED and do not require a lot of extra time.

'I mean, just the fact that they were there, in and out, I didn't think it would be sort of personal, it does put a patient at ease' (Lyons and Paterson,2009, p.27).

'*There was a male nurse; he was so courteous... Even though he took his time, it went quickly and smoothly*' (Olofosson et al.2012, p.209).

Conversely, several studies drew attention to experiences of care which were dictated by a technical-medical culture that placed little emphasis on relational care (Kihlgren et al. 2004, Lyons and Paterson, 2010, Bridges,2008, Bridges and Nugus, 2010). Kihlgren et al (2004) and Nyden et al (2003) reported that much of the technical focus was centred around waiting for test results, with little interaction from ED staff. Bridges and Nugus (2010) assert that prioritisation of routine technical functions resulted in care that was impersonal and lacked attention to the older person's individual needs. Often staff overlooked physical and comfort needs which left many older people feeling their dignity was not preserved, especially around toileting needs (Bridges,2008, Lawrie and Battye, 2012). Furthermore, some staff demonstrated a lack of sensitivity to these particular needs or the impact of long-term conditions on areas such as mobility, all of which caused deep distress for the older person (Spilsbury et al.1999, Olofsson et al.2012).

'*It isn't nice to be taken care of by someone who really doesn't care' (Nyden et al.2003, p.272).*

This lack of attention to the 'little things' resulted in many older people feeling an absence of connection with staff and feeling uncared for (Kihlgren et al.2004, Bridges,2008). However, Lyons and Paterson (2009) stated that many older people considered personal care and attention to be equally as important to their clinical needs. Moreover, Bridges and Nugus (2010) reported that an emphasis by staff on the technical aspects of medical care left many older people with a diminished sense of significance, leaving them feeling they did not matter. This resulted in older people not wanting to share information with staff or to request help when needed (Bridges, 2008). Furthermore, it caused older people to question their self- worth and the legitimacy of their presence in the ED, particularly when they perceived they were less of a priority than (some) other patients (Bridges and Nugus,2010). Moreover, lack of attention to personalised care resulted in '*dehumanising care'* for older people (Maben et al,2012, p.90).

'In the end, I feel like I'm being moved around like a parcel, I'm being moved like a parcel from chair to commode to bed. I feel like a parcel and not a person anymore' (Maben et al 2012, p.90)

Feeling abandoned by staff was another feature of care emphasised by the older people in several studies (Kihlgren et al.2004, Considine et al.2010, Olofsson et al.2012). Many provided accounts of their care where they felt lonely and isolated during the long waiting times they had to endure, despite the presence of ED staff (Considine et al.2010, Olofsson et al.2012). This resulted in them feeling staff were indifferent and inattentive to their needs during these waiting periods. Often ED staff appeared to show a lack of interest in them as patients, failed to respond to questions or engage meaningfully with them, all of which demonstrated to older people a lack of caring and heightened their sense of being a burden to staff (Spilsbury et al.1999, Olofsson et al 2012). These perceptions of failures in care left many older feeling frustrated and dissatisfied (Olofsson et al. 2012).

Several of the studies reported on how older people were very trusting of staff, as they perceived that staff knew what they were doing (Nyden et al.2003. Kihlgren et al. 2004, Olofsson et al.2012). Having trust and confidence in ED staff's judgement and competence was of vital importance for many of the older people due to the fear resulting from their acute medical emergency (Nyden et al.2003). Consequently, for some older people, they relinquished control and adopted a passive stance in their care (Nyden et al.2003, Richardson et al.2007, Bridges,2008, Bridges and Nugus, 2010). Primarily, this was due to older people having confidence in the ED staff's knowledge, abilities and judgement (Olofsson et al.2012, Lyons and Paterson, 2009, Kihlgren et al.2004). According to Bridges and Nugus (2010), this passive stance creates a power imbalance between staff and patients.

Lack of continuity in care was reported in several studies (Kihlgren et al.2004, Richardson et al. 2007, Lawrie and Battye, 2012). These studies highlighted the number of multi-professionals involved in the older person's care journey, which was not conducive to person-centred care or meeting the needs of the older person. This resulted in older people feeling disconnected from staff and unable to establish meaningful relationships with them (Watson et al.1999, Kihlgren et al.2004). A key area identified in Lawrie and Battye's (2012) UK, qualitative study with older people over the age of 75, was the lack of co-ordination and continuity of care on discharge from the acute hospital/ED, with many older people experiencing delayed packages of care. Therefore, their study highlights the lack of a smooth transition from hospital back to their own home.

Lack of comprehensive assessment of older people's needs

The assessment of older people can be challenging as they tend to present with multiple comorbidities, non-specific presentations such as falls, delirium, immobility and frailty syndromes (Lawrie and Battye 2012). Furthermore, Considine et al (2010) reported that due to the complexity of older people's presenting problems, key indicators of acute illness such as immobility, falls and confusion could be missed by triage staff. Additionally, Spilsbury et al (1999) highlighted that staff neither always understood older people's pre-admission circumstances, nor showed concern about future care issues. In general, there was a consensus across several of the studies about the lack of comprehensive assessment of older people's needs (Spilsbury et al, 1999, Nyden et al, 2003, Lawrie and Battye, 2012, Olofosson et al.2012). Whilst some older people valued being assessed quickly in the ED (Lyons and Paterson,2009), most described assessments that were brief and had a tendency to focus on the presenting problem, rather than on their wider needs, which many felt impacted on their current illness (Spilsbury et al.1999). In their study, Spilsbury et al (1999) highlighted that many older people had multiple pathologies and thus their presenting complaint was not the only condition to be considered. Therefore, a true picture of their presenting problem was never captured. Studies by Considine et al (2010) and Stein-Parbury et al (2015) drew attention to the disparity between the rapid assessments employed in EDs and the time required by older people to communicate their health problems. These authors identified that this disparity in time taken to assess impacts on effective communication transfer between older people and ED staff and the time required to assess complexity or consider their wider health issues.

'I waited five hours for the doctor, who just pressed me a little on the stomach' (Olofosson et al.2012, p.210).

According to Nyden et al (2003), other areas of need such as social and personal concerns were frequently not addressed. This resulted in dissatisfaction with staff for not fully exploring older peoples' conditions or giving them enough time to sufficiently assess their needs (Spilsbury et al.2009). Concern that acute health problems were attributed to ageing by staff was also highlighted in Considine et al (2010) study. This may suggest that staff do not take seriously some presentations of acute illness and so important information to aid comprehensive assessment is missed. Additionally, emotional and psychological assessment appeared to be overlooked by staff in ED settings (Bridges, 2008, Lyons and Paterson, 2009). These studies indicate that key areas of older peoples' assessment are overlooked, which suggests that consideration of the physical, psychological and emotional needs of older people are warranted, to ensure a more holistic approach to assessment to prevent the potential for unmet needs.

A recurrent finding following their attendance at the ED was that many older people felt their problem was not resolved (Spilsbury et al.1999, Lyons and Paterson,2009, Lawrie and Battye, 2012). According to Lawrie and Battye (2012), this was attributed to ED staff not being thorough enough in their assessment, and thus the underlying health problem was not addressed, which increased the risk of readmission. Another area of tension that older people reported was the lack of assessment of their discharge needs; moreover, older people felt there was no sense of appreciation by staff of the impact of the illness on them once home (Bridges, 2008).

'I am frustrated about my health problems and not being resolved and being in and out of hospital' (Lawrie and Battye, 2012, p.4).

Ultimately, these studies highlight the need for holistic and comprehensive assessment of the older person's needs.

Desire for information and involvement in care

It was evident from these studies that older people want to have more say about their care and continue to maintain their identity when they attend urgent and emergency care (Bridges et al 2008, Lawrie and Battye, 2012). However, the studies also draw attention to the extent that older people are not involved in decisions about their care or provided with information so they could make informed choices (Kihlgren et al.2004, Bridges & Nugus, 2010).

More time for older people to discuss their concerns and worries was a recurrent theme across three of the studies (Spilsbury et al.1999, Kihlgren et al.2004, Stein-Parbury et al.2015). Specifically, older people need more time to make sense of what is happening to them and to process the information communicated (Spilsbury et al.1999). There was a consensus across several of the studies that despite older people wanting to be involved in their care, many experienced alienation from their care processes (Spilsbury et al.1999, Watson et al.1999, Kihlgren et al.2004, Stein-Parbury et al.2015). Consequently, many relatives/carers felt they had to act as an advocate for the older person to acquire basic information about the ED procedures. This required them to adopt an assertive role in asking questions to obtain vital information for their loved one

(Stein-Parbury et al.2015). Significantly, Spilsbury et al (1999) emphasised the importance of older people and their relatives being listened to and kept informed, so that they felt they were involved in care processes and to avoid any unnecessary concerns.

Opportunities to involve older people in their own care were often missed, particularly when nurses were providing physical care (Spilsbury et al.1999,). Furthermore, it was also highlighted in Nyden et al (2003) study that older people were not actively encouraged to participate in their care and were often overlooked, with evidence of staff taking over decision-making. Significantly, for some older people it was reported that they did not have the chance to share their story about their concerns or be involved in their care (Kihlgren et al 2004 and Lawrie and Battye, 2012). Maben et al (2012) emphasised how older people were made to feel invisible when doctors talked in front of them as if they were not there. This diminished their sense of self-worth and significance as an individual and a human being (Bridges, 2008 and Bridges and Nugus,2010).

Being respected and listened to was identified as highly important to older people's sense of involvement in their care and attributed to mutual respect (Oloffson et al.2012). Conversely, it was shown that a lack of information caused increased uncertainty and psychological distress (Kihlgren et al 2004, Lyons and Paterson, 2009, Considine et al.2010).

Furthermore, there was evidence of ageism, when some staff made judgements about older people's ability to participate in their own care. Worryingly, Richardson et al (2007) study reported that older people were rarely consulted or involved in the discharge process, with some not even being informed of their impending discharge. Similarily, Lawrie and Battye (2012) recounted in their study that many of the older people felt their preferences for care once discharged home were not taken into account. In general, their experiences of discharge were poor, with many people feeling they were discharged too early, despite them informing the ED staff that they felt they were not ready to go home. The importance of providing discharge information and a clear plan of care, with information about newly prescribed medications was emphasised as a significant aspect of discharge planning (Lawrie and Battye, 2012). Yet many older people experienced poor discharge information, especially on medication (Lawrie and Battye, 2012).

'They don't tell you what to do with the parcel (medication*). they think you're supposed to know all about it, but while you're in hospital they don't tell you nothing about what you've got.'* (Lawrie and Battye, 2012, p.2).

In general, the felt need for information was strong amongst older people, so they could be kept advised of what was happening to them (Spilsbury et al.1999). However, some studies reported that little attention was given to older people to meet their information needs (Spilsbury et al.1999, Richardson et al.2007,Lyons and Paterson, 2009); for most, their desire to know and understand what was happening to them was neglected (Watson et al.1999, Richardson et al.2007). When information was communicated by staff, Kihlgren et al (2004) reported that it was frequently not fully understood, due to use of technical jargon. Hence, Watson et al (1999) study in the USA using a qualitative descriptive approach with older people over the age of 65 advocated the importance of using understandable language and tailoring it to individual needs (Bridges, 2008).

'I don't know what's happening … I don't know why they're keeping me here. I don't think they tell you enough, what's causing it and things like that' (Lyons and Paterson, 2009, p.28).

The importance of being involved in decisions concerning admission and discharge was highly appreciated by older people (Kihlgren et al.2004). Moreover, provision of information and being kept up to date alleviated anxiety and reduced any misinterpretations (Spilsbury et al.1999, Bridges, 2008, Lyons and Paterson,2009). Specifically, information on the progress of tests, x-rays and the patient's condition, and in particular, what to expect if their condition worsened was welcomed (Watson et al.1999). Older people were extremely grateful when staff provided them with timely information about their diagnosis (Watson et al.1999) and being well-informed improved the overall perception of a positive experience of care and increased their satisfaction (Lyons and Paterson,2009).

These studies point towards the need for patient-centred experiences which validate older people as equal partners in care.

Environment of Care not Attuned to Meet Older People's Needs

Several studies suggested that the physical environment of the ED might not be 'fit for purpose' for the needs of the older person and the provision of dignified care (Spilsbury et al.1999, Watson et al,1999, Kihlgren et al.2004). The design of the environment and the facilities provided were reported as not conducive to meeting older peoples' basic needs and dignity, particularly around toileting, nutrition and maintaining comfort (Nyden et al.2003). The discomfort of beds and trolleys was especially problematic when older people experienced long waits in the ED (Nyden et al. 2003, Kihlgren et al.2004). The temperature of the ED environment was also a concern for older people, with insufficient access to blankets (Spilsbury et al.1999, Kihlgren et al.2004). Criticisms about the care of older people in the ED were conveyed in Lawrie and Battye's (2012) research report on older peoples' experiences of emergency care. They found many older people were left cold and hungry in the ED with no attention to privacy, demonstrating a lack of respect and dignity.

'*You can imagine. I was lying there for over 23 hour and I was given nothing to eat during all that time. The nurses are not attentive at all'* (Nyden et al. 2003, p.271).

The older people seemed particularly sensitive to the physical environment of care of the ED, especially apparent for those older people with sensory and mobility problems (Nyden et al.2003, Kihlgren et al.2004). Spilsbury et al (1999) particularly drew attention to the needs of older people with hearing loss due to the heightened feelings of isolation they experienced. The noise and chaotic environment aggravated existing hearing and visual problems which resulted in difficulties for older people in understanding what was communicated to them. (Kihlgren et al.2004). The physical frailties associated with the ageing process were noted by Richardson et al (2007), finding that these caused considerable communication barriers between the older person and the ED staff. In addition, the unfamiliarity of the environment was a cause of increased fear for many older people (Nyden et al. 2003, Bridges et al.2008).

It was evident in the studies that many older people saw the ED as a place of safety; conversely the findings also established that it was an environment where at times older people felt unsafe and frightened. Nyden et al (2003) reported older people feeling unsafe, exacerbated by being left alone for long periods, with growing concerns for their safety if their condition worsened. Access to an emergency buzzer was a factor of anxiety reported in Kihlgren et al (2004) study. Concerns of not being able to access the buzzer caused older people to become increasingly scared, especially when they were suffering from chest pains or fears of falling. For some older people, being left alone in a room waiting for a doctor was extremely worrying and frightening (Watson et al.1999, Kihlgren et al.2004). The tendency for older people to be left for long periods of time alone also heightened their sense of fear, worry and anxiety. This sense of fear increased when staff did not check on them, leaving them feeling forgotten in the ED environment (Watson et al.1999, Kihlgren et al.2004).

'I wonder if they are going to find me here'…if only someone could look in and ask how I am feeling…' (Kihlgren et al. 2004, p.171).

In addition, concern for the busyness of the environment and seeing staff running around resulted in many older people feeling they could not make their needs known (Nyden et al.2003, Kihlgren et al.2004). Rather worryingly, Kihlgren et al (2004) also noted that older people who were quite lucid in the ED on arrival became increasingly confused during the long waits.

These studies highlight that the environment of care is not aligned to meeting the needs of older people and can heighten their sense of insecurity and vulnerability.

Summary

This qualitative literature review and thematic synthesis reported the experiences of older people who accessed urgent and emergency care with a particular focus on the ED. The synthesis of fourteen studies provided five overarching themes to illustrate key areas of care highlighting the challenges older people face, both prior to their decision to attend the ED and during their emergency stay.

The review revealed that attending the ED for most older people is a last resort and is often associated with delayed decision-making due to their lack of awareness about the severity of their illness. Thus, many older people rely on significant others such as relatives and HCPs to make the decision for them.

Despite many older people trying to avoid attendance at the ED, it was shown that their admissions were appropriate.

In general, many older people were satisfied with the care they received, despite frequent descriptions of poor care experiences. This was explained by their low expectations of care and high tolerance levels of inadequate or unsatisfactory care. Furthermore, the emergence of more technically oriented care over relational care in the ED resulted in older people feeling a diminished sense of significance and invisibility by HCPs not involving them in care decisions or providing information about their care. Finally, the seemingly unavoidable noisy and busy environment of the ED was often reported to be unaligned with the needs of the older person.

Woven through these experiences are the positive aspects of care where older people felt safe and secure knowing they were in the ED and cared for by highly skilled and competent staff. Where they experienced care through meaningful interactions with staff, it heightened their sense of significance and belonging and reaffirmed that they were being treated with dignity and respect. Staff who anticipated the need to compensate for the environmental shortcomings were held in high regard and shown deep gratitude.

Summary of the Key Points from the Literature Review

Box 1: Key Points from Literature Review

- Limited studies explore the lived experience of older people accessing urgent and emergency care services, therefore their voice is not sufficiently captured
- For most older people attending the ED is a last resource and is concomitant with delayed decision making
- In general, older people are satisfied with their care, however this is associated with low expectations and high tolerance of inadequate care.
- Technical care supersedes relational care in the ED, resulting in older people having a diminished sense of significance and feeling invisible
- The noisy and chaotic environment of the ED did not align with older people’s needs
- Meaningful relationships with staff heightened older people’s sense of worth and belonging and reaffirmed they were being treated with dignity and respect.

Box 1: Summary of key points from literature review

Limitations of the Literature Review

All included studies attempted to explore older people's experiences of emergency care to develop understandings from their experiences. Most studies had different aims in relation to the ED experience ranging from exploring experiences on accessing the ED, waiting in the ED, during the ED and some with an added emphasis on discharge from the ED. Although, the studies each make a distinct contribution to an overall understanding of older people's experience of emergency care, very few studies specifically explored experiences in the over 80 age group (1 study), therefore, their experiences are not explicitly captured. Whilst 4 of the studies focused on the age 75 and over, 2 of these studies were combined with relatives' experiences., therefore the older person's experiences may not be sufficiently explored in depth. Whilst it would appear in the review that the experiences of older people were shared across the age groups (over, 65,70,75 and 80), a more nuanced account of experiences in the over 75's, who are the fastest growing users of emergency care (Banerjee, 2013, NHS Digital, 2019) would enable exploration to see if they had specific needs within the ED, thus advancing our understanding of this population. Furthermore, current models of emergency care could be explored to see how best they meet the needs of this growing population.

The quality of two of the studies in this literature review were relatively poor due to their methodological limitations (see Table 1). This illustrates the need for more robust qualitative research into the 'lived experiences' of older people.

The researcher conducted the literature review independently, and although they took steps to enhance the trustworthiness of the findings of the review by discussing and sharing them with their supervisors, the analytical rigour was not examined by a team of reviewers who could agree or refute the findings; thus, the findings of the review are subjective based on the interpretations of the researcher.

What does the literature review leave unanswered?

As populations age globally, a greater understanding is needed of older people's experiences of health and the services they use to inform and shape service design. Experience and knowledge accumulated with age provides a unique perspective (Elias & Lowton 2014) and in order to drive policy and practice, further research is needed to capture these perspectives in what traditionally is an under-researched population.

Moreover, wider cultural and social issues which impact on the care experiences of older people need to be captured, such as ageism. Culturally an understanding is needed about how older people experience care and to what extent they receive patient-centred care and are involved in decision-making, as indicated in policy (NSF for Older People 2001, DH 2010, Coulter et al 2013). Many older people experience gaps between policy intention and the care they receive (Calnan et al. 2013). Therefore, a deeper and more nuanced understanding from the perspective of the older person about how they experience patient- centred care can further inform why such gaps still prevail. The work of Kitson et al (2012) explored the context of where care is given and the impact of this on the delivery of patient-centred care for older people. They reported that in a time when the older population is growing, there are closures of specialist community hospitals and with a lack of specialist-trained staff in the field of gerontology, it is increasingly problematic to achieve patient-centred care for this population. The studies in this review alluded to the question of whether environments like the ED are ‘fit for purpose’ and shed some light on the need to gain insight about where older people with urgent and emergency care needs should be cared for, in order to broaden our understandings of the social context of care.

How does the review inform policy and practice?

From the limited qualitative studies in this review, there are strong indicators that we need to improve the delivery of clinical care for this group of older patients. This includes determining the patient experience and understanding how staff can be supported to manage the complexity of older people’s needs in fast-paced ED environments. This could then translate into new conceptualisations of service delivery and pathways of care and develop the competencies of staff caring for this population. Importantly, the review has highlighted the need for HCPs to better understand the needs of older people in their working environments.

The review raises important questions about what services fit best with the needs of older people who require urgent and emergency care and how these need to be delivered. There is further scope to ascertain the views and experiences of HCPs on caring for older people in the ED and the suitability of the environment of care for their needs.

Gaps in older people's 'lived experience' of urgent and emergency care

It is important to note that the literature review revealed few studies that explored the lived experience of older people accessing urgent and emergency care services, therefore their voice is not sufficiently captured. Research in the area of older people's experience of urgent and emergency care appears dominated by quantitative research with a focus on 'measuring experience'.

However, the review results suggest that we need to know more from the patient perspective, especially from the viewpoint of the 'lived experience'. Glasby and Littlechild (2000, p.166) stress that the importance of drawing on an individual's lived experience is 'crucial to understanding the context within which the older person is using health and social care services. Therefore, the central focus of this research study will be on the 'lived experience' to enable an in-depth exploration of the individual experience of accessing urgent and emergency care services. This will develop richer understandings about how older people experience urgent and emergency care. Furthermore, this will add to the limited body of existing qualitative research in this important area of healthcare practice. Understanding what is already known informs the need to develop a deeper knowledge and understanding of older people's experiences of urgent and emergency care, which enables the formulation of the research question for the study:

Research Question

What are older people's experiences of urgent and emergency care?

Objectives:

- To explore older people's experiences of urgent and emergency care
- To explore health care professionals (HCPs) perceptions of older people's experiences of care.

Chapter 3: Methodology

Introduction

This research aimed to explore the experiences of older people who accessed urgent and emergency care through their ‘lived experiences’. Therefore, this research is underpinned by the concept that an understanding of the way an individual makes sense of and responds to the experiences within their ‘lifeworld’ is crucial to inform health care practice and the development of services from the perspective of individuals (Benner,1994). To understand individual experiences, a qualitative research approach was chosen as it seeks specifically to understand and describe the world of human experience (Dierckx de Casterle et al 2011). Although, qualitative research incorporates many approaches, it was essential to choose one which had a particular emphasis on the individual meaning of experiences. Phenomenology is a philosophy and a research approach that is committed to the study of the ‘lifeworld’ or lived experience’ (Dowling, 2007). This approach supports the central tenet of the study on the understanding of experiences and the meanings ascribed to those experiences, in this context, urgent and emergency care from the lens of the older person.

This chapter begins with an overview of the role of philosophical positioning in how it shaped and informed the chosen methodology. Phenomenology as a research method is explored and discussed with justification as to why interpretative phenomenological analysis (IPA) was selected as the most appropriate research approach and the ‘best fit’ to answer the research question *‘What are older peoples’ experiences of urgent and emergency care’*? Strengths and limitations of IPA are discussed. Descriptive and interpretative phenomenological approaches are considered, and rationale provided as to why the descriptive approach was unsuitable to answer the aims and objectives of the research.

Philosophical Position

The disclosure of the researcher’s position in relation to the research and the data is vital so the reader can trust their perspective (Pitard, 2017). Berger (2015) contends that positioning is also important for understanding the researchers’ role in the creation of knowledge. Furthermore, awareness of the researcher’s positioning helps towards defining the methodology (Pitard, 2017). According to

Creswell (2003, 2013), acknowledging the researcher's underlying philosophical beliefs and assumptions is an essential step in developing a theoretical framework for the research. Identifying the most appropriate research approach ensures the aims and objectives of the thesis are addressed. Moreover, Bradbury-Jones (2017, p.627) assert the alignment of methodological and philosophical positioning are particularly important to establish for the novice researcher, "*so the blending of methods and orientations translate into a coherent qualitative endeavour*". Additionally, Mason (2002) states once the theoretical position is established, it provides context for the research to inform the methodology. Therefore, it is essential to explain the theoretical position and the underpinning framework to understand the phenomena.

My research was motivated by an interest in understanding how older people experience care in urgent and emergency care environments, the challenges they may face and their response to those experiences. Central to the phenomena, I wanted to understand 'the 'whole experience' from the older persons' perspective as it appeared to them. Crucial to this understanding was the key tenet that knowledge is created through the 'lived experience' of those who have experienced the phenomena. Todres and Holloway (2004) support this view that only those who have experienced phenomena can communicate them to the outside world. Therefore, it is fundamental to 'lived experience' to capture the voice of those who have directly experienced the phenomena so they can convey their meaning and create new knowledge and insights.

Understanding my beliefs that only those individuals that have experienced the phenomena can provide their unique view of what it means to them pointed towards a qualitative approach, as it seeks to explore and understand the meanings people assign to their experiences (Creswell,2013). Qualitative research also aligns itself well to phenomenological approaches to explore 'the lived experience' (Dierckx de Casterle et al 2011). Whilst this view shapes my perspective, I also believe my role as the researcher is to seek out the meanings of those experiences. Therefore, part of the methodological positioning of this study would be to make sense of the older people's experiences (Smith et al.2009).

Ontology and Epistemology

Having established the aim of the study is to focus on older people's experiences and the researchers' role in making sense/interpretation of those experiences orientates the research study towards a qualitative approach that would reflect phenomenological and interpretative aspects to explore meaning. Thus, this study would identify with a constructivist/interpretivist research paradigm that seeks to understand human experience. It is driven by a philosophy that in order to comprehend individuals' experiences of 'being in the world', one must interpret it through the lived experiences of those in it (Polit & Beck, 2004). A paradigm is used to describe the researchers' 'worldview', a set of shared beliefs that informs the meaning or interpretation of data (Guba and Lincoln, 1994). Thus, the paradigm defines the researchers' philosophical orientation and has "*significant implications for every decision made in the research process, including choice of methodology and methods"* (Kivunja and Kuyini 2017, p,26). Locating the research to a constructivist/interpretivist paradigm orientates the researcher to think about the essence of the phenomena under investigation and how to make sense of it. Examining the ontological position enables the researcher to explore the nature of the world and what we know about it, in how it is socially constructed and experienced by individuals (Pitard,2007). Therefore, this study is situated from an ontological position of how experiences are socially constructed by individuals and through the researchers' interpretations sheds light on their lifeworld (Smith et al.2009). This positioning also relies on the epistemological view that knowledge is co-created between the researcher and the researched (Pitard, 2017). Epistemology is used to describe how we come to know something, and through the researchers' interpretation of participants experiences can broaden and deepen understanding of the phenomena (Laverty,2003). In this study's context, the aim is to broaden the understanding of what it means for older people to experience urgent and emergency care. However, Van Manen (1990) asserts that multiple versions of reality exist and with this comes the possibility of various interpretations. This suggests that interpretation is subjective and depending on your personal backgrounds, views of the world may be different.

Understanding of the ontological and epistemological positioning of this study has informed the methodology and methods, given the study's central focus is on the 'lifeworld', which orientates towards phenomenology, more specifically

Heidegger's, due to its emphasis on hermeneutics. Additionally, having established that knowledge is developed through 'lived experience' and individuals will have different experiences of the phenomena, the role of the researcher is to capture the essence of the structures of these experiences by interpretation, based on the participants' assumptions and responses of 'being in the world'. Thus, rooted in phenomenology and hermeneutics, IPA was considered the most suitable methodology to explore the research aims and objectives. IPA's focus is on the examination of how people make sense of their life experiences (Smith et al.2009). This will allow the essence of the experiences to unfold to deepen our knowledge and understanding of the phenomena under investigation. As IPA was inspired by phenomenology and hermeneutics, these will now be discussed to provide background to its development as a phenomenological methodology.

Phenomenology

Phenomenology is a philosophy that is concerned with human understanding and stresses the importance of the 'lifeworld' or lived experience (van Manen 1997). According to van Manen (1997) 'lived experience' refers to experiencing the world while living in it. Thus, how the world is experienced directly or subjectively in everyday life (Finlay, 2009). Merleau- Ponty (1968) relates this to how the person and world are intertwined, which illuminates the dynamic relationship between the two. According to Finlay (2009) the strength of phenomenology is the way it can capture the richness and ambiguity of lived experience, to see the worlds of others from their perspective in new and different ways (Finlay, 2009). Phenomenological research aims to describe the essential structures of a phenomenon (Dahlberg, 2006). Douglass and Moustakas (1985, p.43) emphasise the most important aspect of phenomenology is that it ends with the 'essence of the experience', the essence being '*essential meanings of what makes the phenomenon to be that phenomenon'* (Dahlberg, 2006, p.11).

Phenomenological research has evolved into a range of approaches which increase the complexity and diversity of uses in research, with many philosophers challenging the different methodological strands about which fits best with the principles of phenomenology (van Manen, 2019, Morley,2019, Giorgi, 2011). For some, phenomenology is rigorous and systematic, whereas for others it is fluid and poetic, while some researchers describe and others deeply immerse themselves in interpretations (Finlay,2009). However, this can be hugely challenging and confusing for many researchers, so understanding the underpinning theoretical perspectives and methodology is advocated (Gelling, 2010, Finlay,2009).

Although there are multiple phenomenological variations, there are two broad categories that have been adopted: descriptive and hermeneutic (Finlay, 2009, Finlay, 2012, Tuffour, 2017). Common to both is to convey rich, thick descriptions of the meaning structures of the lived experience (Finlay,2009). There have been several developments of phenomenology over the years, each with their own emphasis on how to explore the 'lived experience' (for example; Giorgi, van Manen, Gadamer, Ricoeur), however the next section will focus on the origins of phenomenology with particular attention to Husserl's (descriptive) and Heidegger's (interpretative) phenomenology.

Origins of phenomenology

The German philosopher Edmund Husserl (1859–1938) is generally considered the "founding father" of phenomenology (van Manen, 1990). He considered Phenomenology to be "the careful examination of human experience" (Smith et al, 2009, p.12). Thus, the goal of phenomenological enquiry is to fully describe the lived experience (Todres and Holloway, 2004). Husserl's descriptive or transcendental phenomenology was so called because it could objectify the meanings of human experiences by looking at the general descriptions of the essences of the phenomena (Smith et al.2009). Husserl developed phenomenology to describe how the world appears to us in our 'consciousness', which he famously called *'go back to the things themselves'* (Smith et al.2009). This central concept in phenomenology on 'consciousness' or 'awareness' which Husserl called 'intentionality' was to focus only on the experiences as they are, without interference from outside influences such as theoretical presuppositions. Husserl believed that the way in which we react to the world is demonstrated through our consciousness (Laverty, 2003). Thus, the emphasis on consciousness means the primary concern is on our interactions with the world and how things appear to us. For Husserl, by discovering the means in which a person knows and understands their experience of a phenomenon, the essential qualities or the structures can be identified to reveal the 'essence' of the experience (Koch,1995). However, Husserl strongly advocated that to achieve the ‘things’ as they are requires a stepping away from our ‘natural attitude’ or our assumptions and beliefs about things (Smith et al.2009). Husserl suggested that the only way to move away from the ‘natural attitude’ was to bracket or suspend any prior assumptions, prejudices or understandings in order to see the phenomena as they are through the lifeworld of the participants (van Manen,1990). Husserl described this bracketing and suspension as a process of phenomenological reduction or epoché. He argued that core to this method was the need to look at the phenomenon with fresh eyes, which he called the ‘phenomenological attitude’ (Husserl, 1970). Moreover, Merleau-Ponty (1962, p.viii) asserted that phenomenology can only be accessed through the ‘phenomenological method’ of epoché and is the ‘intrinsic core’ of phenomenology. Morley (2019, p.165) stated frankly: *‘to not practice, the epoché is to simply miss the foundational point of what phenomenology is all about’*. Thus, achieving epoché is fundamental to understanding Husserl’s notion of phenomenology. Therefore, the researcher needs to be open to the phenomenon in as fresh as way as possible and to bracket out any preconceptions of the world (Finlay, 2009). Failure to bracket may result in biases being shown which may distort the researchers’ considerations of consciousness itself (Moran, 2000). Therefore, all these techniques contribute to Husserl’s ‘*eidetic reduction’* in order to get to the essence or the essential structures of the experience (Giorgi, 1997, Smith et al.2009). However, there have been criticisms regarding the conceptual approach Husserl applied to his phenomenology, in that it lacks a pragmatic approach to exploring the ‘lifeworld’, for example there are no detailed steps to how eidetic reduction can be achieved (Smith et al.2009).

Husserl was associated with descriptive phenomenology where the key aim was to examine the essence or structure of the experiences as it relates to the ‘consciousness’ through eidetic reduction. However, another branch of phenomenology, hermeneutics, emerged from the rejection of Husserl’s notion of suspension and bracketing, due to the belief that this was nearly impossible to achieve, in favour of interpretation of experiences (Tuffour,2017). Whilst Husserl’s work has influenced phenomenology the most (Smith et al.2009), other philosophers like Heidegger, Merleau-Ponty, Gadamer, opted to put aside the Husserlian features of phenomenology and turn to a more pragmatic phenomenological approach with a focus on the ‘lifeworld’ that fits more to everyday life, rather than a conceptual/thinking approach (van Manen,1990).

Hermeneutic Phenomenology

Martin Heidegger (1889-1976), a pupil of Husserl, disagreed with his former teacher's theoretical and abstract approach and developed a new phenomenology called hermeneutic phenomenology. The lifeworld or human experience as it is lived is still the central focus, however where it differs is Heidegger's focus on illuminating the taken for granted aspects of our lives to create meaning and a sense of understanding (Laverty, 2003). To that end, Heidegger's concern was 'being in the world' or 'Daesin', as opposed to Husserl's abstract consciousness. Heidegger proposed that consciousness is not separate from the world of human existence (Dowling, 2007) and refers to the way human beings exist, act or are involved in the world (van Manen, 1990). Therefore, Heidegger uses the term 'life world' to convey the idea that individuals' realities are consistently affected by the world in which they live (Flood, 2010). Thus, the context of human existence is fundamentally significant in existential phenomenology. Through this existence, meanings are constructed by individuals as they engage with the world (Flood, 2010). Heidegger uses the term 'pre-understanding' to describe the structure of being in the world, which cannot be eliminated or bracketed (Koch, 1995). These pre-understandings can be explained by the notion of co-constitutionality, a key feature of hermeneutics, which understands there is a unity between the person and the world in which they live. From this unity the person can construct their experiences, utilising what went before through their prior understandings of the world, whether through objects, language or culture, from which one cannot be detached (Koch,1995, Smith et al.2009). Thus, Heidegger's interpretative phenomenology claims that we are inseparable from our being in the world, and thus we make sense of the world through our existence in the world, rather than being detached from it. Heidegger believed that one cannot discard previous experiences of the world, for which he relates to the concept of 'forestructures' of understanding in how one understands the world and interprets reality (Sloan and Bowe, 2014).

To appreciate how the person exists in the world requires a shift from description of the essence to the search for meaning embedded in everyday practices through interpretation (Lopez and Willis, 2004). Therefore, in hermeneutics, there is greater emphasis on the contextual meanings present (Oxley, 2016). This requires the researcher to focus on describing the meanings of 'being in the world' and the meanings ascribed to those experiences. Heidegger makes a distinct difference here in recognising the role of the researcher in identifying the essence by their active participation in the search for meaning. Unlike Husserl, where the researcher is asked to suspend and bracket their prior assumptions and views, Heidegger acknowledges that the researcher's views of the world are 'inextricably intertwined' with the way in which they interpret the individual's experiences (Oxley, 2016, p.56). However, it remains important for the researcher to adopt a reflexive attitude and acknowledge any pre-existing knowledge or pre-conceptions that they bring to the phenomenon (Oxley, 2016). Hence the researcher needs to be aware of their own forestructures to avoid unduly influencing the data.

Heidegger developed the concept of the hermeneutic circle to convey the dynamic relationship between the whole by looking at the part (Smith et al.2009): for the researcher to engage with the data and to understand the whole experience through the parts, they need to challenge any preconceptions (Oxley,2016). This understanding of the whole from the parts is core to the principles of interpretative phenomenology (Smith et al.2009). This way interpretation becomes cyclical since sometimes it is not until we experience the 'things themselves' that we uncover the forestructures (Davidsen, 2013 p.323). Therefore, the researcher needs to be open to the data as presented to them. Thus, there is a dynamic relationship between the researcher and the participant to influence the interpretations. Interpretative phenomenologists therefore believe it is not possible or desirable to bracket their preconceptions or knowledge and that a fusion of both the participant and researcher's meaning-making develops our understanding of the phenomena (Koch,1996, Gadamer, 1976).

Descriptive versus Hermeneutic Phenomenology

Both descriptive and interpretative phenomenological approaches share the same epistemological foundation laid by Husserl, however, considerable methodological and epistemological differences have evolved over recent years (Matua and van Der Wal, 2015). Therefore, it is prudent when choosing a phenomenological method to acknowledge these differences to meet the requirements of the research study (Matua and van Der Wal, 2015). However, it is also widely accepted that there are numerous shortcomings in the application of phenomenological approaches to research (Englander, 2016). Thus, a greater understanding of the distinguishing features of descriptive and interpretative phenomenology will assist the researcher in their decision-making to ensure when planning their study to identify the most appropriate method. This will also promote accurate application of the key features of the chosen method and so have the potential to generate useful knowledge for health care practice (Lopez and Willis, 2004). Therefore, it was essential to develop my understanding of the difference in approaches to arrive at the correct method to address the aims of the thesis.

There are important differences between Husserlian transcendental (descriptive) and Heidegger’s hermeneutic (interpretative) phenomenology (Koch,1996), however the main tenet of the two is they both seek to uncover the lifeworld or human experience as it is lived (Smith et al.2009, Sloane and Bowe, 2013). It is important to note that one approach does not supersede the other nor diminish each of their value in identifying the essences of human experience (Sloan and Bowe, 2013).

Epistemological differences

The epistemological assumptions of knowing have distinct differences between descriptive and hermeneutic phenomenology, to highlight how we understand the world and our relationship within the world and reality (Koch,1995). Husserl emphasises knowing through our consciousness, whereas Heidegger’s hermeneutics focuses on how people come to understand (Koch, 1995). Husserl’s descriptive phenomenology of ‘*going back to the things themselves’ to* describe the everyday conscious experiences is the central tenet (Reiners, 2012). Husserl believed there are key features that are common to all individuals who have an experience which he named the ‘universal experiences’ or ‘structures’. Therefore, the aim was to identify the common experiences so a generalised description could be known (Lopez and Willis, 2004). Thus, once the structures of the experience are unveiled, the researcher then has arrived at the essence of the experience (Sloan and Bowe, 2013). In contrast, Heidegger rejected Husserl’s views of how the lived experience is explored and advocated for hermeneutics as a research method grounded in ontology since the ‘lived experience’ is an interpretive process (Dowling, 2007). Heidegger asserted that humans are embedded in their world and are inextricably linked with social, cultural and political contexts (Heidegger, 1962). Heidegger’s work ‘*Being in Time’* published in 1927 proposed that ‘consciousness is not separate from the world of human existence' (Dowling, 2007, p.133). Thus, Heidegger work is grounded in existential phenomenology. Heidegger's hermeneutic phenomenology of *'being in the world'* was an attempt to be pragmatic and provide clarity to explain one's existence and relationship with the world. Heidegger believed that hermeneutics goes beyond mere descriptions, and that one needs to look for meanings embedded in common life practices (Lopez and Willis, 2004). Core to this belief was that the meanings are not always apparent to participants but can be gleaned from their narratives (Lopez and Willis, 2004). Central to this concept is the role of the researcher to make sense of how the participants are making sense of their experiences (Smith et al.2009). However, to achieve this deeper interpretation, it has been argued that this process is complex, and for it to be successful there is a reliance on the researcher to engage with the data interpretatively (Smith et al.2009, Oxley,2016).

Methodological differences

Methodological differences have emerged over the years with the main shift being from 'pure description', as proposed by Husserl, to one of interpretation of experience, proposed by Heidegger (Lopez and Willis, 2004, van Manen, 2011). Descriptive phenomenology seeks to explore, analyse and describe a phenomenon while maintaining the richness and breadth of the experience by coming to it with a 'freshness' (Matua and van Der Wal, 2015, Husserl,1970, 1983). This requires the researcher to use the phenomenological technique of epoché to suspend or bracket all preconceptions in order to discover the 'lifeworld' in its 'purest' form (van Manen, 2011). Giorgi, a follower of Husserl (1997, p,237) developed the descriptive phenomenological method where the primary focus is the interest *'in the object in its phenomenal status',* in other words the phenomenon as it appears. Whilst he refined the original approach, he remained faithful to the Husserlian philosophical foundations (Englander, 2016). Giorgi (2011) felt strongly that in order to be true to phenomenology, the fundamental principle of epoché had to be applied. Accordingly, Giorgi (2011) asserted the absence of epoché in interpretative methods therefore failed to meet the requirements of phenomenology:

'Without the phenomenological reduction one cannot claim that a method is phenomenological because the reduction is the entrée to the phenomenological domain' (Giorgio, 2011, p.201).

Giorgi (2009) believed that Husserl's original approach of 'consciousness' and 'reality' needed to be modified in order to be more sensitive to issues in psychology and psychiatry, thus broadening its application. Merleau-Ponty (1962, p.viii) also vehemently supported epoché for philosophical inquiry; *"Phenomenology is accessible only through the phenomenological method."* Hence, this strongly suggests that without the epoché, there is no phenomenological inquiry (Englander, 2016). There has been much debate regarding the technique of bracketing in phenomenology, for example Moustakas (1990, p.38) favours the distancing of the researcher from the phenomenon being studied; in contrast, LeVasseur (2003) was critical of bracketing due to the detached attitude the researcher had to adopt.

Opposing the view of epoché, Heidegger (1962) asserted that it is impossible for the researcher to free their mind of background understandings. Significantly, for Heidegger, personal knowledge is accepted as both useful and necessary for interpretative research. However, at the same time, the researcher needs to make any preconceptions explicit, in particular, how they are being used in the inquiry (Le Vasseur, 2003). Koch (1995) highlights the importance of Heidegger's concept of co-constitutionality, in which the findings the researcher arrives at are a blend of meanings of both the participant and the researcher. However, to arrive at the meanings, the researcher needs to engage with continuous review and analysis of the text between the parts and the whole (Reiners, 2012). Gadamer (1976) called this the 'fusion of horizons' to explain the intersubjectivity of understanding and interpretation between the researched and the researcher. This fusion is shaped by their experiences and the meanings they ascribe to these (Lopez and Willis, 2004). Therefore, interpretation of the lifeworld is fundamental to Heidegger's interpretative phenomenology. According to Reiners (2012), Heidegger makes it very clear that the essence of human understanding is hermeneutic, as our understanding of the everyday world is derived from our interpretation of it. However, in hermeneutics there is an awareness of the subjectivity of interpretations, as there could be more than one interpretation of the narratives depending on the focus of the research (Lopez and Willis, 2004).

To conclude, interpretative phenomenology is useful when the research question asks for the meaning of the phenomenon and the researcher does not bracket their preconceptions or assumptions of the world. Descriptive phenomenology is used when the researcher wants to describe the phenomenon to identify the essence of the lived experience and brackets any previous biases or assumptions.

Choosing IPA

Phenomenology was selected as a suitable qualitative research methodology to address the research aim due to its focus on lived experience and the meaning attached to these experiences of older people who access urgent and emergency care. Central to the study is the concept that an understanding of the way the older person makes sense of and responds to their experiences within their ‘lifeworld’ is crucial to inform health care practice and the development of services from the perspective of individuals themselves. However, it was important to have a clear understanding between descriptive and interpretive phenomenology to decide which method was most appropriate for the study as both approaches focused on lived experience. This was to make sure the value of the research was not compromised (Reiners, 2012). Heidegger’s hermeneutic method contributed to my understanding of the importance of intersubjectivity of understanding and interpretation between the researcher and the research participant. Furthermore, Heidegger’s emphasis on the hermeneutic circle recognised that the natural attitude of the researcher cannot be divorced from the research process, but rather forms an important and explicit part of it, reinforcing my positioning. Therefore, the traditional descriptive phenomenological approach proposed by Husserl, which aims to facilitate an unbiased exploration of lived experience did not align to the deeper exploration and interpretations of older people’s experiences the study aims to achieve. Thus, this moved the philosophical underpinning away from Husserl’s transcendental phenomenology and towards a hermeneutic phenomenological stance. I considered that key to the aims and objectives of the study was to ‘give voice’ to the older people’s experiences. The literature review highlighted the unique needs of the older person in the ED but their perspective of their experiences are seldom heard. IPA is a methodology and a method and is influenced by three main theoretical foundations of phenomenology, hermeneutics and idiography (Smith and Eatough 2007; Smith et al. 2009). Therefore, IPA was chosen as the most appropriate approach as all three of these foundations were considered to be of central importance to ‘give voice’ to the older person to develop unique insights into their experiences of urgent and emergency care.

IPA

IPA is a relatively new qualitative research method that is interpretative as well as phenomenological (Smith et al.2009, Seamark et al 2004) and is strongly influenced by the hermeneutic version of phenomenology of Heidegger and Gadamer (Smith et al. 2009).IPA was first developed by psychologist Jonathan Smith in 1996 (Smith,1996). It has also gained attention as a flexible and inductive phenomenological research approach (O'Mullan et al.2019). Over the years, IPA has emerged as a method applicable to an extensive range of psychological, health and social inquiry and because of its links to the 'real world' offers the researcher the opportunity to integrate research and practice (Reid et al 2005). Furthermore, IPA is also favored by healthcare researchers due to its focus on listening to the voice of service users in the NHS (Reid et al.2005, Robert and Cornwell, 2013). IPA addresses this by actively engaging with participants who have experienced a phenomenon to express their views and experiences (Reid et al.2005).

IPA is appropriate for exploring in detail the phenomena under investigation, in this case older peoples' experiences of urgent and emergency care and is concerned specifically with the individual's perception of their accounts or experiences of the event (Eatough and Smith,2017). IPA views participants as experts in their own experiences and can offer researchers understandings of their thoughts and feelings through their own stories, in their own words and in as much detail as possible (Reid et al.2005).

IPA is connected to the core principles of phenomenology through paying respectful attention to a person's direct experience and by encouraging research participants to tell their story in their own words (Smith et al.2009). IPA involves the detailed examination of participants' 'lifeworld', their experiences of a particular phenomenon, how they make sense of these experiences and the meanings they attach to them (Smith, 2004, Smith, 2011). Smith et al (2009) draws on Heidegger's 'being in the world' to explain that individuals are actively engaged in the world and are constantly reflecting on their experiences in order to understand them. Therefore, as IPA is firmly anchored to key phenomenological understandings of the 'lived experience', it is a good fit with trying to achieve a deeper understanding of the multidimensional experiences of older people's experiences of urgent and emergency care (Smith et al.2009). The facility for highlighting unique perspectives as well as shared experiences is one of the cornerstones of IPA (Smith, 2004, Smith and Osborn, 2008). The outcome of a successful IPA is to 'give voice' to the participants, this means capturing and reflecting on the principle claims and concerns of the participants (Larkin and Thompson, 2012). For this study, the meaning of how older people experience urgent and emergency care and how they make sense of their experiences cannot be understood without older people themselves telling their own stories in their own voice. Thus, allowing HCPs to understand healthcare and the experience of acute medical emergencies from the viewpoint of the patient.

Theoretical underpinnings of IPA

IPA and Phenomenology

IPA is anchored to key phenomenological understandings of the 'lived experience' (Eatough and Smith, 2017, Gil-Rodriguez and Hefferon,2015). Whilst IPA has the fundamental basis of Husserl's examination of 'the thing itself' through a focused and careful examination of lived experience, it is also concerned with how an individual is embedded in the world through their interpretations of that immersion (Tuffour, 2017, p.3). Hence, IPA is strongly connected to Heidegger's 'being in the world'. Smith (1996) has therefore integrated the philosophical foundations of Husserl and Heidegger, with the influence of the latter more aligned to IPA's concern with examining how a phenomenon appears. Other philosophers, such as Merleau-Ponty and Sartre also strongly guided IPA's philosophical stance. Merleau-Ponty work focused on the 'embodied' nature of our relationship with the world and the primacy of the individual perspective. Sartre developed Heidegger's 'being in the world' to 'becoming ourselves', in how as individuals we are always in the process of 'becoming' and thus, only by existing and acting in certain ways can we give meaning to our lives.

Smith's IPA is concerned with exploring the individual's personal perception of their experience as opposed to producing an objective account (Smith et al.2009). IPA aims to understand the experiences as it is lived by an individual and the significance of why it matters to them, thus illuminating the 'particular experiences as experienced by particular people' (Eatough and Smith,2017, p.4).

Therefore, IPA is concerned with the microanalysis of individuals' experiences and nuances arriving from such an experience (O'Mullan et al.2018, Smith et al.2009). According to Eatough and Smith (2017) the focus on IPA's explicit commitment to understanding the phenomena of interest from a first-person perspective, and the value of subjective knowledge to deepen understanding, is what is appealing to researchers (Eatough and Smith, 2017). For the researcher this means they need to engage with a deeper level of analysis with a more interpretative focus to reveal the participant's 'lived experience' (Heffernon and Gil-Rodriguez, 2011). A degree of questioning is called upon to develop the analysis and is seen as beneficial to increase understandings from the data (Smith et al.2009). The findings must be firmly rooted in what the participants are actually saying, by providing direct quotes to substantiate the claims made (Pringle et al.2011). When the researcher arrives at the findings, they are not seeking to identify commonalities, rather there is more of an emphasis on providing a nuanced account due to looking for convergence and divergence across participants (Smith et al.2009).

According to Smith and Osborn (2005), IPA is useful to examine lived experiences that are complex and difficult to articulate. Furthermore, Smith (1996, p.206) suggests that IPA through the detailed examination of participants accounts provides insights into people's lives whose voices may otherwise not be heard. This aspect of IPA was in keeping with the aim of the research study to gain insight into the experiences of older people, to hear their voices of their direct experiences of care that are often neglected in healthcare practice. Thus, IPA offers access to experiences of a phenomenon that are currently lacking in this area of older people's care. Therefore, IPA as a phenomenological approach has much to offer in examining experiences to expose new understandings and knowledge of an under-investigated phenomenon. Not only does IPA provide new insights into the individual experience, it also contextualises them in relation to society and culture in which they live (Lopez and Willis,2004).

IPA and Hermeneutic Phenomenology

IPA strongly connects with Heidegger's hermeneutic phenomenology to explore and interpret the personal lived experience of individuals (Tuffour,2017). Hermeneutics plays an important role in IPA by offering important theoretical insights through its emphasis on meaning-making to recognise the significance of the experience for the participants (Larkin and Thompson,2012). Therefore, hermeneutics moves away from descriptive phenomenology towards interpretation (Oxley,2016). IPA is therefore founded on an interpretative phenomenological epistemology in order to access the universal essence of a phenomenon (Smith et al.2009). To assist the researcher in reaching the essences of an experience(s), Heidegger's hermeneutic circle is fundamental to the research process. Thus, Heidegger's hermeneutic circle is a core concept in IPA which emphasises the 'dynamic relationship between the part and the whole' (Smith, 2007. P.28). This means that any given part can only be understood in relation to the whole, and the meaning of the whole can only be understood in relation to the parts (Smith et al, 2009). The aim of the hermeneutic circle is for the researcher to ask the relevant questions to ascertain the 'meaning of being' which requires a reciprocal process of back-and-forth questioning, leading to the discovery of ideas and knowledge about the phenomenon (Tuohy et al.2013). Thus, the meaning-making comes from the participant making sense of their world and the researcher making sense of the participant's experiences. The hermeneutic circle allows the researcher to engage actively with the research process to uncover the participant's 'lived experience' by their reflective process of interpretation to make inferences from the data on the individuals embodied sense of the world (Reid et al.2005).

The role of the researcher in interpretation is fundamental to understanding the meaning ascribed to the experiences by participants. Smith et al. (2009) asserts that the phenomenon can be hidden within the participants' accounts and the researcher through immersion in the data interpretively can provide deeper meaning whilst remaining embedded within the participants' narrative. Thus, only through application of the Hermeneutic circle can the researcher begin to interpret and understand lived experiences (Heidegger,1962 p.153). However, IPA acknowledges that whilst the researcher attempts to access the participants' 'personal world' insofar as this is feasible, it requires the researcher to reflect on their own preconceptions in order to make sense of the participants experiences (Brocki and Wearden,2006). Acknowledging biases, preoccupations and assumptions reflectively follows Gadamer's influence on IPA in how our 'fore-understandings' shape the researchers' inquiries for the purpose of understanding (Eatough and Smith, 2017). Therefore, this method focuses on 'understanding the experience' from a fusion of both the participant and the researcher (Parahoo 2006: p.69). It acknowledges that both researcher and participant have their own preconceptions, beliefs of the experience and that these interpretations are essential to the understanding of how people experience phenomena differently' (Parahoo 2006, p.69). However, for an effective IPA, there is a reliance on the participants to be able to articulate their views and experiences of their lifeworld, and for the researcher to be able to reflect and interpret these experiences (Reid et al.2005).

It is also important to note that IPA is concerned with participants' subjective experiences, rather than their objective accounts, and these experiences may be interpreted differently by each individual, even when exposed to the same phenomenon (Biggerstaff and Thompson, 2008). Likewise, as a subjective research approach, two researchers may interpret the same data differently (Tuffour,2017). This dynamic relationship between the participant and the researcher resonates strongly with healthcare practice, where patients will talk about their health differently and HCPs may have different views about their patients' perceptions of health (Biggerstaff and Thompson,2008). Thus, IPA is a suitable method to understand how patients make sense of those healthcare experiences from their viewpoint.

Idiography

IPA is idiographic in that it is committed to the detailed and in-depth examination of individual experiences (Smith and Osborn, 2015). It seeks to learn from each participant's individual story through a deep individual analysis, case by case, then moving to more general claims (Smith and Osborn, 2015).Thus, each individual case is central to IPA research, as the researcher seeks to understand as much as possible about their experience before moving to the next case (Noon,2018). Therefore, idiography is concerned with focusing on the particular and the individual details (Oxley, 2016). This means as a qualitative approach it seeks to understand their perspectives from the participants themselves, with an emphasis on individual experience. Hence, each individual experience is important, before moving to what is common and distinct amongst all the participants in the study (Gil-Rodriguex and Hefferon, 2015). Thus, IPA remains faithful to the individual experience and by doing so, maintains a balance between what is distinct and what is shared across the accounts of the group of participants (Reid et al.2005). As a result, the pursuit of generalisation is not a defining feature of IPA (Smith, 2004). Through an idiographic approach, the centrality of the experience for an individual is illuminated to identify general themes in the lives of all individuals. Thus, the noteworthy aspects of general experiences can be achieved through connecting to the uniqueness of the individual lifeworld (Eatough and Smith,2017).

Accordingly, Smith and Osborn (2015, p.42) state a small sample size contributes positively to the idiographic approach as it enables the ‘micro-level’ reading of the participants’ accounts, offering the possibility of a deeper understanding of the individuals’ experiences. The focus on the individual experience enables the exploration of their ‘personal meaning’ and how they ‘make sense’ of that lived experience from a multiple-level perspective (Perry et al.2011). Reid et al (2005) assert that IPA’s idiographic approach enables the researcher to engage with the research question at an individual level to uncover ‘what is it like to experience pain’, for example? It also allows us to better understand the decisions individuals make in their life, which may be difficult or complex.

Strengths of IPA

Phenomenological research enables the perspectives of older people to be revealed by offering them the opportunity to allow them to ‘give voice’ to their views and experiences of urgent and emergency care. IPA offers an idiographic approach that is concerned with the uniqueness of an individual’s experience and meanings (Smith et al.2009) and therefore offers a framework for developing deep insights into the experiences of older people accessing urgent and emergency care. Similarly, it offers a person-centred approach for understanding the experiences of older people so that the findings have potential to develop into interventions and services that meet their individual needs. A further strength of IPA is its recognition that contextual factors influence how meaning is constructed by the individual, but also reveals the shared aspects of an experience across the participants. These shared similarities can be used to develop deeper understandings of their needs (Clarke, 2009). IPA has a focus on the ‘life world’ and this study has the potential to inform policy and practice from the voice of the service user, in other words by people who access and use services and the meanings they ascribe to those experiences, e.g. what is it like to be an older person in an ED department?

Limitations of IPA

There have been several criticisms of IPA as a research method, which mostly centre on deficiencies in achieving phenomenological rigour. Morley (2019) attacked IPA for not keeping to phenomenological tradition, asserting it was only phenomenological in name only, and Giorgi (2011, p.207) was particularly vigorous in his criticism of IPA's claim to be phenomenological. He identified serious failings such as its connection to '*hermeneutic tradition is vague, loose and ultimately, superficial'*, with the main attack being its lack of emphasis on phenomenological reduction. He asserts that if reduction is not used, then the analysis cannot be phenomenological. Furthermore, he also contested that simply using the terms 'lived experience' or 'investigation of meanings' is not enough to justify a specific research approach as phenomenology (Giorgi, 2011, p. 205). These criticisms highlight the significance which phenomenological reduction has for some phenomenologists, strongly reflecting their philosophical stance. However, Smith et al (2009) argue that the purpose of IPA is to attempt as far as possible to gain an insider perspective of the phenomenon, whilst acknowledging the importance of the researcher in making sense of the participants' understandings of their experiences, providing they articulate the influence their biases and assumptions have on the research. Therefore, the dynamic relationship between the researcher and the participants in mean-making is considered a strength and not a limitation of IPA research.

Questions have also been raised on how accurately IPA can capture the meaning of experiences, rather than just being the opinions of the researcher (Tuffour, 2017). This criticism calls into question the interpretive skills of the researcher required to provide the nuances of the experiences. Furthermore, Willig (2013) also queried the degree to which participants could provide the researcher with rich and vivid texture of their experiences. However, Smith et al (2009) recognised this may occur and emphasised the role of the researcher to immerse themselves fully in the data, so, revealing at an interpretive level, the meanings behind the data (Oxley, 2016). According to Pringle et al (2011), without active involvement of the researcher in the analysis, the meanings of the experiences may not fully be brought to light. Hence, there appears to be tension between the skills required of the researcher and the interpretive immersion in the data to reach the meanings of the experiences.

The idiographic approach used by IPA has also been criticised for the inability to make generalisations, and for being 'subjective' and 'impressionistic' (Pringle et al. 2011, p.21). However, IPA does not seek to make generalisations; rather the aim is to allow for deeper insight into the participant's experience of the phenomenon being investigated from which wider implications can be considered (Reid et al.2005, Hefferon and Gil-Rodriguez, 2011). Whilst IPA is subjective and individual researchers may reach different interpretations of the same data (Tuffour,2017), the researcher can take steps to ensure the account is credible by conducting an audit trail (Reid et al.2005). However, according to Smith et al (2009) IPA does not seek a single truth but rather a coherent and legitimate account that is true to the participant's narrative.

One concern is that IPA research results in primarily descriptive studies which lack depth, with little difference to a standard thematic analysis (Smith,2010). Failure to develop the analysis to a sufficient interpretative level is a common weakness in poor quality IPA research and is an area in which novice researchers require a lot of supervisory input (Hefferon and Gil-Rodriquez, 2011). Therefore, several steps may be taken to increase the rigour and validity of the research and enhance the findings, such as reflexivity, triangulation of methods and use of more than one method (Pringle et al.2011).

Reflexivity in IPA

The importance of reflexivity has been highlighted as an important feature of IPA research (Smith et al.2009). Acknowledging the 'fore-structures' or prior experiences and assumptions is fundamental to the interpretative approach of IPA (Smith and Osborn, 2008) because of the active role IPA researchers take in interpreting data, so it is prudent that they reflect on how their involvement affected the research process (O'Mullan et al.2018). Researchers achieve this through personal reflexivity: by making their subjective judgements about the data, while making it explicit how their preconceptions shape the knowledge and understandings made (Smith and Eatough,2007). Moustakas (1990) advised reflexivity and journaling to prevent any biases that may influence the results. Being reflexive through self-evaluation and analysis provides an openness and freshness to the data that is free from views or perceptions which may taint the data (Finlay, 2002, p. 536). It is through reflexivity that the researcher can engage with the data to provide new and valuable insights on the phenomenon (Biggerstaff and Thompson,2008). Through critical reflection, the researcher of this study employed self-awareness by identifying any preconceptions and biases that may have impacted on the data generated. Additionally, a reflexive journal and field notes enabled the researcher to critically self-question and analyse the decisions and ideas made about the research process and themes generated. The reflexive nature of the analysis and any potential biases were shared and discussed with the supervisors to address how they may influence the findings.

Summary

This chapter justifies the chosen methodology for this research study which has a clear focus on understanding the lived experience of older people who access urgent and emergency care. IPA has a clear fit with exploring lived experience and gives voice to those individuals who may seldom be heard. Through the emphasis on the individual accounts of the older peoples' experiences, telling their story in their own words will develop new insights and knowledge to inform healthcare practice and shape services around their unique needs.

Chapter 4: Study Design and Methods

Introduction

The previous chapter established and justified the underpinning methodology of interpretative phenomenology for the research study on older people. This is a qualitative mixed methods two-stage study design. The first stage of interviews with older people used an interpretative phenomenological approach to direct data collection and analysis (IPA). Stage two of the study used qualitative methods of focus groups (data collection) and thematic analysis (data analysis) to explore and analyse HCP' views of older people's experiences of care. This chapter provides discussion on the study design, the methods used to answer the research question; the sampling and selection criteria, data collection and analysis. Measures to promote trustworthiness throughout the research process will be discussed. These will be considered in turn for both stages of the research. Ethical considerations will be presented since they had important implications as to how the study was conducted. Reflexive engagement with the methods will be discussed in chapter 9.

Study Design

Qualitative research is an activity that situates and locates the observer in the world (Denzin and Lincoln, 2005). The aims and objectives of the study were to explore the experiences of older people who accessed urgent and emergency care and to understand their perspective through their lifeworld. A qualitative interpretative phenomenological approach (IPA) using semi-structured interviews with older people was chosen as the most appropriate method to explore this. The secondary aim of gaining the views of HCPs through focus groups enabled access to the phenomenon from more than one perspective. The exploration of one phenomenon from multiple perspectives can help the IPA analyst to develop a more detailed and multifaceted account of that phenomenon, (Reid et al.2005) and at more than one time point (Smith et al. 2009). Thus, a qualitative mixed methods two-stage study design was chosen to enable multiple perspectives of the same phenomenon to be illuminated. The combination, using methodological triangulation within qualitative methodology, was used to broaden understanding of the older people's experiences of urgent and emergency care (Bekhet & Zauszniewski, 2012, Casey and Murphy,2009). Furthermore, methodological triangulation increases the richness of the data collected and strengthens the research design (Smith et al.2009). Utilising methodological triangulation enabled the different dimensions of the same phenomenon to be captured to provide greater depth, validity and understanding of older people's experiences of urgent and emergency care (Mason, 2002, Green & Thorogood 2014).

The two- stage study comprised of:

1.Semi- structured interviews with older people

2.Focus groups with HCPs

Qualitative First stage

Semi-structured interviews with older people

Semi-structured interviews are the exemplary method for IPA and facilitate the participant's ability to tell their story or 'lived experience' in their own words, which is a central premise to IPA (Smith et al, 1997, Smith and Osborn, 2008, Reid et al.2005). Thus, semi-structured interviews were specifically chosen to ensure a good fit with IPA methodology and to enable the collection of rich data to examine the phenomena under exploration.

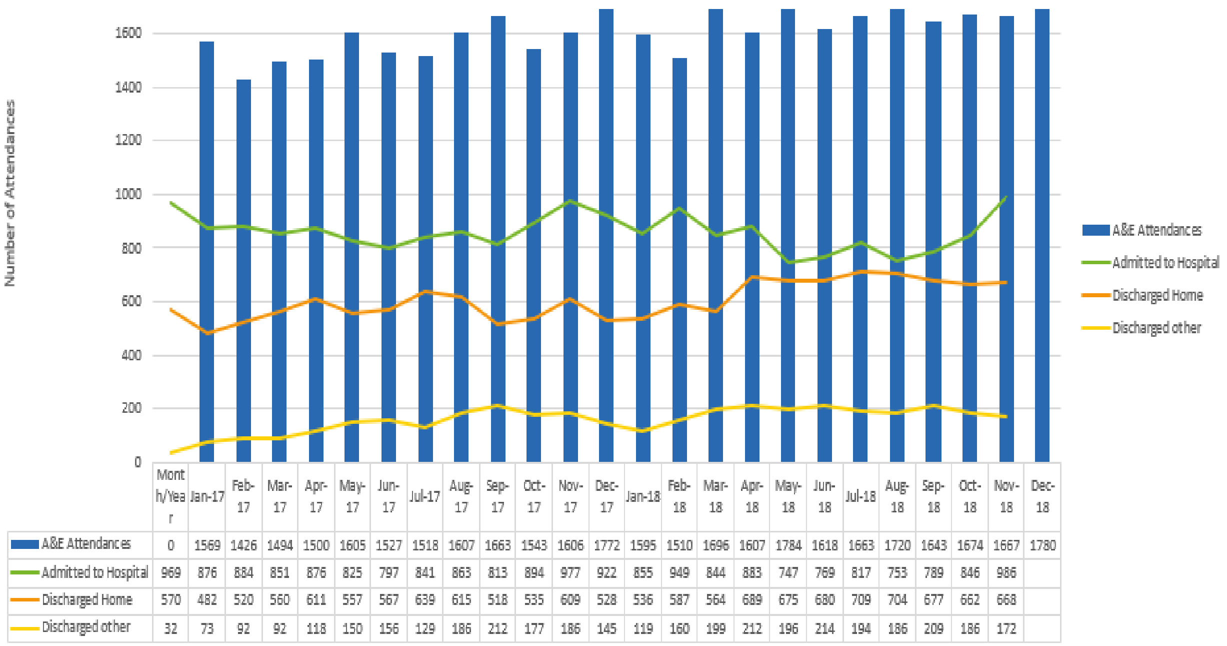
One to one semi--structured interviews were used to collect data from ten older people who attended urgent and emergency care. IPA studies are conducted on relatively small sample sizes. The aim being to find a reasonably homogenous sample, so that within the sample, one can examine convergence and divergence in some detail (Smith et al. 2009, p.3). Each transcript is looked at in depth and the intensity of this activity means that smaller sample sizes are enough for IPA to be realised (Smith et al. 2009). The small sample size allows for deep engagement with the participant, to listen attentively and probe more in order to learn more about older people's 'lifeworld' to produce rich data; if not the data could be too thin for analysis (Smith et al. 2009, p.58).

The concept of saturation, when the collection of new data does not shed any further light on the issue under investigation (Glaser & Strauss 1967) does not fit with the aim of IPA, as it is concerned specifically with the individual's perception of their accounts or experiences of the event to produce the 'rich description' of their ‘lifeworld’ (Smith et al.2009). Therefore, when using an IPA approach, data saturation is often not possible or indeed desirable (Hale, Treharne and Kitas, 2008). Hence, the small sample size of ten participants provided the rich data based upon the older persons ‘lived experience’ which is the primary goal of employing IPA as a framework (Sly et al. 2014). Primarily, the aims of the study are the ultimate driver of the study design, and informs the sample size (Charmaz 2006, P.114). Supporting this view Guest et al (2006, p.78) conducted a systematic analysis of their own data found that by attaining high levels of homogeneity among the sample population, six participant interviews were sufficient to enable meaningful themes and useful interpretations. However, they acknowledged that the skills of the interviewer clearly influence the quality of data collected, which impacts on the rich descriptions desired for IPA (Guest et al. 2006).

In order to get depth, accuracy and freshness of the older person’s experience, semi-structured interviews took place within four weeks of the participants leaving the acute hospital. The rationale for this is supported by a study by O’Cathain et al (2010) who found that a recall period of three months in the population of older people can be used to estimate experiences; however, one month is more accurate for estimating their use of the urgent and emergency care system. This enabled older people to share their experiences whilst they were still fresh but also allowed for a more accurate narrative of their use of urgent and emergency care services. Furthermore, the timeframe of four weeks would not place potential participants under pressure while still in hospital, so they had sufficient time to recover and reflect on their experiences of care. The literature identified that older people have the highest rates of hospital readmission (Conroy et al.2011, Banerjee et al, 2012, Fry et al.2014. Accounting for this, if a participant was identified as being readmitted to urgent and emergency care within the four-week timeframe, their experience would also contribute to the description of the ‘lived experience’ and they were not excluded from the study.

Study Setting and Sample

The research site was a large, district general teaching hospital in the South East of England with urgent and emergency care services, such as an Emergency Department (ED), Acute Medical Assessment Unit (AMU) and an Older People’s Medicine ward (OPM). These areas reflect the current trends in closer integration of A&E services with acute medical units to ensure prompt responses and fast-tracking systems for older people, based on their individual needs and to facilitate the current A&E performance indicators (DH, 2011). These are the areas of urgent and emergency care service provision that older people will access in an acute hospital setting. The site was purposefully selected as recent data (HES 2017)(See Fig 2) identified that the A&E department alone had 37,007 patients over 80 years old from the period January 2017 to November 2018. Of these, 19,657 were admitted to hospital, accounting for approximately 53% of the total number of over 80s who attend the ED, and 13,912 (37%), were discharged home. The research site has a higher than average population of older patients attending the ED, with on average 10% of attendances being patients over 80 years old (NHS Digital, 2018/19). This demonstrated that there was access to the sample population to study the phenomena under investigation, and the importance of understanding how services can be improved for older people at a local level.



	Month/Year	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
A&E Attendances	0	1569	1426	1494	1500	1605	1527	1518	1607	1663	1543	1606	1772	1595	1510	1696	1607	1784	1618	1663	1720	1643	1674	1667	1780
Admitted to Hospital	969	876	884	851	876	825	797	841	863	813	894	977	922	855	949	844	883	747	769	817	753	789	846	986	
Discharged Home	570	482	520	560	611	557	567	639	615	518	535	609	528	536	587	564	689	675	680	709	704	677	662	668	
Discharged other	32	73	92	92	118	150	156	129	186	212	177	186	145	119	160	199	212	196	214	194	186	209	186	172	

Figure 2: Attendances over 80-year-old with number of patients admitted to hospital/discharged to any other place.

Sampling

Service users: Older People

In IPA, purposive sampling is used to obtain a homogenous group in terms of people in similar circumstances (Seamark et al 2004) and have had experience of the phenomenon being explored. Purposive sampling, therefore, was employed to ensure that, as far as possible, a mix of older males and females were included, to provide a variety of experiences regarding older people who have experience of urgent and emergency care. However, care was taken to ensure the older people's characteristics were representative of spread of age group (range of over 80s) gender, living and marriage status, carer to enable sufficient variation of characteristics and shared experiences of urgent and emergency care. These characteristics were of interest also, as they may inform experiences of urgent and emergency care. Past employment was not sought in case it prompted painful thoughts or memories which may have caused distress.

Inclusion criteria

Inclusion criteria (see Table 4) for the study were as follows: older people over the age of 80 with capacity to consent, who had experienced urgent and emergency care and were well enough to be approached to invite to participate in the study, at the point of discharge. Interviews must take place within four weeks of discharge from urgent and emergency care to aid recall of care experience. Those who lacked capacity to consent, had poor command of the English language or lived in a nursing home were excluded.

Inclusion criteria	Exclusion criteria
Age over 80	Not have decisional capacity to make informed consent under the Mental Capacity Act (2005)
Experienced urgent or emergency care	Reside in a residential home
Participants interviewed within four weeks from discharge	English not their first language or poor command of the English language
English as first language or good command of the English language	
Participants had to have capacity to be able to participate in an interview for at least 45-60mins	

Table 2 : Inclusion/Exclusion Criteria Older People

Ethical Approval

This study gained approval from the Cambridgeshire East research ethics committee on the 21st Sept 2015 15/EE/0268 (Appendix D) and from the Research Governance Committee covering the research site on the 1st March 2016 178620 (162-10-15) Data collection was undertaken between March 2016 and August 2017.

Recruitment

Once ethical approval had been obtained, recruitment for individuals to participate in the older people interviews began in early March, with the first participant being interviewed in June 2016. A flow diagram is used to explain the older person recruitment processes (See Fig 3)

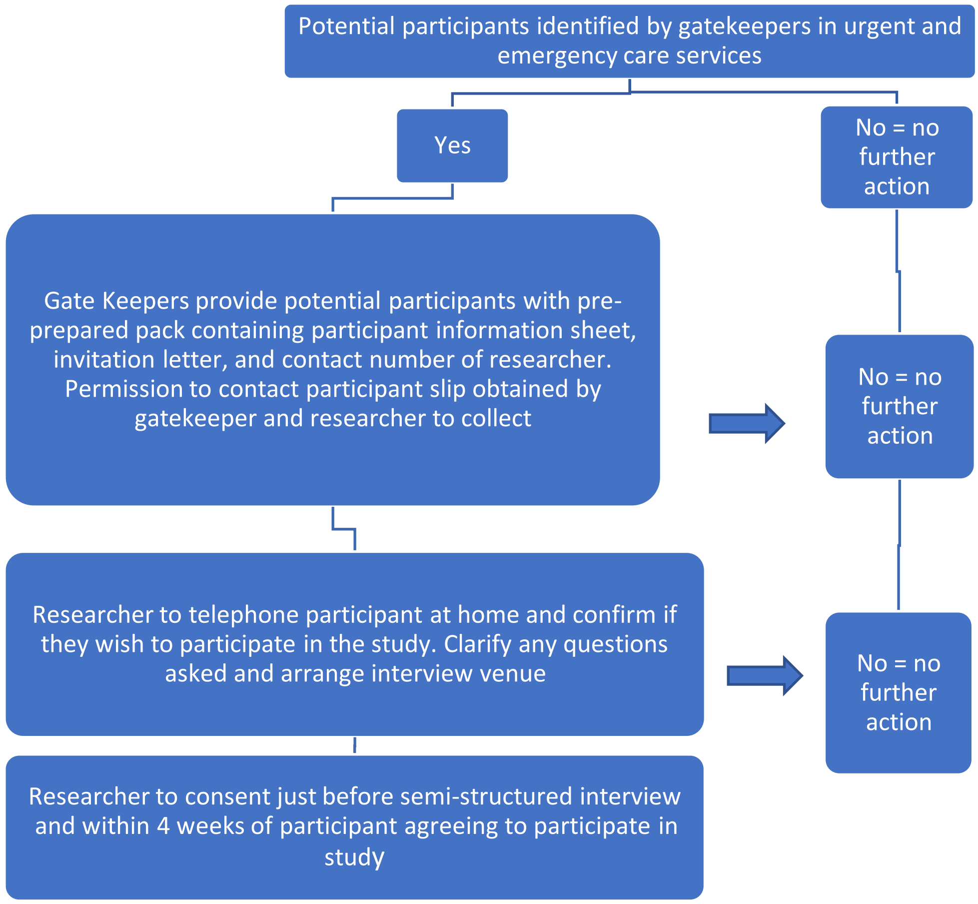


Fig 3: Recruitment flow of service users: older people

Gatekeepers

Prior to recruitment, in-depth meetings were initiated with the primary gatekeepers at the proposed research site. Gatekeepers were identified who played key roles in older people’s services at the research site. Creswell (2007) emphasises the important role of gatekeeper in gaining access to potential participants. The primary gatekeepers were the clinical director for older people’s medicine (Gerontology Consultant), clinical research nurse, advanced nurse practitioner in older people’s medicine and an ED sister. Discussion with the gatekeepers informed them of the population, the characteristics and the inclusion and exclusion criteria to ensure suitability of the participants. The older people’s medicine team were already pro-active in the area of research for older people and were very supportive of the research study.

Recruitment material

Patient and Public Involvement in Research (PPiRES)

The study aimed to give voice to older people and their experiences of urgent and emergency care. To ensure that the recruitment material and interview questions were appropriate for the intended participants, commentary was sought from PPiRES. Active involvement from members of the public has been highly encouraged as best practice to enrich research and make it more relevant to the public (Bergold, 2012; National Institute for Health Research, 2016, Keenan et al.2019). The Public and Patient Involvement in Research (PPiRES) offers a unique opportunity to involve lay people in the research process at all different stages, from decisions on what research should take place, to interpretation and dissemination of research findings (Keenan et al.2019). Having volunteers such as lay people, patients and carers is valuable in gaining their perspective and adds another layer to the robustness of the study to ensure the feasibility of the study and to gain insights that a researcher may not have thought of.

A meeting was arranged with members to discuss the aim of study, examples of the materials, and interview questions, gaining valuable insights and views to be taken forward in the development of the recruitment material and interviews. For PPiRES members who could not attend the group, material was sent to them via email. The group provided useful and positive feedback on the recruitment material and questionnaire for the older people and gave their support for the study (See Appendix E). The epistemological argument that experiential knowledge and insights from patients, carers and service users benefits health research was evident in the collaboration with PPiRES members but was also aligned to the positioning of this study; that improving healthcare practice can be advantaged from the experiences of those who directly use it (Beresford,2005).

Recruitment of patient participants

A purposive sample of ten older people over the age of 80 were recruited from one large acute teaching hospital trust in the East of England that provided ED, AMU and OPM service and who also specialised in older people's medicine. Participants were aged between 82-90 and included both male (5M) and female

(5F) patients. All patients recruited had experienced attending the ED, AMU +/- OPM. The older people participants attended the ED with a range/variety of self-reported acute medical emergencies, mostly cardiac and respiratory illnesses, and those participants who were admitted and discharged on the same day were due to falls (See Table 5). Older people who met the inclusion criteria were approached by key gatekeepers at the research site and those who were willing to participate or who wished further information were given a covering letter and a patient information sheet (PIS),and completed a ‘permission to contact’ slip. The researcher contacted these potential participants by phone and if they wished to join the study, an appointment was made at a choice of location: the person’s own home, a room within the researchers place of work or another location convenient for the patient, providing it complied with the code on safety of social researchers (SRA 1999) and was within the four week threshold of recall, as per inclusion criteria.

Demographics of Included Participants

The mean age of the ten participants was 85 years old: four were married and lived with their spouse, one of whom was a carer for a wife with advanced Dementia; six were widowed and lived alone, five of whom had family members to support them, and one dependent on neighbours. General self-reported information from the participants was also obtained to capture the participants care journey (See table 5).

Sex Male/female	Age	Marital status	Home situation	Reason for Admission Self-reported	Attendance profile	LOS (self-reported)	Discharged
Male	88	Married	Lives with wife	Soft tissue injury to thumb and cardiac palpitations	ED-AMU	1 day	Home
Female	85	Widow	Lives alone	Heart Failure and Cellulitis End of life DNA CPR	ED-OPM	5 days	Home
Male	86	Married	Lives with wife (Carer)	Chest Pain	ED-OPM	4 days	Home
Male	82	Married	Lives with wife	Angina	AMU-OPM	1 night	Home
Male	87	Married	Lives with wife	Chest pain and Collapse	ED-OPM	1 night	Home
Female	83	Widow	Lives alone	Chest Pain Angina	ED-OPM	1 night	Home
Female	85	Widow	Lives alone	Chest Pain and Palpitations	ED-AMU-OPM	4 nights	Home
Female	90	Widow	Lives alone	Fall	ED	4 hours	Home
Female	86	Widow	Lives alone	Fall	ED	4 hours	Home and with physio assessment
Male	85	Widow	Lives alone	Fall Fracture finger	ED	3 hours	Home

ED- Emergency Department, **AMU**-Assessment Medical Unit, **OPM**, Older People's Medicine ward **LOS-** Length of Stay

Table 5: Participant Information

Challenges in recruitment of older people

Recruitment commenced in March 2016, following ethical approvals and was conducted over a period of 18 months. Challenges recruiting older people who were directly discharged from the ED delayed the progress of the study. Initially recruitment by key gatekeepers achieved participants who went from the ED to AMU and then on to the OPM ward, as they had direct access to these patients. However, there were challenges to recruitment of patients who accessed ED only, due to the busyness of the ED and possibly the short timeframe of attendance (within the four-hour window). However, gentle reminders to the ED gatekeepers eventually identified three older people who were willing to participate. Overall, this extended the recruitment process by eight months.

Data collection

Service Users: Older People

Following consent, semi- structured interviews were conducted using an interview guide, which was developed around the aims of the thesis (see appendix F) to obtain in-depth accounts of older people's experience of urgent and emergency care. With permission, all interviews were audio recorded. Each interview commenced with an open, pre-planned question that enabled the older person to talk at length about their experience. This was primarily narrative or descriptive. in keeping with the aim of IPA (Smith et al. 2009). Each interview lasted approximately 60 minutes which enabled the older person's narrative of their 'lived experience' to be heard and captured. Four participants were interviewed with their spouses present and one had their daughter. All other participants were interviewed alone. Within the design it was foreseeable that if the carer/relative volunteered information which captured further the older person experience, the data would be collected too. However, if this conflicted with the older person's perspective it would be omitted. In the event, the carer/relatives did not contribute much in the interviews and thus none of their data was used. Grove et al (2012) recommend that interviews are held in a quiet, private room and that the participant should be given the choice of venue (Clarke 2006). Nine participants chose to be interviewed in their own homes and one participant was interviewed in a room at the researchers place of work. All participants were interviewed within the four-week threshold of memory recall, as per inclusion criteria.

Data analysis - Older People

Data analysis for the older people interviews were subject to IPA. The essence of IPA lies in its analytical focus towards the participants' attempts to make sense of their experiences (Smith et al.2009 p.79).There is no definitive or prescribed single 'method' for data analysis in IPA and it has been characterised by a healthy flexibility in the development of analytical approaches (Smith et al.2009 p.79). However, there are a common set of processes that are applied to IPA; these are moving from the particular to the shared, and from the descriptive to the interpretative (Smith, Flowers and Larkin, 2009:79).

Smith et al (2009) provide a systematic approach for the IPA analytical process, which they advocate for the novice researcher. This framework was used as a road map for analysis but a degree of flexibility within the analytic process was also maintained. Patton (1990) also emphasised that qualitative analysis guidelines should not be used as a set of rules, rather a degree of flexibility should be applied. IPA emphasises the importance of the positive process of engaging with the participant, however analysis is a joint product of the participant and the analyst who employs a double hermeneutic approach (Smith and Osborn 2008). This process involves two interpretations, the first being the participant's meaning-making whereby they interpret their own experience, followed by the researcher's sense-making by interpreting the participant's account (Smith and Osborn 2008, Smith et al. 2009). This enables a process of questioning, uncovering meaning and further questioning to enable the researcher to interpret and understand the phenomenon under investigation (Moran, 2000, Smith, 2007).

Each interview was transcribed verbatim before being subject to deep analysis using the systematic approach to IPA recommended by Smith et al (2009).

The following is a summary of the key analytical areas to guide the researcher (Smith et al.2009) (See Table 6).

Stage	Activity
Reading and re-reading	The first step involved actively engaging with the first participant's interview by becoming immersed in the data to ensure that the participant becomes the focus of the analysis. This was achieved by reading and re –reading the text to gain an understanding of the narrative.
Initial Noting	Analytical notes and comments were made which examined the semantic content and the language used, initially at an exploratory level. This involved a degree of interpretation to understand the things that mattered to the participant and to ascribe meaning to these things for them. Interpretative conceptual comments were commenced, whilst staying close to the participant's meaning.
Developing emerging themes	Developing the emerging themes involved narrowing down the analytical comments to focus on the most important data whilst remaining true to the participant's lived experiences. Input from my supervisors were sought at this stage and from the IPA network to allow for discussion for checking of emerging themes and to see if similar themes were uncovered.
Searching for connections across themes	Searching for connections across the emergent themes involved looking for similarities and differences. These themes were then mapped so that emerging subordinate themes were identified.
Moving to the next case	In keeping with the idiographic approach of IPA, understanding as much about one case before moving onto the next case was essential. Each case was then analysed in its own terms which is helped by bracketing of ideas or prejudgements from the previous case. A reflective diary was used to support the process of 'bracketing off'.
Looking for patterns across cases	The final stage involves looking for patterns across cases and involves digging deeper into the data which required a higher level of interpretation. It involved looking for differences as well as similarities, identifying connections and renaming themes so a deeper understanding of the data was developed (Cassidy 2011). A table was generated within which were superordinate and subordinate themes with corresponding participants quotes. This aspect of the process of IPA took time to reach the interpretative levels required and proved challenging. This will be discussed in the reflexivity section in Chapter 9.

Table 6: Stages of IPA Framework

The Gem

Smith (2011) introduced the concept of the ‘gem’ for its capacity to illuminate participants’ experiences to provide deep insights on what they mean to the individual and for the participants as a whole. The gem can be found in the single utterances or small participant passages that draw the researcher to the power of what has been said or is intriguing but requires further analytical enquiry. Therefore, through further interpretative endeavour the researcher is enabled to provide meanings, which supports understanding of the participant’s experience. Additionally, Smith (2011) and Shinebourne and Smith (2010), acknowledge the important role that metaphors have as a source of rich description and meaning. Thus, through data analysis, specific use of metaphors by the participants and examples of ‘gems’ will be sought to contextualise meaning making of older people’s experiences. Examples of these will be explored in chapter 5 (pages 124 and 134).

Trustworthiness

Trustworthiness is *“ensuring – and demonstrating to others – that data generation and analysis have not only been appropriate to the research questions, but also thorough, careful, honest and accurate”* (Mason, 2002, p.188). Mason (2002) discusses the need to demonstrate the trustworthiness of data generation and of the researcher’s interpretations. In IPA the researcher must convince the reader that the research method is appropriate in answering the research question(s) and providing explanations. It also needs to convince the reader that the data analysis process is rigorous, and the researcher’s interpretations are transparent.

Whilst there is no specific method to assess trustworthiness in IPA, Smith et al (2009) advocate the four principles proposed by Yardley (2000, 2008). Therefore, this method was used to demonstrate trustworthiness in the study

Sensitivity to context:

The aim of this principle is for the researcher to demonstrate close engagement with the idiographic approach. Therefore, the interview process in this study captured good data from the participants through close engagement with the participants narrative accounts of their experiences. A good IPA study will also have a considerable number of verbatim extracts from the participants to support the arguments being made (Smith et al.2009). Thus, numerous quotes were used, giving the participants' sufficient voice in the study, allowing the reader to check the interpretations being made.

Commitment and rigour:

Smith et al (2009) suggest that the researcher shows attentiveness to what the participant is saying by digging deeper, through skills of probing and picking up cues, and asserts that this can be challenging for the novice researcher. Yardley (2008) affirms the need for in-depth engagement with the topic and developing skills and competence in the method used. As a novice researcher new to IPA I developed my skills through the personal and professional development programme at the university in which I am undertaking my doctorate studies, which included sessions on methodology, interview techniques and data analysis. I also joined the East Anglian IPA Research Network. Yardley (2008) and Smith et al (2009) define rigour as the thoroughness applied in the data collection and breadth of analysis. I had in-depth discussions with my supervisory team to review the attentiveness I paid to the data, my interview technique, and data collection and analysis skills. Ongoing supervisory meetings also enabled review of my progress and allowed for discussion that promoted a 'deeper curiosity' with the data and encouraged reflexivity.

Transparency and coherence

Smith et al (2009, p.182) state that transparency refers to how clearly the stages of the research process are described in the write-up, and that there should be coherence between the research that has been carried out and the underlying theoretical assumptions of the approach being utilised. Using an audit trail, I enhanced the transparency of my analysis by maintaining a thorough collection of documentation regarding all aspects of the research (Shaw,2010).

This study used a mixed-methods qualitative approach of IPA for older people, and thematic analysis for HCPs; therefore, Smith et al (2009) affirm the need for these approaches to be clear in how they have been mixed. Through clear application of IPA (Smith et al. 2009) and thematic analysis frameworks (Braun and Clarke, 2008) I endeavoured to achieve this.

Impact and importance

The final principle according to Yardley (2000) is that the real test of the study's validity is whether or not it tells the reader something interesting and useful. Therefore, it is of importance that the researcher conveys the clinical relevance of the study from the initial proposal to the final write-up of the findings in the discussion section of the thesis. The findings have identified several pertinent areas of practice and policy from the perspective of the older person, and through this I have been able to shed light on these valuable insights.

I also used specific measures recommended by Guba & Lincoln (1994) to promote the trustworthiness of the study:

Triangulation:

The use of more than one perspective to inform the research process was used to both deepen the level of analysis and promote trustworthiness. This was achieved through the use of different data sources such as semi-structured interviews for older people, focus groups for HCPs and different research methods for analysis of data; IPA for older people and thematic analysis for the focus groups.

Researcher validation will also ensure that data analysis is verified from more than one person's perspective. For the purposes of this study, data analysis process was supported and reviewed by my supervisors and also at the IPA research network group.

Peer debriefing:

Peer debriefing is a method advocated to improve the credibility of qualitative research (Lincoln & Guba, 1985). Peer debriefing involves the exploration of the data analysis with a disinterested peer (someone who is not closely associated with the study), primarily a colleague who has experience of qualitative methodologies. In this case, a senior researcher who had supervised PhD students in IPA and thematic analysis supported me in developing my conceptual skills in data analysis, offering me the opportunity to develop a deeper understanding of the data and the research design.

I also submitted poster presentations at an institutional level at the Postgraduate Research Student Conference and gave oral presentations on the underpinning methodology, interim and final study findings at their annual conferences. I also gave oral presentations at a national level at the British Society of Gerontology annual conference, and locally at the research site at the OPM research meetings. This allowed for the opportunity of feedback from peers to enhance the quality of the findings.

Reflexive journal:

This took the form of a personal research diary written throughout the course of the study. The researcher's preconceptions may not be clear at first and only come to light through further engagement with the text and a willingness to reflect (Smith et al. 2009). This reflexive approach facilitated reflective insights and understanding, as well as the provision of a log of decisions made with rationales which supported and contributed to the audit trail. The use of a research diary has been described as a good practice in qualitative research to support the researchers' engagement with the research process and the decisions made (Braun & Clarke, 2013).

IPA uses a double hermeneutic approach which focuses on 'understanding the experience' from a fusion of both the participant and the researcher (Parahoo 2006, p.69). Therefore, according to (Smith et al.2009) reflexivity is an essential part of engaging with this process. Using the research diary enabled my preconceptions and their potential influence on the interpretation and analysis of the data to be highlighted and explored.

Fieldwork Notes

Rodham et al (2015) advocate the sharing of fieldwork notes after each interview to provide context to fellow analysts. Therefore, this approach was shared with my supervisors after each interview.

Audit trail:

IPA does not look to produce a definitive analysis, but the data presented should support the claims made by the researcher (Smith et al.2009). Therefore, it is strongly advocated that the researcher should provide an audit trail which can be independently scrutinised to trace the development of the analysis from transcript to the final presentation of themes. A clear audit trail was undertaken for the duration of the study.

Transferability

IPA emphasises the individual account of participants' experiences of a phenomenon (Pringle et al 2011). This study explored a specific group of people and captured the essence of that experience in the words of the individuals. These accounts should resonate with others who have had similar experiences and, in that context, bring new insight and understanding to this area of health care practice. Transferability was also enhanced by the detailed, honest and clear presentation of the research process and data.

Dissemination of the study findings and a transparent audit trail will enable other researchers who are interested in this field to increase their understandings of older people's experiences of urgent and emergency care. In IPA the focus is on the possible transferability of findings from group to group rather than on generalisations (Smith et al,2009). It is also widely known that IPA is subjected to different interpretations by different researchers (Tuffour,2017). Thus, whilst the interpretations presented in this study are considered credible and meaningful, they may not be the only interpretations of the data (Hearn et al.2017).

Ethical considerations

Qualitative research seeks to probe human existence in detail and therefore, there may be ethical issues because of the focus on an individual's private 'lifeworld' (Brinkmann and Kvale, 2005). Participant safety is therefore central to the researchers' agenda as the potential of harm to participants may depend on the nature of the research (Patton, 2002). Minimising harm or doing no harm are the fundamental ethical principles to which the researcher needs to adhere when conducting research which follows the Research Governance Framework for Health and Social care guidance (2005) and is in line with research ethics as laid out by (ESRC 2015) guidelines. Additionally, all research should comply with all legal, ethical and regulatory guidelines (DH, 2005, safeguarding vulnerable adults, 2006). Ethics approval was sought from the local Research Ethics Committee (REC) and the Research Governance Committee and was granted approval on assurance the study demonstrated appropriate measures to ensure participant safety, informed consent, data protection and anonymity of participants (ESRC 2015). The researcher also completed a series of personal and professional development (PPD) training sessions that explored and considered ethical issues around safeguarding and working with older people. The researcher also maintained their own safety as most interviews were in the older person’s homes, therefore the Code of Practice for the Safety of Social Researchers (SRA 1999) was used.

Minimising Distress

This study had a focus on older people who may be viewed as a vulnerable population but should not be excluded from participating in research and the potential benefits they can bring (Diener et al.2013). The researcher must consider in the study design that any research with older people may cause distress or harm. In the context of this study there was the potential of an emotional impact on older people due to the nature of having to attend urgent and emergency care due to the threat their acute illness may have posed to their lives. Thus, the older people participants were offered the opportunity for a close family member to be present at the interview, if they wished. They were informed that if the interview caused distress then it could be stopped or paused, at their discretion. Should they need support following the interview they were provided with the contact details of the researcher and of services that may be able to support them, or a service of their own choice. No participants conveyed distress to the researcher.

Consent

Informed consent was obtained from all patients participating in the face-to-face interviews. All research participants must participate in a voluntary way, free from any coercion (ESRC 2015). The informed consent documented that the participants had the opportunity to withdraw from the study at any time without prejudice to future treatment, and this was reiterated in the participant information. In discussion with the gatekeepers it was determined that the best time to approach the potential participants was at the point of discharge. All potential participants received from the gatekeepers a study pack comprising a participant invitation letter, participant information sheet, contact details of the researcher and consent form.

It is accepted that the potential for coercion exists where the participants' health carers are staff are assisting in the recruitment process and negotiating access on the researcher’s behalf. Robust consent processes and participant information resources confirm that participation is voluntary and that they are free to withdraw at any time without their legal rights being affected. The gatekeepers explained the aims and objectives of the study and the requirements in terms of commitment from the participant. The patient information sheet provided information on the aims and purpose of the study, the benefits and risks of the study and who to contact for further information. The four-week window from invitation to gaining consent allowed the participants to seek further information or clarifications about the study and if required, discuss it with their families or carers to make a fully informed decision about whether to participate or not. The consent form confirmed that the participant had understood the purpose of the study and what was being asked of them. Verbal and written consent was obtained face-to-face prior to the interview. Consent was signed by the participant and countersigned by the researcher to acknowledge that the purpose of the research had been understood and consented to. All participant resources can be found in (Appendix FGHI).

Confidentiality

Confidentiality was maintained throughout the study period. All the participants’ identities were pseudonymised from interview, identifiable by the researcher alone (DH, 2003) and stored in accordance with general data protection regulation (Data Protection Act, 1998 and 2003) and the universities data protection policy. The participant information sheet provided details about data storage and generation to allow each participant to make an informed decision about this aspect of participation.

Qualitative Second Stage

Focus Groups with Health Care Professionals

Focus groups are a popular choice for collecting data in qualitative research to allow multiple voices to be heard at one sitting, although they can make it difficult to develop the *phenomenological* aspects of IPA (Smith et al. 2009, p.71). Therefore, the focus groups were not subject to IPA. The main aim of the focus groups was to gain the HCPs' perspective of how older people experienced care and their experiences of caring for older people, to enable access to the phenomenon from more than one perspective. The focus groups explored these areas to gain HCPs' perspectives using a vignette to guide the discussion.

Focus groups as a qualitative method are particularly useful for exploring participants' knowledge and experiences and can be used to examine not only what they think, but how and why they think that way (Kitzinger 1995). As focus groups are used for generating information on collective views, they also enable the meanings behind those views to be explored, which support the aims and objectives of the thesis (Morgan,1998). Furthermore, focus groups can benefit from the interactions between participants that allow '*reciprocation, exploration and elaboration of ideas'* that do not occur if a one-to-one interview approach is used (Bender and Ewbank, 1994, p.63). According to Cleary et al (2014) these interactions have the potential to create a synergistic 'sparking-off' between group members which can enhance the exploration of the subject focus in depth. Moreover, group interaction through discussion allows a high level of face validity which permits confirmation, reinforcement or contradiction and thus generates a rich and complex data set (Kitzinger, 1995, Greenhalgh and Taylor,1997).

Caring for older people in the ED is an integral part of the work of all HCPs in this area of practice. It is claimed that the interactions and discussion between participants in focus groups helps them become more inclined to reflect and consider upon aspects of their daily lives that are usually taken for the granted (Morrison (1998) cited in Acocella ,2012). Hence, the focus group aimed to capture the HCPs' perspective on their everyday thoughts and feelings regarding the older person's care journey in the ED by enabling them time to share these views. Focus groups are not without their disadvantages, and Acocella (2012) argues that the presence of other individuals may both inhibit those who feel less inclined to discuss their views in a group, or influence others in how a judgement or answer is given, which can push participants to express more socially desirable and stereotypical answers. Consequently, the phenomenon cannot be explored in depth or freely.

Vignette

The use of vignettes in qualitative research have grown in recent years (O'Dell et al, 2012, Spalding and Philips, 2007). O'Dell et al (2012, p.703) draw on the researchers' phenomenological position in the use of vignettes as a methodological approach, in which they state there are 'multiple ways of representing reality'. This view would support the underpinning methodology of this study to draw on different perspectives/methods to explore the same phenomenon.

Vignettes in qualitative research are used as elicitation tools to facilitate an exploration of participants' responses to hypothetical situations (Wilks 2004). However, the vignette was developed (See appendix J) from the collective narratives of all ten participants, which was crafted into one older person's ED journey and was used to obtain specific content information in order to explore the thoughts, perspectives and experiences of HCPs' who work in urgent and emergency care. Furthermore, the vignette was created to represent the themes and findings of the interviews with older people, thus, there was an explicit focus on these areas in the group discussion with HCPs. Hughes and Huby (2002,2004) support this approach in the development of a vignette to ensure they are realistic and believable. The aim was to create as near to 'real life cases' of older peoples' experiences to enable HCPs to identify with the older person's story and evoke feelings and aspects of themselves in the characters of the vignette (Young 2011). Hughes and Huby (2002,2004) also advocate the use of vignettes to explore participants' perceptions and reactions. Crucially, the vignette was also chosen as a qualitative tool to illicit HCPs' perspectives on the phenomenon, as it enabled participants to freely express themselves without the risk of feeling personally exposed to the interviewer or other participants

(Brondani et al.2008). Nonetheless, vignettes are not without their challenges; O'Dell et al (2012) highlight when researchers struggle to interpret the responses as participants shift between discussing vignettes as themselves and then move to what 'ought' to happen. However, they suggest the best approach to interpretation is to explore the dominant shared responses. Utilising the vignette approach in this study enabled rich data to be produced to further our understanding of older people's experiences in the ED from HCPs through a shared perspective.

Sampling

Purposive and opportunistic sampling was used to select HCPs from the proposed research site with a broad range of experience in caring for older people (Braun and Clarke, 2013). Purposive sampling was used to align with qualitative studies that seek thick description (Creswell,2007). Therefore, the sample had to have a broad representation of age, sex, position and ED and urgent care experience. The aim of the focus group was to obtain several perspectives about HCPs' views and experiences of caring for older people who accessed urgent and emergency care, plus their thoughts on how older people view their care experiences. The sample aimed to include a multidisciplinary skill mix to include doctors, nurses, occupational therapists, physiotherapists, social workers, health care assistants, and discharge co-ordinators, as they all have first-hand accounts of caring for older people in urgent and emergency care environments. Staff with a range of years in post, from newly qualified to several years in post were sought to provide variations in experience and viewpoints from a number of different professional perspectives. This variety in the sample was proposed as the aim was to recruit HCPs with different experiences of caring for and understanding the experience of older people, and to explore to what extent their personal qualities and professional training affected the patient experience (Benner, 2001).

Inclusion Criteria

All ED and urgent care health professionals were eligible to participate, providing they had direct contact and responsibilities of care for older people. (See Table 7). Due to the busyness of these environments of care, they also had to commit to a focus group that could last up to 60 minutes and have a good command of the English language to enable full participation in group discussions. HCPs that were not employed permanently by the Trust, for example agency or bank staff, were excluded as it was felt they would not have the same responsibility of meeting organisational demands and organisational contexts of care as permanent staff. Therefore, a true representation of HCPs' experiences may not be captured.

HCPs must be employed permanently by the trust	**HCPs that are not employed permanently by the trust for example agency or bank staff.**
HCPs must have direct contact and responsibilities of care for older people in the ED and urgent care environments	HCPs who work in the ED and urgent care environment but do not have direct contact with older people
Good command of the English language to fully participate in group discussions	Poor command of the English language
Be able to commit to a 60- minute focus group	
Over 18	

Table 7: Inclusion and exclusion criteria HCPs

Ethical Approval

The overall study gained approval from the Cambridgeshire East Research Ethics Committee on the 21st Sept 2015 15/EE/0268 and from the Research Governance Committee covering the research site on the 1st March 2016 178620(162-10-15). However, part of the ethics committee approval was the requirement to review the background questions that would be sent to the HCPs prior to the focus group, via a notice of substantial amendment. These background questions could not be produced until all the older people interviews had been completed (August 2017). The transcriptions of the interviews with older people had to be completed, followed by the analysis and identification of themes. Only then could the vignette be developed, upon which the background questions were based. This significantly delayed the second phase of the study. The background questions with a copy of the vignette were submitted to the Cambridgeshire East Research Ethics Committee for substantial amendment and approved on the 11th Dec 2017 15/EE/0268/AM02. The amendment then required approval from the research site following HRA assessment, which was confirmed shortly after (through IRAS).

Recruitment

Once ethical approval for the substantial amendment was obtained, recruitment for participants for the focus groups began in late December 2017, with the two focus groups being conducted on the 26.01.18 and 02.02.18. A flow diagram is used to explain the HCP recruitment processes (See Fig 4).

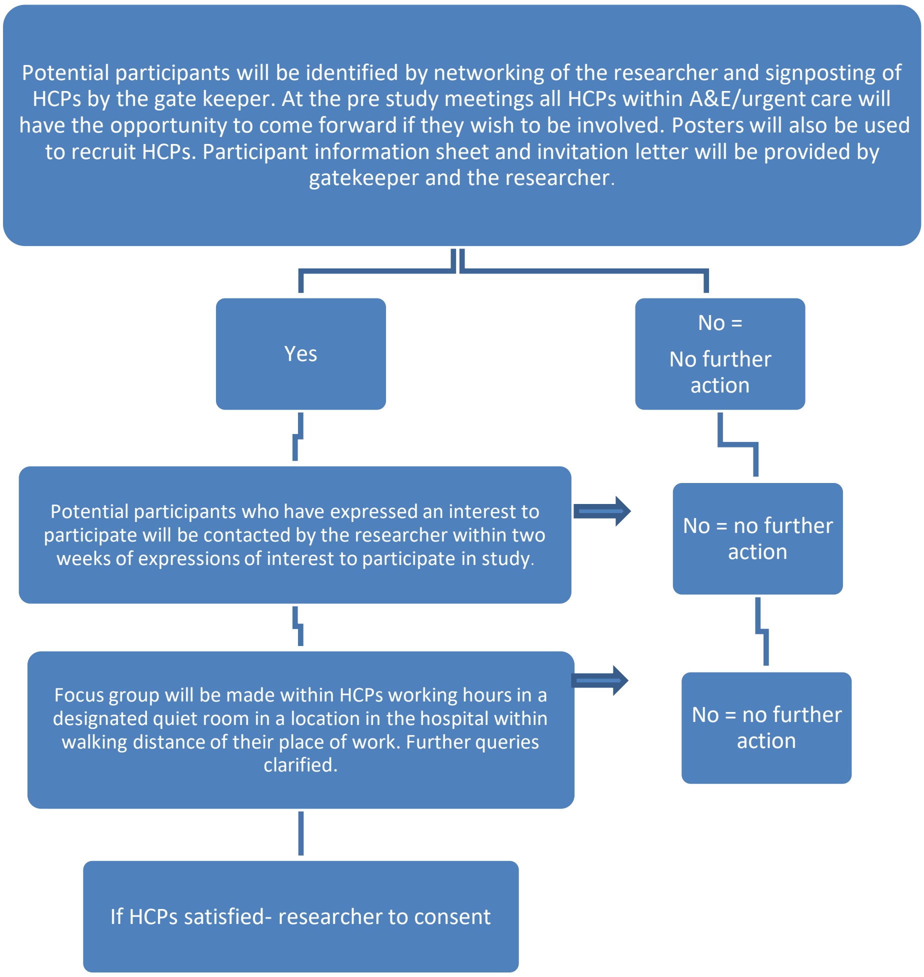


Fig 4: Recruitment Flow of Service Providers: HCPs

Recruitment: HCPs

Purposive and opportunistic sampling were used as appropriate approaches to recruit HCPs for focus groups (Braun and Clarke, 2013). The recruitment processes identified for HCPs were discussed with the gatekeepers who agreed to support and carry out these.

Recruitment approaches

An A4 poster (see appendix K) was created to invite HCPs to volunteer to the study and placed in key areas within the emergency and urgent care services, such as nurse stations, staff rooms and noticeboards, with a contact number for the researcher given so potential participants could seek further information or clarification regarding the study.

The main gatekeeper (Director of Older People's Medicine) signposted the researcher to senior members of staff and HCPs within the urgent and emergency care services who assisted in the researchers' dissemination of the study in order to recruit the HCPs for the focus groups. This facilitated access to potential HCP participants with opportunities to inform them about the study, through departmental and research meetings.

From these recruitment approaches, when HCPs expressed potential interest, the researcher or the gatekeepers provided them with information on the aims and objectives of the study; those who then expressed an interest were given a study information package containing participant information sheets (PIS), invitation letters and consent forms for them to take, read and further consider whether they wished to participate in the study. All participant resources can be found in Appendix LMNOP. A range of 30 HCPs from different disciplines working in urgent and emergency care environments expressed their interest and availability to participate in the focus group discussions.

Recruitment challenges

The main challenge was release of the HCPs on the day of the focus groups due to the busyness of their practice environment and work commitments. This is a recognised challenge when recruiting HCPs who work in busy clinical environments, which can result in a lack of their time or ability to participate in research (Flynn et al.2018, Hysong et al. 2013). Due to the short timeframe, and limited opportunities to attend the meetings to access busy HCPs, recruitment was very time-consuming. (Hysong et al.2013). This required a degree of flexibility, perseverance, good communication skills and development of good working relationships with staff to achieve the desirable recruitment target (Newington & Metcalfe, 2014). Of the 30 HCPs who volunteered originally to take part in the focus groups, on the day eight HCPs attended focus group 1, and seven attending focus group 2. Whilst the dates were set and provided in advance, the scheduling of the focus groups cannot flex to accommodate unpredictable changes in ED environments such as emergency situations, workload and staffing levels (Flynn et al.2018). However, the numbers recruited allowed for the potential of dropouts on the day to ensure that the minimum to maximum levels of 7-10 participants were reached. Initially there was disappointment in both the lower numbers and non-availability of OPM and ED consultants and social workers, as there was a concern that the range of HCPs to achieve maximum variation and experiences may not be achieved. Of concern was the potential that low participation rates could impact negatively on the research results (Erwing et al.2004) Nevertheless, it was understandable due to the nature of their work. Engagement with this disappointment is explored in Chapter 9 on the section on reflexivity. Despite these concerns, the focus groups achieved the variation of characteristics and shared experiences required. Crucial to the participation of the staff in the focus groups was the importance of the researcher to develop rapport and trust with the HCPs at the research site.

Data collection

Participants were invited to participate in one of two focus groups with dates made available to them in advance. To capture the range of HCPs' experiences and views, two focus groups were proposed, with the aim of having a minimum of eight to a maximum of ten participants in each group, an optimum size for group discussion without being too large. It enables enough variation of characteristics, but enough shared experience to allow shared dialogue (Kitzinger, 1995). It is argued that fewer than two focus groups raise the question of true representation and whether adequate data collection and the emergence of themes across and between groups can be achieved (Halcomb et al.2007). In liaison with the gatekeepers and managers within the practice setting, it was decided to arrange the focus groups within staff working hours to maximise the number of participants able to contribute to the study, which was felt to be an important area of healthcare research. HCPs were to inform their managers in advance if they were participating, to ensure staff cover. Due to the busyness of the practice environments each focus group was expected to last up to 60 minutes, which would be an appropriate timeframe to develop in-depth discussion and shared experiences. A room was booked within easy access of the participants' practice environment and details sent to participants in advance of the focus group. The focus groups were facilitated by the researcher who has skills in facilitation. The facilitator must have good interpersonal skills to engender participants' trust and to increase the likelihood of open and interactive dialogue (Gibbs 1997). To generate sufficient relevant information there needs to be good group interactivity, in which the facilitator can play a role. (Cleary et al. 2014). The focus groups were guided by a set of background questions and discussion guide (See appendix OP) that focused on the detail of the vignette. This directed the HCPs perceptions, experiences, thoughts and feelings at the older person's care journey to evoke responses and stimulate discussion. Prior to attendance the participants were sent the vignette and background questions, to enable sufficient time for them to engage with the patient's journey and an understanding of the questions that may be explored. This allowed some preparation to consolidate their thoughts and avoided 'surprises' on the day. The facilitator ensured each participant had time to contribute and respond to validate each participant's contribution to the group. A scribe was present (this was the researcher's supervisor who had experience of focus groups) to take notes and record key areas of discussion and observe interactions to support accurate data collection. The group were audio-recorded, and the presence of the scribe was explained through the participant information sheet, and consent obtained. Participants completed brief, anonymous demographic information at the time of the focus groups and are described in Table 8 and Table 9.

Sex Male/female	Place of Work	Role	Years Qualified	Years of working in urgent + emergency care
Female	AMU	Clinical Lead Physiotherapist for AMU	13 years	10 years
Male	ED	ACP*	15 years	15 Years
Female	AMU	SN*	1 year	1 year
Female	AMU	Discharge Co-ordinator	N/A	9 months
Female	ED/AMU/OPM	ACP OPM	8 years	8 years
Female	AMU	Dr OPM	7 years	5 years
Female	AMU	HCA*	N/A	5 years
Female	AMU/OPM	Senior OT*	14 years	9 years

ACP- Advanced Care Practitioner, HCA -Health Care Assistant, OT-Occupational Therapist, SN -Staff Nurse

Table 8: Demographics of participants of FGD

Sex Male/female	Place of Work	Role	Years Qualified	Years of working in urgent + emergency care
Male	AMU	HCA*	N/A	17 Years
Female	ED	ACP *	13 Years	12 Years
Male	AMU/ OPM	Senior Pharmacist	35 Years	10 Years
Female	A&E/ OPED	Physio	10 Years	2 Years
Female	AMU/OPM	OT*	10 years	2 Years + 3 Months
Female	ED	TACP*	9 Years	5 Years
Female	ED	Staff Nurse	1 Year	5 Months

***HCA- Health Care Assistant *ACP- Advanced Care Practitioner**
***OT -Occupational Therapist *TACP- Trainee Advanced Care Practitioner**

Table 9: Demographics of participants FGD 2

Data analysis

Transcripts of the audio recordings of both focus groups were subject to thematic analysis (Braun and Clarke, 2006) using an inductive approach. Thematic analysis (TA) is a method for identifying, analysing, and reporting patterns/themes within data (Braun and Clarke 2006). Thematic analysis is commonly used method to analyse focus group data (Creswell,2007). The audio recordings and the data from the focus groups were transcribed verbatim, analysed and coded in relation to emergent themes using a qualitative thematic analysis approach (Silverman 2011, p.208). This informed how the themes (converge/diverge) relate to the phenomenon under investigation (Braun and Clarke 2006). An inductive approach means the themes identified are strongly linked to the data themselves and through interpretation there is an attempt to theorise the significance of the patterns and their broader meanings and implications (Patton 1990). Recurrent themes were compared across participants and groups and attention was paid to any views that may indicate an alternative view. The group rather than the individual responses is most critical in focus group thematic analysis (Bender and Ewbank 1994) and as such the number of groups that discussed a theme or subtheme was given greater consideration than the individual responses.

Identifying Themes

Braun and Clarke (2006) thematic analysis offers a step-by-step approach as it offers a more accessible form of analysis, particularly for those early in a qualitative research career, however a degree of flexibility was applied, as advocated by Patton (1990). The key to identifying a theme is whether it captures something important in relation to the overall research question (Braun and Clarke 2006).

The Process of Thematic Analysis (TA)

The first step in the process starts with the researcher familiarising themselves with the data, looking for patterns of meaning in the data. Analysis involved a constant moving back and forward between the data set. This stage involved note-taking or marking ideas for coding, before the formal process of coding begins. Next codes were applied to the data that could be assessed as meaningful to the phenomenon; in this case HCPs' perspectives on caring for older people in urgent and emergency care. This was followed by analysing the codes, and consideration of how different codes might combine to form an overarching theme. At this point themes were reviewed to consider the development of relationships between themes to establish any overarching themes. Finally, clear definitions and names were generated for each theme, with the final analysis revealing selected extracts that were true to the participants' data which was then related back to the research question and literature.

Braun and Clarke (2006) assert that TA is not wedded to any pre-existing theoretical framework and therefore it can be used within different theoretical frameworks. However, they affirm the importance is to make the theoretical position of a thematic analysis clear and transparent. In this respect, the positioning of TA within the study underpins the 'contextualist' method, in that the analysis will acknowledge how HCPs make meanings of their experience of caring for older people in an urgent and emergency care environment and in turn, how the broader organisational and social aspects of care impact or impinge on those experiences. It is important to consider that the meaning-making of the HCPs will be in the context of a group discussion and in that respect, McLafferty (2004) argues that it is crucial to maintain a sense of the whole group, as it is data from the whole group that form the unit of analysis and not the individual contributions of group members.

The coherence and the replicability of the themes found by the researcher were reviewed by the supervisors to assess the reliability of the findings.

Confidentiality

The participant information provided information on the steps taken to assure confidentiality, and it was made clear that all the information shared would be kept confidential. The group were informed that their contributions to the discussions would be anonymised and they would not be identified in the findings.

Consent

A study pack containing the participant information leaflet and invitation letter was provided to all participants who freely volunteered to participate in the focus groups. Also included was the consent form, which the participants were asked to read and sign and bring to the focus group. All participants had the researcher's contact details should they wish to discuss any aspect of the study or seek clarifications This approach was used to reduce the time spent on consent due to the limited time available for the discussion. The consent forms were collected by the facilitator before commencing the focus group discussion. At the beginning of each focus group the facilitator again asked attendees if they agreed to participation in the focus group and should they wish, they could opt out at any time. All participants were informed the discussion would be audio recorded and were also verbally asked for their consent to this. There were no objections.

Ethical considerations

It is noted that focus groups can explore some topics which may be emotive and personally sensitive, so steps are taken to maintain participant safety and promote confidence in the focus group process, justifying the use of this approach to explore issues of clinical and professional importance (Cleary et al.2014).

It is accepted that there is some potential for coercion to occur when using gatekeepers who are known to the participants, however robust consent processes can mitigate this to ensure that the participation is voluntary. The participant information sheets reassure HCPs that their participation is voluntary, and that they are free to withdraw at any time without giving any reason and without this affecting their employee status.

There is also the potential during the discussion that participants may become sensitive or that there may be disagreements about some of the points explored, however the facilitator made it clear at the beginning of the group that there were ground rules and that there was no obligation to participate in the discussion or feel pressurised to speak. Importantly, they were informed that they need not share personal beliefs or stories or share any knowledge they were not comfortable with sharing.

Summary

In summary, the two-stage design of the study consisted of semi-structured interviews with older people about their experiences of care following urgent and emergency care. Subsequently the views of HCPs were sought using a vignette to guide the focus groups to illicit their perspectives of how older people viewed their care, and their experiences of caring for older people. The use of semi-structured interviews and focus groups with a vignette have strengthened data collection and have made a methodological contribution to developing understanding of older people’s experiences of urgent and emergency care. The aim was to provide a transparent audit trail illustrating the methods used, the decision-making and planning of the research design, to demonstrate its coherence with the underlying philosophical stance. Awareness of the underlying ethical issues and strategies to support trustworthiness enabled a sound base to appreciate how the study proceeded.

Chapter 5: Findings Older People

Introduction

This chapter presents the findings from the interpretative phenomenological analysis of the interviews with ten older people about their experiences accessing urgent and emergency care services. These are based on the participants' narratives and provide an interpretative account of older people's experience of urgent and emergency care. Interpretation of participants' accounts is an essential part of IPA research (Larkin &Thompson 2012). Although it is acknowledged the analysis is subjective, the arrival at the findings is systematic and rigorous (Smith et al.2009, p.80). It is also recognised that due to the interpretative nature of IPA, individual researchers may find different interpretations and experiences of the same phenomena (Smith et al. 2009). Therefore, it is accepted in IPA that multiple interpretations broaden and deepen the understanding of the participant's lifeworld in a particular context (Larkin & Thompson 2012). Through the interpretations and understandings of the participants' experiences and the meanings they ascribe to them, the study has enabled the participants' voices to be heard, so allowing a deeper, nuanced understanding of those experiences.

This study has revealed a deeper level of knowledge about the meaning that participants have given to their experience of urgent and emergency care. Five superordinate themes were identified: '***conflict with legitimacy', 'a need for safety', 'attentiveness to need', 'crisis of identity' and 'disempowering self'***. Each superordinate theme had between three to four subordinate themes (see Figure 5). The prevalence of each participant across superordinate themes is presented in Table 10.

Through these themes, the essence of the participants' lived experience and meaning making of experiencing care in an urgent and emergency care environment is captured. To do justice to each of the participant contributions, verbatim extracts of the interviews have been chosen, representing the most powerful illustrations of the individual's experience (Smith et al. 2009). Diagrammatic representation of the subthemes is provided in the introduction to each theme. Tables are also provided at the beginning of each theme to indicate the prevalence of the superordinate themes with the subordinate themes across the participants (Smith et al.2009).

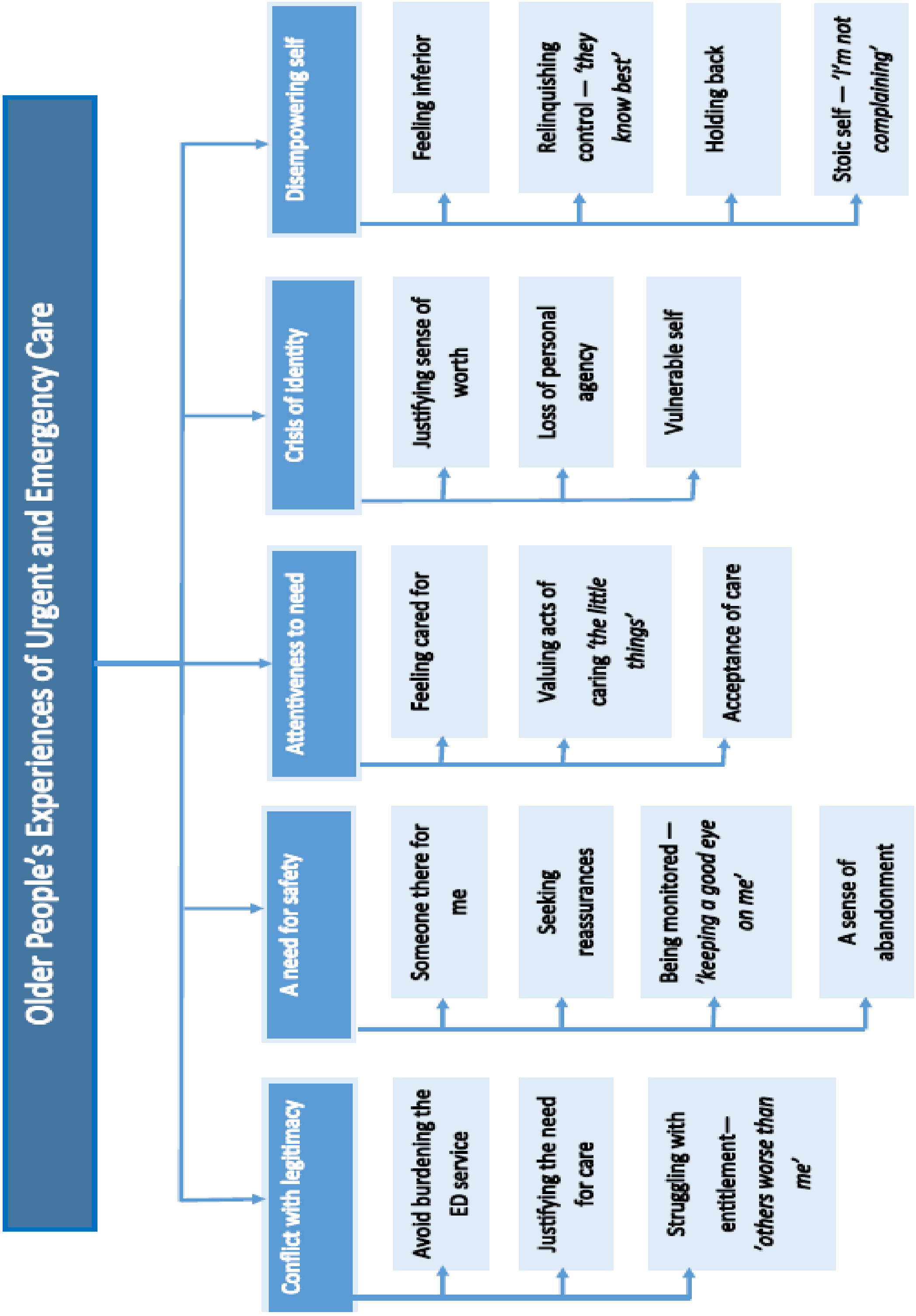


Figure 5: Superordinate with Subordinate Themes of Older People's Experience of Urgent and Emergency Care

Superordinate Themes										
	James	Molly	John	Mark	Agnes	Stephen	Ruth	Florence	Charles	Ann
Conflict with Legitimacy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
A Need for Safety	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Attentiveness to Need	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Crisis of Identity	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Disempowering Self	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes

Table 10: Prevalence of each participant across superordinate themes

The Interconnectivity between the Five Superordinate Themes.

It became apparent through the analysis of the participants' narratives that all five superordinate themes are firmly inter-related as there is much movement and flow between them (see Fig:6). Therefore, whilst each individual superordinate theme is distinct, the whole experience must be understood through their relationship with each other. Through interpretation of these relationships, we can begin to understand the experience of older people when accessing urgent and emergency care. For example, the superordinate theme 'need for safety' inter-relates with 'attentiveness to need', since both frame how older people relied on staff to feel safe and cared for. Furthermore, 'conflict with legitimacy' relates to 'disempowering self' and crisis of identity, in that older people felt the need not only to justify their need to attend urgent and emergency care, but their sense of worth to be treated. This means that all superordinate and subordinate themes are central to the understanding of how older people experience urgent and emergency care.

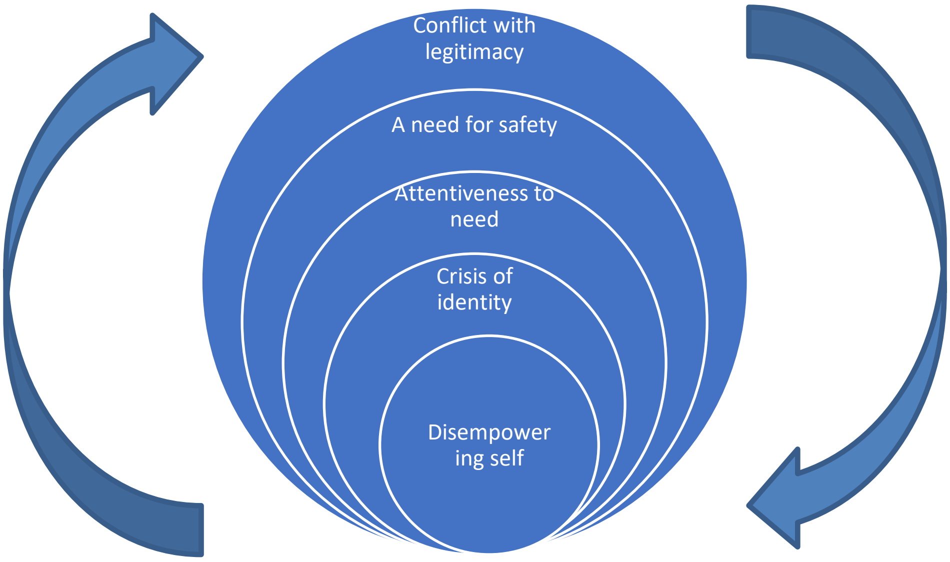


Figure 6 The interconnectivity between the Five Superordinate Themes

Conflict with Legitimacy:

This superordinate theme is made up of three subordinate themes; ‘***avoid burdening the ED service’***, ‘**justifying *the need for care’*** and ***‘struggling with entitlement’***. (See Fig 7) The prevalence of each participant across the subordinate themes is presented in Table 11.

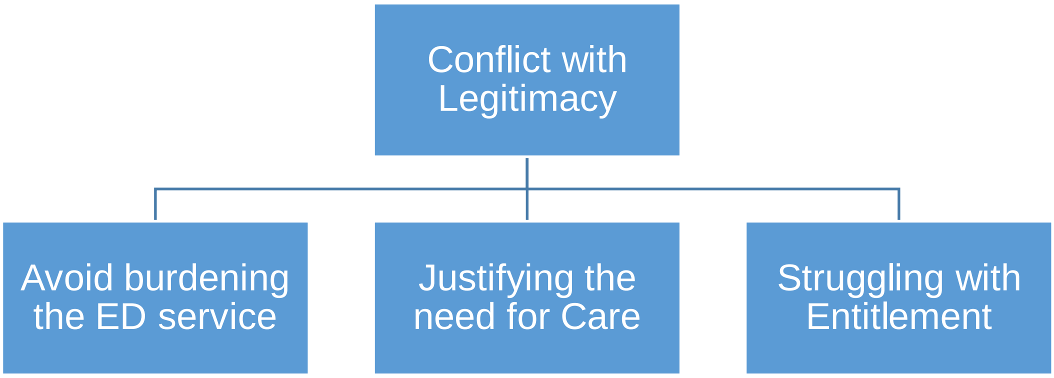
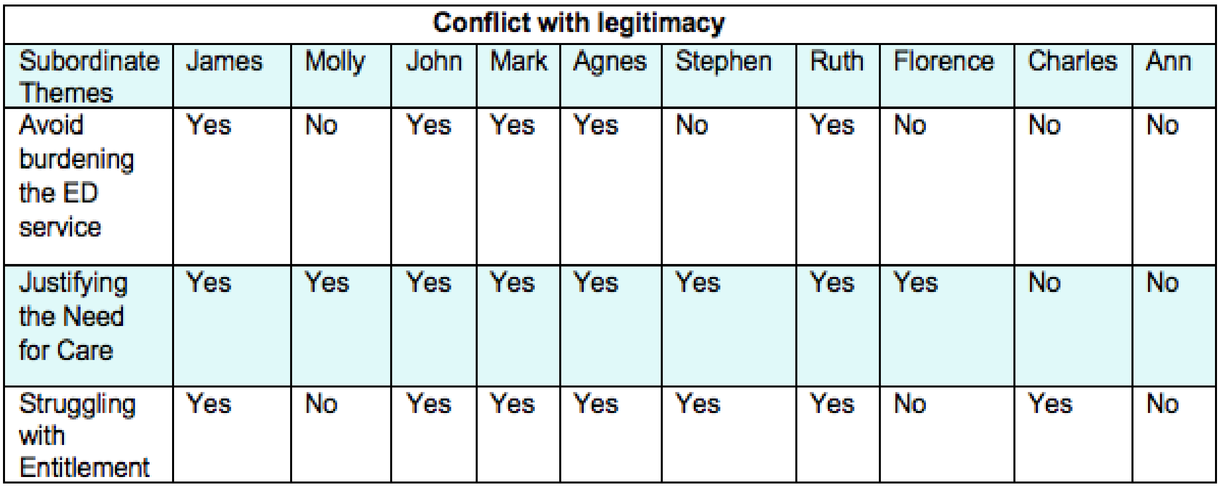


Fig: 7 Overview of Superordinate Theme with Subordinate themes



Conflict with legitimacy										
Subordinate Themes	James	Molly	John	Mark	Agnes	Stephen	Ruth	Florence	Charles	Ann
Avoid burdening the ED service	Yes	No	Yes	Yes	Yes	No	Yes	No	No	No
Justifying the Need for Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Struggling with Entitlement	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	No

Table 11: Prevalence of each participant across subordinate theme- Conflict with Legitimacy

This superordinate theme captures the participants’ experiences of their attempts to legitimise their need for care. Importantly, they wanted to be recognised as valid users of urgent and emergency care services. Consequently, many of the participants experienced personal conflict in justifying their own urgent and emergency care need and their entitlement to access these services. This resulted in participants questioning whether their medical need warranted contacting the emergency services and in doing so, downplaying the seriousness of their own illnesses. In addition, they felt that they were a burden on the ED services, comparing themselves to other patients in the ED department whom they felt were more deserving of care than themselves.

Avoid burdening the ED service

This subordinate theme highlights the extent to which participants considered their need to attend the ED, to avoid burdening the urgent and emergency care services. There was an understanding that these services should only be accessed in a genuine emergency. Furthermore, fear of wasting health care professionals' time resulted in many participants being reluctant to call out the emergency services or attend the ED.

This fear of being a burden revealed the participants' awareness of the social and public discourse presented in the media of an overstretched NHS, which they felt blamed older people for the extra pressure put upon it. Some participants even referred to longevity itself as a burden on society and the NHS and felt they were stigmatised for living longer.

> **"I suppose a lot of it is medicine has improved enormously, we're now living longer, puts more pressure than ever on" (Stephen).**
>
> **"You know that, it's been quite a major publicity on what's happening in hospitals and doctors and so forth, and, and when you see the waiting times for people to come into hospital, you, you know there's masses of problems going on" (James).**

Consequently, fear of wasting healthcare professionals' time was a factor in the participants' decision-making whether to seek urgent and emergency care or not.

> **"You know, 'cause if you're wasting their time, that's, that's no joke, I mean their time is so precious" (Agnes).**

Knowing what constituted an urgent or emergency medical need left many participants self- assessing whether their condition warranted contacting the emergency services.

For Ruth, seeking permission to call the emergency services validated that she had genuine needs to access emergency care.

> **"As much as I don't like calling the ambulance out, 'cause of how busy they are, but that's reassuring isn't it - I said would I be in my rights to call the ambulance out if I get these pains, and she said yes" (Ruth).**

Similarly, other participants often delayed seeking help, relying on others to make the decision for them, including family members. For Agnes, despite having angina for several years, she had difficulty in assessing whether the emergency of her symptoms necessitated a decision to call the ambulance. Thus, she relied on her daughter to evaluate the emergency of her symptoms.

> **"You're getting…you look funny now", she say, "your pain" she say, "you're still getting the pain" (Agnes)**

However, some participants felt unconvinced of the necessity to go to the ED and assumed the GP or paramedics were 'playing it safe', rather than there being a legitimate need.

> **"Well, I mean, I just accepted that my GP, and it wasn't one of the GPs I know. She was very conscientious and the fact that she spotted immediately that I was having problems breathing, meant that she was playing on the safe side and she wanted to get me checked out" (Mark).**

Despite the reassurances from the GP, Mark still felt he was undeserving and minimised the extent of his problem.

> **"I felt a bit of a fool in me requiring an ambulance when (my wife) could have taken me up to the hospital" (Mark).**

Furthermore, fear and stigma of being labelled negatively by health professionals heightened participants' feelings of being a burden on the emergency services and the ED. Consequently, some participants challenged the decision of the paramedic or GP as to whether it was the right course of action to attend the ED, some even questioning the need and seriousness of their medical complaint.

"But should the medics, when the ambulance comes, should they have put me in? Was it, was it bad enough to take me in to hospital? (John)

Identified within this theme is a strong awareness of the pressures on the NHS, in particular the urgent and emergency care services, resulting in participants' conscious recognition that these services must only be accessed in a genuine emergency. Thus, participants struggled with appraising their own emergency needs, often delaying seeking help to avoid burdening the emergency services.

Justifying the need for care

This theme illustrates participants' anxiety about their entitlement and worthiness to be in the ED. Given the meanings attached to the previous theme (see-avoid burdening the ED service) by participants, not wanting to burden the ED service, they went to great lengths to justify their symptoms and medical need to staff to demonstrate their appropriateness. This highlights the struggles older people have in their urgent and emergency care journey in justifying their attendance at the ED. Prior to arrival they are questioning their need and once in the ED they continue to justify their attendance. Therefore, this conflict with their own legitimacy is continuous, so much so, that some even identify themselves as a fraud or an imposter.

Once in the ED, positive reassurances from staff affirmed to participants that they had taken the right decision to attend the ED, confirming to them that they were legitimate users of emergency care with a genuine need.

> **"That make you feel better you've done the right thing by coming to hospital and sorting it out. You know you're not wasting their time. I just felt as though that was alright for me to be there. I done the right thing by coming in" (Agnes).**

Having symptoms which supported the seriousness of their condition enabled participants to justify attending the ED, and physiological measurements provided further evidence and reassured participants that they were appropriate users of emergency services.

> **“But when they came out this time, cause my blood pressure was really high, pulse rate was low that was why they took me in” (Ruth).**

> **“I felt quite fine again, but they still insisted on taking my tests. I was feeling fine again by then and apart from the time in the, in the A&E when they asked me to stand up and take my blood pressure, I did feel, well I nearly went out again didn’t I” (Stephen).**

Feelings of being a fraud or imposter reinforced participants’ feelings of unworthiness to be in the ED and created uncertainty and anxiety around being in the ED.

“I mean I felt a bit of a fool in any case, you see I really did feel that it was a bit of an over-reaction on the GP’s part because I felt alright, apart from being a bit breathless” (Mark).

For John, his feelings of being a fraud were heightened when staff were unable to ascertain the underlying problem for his cardiac symptoms. Therefore, he became disillusioned with his care whilst continuing to assure staff of his genuine symptoms. Consequently, seeking validation by the staff that his attendance was justified and that there was something wrong with him became his focus.

> **“We can’t find nothing wrong with you. I had chest pains they thought that was cardiac, but it wasn’t” (John).**

In summary, this subordinate theme highlights participants’ efforts to make sense of their own need to be in the ED, looking to staff to validate them as appropriate users of emergency care.

Struggling with Entitlement

This theme describes how the participants compared themselves to other patients in the ED. Often they showed deep sensitivity to others’ needs, regardless of their own concerns. Despite having genuine medical problems, themselves, they often felt other patients were more deserving of care than they were. This resulted in the participants struggling with their entitlement and need to be treated and cared for.

> **"You didn't know what other people, what was wrong with them, why they were there, or are they worse than me. Other people worse than me" (James).**

> **"You know, when you see all these cases what were in there and a lot worse than I am" (Agnes).**

Assumptions around entitlement to be in the ED led participants to appreciate that priority of care and treatment was afforded to those patients whose needs they perceived to be worse than their own.

> **"Some of 'em are a damn sight worse than you and they're looking after them, you know, it's, 'cause there's people in there worse than me" (John).**

Despite John's concern for others, he struggles to make sense of which patients are a priority and so goes through a process of measuring his own care needs against others. For John this process involves identifying levels of entitlement, dependent on urgency of need, which he feels detracts from the assessment of his complaint.

> **"'Cause, see you might be halfway through being assessed and somebody else comes in a bit more urgent than you, and they overtake you" (John)**

Feelings of guilt and unworthiness to be in the ED led some participants to feel their claim to space should be less than those with more severe illness. Accordingly, compassion and understanding were shown to other patients demonstrating the participants' sensitivity to their needs.

> **"Well I was sitting there reading a book and there were other people around who were ill (laughs) and I thought 'hmm'. I was very**

> **conscious of the fact that I was taking up space in the hospital, which could be used by somebody else" (Mark.)**

Furthermore, high levels of generosity and compromise were shown by participants' willingness to accept waiting times, delays in receiving test results or giving up their bed for others because they felt other patients' needs were a priority over theirs.

> **"I was quite happy about it, because I knew perhaps, their issues were worse than mine, so I was quite happy to move to another, another ward" (Ruth).**

Despite Ruth compromising for other patients who she felt were deserving of her bed, she also saw certain patients as not deserving or entitled to care, due to their illness being a result of their own creation.

> **"I think it's disgusting how the people come in, the people that don't really need to be there in the re-sus room, and someone, a man came in, obviously I couldn't see him, but the language was coming out and then the noise, shouting and yelling. "People self-inflicted, drinking and all that kind of thing" (Ruth).**

As seen, this subordinate theme demonstrates the degree to which older people are concerned for others and not themselves. It is evident that older people play down their symptoms and struggle with their entitlement to receive care, often perceiving others being in more need. Therefore, participants experience real tension in establishing their own legitimacy to be in the ED.

In summary, this theme reflects the participants great significance attached to being recognised by staff as genuine users of urgent and emergency care services. Furthermore, factors such as the current social and public discourse of blaming older people for the chaos in our hospitals means participants feel a need to demonstrate their appropriateness, entitlement and legitimacy to be in the ED and urgent care services.

A Need for Safety

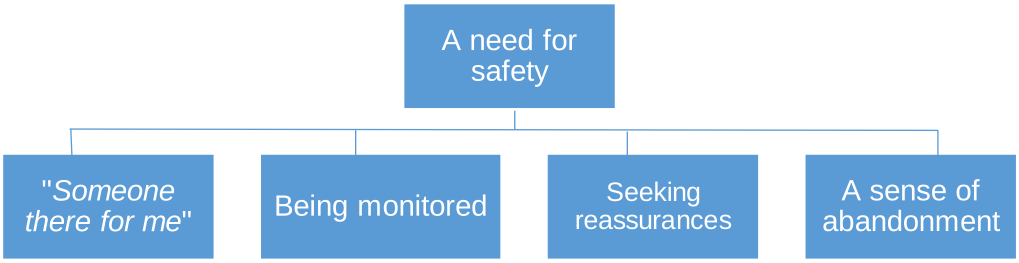
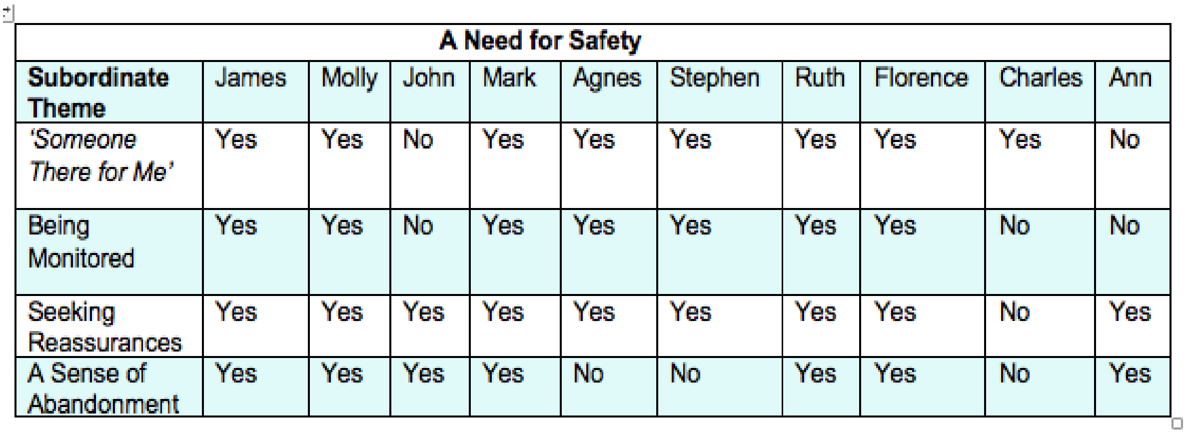


Figure 8: Overview of Superordinate Theme A Need for Safety with Subordinate themes



A Need for Safety										
Subordinate Theme	James	Molly	John	Mark	Agnes	Stephen	Ruth	Florence	Charles	Ann
'Someone There for Me'	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Being Monitored	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No
Seeking Reassurances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
A Sense of Abandonment	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes

Table 12: Prevalence of subordinate theme across participants: A Need for Safety

This superordinate theme with its four subordinate themes, **'Someone there for me', 'being monitored', 'seeking reassurances', 'a sense of abandonment**' (See Fig 8 and Table 12) captures the significance participants placed on feeling safe in the ED. Due to the seriousness of their conditions, feelings of fear, anxiety and uncertainty were common , resulting in participants seeking reassurances from staff that their condition had not worsened. This illustrates that due to the proximity to staff and associated monitoring of their condition being in the ED affirmed to participants that they were in a place of safety. This sense of safety and reassurance was further enhanced by the competencies and skills of the urgent and emergency care staff.

In contrast, for some participants their sense of safety was affected by feelings of abandonment during different care transitions. Specifically, for some participants this happened when they were left for long periods without interactions from staff; for others, when they moved from high levels of proximity to staff such as in the ED, to lower levels on the wards. Moreover, participants were fearful when they were transferred in the middle of the night to side rooms on wards. Continuity of care was absent for many of the participants following discharge from hospital to home, often feeling neglected from lack of follow-up care from their GP, difficulties in accessing GP appointments and delays in receiving diagnostic results. As will be seen, these feelings of abandonment resulted in fear, isolation and uncertainty.

Someone there for me

The visibility and presence of health care staff in the ED resulted in a strong sense of safety and security for most of the participants. The urgency of the participants' condition necessitated reliance on, and trust in ED staff to both manage their condition and reduce their anxiety and stress in the urgent care environment. Staff appearing to devote their whole attention to participants provided a real sense of reassurance and comfort, with a feeling that there was someone there for them when they felt scared and vulnerable.

> **"So, there was no problem with nothing to worry about, cause I knew there was someone there for me" (Ruth).**

> **'There must have been getting on for 40 people in there, and they were all going and there was a nurse there the whole time, so I don't think we got too much to worry about" (Charles).**

Significantly, for some participants the fear of being left alone was heightened due to the seriousness of their problem. For them the proximity to staff, primarily the medical and nursing staff, gave them a sense of comfort.

> **"You could see they were here, there and everywhere; they just didn't leave people on their own, that was, that was tip top. Well as**

> **soon as I got in there, I felt safe. I felt really safe. I did honestly feel safe. I did. Yeah, I did really" (Agnes).**

Despite the chaos within the ED, it was evident that participants had a sense of reassurance knowing that staff were nearby and from the frequency of interactions they had with them.

> **"But there wasn't anyone away from us that long so they were coming and going all the while ''here I am again" won't it. I felt comfortable, I was being looked after, I was safe" (Stephen).**

The efforts and actions of staff to reassure and make participants comfortable reduced the anxiety and stress brought on by the suddenness and seriousness of their condition and the unfamiliarity of the ED environment.

> **"I thought the attention I had, I mean, I was comfortable, and I was safe. So that was a big thing for me. Fairly comfortable anyway" (Florence).**

In summary, staff presence combined with their attentiveness and reassuring actions enabled many of the participants to feel safe and secure at a time of heightened stress and anxiety when they were faced with uncertainty about both the seriousness of their medical condition and an unfamiliar environment.

Being monitored

The high levels of attentiveness identified in the previous subordinate theme (*'someone there for me')* provided participants with positive experiences of feeling safe. In addition to valuing proximity to staff, the frequency of monitoring and the taking of physiological measurements and investigations provided further reassurances. Many of the participants' narrative accounts focused specifically on those actions of staff which reinforced to them that they were being closely monitored and observed.

> **"I was actually in the bed in the, in the A&E but they still didn't leave me on my own, they were backwards and forwards and keeping a good eye on me" (Ruth).**

Staff showing a genuine interest towards participants reinforced their sense of security and that they really cared. For Agnes, a genuine interest in her well-being made the care personal and meaningful which provided her with assurance that she was safe.

> **“That just made me feel safe all the while. She could have been my daughter, how she looked after me. They didn’t leave me on my own, they were backwards and forwards and keeping a good eye on me” (Agnes).**

The professionalism, efficiency and competence of the ED staff promoted participants’ confidence and comfort as it provided them with reassurance that staff had the skills to care for them.

> **“Very, very professional. I mean there was nothing wrong at all. They were very comforting” (Molly).**

However, for Ruth, the perceived inattentiveness of staff to her prescribed medications, and lack of attention and awareness of her allergies, left her feeling unsafe and doubting their competencies. Ruth’s sense of security then shifted to concern, demonstrating the ever-changing dynamics of experiences older people face in the ED.

> **“I told them what my allergies were and I told them what medication I was on, but somehow along the line that got changed over, so the medication they were giving me, so I said to her what’s that tablet for, and she said that’s for (inaudible) and I said well I’m not on that one, I said, I’m allergic, so she said it’s not on your allergies, so I said yes it is and I showed them in my book, these allergies and the Lansoprazole that I should be on they stopped”(Ruth).**

In contrast, Agnes found the attention by the nurse to her adherence to medication not only increased her own confidence in self-management but also reassured her the nurse was checking that she understood how to take her medication.

> **“She asked me how I take my tablets and when I take them and everything, you know, and I knew that I was right in explaining to her how I take my tablets, so I felt confident that I am taking them right. I am taking all my tablets and I am on a lot of tablets, yeah” (Agnes.)**

It was evident from the narratives that there were different levels of monitoring, interactions and connections from staff, based on the priority of needs of participants. However, key to this was the need for participants to feel safe and where staff’s actions were reassuring, responsive and meaningful, this resulted in higher levels of security felt by participants.

Seeking Reassurances - ‘Get checked out”

Fear and uncertainty about the severity of their condition or cause of symptoms brought some participants to the ED to seek reassurances. Therefore, the ED was viewed as a place of safety and the most appropriate place to go for their needs. Other participants sought advice from their GP regarding the seriousness of their symptoms and the need to attend the ED. More often this resulted in a referral to the ED by the GP. This contrasts with the previous theme ‘avoid burdening the service , however, many of the older people were still concerned for ‘self’ and, supported by their family or HCP, enabled them to justify their need to seek reassurances.

> **“So, I thought the best thing to do would be to get myself to the AMU to get checked out, which is what we did” (James).**

Once in the ED, reassurances from staff that they were in the right place and supported them with managing their condition lessened the participants’ fear, enabling a less frightening experience for them.

> **“I can’t just get my breath and it’s very frightening. And they did everything they could to put you at ease. It was very frightening. But as I said they do all they could to put me at my ease” (Molly).**

Being responsive to participants' needs and promptly informing them about their investigation results and how they would be treated and managed provided further reassurances.

> **"He come back he said everything alright with your blood, you know, and he said we're satisfied with that" (Agnes).**

However, some participants had negative experiences of care with delays in communicating results, which increased their anxiety, concern and uncertainty.

> **"I kept on wanting to say oh dear is it broken? I had several x-rays and that worried me, because I thought why did they have to do it again? But anyway, in the end they said no, we've searched all areas and it isn't, you haven't broken a bone, you've bruised it" (Ann).**

It was evident through the narratives that some participants sought reassurances from staff about their complaint, for others, it was to seek assurances. Significant concerns identified were how they would cope with their condition, what to expect and what to look out for if their condition worsened again.

> ***"I was really worried about how am I going to manage, because I was already on my own. You are just wondering, nobody ever said this will take two days and you will be back to normal and If you have a walking stick you will be perfectly alright, they didn't explain anything about it you just got on with" (Ann).***

For Ann, the lack of advice or reassurances about what to expect when she went home following her fall instilled a sense of fear and worry, exacerbated by the fact that she lived alone. Despite this she accepted reluctantly that she was going to be discharged.

As can be seen within this theme, participants relied on nurses and doctors to reassure them about their condition, provide them with their results and ease their worry and anxieties about what was happening to them.

The Gem – A Need for Safety

In the study findings on older people quotes from two participants were identified to illustrate ‘gems’ in the context of their meaning making about what encapsulated their lived experience in feeling cared for and safe within the urgent and emergency care environment. Of significance is the use of metaphor to express basic human needs. Thus, the experience of caring is presented metaphorically to convey a more vivid and deeper level of understanding about what it means to the participants to feel properly cared for (Shinebourne and Smith, 2010).

The first ‘gem’ is taken from a quote by Agnes of her account of the importance of being monitored and the presence of staff to feel secure during an acute medical emergency within the theme **‘A Need for Safety’**

> **“That just made me feel safe all the while. She could have been my daughter, how she looked after me. They didn’t leave me on my own, they were backwards and forwards and keeping a good eye on me” (Agnes).**

In this quote, positive caring experiences are understood by Agnes to be personalised as if she were being cared for by her own daughter. I felt the strength of this quote was the association of care that evoked a strong sense of connection for Agnes to those that she was being cared by, as if she were their family member. This suggested that Agnes felt secure knowing that the nurse was treating her like a family member, which resonated a feeling of being nurtured, fostering a sense of well-being and safety. I felt this was significant, as Agnes understood the seriousness of her condition, provoking an awareness of her own vulnerability . Thus, the need to feel safe was paramount to minimise the threat posed to her. I believe this could be attributed to Agnes’s fear of her impending mortality, which heightened her anxiety, and therefore the need to feel safe was an essential feature of her care. Accordingly, for Agnes, it was understood that a sense of familiar presence and monitoring by the nurse significantly alleviated some of these stresses.

It was considered that clearly defined in Agnes's account were her feelings about the genuine interest, care and attention shown by the nurse towards her and that reinforced a sense of security. It appeared that for Agnes, it positively emulated care as if it was delivered by her own daughter. This highlights the value of personal and meaningful care that was understood to provide Agnes with assurances that she was safe and supported at a time of crisis. Critically, it also demonstrated the actions of the nurse that were highly valued by Agnes, where she felt their whole focus was fully on her needs. This appeared to provide much needed safety assurances to Agnes.

'*Keeping a good eye on me'* immediately drew my attention to the aspects of care that demonstrated attentiveness, and vigilance. For Agnes, it was understood as being the individual acts of surveillance and monitoring that were delivered with a genuine interest in her needs and safety that conveyed to her that the nurse was truly present for her. It appeared that Agnes felt that close proximity to the nurse was an essential element of care, and was critical to her in seeking confirmation of her safety and that someone was nearby if her condition should deteriorate. For Agnes, this appeared to be an important feature of her care due to the significant threat to her health. This emphasised for me the significance of how feeling safe and secure was an important aspect of receiving dignified care in an ED environment.

Box 2 : Example (1) of the Gem Process

A Sense of Abandonment

This relates to the feelings of abandonment some participants experienced during their urgent and emergency care journey. Central to this was a concern at being lost in the busy environment of the ED, being left on their own and having no understanding about their condition and how it was going to be managed. Furthermore, decisions being made without involving them caused distress. This suggested to participants a lack of interest by staff in their individual needs and contributed significantly to a belief they were being ignored and neglected.

> **"You still were just left with there's something wrong with my heart? You didn't know from what they said to you, you didn't quite understand the full details?" (James).**

> **“Well because they were running around all the time, I was just left there doing nothing” (Florence).**

Of significant concern for participants were their perceptions of being neglected during care transitions, particularly when moving from the ED to the ward, at the point of discharge and then once home, in the immediate days after discharge. For many, participants moving from the ED to a side room, often in the middle of the night, resulted in feelings of isolation, vulnerability and uncertainty. This was in stark contrast to the busy ED and proximity to staff where they were continuously monitored and reassured.

> **“Early hours in the morning and that was in, that was in darkness but that was the only thing, I was a little bit concerned about that nobody came to see me. I say, if you’re in a ward and come down from somewhere, another ward, into, where you’ve had all the care, you come into a little ward singly on your own and no one around you” (Ruth).**

Of concern is that many participants were moved two to three times during a twenty-four-hour period, leaving them feeling disorientated, scared and distressed.

> **“So I went to bed there, and 2 o’clock she woke me up to say that she’ll move me down to ……., which I was trundled down in the bed to ….. ward” (Mark).**

Once patients were informed of their discharge, some of the participants’ narratives reveal minimal involvement in the decision about their discharge.

> **“I don’t think really and truly I should have been let out” (Florence).**

Furthermore, lack of specific discharge information left some participants feeling inadequately prepared to manage their condition or medical problem once home. Although this negatively affected their care experience, they were reluctant to volunteer their fears or anxieties. Consequently, they were unquestioning and assumed a passive role, accepting the discharge process.

> **“If they just explained more what had happened, why it had happened and how I was going to get better. I don’t think I ever talked about the accident when I was discharged” (Ann).**

Following discharge home, many participants experienced poor communication and lack of follow-up or support from their GP, or difficulties in accessing their GP, creating more layers of anxiety and uncertainty, which for many made them feel isolated and unsafe on discharge.

> **“The surgery never bothered once to find out about me. So that’s where it goes wrong in my opinion. No there was no contact from anybody really” (Florence).**

“The only person that’s let me down is my doctor’. When you’re out of hospital that’s the problem” (Molly).

For Molly, poor discharge information about how to take her medication left her feeling unsafe and anxious, thus she delayed taking her medication until she received the correct instructions from her GP, which did not occur.

> **“It says on take as directed, well I haven’t been directed. I don’t know whether to take them or not” (Molly).**

When seeking support from their GP, some participants recalled delays in the GP receiving the discharge letter from the hospital, preventing them from receiving follow-up advice and support.

> **“Quite a long time for this (ECG results from the ED) to filter down through from the hospital to GP” (Charles).**

In contrast when discharged from the ED, some participants were reassured by positive follow-up that was timely and responsive.

> **“On the Monday the doctors’ surgery rang me to say that they wanted to see me and I got an appointment the next day. And then from that day on I had about 3” (Stephen).**

Feelings of abandonment were experienced throughout many of the participants' journeys through urgent and emergency care, continuing once home in the immediate days following discharge from hospital. This left some participants feeling neglected, isolated and uncertain as to how their care was to be managed.

In summary this theme identifies that at a time of emergency crisis, the services of the ED and urgent care made participants feel safe and secure. However, it was evident that participants had variable experiences of feeling safe in the ED and their subsequent care journey.

Attentiveness to Need

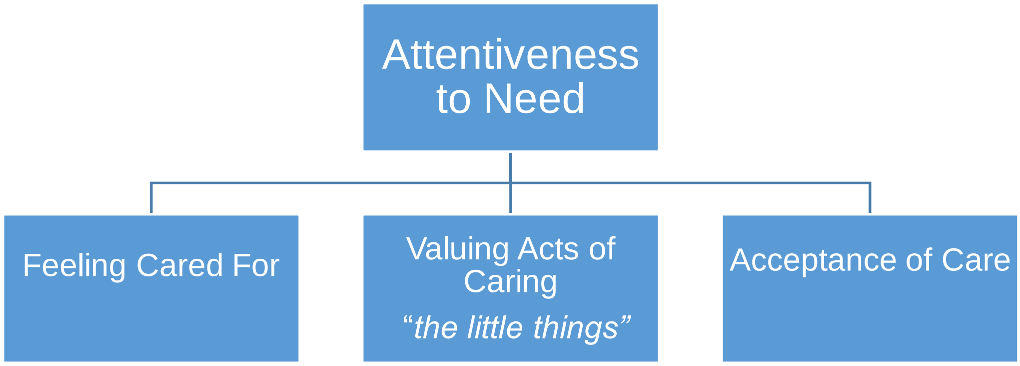
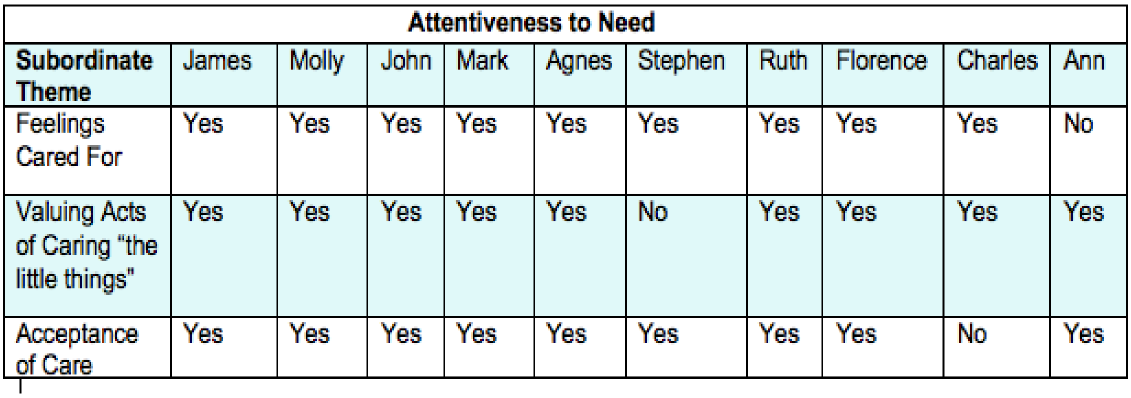


Figure 9: Superordinate Theme Attentiveness to Need with Subordinate themes

This superordinate theme with its three subordinate themes, **'feeling cared for', 'valuing acts of caring', 'acceptance of care'**(see Fig 9 and Table 13) addresses the significance that interactions with staff had to make participants feel cared for. The high activity in an urgent and emergency care environment results in care which is technical and fast-paced. However, what mattered most to participants were those moments of interaction with staff where all the attention was on them to meet their individual needs.

Little acts of kindness, taking the time to talk and listen, demonstrated to participants the caring actions of staff, showing empathy, compassion and respect. These were most valued by participants, reassuring them that they were genuinely being cared for and that they mattered, even in a busy environment. Ultimately, it was these relational aspects of care appreciated by participants, making them feel valued, connected to staff and provided them with reassurance that they belonged in the urgent and emergency care environments.

Therefore, there is a dichotomy between the technical care in the ED and the relational aspects of care which participants most valued. Despite feeling a connection to staff who showed them kindness, compassion and respect, many participants were still reluctant to make their needs known to them due to the perceived high activity environment and staff workloads. Often this resulted in participants making choices to meet their needs which compromised their own safety.



Attentiveness to Need										
Subordinate Theme	James	Molly	John	Mark	Agnes	Stephen	Ruth	Florence	Charles	Ann
Feelings Cared For	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Valuing Acts of Caring "the little things"	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Acceptance of Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes

Table 13: Prevalence of Subordinate Themes Across Participants-Attentiveness to Need

Feeling Cared For

Feeling cared for was a constant theme that resonated with many participants and highlights the meaningful relationships they had with staff which made participants feel connected to them and that they mattered. The caring attributes of staff who treated them as individuals were the foundation of participants' positive experiences of care.

> **"Well they did care, I know they did care about me, everything they said was all about how you feel" (Agnes).**

Conversely, staff who appeared too busy, with little interaction with the participants left them feeling that they did not matter. Hence, this increased participants' feelings of isolation, anxiety and vulnerability, in what for some was an already threatening and unfamiliar environment.

> **"So, I felt a little bit, where are they, and then of course realised what a busy night they have, I understood why nobody's come to see me" (Ruth).**

In addition to the caring attributes of staff, further valued acts of caring were apparent when staff attended to participants' physical comforts, meeting their hierarchy of needs.

> **"I tried to get up and went to the toilet and come back and after a little while she asked me: Did I want a drink of water, which I reckon is pretty good" (Charles).**

However, attention to the participants' physical comforts was not received by all participants, even within the same care environment. Rather, some felt that their basic needs for comfort were not maintained, with others describing being left without food or a drink and when water was available, it was left out of reach.

> **"I got into a bed, little bed, in a ward in the A&E and then of course it, it took a long time, you got no refreshments at all, no drink. There was some water there, and I couldn't reach it" (Florence).**

Furthermore, Florence felt the care she received lacked attention to her individual needs, leaving her feeling that staff were not accessible, available or responsive.

> **"I shouted or waved if I wanted anybody. No, no, no bell or buzzer, no. I didn't see it anyway" (Florence).**

It was clear that participants experienced different levels of attention from staff which made them feel either cared for or uncared for, ultimately affecting their care experiences. Staff actively engaged in building rapport reassured participants that staff were genuinely interested in them, so enabling a deeper understanding of the individual's needs. Of significance, this made participants feel able to share their concerns, contribute to their own care and ask questions about their condition and how it would be managed.

> **"Made you feel that, that there was someone who really cared, that you were getting better" (Molly).**
>
> **"She was really trying to get to the bottom of my problem" (John).**

Furthermore, participants valued the efforts staff made to listen to their problems regarding their condition, taking their time and not rushing.

> **"They asked you questions about things, they didn't seem in no hurry at all, asked what you done, how'd you do it and how'd you feel" (Charles).**

In contrast, participants felt disconnected from staff where interactions were brief and focused mainly on the technical and functional aspects of care.

> **"Well they kept coming and taking me blood pressure, frequently, and otherwise you were just left lying there" (Florence).**

Whilst these aspects are a necessary component of urgent and emergency care, the lack of attention by staff to the relational aspects of care left participants feeling they could not voice their needs or ask questions about their condition. Consequently, participants were left with limited understanding of their condition and treatment and for some this left them with unmet needs.

> **"And just wondered what was going to happen really. A lot of questions in my own mind" (James).**

For Mark, lack of communication about the purpose of tests and how long these would take made him feel isolated, with no clear understanding of when this information would be communicated to him.

> **"I sat down, I had a cannula fitted, took some blood tests and I sat there waiting for the, the results of the tests. I had, when it got to about half past ten and I hadn't seen anybody, I asked the nurse" (Mark).**

For staff working in these environments this may be an everyday practice but for the participant, no clear explanations or signposting can increase individual frustration and anxiety.

In addition to relationships with staff, some of the participants emphasised how the noisy and busy environment negatively influenced their care experience, impacting significantly on their recovery and not conducive to a therapeutic environment.

> **"I get more peace at home than I would there. It made me feel worse. "Cause I said to the nurses, "if you don't do something about it, I'm going to sleep in the toilet and shut the door". She said "you can't". I said "I will". I was so desperate" (John).**

John was further distressed from being cared for in a windowless and cold care environment.

> **"But that single ward was number … and they got no heat in it and no windows" (John).**

In contrast, some participants felt that care environments which specifically focused on older people's care fostered a strong sense of being looked after.

> ***"The whole ward was designed to look after elderly people. But they look after you and take you to (OPM ward)….. and it is an older person and you're well looked after" (Molly).***

Through their narratives, participants identified what mattered to them in the relationships they had with staff. These highlight the multidimensional approaches to care and the attributes of staff that facilitate patient-centred care. Whilst relationships with staff were of central importance and strongly shaped the participants' feelings of being cared for, the environment of care also influenced the wellbeing of the participants and the quality of care they received. This suggests that some participants had specific environmental needs as well as needing meaningful relationships with staff to make them feel cared for.

Valuing Acts of Caring – “the little things”

This subordinate theme captures the importance participants ascribed to the “little things” that staff did to make them feel cared for and meeting their individual needs. The little acts of kindness by staff, such as covering them with a blanket when they were cold, taking them to the toilet to maintain their dignity, informing their family that they were safe and being cared for without being asked, were appreciated by participants in the ED. These small kind gestures illuminate the significance of the “little things” that are highly valued by participants, resulting in positive patient experiences, and recognising the universal need to be looked after.

> **“You know, there’s all lots of little things that, you know, where they care for you” (Ruth).**

Going above and beyond participants’ expectations of staff was highly valued and of central importance to their care experiences, demonstrating to them that staff would go ‘the extra mile’ to care for them.. Staff who indicated that nothing was too much trouble evoked a sense of care that was personal and meaningful. Feeling that help was given when needed showed participants how responsive and attentive to their individual personal needs staff were.

“There was a lady, tall lady and she was called (name), and she was lovely. She was really good, she was tall lady and she carried me out of bed, ‘cause she said “Oh that’s alright, you. I ain’t got to get the steps” “That was proper care” (Agnes).

Significantly, these more meaningful acts of kindness made the care they received stand out, leaving them with a huge sense of gratitude towards staff.

> **“It was quite cold in the cubicle but even though one doctor was rushed he came in and said “well you look cold”, so he got a blanket and wrapped it around me, he said “you’re like a little bug in a rug”. That was caring, that’s what I call caring for somebody” (Ruth).**

Participants also appreciated the small acts of kindness that respected their privacy and dignity, especially around maintaining their independence with toileting needs.

> **"You were taken to the toilet, and she waited outside the toilet where I went and if you wanted anything you just got to press the bell and she'd come in to me, you know" (Agnes).**

It is evident that participants ascribed great importance to the "little things" which made them feel cared for through the quality of interactions with staff who treated them with care and dignity. Furthermore, staff with qualities of kindness and compassion were highly regarded.

The Gem – Attentiveness to Need

The second 'gem' explored is from Ruth to illustrate the superordinate theme **Valuing Acts of Caring – "the little things"**

> **"It was quite cold in the cubicle but even though one doctor was rushed he came in and said, "well you look cold", so he got a blanket and wrapped it around me, he said "you're like a little bug in a rug". That was caring, that's what I call caring for somebody" (Ruth).**

In this quote I was immediately drawn to the expression *' you're like a little bug in a rug'* which evoked thoughts of being warmly tucked up in a blanket to be protected from the cold ED environment. However, it is this 'little' act of kindness shown by the Doctor that demonstrated, and is understood by Ruth, as an action that, even in the busyness of the ED environment there was still time for a professional to show kindness and caring by noticing she could be cold. It was felt that for Ruth, this act of anticipating need meant she had a sensitive awareness to her comfort and needs being considered, without even being asked . Thus, it was felt that this revealed to Ruth that the individual attention to meeting her needs shown by the professional exhibited genuine interest in her as a person. As a consequence, it engendered a sense of being respected and shown dignity as an individual. The key area that was interpreted from this quote was that it was the little things that were highly valued and were understood as showing care and consideration, which for Ruth meant that she was someone who mattered.

From Ruth's account I also deduced that implicit judgements were being made about the quality of caring behaviours she encountered. Moreover, the salient point here is how being cared for is determined by Ruth. It is the small, unexpected gestures of kindness and compassion that stood out and were received with gratitude and appreciation. This was felt to highlight that it was these little things that made the most difference and initiated the notion and understanding of being cared for. This simple act of kindness by the Doctor emphasises what the importance of meaningful actions can be, but also how the humanistic side of caring can be valued and can have a major impact on patient experience. Furthermore, it also underscores the significance of the emotional and human connection between the older person and the health care professional.

I also noted Ruth's strong awareness of how rushed the professional was, yet the caring empathetic approach demonstrated to her did not require a lot of extra time despite the busyness. It illustrated to me that the caring encounter by the doctor which demonstrated a positive relationship required minimal effort, time or resources, but fundamentally was extremely important to Ruth as an individual. Ultimately, I interpreted that even within the busyness of the ED environment, this brief caring encounter left Ruth with a deep impression of what she felt represented true caring. As a consequence, the elements of care emphasised by Ruth and that were understood to be of central importance were the 'little things' such as making sure she was warm and comfortable. Through these caring actions Ruth felt treated as an individual, which heightened her sense of worth and significance.

Importantly, the two gems identified (p.124 and p.134) were felt to illuminate the importance of the role of the professional in humanising care and allaying fear and anxiety by providing person centred care that addresses the basic care needs to feel cared for and safe. The accounts of Ruth and Agnes strongly suggest that relational care is highly valued and influences the older person's

Box 3 : Example (2) of the Gem Process

Acceptance of Care

This subordinate theme describes how all participants were universally very accepting of the care they received, often affirming they had received good care. However, within their narratives are contradictions, where participants experienced both positive and negative experiences of care. Surprisingly they were uncritical of poor care, which may be explained by the insights gained in the previous subordinate theme, in their need to justify their legitimacy and entitlement to be in the ED.

> **“There was a delay, but it wasn’t huge delay and grin and bear it” (James).**

Furthermore, all participants had strong empathy for staff, perceiving them to be overworked and busy. Because of this they were genuinely grateful and appreciative of staff, and were accepting and largely uncritical of the care they received. As a result, they sometimes asked little from staff, often resulting in participants not making their needs known and sometimes taking risks which could compromise their safety. Where there were unmet needs, participants made allowances for staff due to the high activity of the ED and urgent care environments.

> **“The staff are very busy, they are run off their feet and overworked, so I didn’t want to press the call bell to ask them to bring me to the toilet, so I took myself there. I was a bit concerned because I was frightened, I weren’t going to get my breath and I would go down” (Molly).**

All participants reported positive experiences of care and were grateful for the care received.

> **“I can’t thank them enough - you’re getting first class treatment” (Agnes).**
>
> **“First class. Absolutely first class. I got no complaints at all” (Stephen).**

However, they demonstrated high levels of tolerance and acceptance of the care they received, thus normalising the less satisfactory experiences they had, and providing reasons to justify why their care needs were unmet.

> **“The only thing I had a long wait because it was so busy (in the ED), but everything was done for me. So I was prepared to wait that time (Molly).**
>
> **“Everything takes time don’t it, you can’t sort of rush these things can you, so, I don’t think so” (Charles).**

High levels of empathy were shown towards staff for the conditions in which they were working, and allowances made due to the high activity of the care environment.

> **“They wanted to really help you. But they really hadn’t got the time” (John).**

However, many participants made assumptions that staff were busy due to their workloads, based on their observations and experiences of staff. This resulted in the participants’ perceptions that the staff were too busy and understaffed to care for the number of patients under their care.

> **“I mean night-time there was just two nurses, one doctor, one male, one female and they’re on the go the whole time, they hadn’t any rest at all” (Molly).**

For Molly, this left her feeling critical of other patient behaviours which she thought were adding to the staff’s pressures resulting in her not seeking help for her own needs, for fear of adding to this pressure.

> **“The bells were going all the time, you know people, weren’t considerate enough for them, I think, they asked more. I asked as less as I can” (Molly).**

> **“Yes, that was all very good, as I say it was only the fact that there was so much hanging about. But I guess that was not within their**

> **control, because it depends on how many people are in their department that day" (Ann).**

Whilst participants were reluctant to criticise the staff or service, they were more willing to indirectly criticise factors such as the conditions that staff had to work in, with blame directed at lack of resources.

> **"I appreciate they're under pressure and there are a shortage of doctors, so, yes, but it's still just annoying" (Stephen).**

There were many examples from participants who although stating they received good care, interspersed their narratives with some qualifications. For example, John expressed many contradictions, identifying the care he received as wonderful, yet giving examples of having long waits for assistance, poor information provision and delays in discharge.

> **"Care couldn't, couldn't be better" (John).**
>
> **"We'll be back in a minute, we'll be back in a minute" they kept saying, "back in a minute", but you, that, that minute was bloody hours" (John).**

However, there was a strong sense that participants accepted such care because of their inability to change the situation or challenge it.

> **"Well I don't think they were very responsive, but they were so busy, so many people there in A&E. I mean I was comfortable I suppose, because I wanted to go to the loo, so I had to walk with a frame". (Florence)**

Interestingly, but unsurprisingly given the media discourse around older people putting pressure on NHS services, and the lack of resources in urgent and emergency care, several participants compared their care experiences as exceeding their expectations when likened to what they knew from the media.

> **"I suppose I was surprised with the efficiency that. I suppose you tend to when you see what it is on the television, you assume that's all over and it isn't, is it. Some places are worse than others" (Agnes).**

In summary, this theme highlights that positive experiences of care for participants were associated with the ‘little things’ staff do to make them feel treated as an individual and that they mattered. Staff were highly appreciated and evaluated well in what the participants perceived as an under-resourced and pressurised NHS. This resulted in them not always making their needs known and sometimes taking risks that compromised their own safety. Generally, they had unconditional acceptance of the care they received and were uncritical of staff, even if their needs were not met. The influence of the media on how the participants viewed the care often left them feeling that care exceeded their expectations.

Crisis of Identity

Figure 10: Superordinate Theme Crisis of Identity with Subordinate themes

Crisis of Identity										
Subordinate Theme	James	Molly	John	Mark	Agnes	Stephen	Ruth	Florence	Charles	Ann
Justifying Sense of Worth	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Loss of Personal Agency	No	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No
Vulnerable Self	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes

Table 14: Prevalence of Subordinate Theme- Crisis of Identity across participants

This fourth superordinate theme, with its three subordinate themes, **'justifying sense of worth', 'loss of personal agency' and 'vulnerable self'** (See Fig:10 and Table 14) relates to how participants' own sense of identity changes and alters due to illness. This affects their sense of worth and autonomy ('vulnerable self'), where signs of ageing and frailty confronted them with awareness of how vulnerable they were as an older person and as a recipient of care.

Threats to identity include staff not treating them as individuals and not actively involving them in their care or decision-making. Although there was a strong desire to preserve autonomy, some participants did not exert it, instead relying on staff to make decisions for them or being unquestioning when decisions were made for them. Inevitably, this led to conflict of identity between the desire to exert their autonomy versus reliance on others.

In addition, the noise, bustle and sometimes intimidating environment of the ED threatened the participants' identity by confronting them with how vulnerable these environments made them feel as an older person. As seen in this theme, and its interrelatedness with '*a need for safety*' and '*attentiveness to need'* the environment impacts on the participants' feelings of safety, being cared for and vulnerability. Furthermore, the participants in this theme had to justify their sense of worth in the ED, but also seen in theme *'conflict with legitimacy'* they had to justify they were genuine users of emergency care.

Justifying sense of worth

This theme conveys how personal identity is central to the participants' feelings of having a purpose in life, the need to have a sense of worth and to be valued. However, this sense of identity was threatened and altered when individuals became ill and had to attend urgent and emergency care. In these environments, the participants felt the need to defend and justify their sense of worth to be treated and cared for as an individual, and to hold on and preserve their identity.

> **"You're just as good as you always were. they don't know what you've done in your life". (Molly)**

Moreover, in the extract above Molly emphasised her strong need to preserve her identity and self-worth due to staff only having a snapshot view of her in the brief care encounters they had with her. She advocates the need to see the person, not just the older person requiring care.

Being respected and valued by staff as an older person was seen for some participants as a factor that promoted their own sense of worth. This was demonstrated to the participants when staff treated them as human beings and individuals, and by showing them kindness and compassion, conveying to them that they mattered. Furthermore, treating the participants as worthy and important maintained their respect and dignity while at their most vulnerable.

> **"I was treated as an older person that needed some respect. That was the thing, you were respected more than anything" (Molly).**

For Agnes, the care, kindness and attention she received to manage her condition reinforced her sense of worth.

> **"That make life worthwhile don't they, when they say come on we'll get you right, we've got to get you right" (Agnes).**

Having a purpose in life highlighted to some of the participants the value and meaning they had in their own life to be well for their significant others. Knowing that staff cared for them facilitated the importance of restoring their identity.

> **"My daughter is a pharmacist and she insists that I exercise so. Which is, yeah, that's fine. I even wear one of these. A fit bug" (Stephen).**

Other participants evaluated their personal identity by emphasising their independence and autonomy prior to their presentation at the ED. They saw the ED as a place to make them well again, so they could return to normal and preserve their identity.

> **"Well I'm still able to go for a walk, I'm still able to go and bowl, if I couldn't do that then I'd probably be looking for the end, but whilst I'm capable I'll just carry on" (Stephen).**

Some participants had positive experiences of being treated as individuals, without the fear of being subject to remarks about their age.

"Well, I just seemed to be treated the same as everybody else, I mean there were a lot of old people in there though! And I didn't feel I was being picked on because I was elderly. I wasn't made to feel old" (Florence).

For Mark, the development of services and clinician roles built around the needs of older people made him feel connected to staff who understood older people's conditions and empowered him to discuss his problems freely with the consultant.

> **"She said no, she's a specialist in older people's medicine. Which I said "Great I'm glad there is someone like that to talk to" (Mark).**

In summary, the participants had a strong sense of their own value which was influenced by their connections to others such as their family and friends, However, this was threatened when they became acutely unwell. Therefore, the support of health care professionals to regain their purpose and meaning was of significance.

Loss of personal agency

Personal agency was challenged for many participants when they came into the ED due to the severity of their condition or reduced physical functioning. Therefore, the extent to which some participants could exert their autonomy was restricted due to their dependency on others, most notably health care professionals. However, despite these challenges, many of the participants wanted to retain their independence and autonomy and for their voice to be heard so they had control over their care.

> **“I think life is, you can deal with problems, you know what they are, it’s when you don’t know what they are it becomes difficult” (Mark).**

Yet, many participants felt their autonomy was undermined by staff who did not actively listen or provide participants with enough information about their care or the opportunity to be involved in decisions about care. Consequently, their personal identity felt threatened due to their inability to be involved in decision-making about their own care.

> **“They didn’t really explain to me and then shifted me off. It seemed miles, I thought I’d gone to another hospital” (Florence)**

Conversely, some participants did not exert their personal autonomy, relying on health care professionals to make the decisions for them.

> **“No, I was happy for them to make the decisions really. Well, because some things I don’t want to hear about” (Ann)**

Other participants were unquestioning when decisions were made for them which went against their own beliefs and expectations.

> **"They let me out, they shouldn't have let me out there I don't think I was right, anyway they let me out" (Florence).**

Needing to know more about what was happening to their bodies, understanding how their condition was (or would be) managed and treated, endorsed the participant's choice and autonomy. This was of major importance to individuals.

> **"Old age is just a general term, but it would be nice to still to know you might say possibly oh, as you get older your knees haven't got the strength they had before, and you've been bending too much, or something like that" (Mark).**

> **"Well I like to know what's going on with my own body" (Molly).**

Additionally, for some participants being heard and listened to by staff was deeply important to their ability to feel actively engaged in the decisions being made about them and that their views and opinions were respected. Furthermore, the significance of active listening by staff empowered the participants to be freely able to exert their autonomy.

> **"Nowadays, you know the medical staff are very good. They treat you better, they do explain things. They talk good and they listen and that's important that they actually listen to what you say" (Mark).**

On the other hand, not being listened to or made to feel their opinion did not matter diminished some participants' sense of worth, making them feel undervalued in the relationships they had with staff.

> **"Well I dunno, I don't, I, I don't think they believed you I thought bloody 85 year old, you know your own body, Christ" (John).**

Moreover, for some participants the urgency and emergency of their condition or reduced physical functioning impeded their ability to exercise their choice and autonomy, which consequently impacted on their levels of personal agency.

> **“Because it was painful and I walked, I wondered if I was doing myself any harm by walking or whether I should stop walking. But they didn’t ever explain about that” (Ann).**

Despite some participants’ frailty, their determination to maintain their autonomy was central to their identity.

For Molly, who stated she was nearing the end of her life, putting her affairs in order was important to maintain her autonomy.

> **“There’s nothing they can do for me. That is the thing, I mean, we all got to go sometime, but I wanted to know when, so I could get my affairs in order so (daughter) doesn’t have so much worry” (Molly).**

For Florence, dissatisfaction about being discharged too early following a fall was the driver for her wanting to regain her independence quickly, so she organised her own rehabilitation in a nursing home.

> **“I can’t get on here (home) I’ll have to go in a home or something for a while. And they (nursing home) really put me on the right track. They got me so much better, I was there two weeks” (Florence).**

In summary this theme highlights the importance for the participants to remain in control about the decisions that matter to them. However, they faced many challenges to maintain their sense of agency through the inactions of staff to involve them in their care or through their own deterioration in health. Where staff promoted autonomy, it increased the participants’ belief in their ability to exercise involvement in their care.

Vulnerable Self

Attendance at urgent and emergency care heightened the participants' awareness of the vulnerabilities of ageing. It alerted them to the physical impacts of getting old, of their bodies slowing down and the development of health conditions which directly contributed to their attendance at urgent and emergency care. This resulted in altering the participants' established sense of identity, from independence to being more dependent on others for information and managing their medical needs. Participants' sense of vulnerability also inter-related to '*a need for safety*' and *'attentiveness to need'* themes in how they depended on staff to reduce their sense of helplessness through feeling cared for and safe.

"But when you stumble about a bit, like if I get up quick that's when I gotta watch out, I've got to remember take things slower" (Charles).

Once in the emergency department, the noise, the busy and sometimes intimidating environment increased participants' fear, worry, distress and sense of vulnerability.

> **"There were all these people coming in and they were shouting and screaming" (Florence).**
>
> **"Pretty impersonal, you're not quite sure what's going to happen next, you think you are about to be whisked away for something or another. It's a nerve-wracking place" (Ann).**

The severity of their condition(s) often left participants concerned and fearful of the outcome, exacerbated by not knowing the cause of the problem, increasing their feeling of stress and vulnerability.

"I think an older person get more concerned, I think there's you know, probably so, because your closer to the end" (Stephen).

Feeling ignored and left waiting for long periods without interactions from staff significantly increased participants' feelings of vulnerability (and threatened their identity) by impacting on their sense of worth.

> **"I was just left then, and I didn't know what was gonna happen. People kept walking up and down". (Florence).**

For John, this change of role from carer of his wife with dementia to being cared for caused a crisis of his own identity, exposing how vulnerable both he and his wife were. Whilst this was not experienced by the other nine participants, John's experience of being admitted to hospital highlights the unseen vulnerabilities of older people who keep silent about their concerns and anxieties, and which affects their sense of self.

> **"And course I was worried about her all the time I was in the hospital. 'Cause she's there on her own. I was panicking a bit, so I was on the mobile phone every day. Kept ringing her up to make sure she was alright" (John).**

Dependency on others for care disrupts the participant's identity with a realisation of how vulnerable they are when they become unwell.

> **"Your mind is racing away, you know, what is this? What is that? What's going to happen next? Perhaps with age you get, you might get more anxious, that you want to know now, why are they doing that, or what's that for?" (James).**

The actions of staff to put participants at ease and manage their distress reduced some feelings of vulnerability and such attention enhanced the individual's sense of worth by being cared for.

> **"The nurses never left me and she kept saying am I alright and having any pain or any discomfort, or are you comfortable and everything. They made sure that was alright" (Agnes).**

Inevitably in this theme, participants had different experiences of being empowered to maximise their own agency, which could either compromise or strengthen an individual's sense of identity. The actions of staff to promote choice and autonomy for participants facilitated respect and dignity when they were at their most vulnerable. Participants arrived at urgent and emergency care with an established sense of identity and the findings emphasise that they wanted to maintain this. This process was facilitated by staff who supported and recognised the individual needs and vulnerabilities of the participants and acted accordingly whilst they were in their care.

Disempowering self

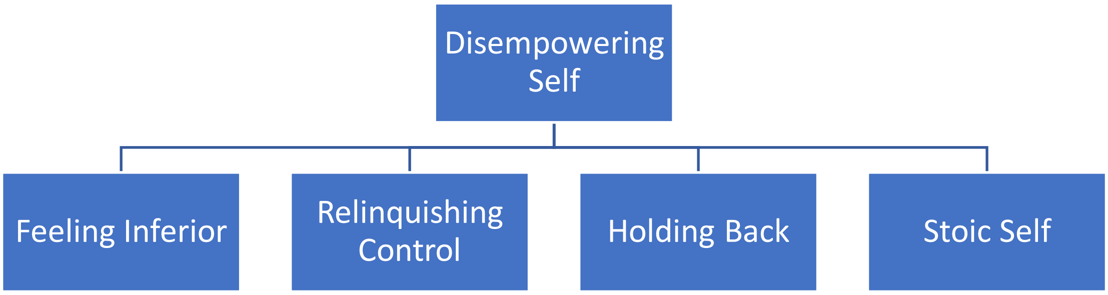
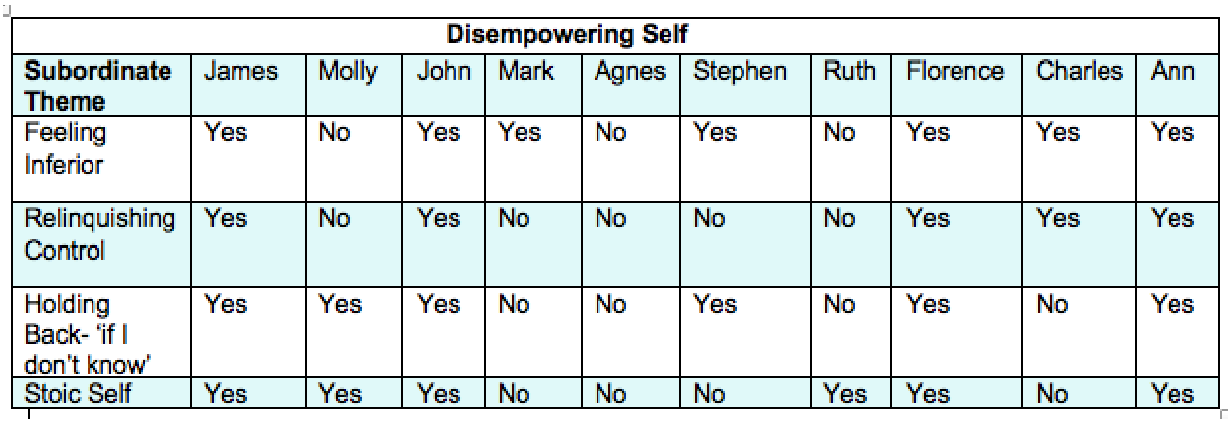


Figure 11: Superordinate Theme- Disempowering Self with Subordinate themes



Disempowering Self										
Subordinate Theme	James	Molly	John	Mark	Agnes	Stephen	Ruth	Florence	Charles	Ann
Feeling Inferior	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes	Yes
Relinquishing Control	Yes	No	Yes	No	No	No	No	Yes	Yes	Yes
Holding Back- 'if I don't know'	Yes	Yes	Yes	No	No	Yes	No	Yes	No	Yes
Stoic Self	Yes	Yes	Yes	No	No	No	Yes	Yes	No	Yes

Table 15: Prevalence of Subordinate Themes Across Participants-Disempowering Self

This theme, with its four subordinate themes, **‘feeling inferior’, ‘relinquishing control’, ‘holding back’ and ‘stoic self’** (See Fig:11 and Table 15) conveys how some participants felt they lacked the knowledge and confidence in communicating with HCPs, or being involved in decisions about their care . Ultimately this results in a disempowering process in which the participants felt inferior and lacking in self-esteem. Consequently, they were happy for others such as health care professionals and family to make decisions for them because ‘they know best’. This limited their shared decision-making capability whereby they held back from being involved in care decisions.

Participants were stoical about the care they received even if it was inadequate to meet their needs. Some participants stated firmly that they were not complaining about their care, despite identifying care they were unhappy with. Therefore, they were content to put up with care which they thought was good enough, not wanting to appear ungrateful. This left many participants as passive recipients of care, acquiescing to existing care processes and the care recommendations of staff.

Feeling Inferior

Some of the participants' accounts illustrate how they felt disempowered to engage with health care professionals due to their own lack of medical knowledge or not knowing the appropriate questions to ask about their care. This left them feeling inferior and subsequently lacking the confidence to seek information or share their concerns about their illness or condition, despite wanting to know more about their care.

> **"I'm not a doctor so I don't know what they were doing exactly, apart from blood pressure and taking my pulse" (Stephen).**
>
> **"I wanted to know more, I wanted to ask more, but when you are not knowledgeable, you feel it's difficult to ask proper questions. You don't really know what is happening to you. Your mind is racing away" (James)**

James's narrative conveys his own attitudes towards himself, being self-critical about his own lack of medical knowledge. He struggled to gain information about his care because of his assumptions about what constituted an appropriate question. This self-stigmatising behaviour created a self-imposed power imbalance, causing barriers in communicating with health care professionals.

Furthermore, James also had a negative view of the value of his own opinions, demonstrating his diminished sense of self-worth:

> **"You might have an opinion, but it couldn't be possibly be professional, so keep your mouth shut and let them get on with the job" (James).**

HCPs' failure to acknowledge participants' concerns resulted in them feeling a lack of control or being powerless to change things. Therefore, participants felt disempowered by what they perceived as HCPs not taking them seriously or listening to them. Consequently, this led some participants to return to the ED with the same problem which had not previously been addressed.

> **"See within a fortnight of when I went in the first time to when I went in the second, it don't change does it? They told me the first time it wasn't me heart, but they won't believe it, so they tried it all again when I went in the second time" (John).**

For John, the lack of a holistic approach to his multiple symptoms caused frustration and dissatisfaction with HCPs. Their focus on the primary presenting complaint resulted in incongruence between John's and the HCPs' perceptions of the underlying problem. This resulted in John feeling an imbalance in power and that he had no control over his situation and thus unable to articulate his needs and concerns.

> **"When you were in the Emergency Department, they're saying, we're, we're only here to look after this problem. That was my diagnosis of it yeah" (John).**

Empowering actions by staff enabled participants to feel confident in asking questions and engage in respectful dialogue, thus treating them as individuals. Being approachable, putting participants at ease, providing them with information so they had a greater appreciation and understanding of their illness facilitated reciprocal relationships. These type of actions by staff demonstrated to participants that they were more equal partners in care.

> ***"Well, yes, they did explain what was happening, you know they talked to you properly. They didn't talk down to you or anything. I felt when I was talking to (Dr name), she's a very easy person to talk to and I felt I could then ask her questions without a problem and that's when we got the information that I'd got the angina" (Mark)***

In summary, this theme highlights that where participants lack confidence in their knowledge to ask appropriate questions about their care can leave them feeling unequal and disempowered in their relationships with staff. Where staff used empowering approaches, some participants felt they were treated with respect and as equal partners in care.

Relinquishing Control

Self-disempowering behaviour by participants was characterised by a tendency towards a negative view of themselves and their contributions to care decisions. At times, participants relinquished control by abstaining from seeking information or asking questions about their conditions, relying on family members to represent them. Many participants devalued their contributions to shared decision-making, feeling their opinion and knowledge made them unworthy or unable to participate. This led to participants deferring very readily to HCPs to make decisions for them as ‘they know best’, thus reflecting and reinforcing the unequal relationships they felt they had with staff.

> **“I thought well there, they’re the medical profession; they know what they’re doing. And I just shut up” (John).**

Fundamental trust in the professionals’ judgements and decisions, combined with feelings of inferiority in their own knowledge base, resulted in participants abstaining from active participation in their care, with some questioning their role in making decisions about their care, feeling this was very much the remit of the professionals.

> **“I accept that because I’m aware of my ignorance and I need to let other people get on and make the decisions” (James).**

> **“They ask you different questions one thing and another, but apart from that you have to leave it to them ‘cause they should know what they’re doing more than I do” (Charles).**

By relinquishing control to others, family members were often tasked to find the necessary information about a participant’s care. Several participants lacked the confidence to initiate a conversation with HCPs remained silent, and felt that family members were better equipped to converse with them.

> **“My daughter had no compunction whatsoever in seeking out the doctor and asking him about things. I mean no doubt I’m quite sure she wasn’t a nuisance, but erm, she didn’t feel you had to be quiet and do as you are told So, I’m sure she wasn’t a nuisance, but she just felt that you were entitled to do that” (Ann).**

Feeling powerless to change the organisational processes of care or feeling some lack of control in how they received care from staff left participants accepting the existing processes and the care recommendations of staff.

> **“There was nothing to do, I couldn’t put any pressure on anybody, I have no right to ask for any special treatment. So, grin and bear it really, there was nothing else to do” (James).**

> **“There ain’t much I can do about it. Shortages are something we’ve had to learn to live with”. (Stephen).**

In summary, participants’ conviction that the HCPs knew best and were the most suitable people to make decisions about them, prevented them from actively engaging in their care.

Holding Back

This subordinate theme captures the reluctance of some participants to being involved in their own care, meaning that they held back from being involved. Avoiding knowing was thus a coping strategy that some participants adopted. Interestingly, for some participants there were tensions between wanting to know and not wanting to know. This illustrates one facet of the many contradictions that some participants experienced as they moved through the emergency care pathway.

‘Holding back’ also inter-relates with ‘relinquishing control’ theme as participants held back from being involved in their care due to feeling inferior about the extent of their medical knowledge.

In this extract, which highlights elements of these contradictions, John is self-questioning, yet abstained from asking the staff questions.

> **“I wonder why, what’s this and what’s that and then you ask yourself all manner of questions. It’s ignorance on my part” (John).**

He then further states:

> **“Well, if I don’t know I don’t worry about it” (James).**

For Ann, fear and embarrassment was a potential barrier to her wanting to know more about her medical problem.

> **“Well, because some things I don’t want to hear about. I mean this here is nothing embarrassing or unpleasant about it, but you could have some things that you could have some things that older people are still a bit squeamish I suppose really” (Ann).**

Nervous of being a nuisance, or fearful of being labelled annoying were additional factors that contributed to some participants holding back from asking staff questions about their care.

> **“I can talk about it now but I’m very nervous about doing it (asking questions) and hoping they’re not going to be annoyed. They’re not annoyed these days they expect people to talk to them, don’t they?” (Ann).**

Ann’s experience above highlights how some participants could be submissive in the relationships they have with staff and how such attitudes disempowered and inhibited their engagement with them.

Stoic self

This theme captures the stoicism of participants who appeared very accepting of the care they received but who also felt they had no influence to change existing care processes or complain about care if they were dissatisfied. Therefore, they readily accepted the existing organisational processes of care and did not object to the care received.

Many participants adopted such a stoical approach, with the view that nothing much could be done about the system and therefore the best approach was acceptance.

> **"I can't see how anything else can be changed from that, I mean it's the A&E and it takes in everybody doesn't it, so you have to really just go along with what they're having to do" (Ruth).**

Some participants were reluctant to complain, not wanting to be considered difficult or labelled as 'complainers'. This was also because of gratitude for the care they received and their appreciation that other people's needs may be greater than theirs. This inter-relates with the first theme of 'conflict with legitimacy' in respect of how they felt 'others were worse than them' and therefore they had little justification to complain.

> **"And they're all sitting in the middle and talking and laughing, all the doctors and people, I don't know, I mean I'm not complaining about it" (Florence).**

> **"What's the point in making a noise about it? It's been dealt with. So, leave it alone. Let them get on" (James).**

For Ruth, despite having to change location three times during her emergency admission, she remained stoical and did not complain.

> **"I know there are emergencies worse than me that needed the beds. (Ruth)**

As well as being stoical, some participants demonstrated high tolerance levels about having to wait long periods to be seen or being positioned in corridors whilst waiting for the ambulance or to free up bed space.

> **“Into the corridor till the ambulance man came and picked me up. Waiting over an hour, so I was prepared to wait that time. Yeah, I weren’t bothered about it, you know” (Molly).**

Feelings of having no control over care decisions left some participants feeling alienated from the decision-making process, particularly relating to discharge decisions made by staff. Despite a lack of choice and involvement in their care, they did not voice any objections and appeared resigned to the decisions made for them. In these circumstances, participants felt that the staff retained the power in the decision-making processes, thereby a disempowered and passive role was assumed in the care decision-making process.

> **“I don’t think really and truly I should have been let out. ‘Cause I had an accident in the loo, with the bowels and had to clear it up”. (Florence)**

For John, no confirmed diagnosis as to the cause of his medical complaint left him feeling abandoned and that he had no control over the decisions made for him.

> **“They can’t find nothing wrong with you. That’s, wanna just shut the door then”. (John)**

Ultimately, this unwillingness to complain or assert themselves resulted in less active engagement with HCPs in care decisions.

In summary, this final superordinate theme highlights the tensions between the disempowered stances that participants themselves adopted, and staff actions which inadvertently alienated individuals from their care. Together they impact greatly on individuals’ levels of confidence, self-esteem and ability to be involved in their own care. Furthermore, the stoical approach may mask underlying concerns and anxieties which individuals are reluctant to share, thus creating barriers in shared decision-making and exacerbating the perceived power imbalances between individuals and healthcare staff. However, where staff involved them in their care, such empowering actions demonstrated to the participants that they were equal partners in care.

Summary

In this findings chapter, the five superordinate themes of the experiences of ten older people who accessed urgent and emergency care have been described, to capture the essence of those experiences. The experiences for older people unfolded through the interpretive analysis and identified the many challenges individuals face when their urgent and emergency care needs required a visit to the ED or AMU. Older people exerted a moral judgement on whether their medical need was deserving of calling the emergency services or attending the ED. This is rooted in older people's awareness of the social and public discourse stereotyping them as bed-blockers. blamed for the chaos in hospitals, and regrettably seeing longevity as a burden to society. Consequently, individuals needed to demonstrate their appropriateness, entitlement and legitimacy to be in the ED and urgent care services. Subsequently, validation by staff that they were genuine users of urgent and emergency care was significant in their experiences of care, so they were not seen as wasting time or resources. Person-centred approaches, more attuned to the individual needs of the older person and little acts of kindness, reaffirmed that staff genuinely cared about them and underpinned the more positive experiences of urgent and emergency care. Valued reassurances from staff, recognising and understanding the anxieties and fears older people experience due to the uncertainty of their medical needs emphasised sensitivity at a time of increased vulnerability. Older people were very grateful for the care they received, and staff were highly appreciated and evaluated well in what the older people perceived as an under-resourced NHS and environment that is highly pressurised. Nevertheless, fear of over-burdening the system and staff often resulted in older people not making their needs known, leaving them struggling with unmet needs. Despite this, they were generally accepting of the care they received and were largely uncritical of the staff. However, individuals were more disapproving about their lack of autonomy in decisions made about them, especially around discharge and the quality of information that they received. Furthermore, they felt abandoned once home by the lack of follow-up care from their GP, which left them feeling vulnerable and isolated.

Critically, the findings not only illustrate the unique needs of the participants who accessed urgent and emergency care services but also brought to light their environmental needs. Importantly, new insights were gleaned into how the current public and social discourse was being absorbed by the participants, resulting in self-stigmatisation by participants who viewed themselves as a burden to society and the NHS. This had implications for how older people sought help for their urgent and medical needs and acted as a barrier in promptly accessing appropriate care

The next chapter will discuss the main findings from the older people interviews in relation to the current literature and practice, and new information will be highlighted.

Chapter 6: Discussion Older People

Introduction

This study has identified five superordinate themes, *Entitlement and Legitimacy to care, The Dichotomy of Safety in the ED, Relationships with Staff, Maintaining a Sense of Being Valued and Empowering Older People in their Urgent and Emergency Care Journey* (Chapter:5). Whilst each older person's experience is unique to them, these can be interpreted to provide new understanding and insight about what it is like for an older person accessing urgent and emergency care.

This chapter will place the findings within the wider literature and theory, and draw on conceptual links between the five superordinate themes to deepen the interpretative process (Smith et al.2009) and further strengthen understanding of older people's experiences of urgent and emergency care. Thus, the discussion demonstrates how the findings from this study make valuable contributions to the care of older people accessing this care, and identifies key implications for policy and practice with the potential to translate into improving the quality of care for older people who access these services.

This study has revealed further knowledge about the challenges and difficulties older people face when accessing emergency care, their unique needs making them a distinct group within these settings, and the barriers and facilitators to meeting those needs. Furthermore, it provides new insights on how the public and social discourse of being a burden to society and the NHS ageing is being absorbed by older people, impacting greatly on their health-seeking behavior, their sense of worth and autonomy.

Entitlement and Legitimacy to Care

The participants in this study revealed that the first steps to accessing urgent and emergency care services were difficult, specifically, deciding whether to call the emergency services or attend the ED. Strong feelings of being a burden to others and to society significantly affected their decision-making. Delays in seeking help centered on concern about their entitlement and legitimacy to receive emergency care, fear of burdening their family and the health care service. Moreover, public discourse and media representations of older people as burdensome to the NHS and society led to stigmatisation. Additionally, their concern of adding to the NHS's burden made it more difficult to assess whether their illness required emergency care, with many attributing their symptoms to the signs of ageing. The complexity associated with decision making to attend the ED often left the older person relying on others such as family members or the HCPs to make the decision for them.

Many of the participants felt they were a burden to others, and experienced strong emotions of guilt, anxiety and worry about whether to seek help for their emergency needs. The emotions of feeling a burden were similarly described in a recent qualitative study by Gudat et al (2019) exploring the experiences of frail older patients with palliative care needs. They found that many older people suffered strong negative feelings and suffering from their belief that they were a burden to others who care for them. Many of the participants in this current study were frail older people with multiple self-reported long-term conditions. The literature generally characterises frailty as a time of increased decline in health and well-being, loss of social function, vulnerability, loss of agency and dependency (Skilbeck et al, 2018, Gilleard and Higgs, 2010, Higgs and Gilleard, 2015). Thus, increased dependency compounded many of the older people's level of perceived burden, especially for those with frailty, whose sense of autonomy and self-worth was significantly impacted. Primarily, not wanting to trouble their family or HCPs delayed them from seeking help when they needed it most, particularly those dependent on others for care and support due to living with multiple long-term conditions and frailty.

Exacerbating some of the participants sense of being a burden is the media representation of older people putting increased pressure on the health care service. Thus, these messages of longevity as a burden were being absorbed by many of the participants in this study when they required the emergency services. Media representation of older people, such as reports suggesting longevity in older people may '*devastate health care systems and ultimately the economy*" (Fraser et al. 2016, p.1029) further added to their sense of being a burden to the NHS and to society, resulting in self-stigmatisation. Using critical discourse analysis, to examine the role of the media in how age and age identities were socially constructed, Fraser et al. (2016) described stereotypical depictions of age-related conditions in the media leading to important health consequences for older people, with fewer seeking help for their illnesses. Further, these public discourses affect how society thinks about older people and stigmatises them as a distinct group: they are presented as burdensome, costly, dependent, frail, vulnerable and infirm, positioning them as a burden and dependent on health and social care services (Fealy & McNamara, 2009). Hence, it is not surprising that older people see themselves as a burden and a challenge to society.

In addition to the negative stereotyping of ageing in the media, much of the social and healthcare policy, for example 'Get Ready for Ageing (Lords,H.O., 2013), and Future of an Ageing Population (Government Office for Science,2016,2019) describe the burden associated with the rise in the ageing population on the economy and health services (Fealy & McNamara, 2009, Lloyd-Sherlock et al, 2016) and in an alarmist tone (Fealy & McNamara, 2009). According to Officer et al (2016) the representation of older people as burdensome and costly are serious barriers to developing good public policy on ageing and health. Consequently, policy to promote positive ageism may have negative consequences in how older people absorb these messages. Studies that have explored the perceptions of ageing by older people found that that those who internalise the negative stereotypes of ageing such as 'burdensome' 'costly' and 'dependent' have shown less adaptive strategies for maintaining health and less utilisation of services if their health deteriorates (Wurm et al. 2013, Levy, 2002).Such representations of older people adding pressure on the health service reflects the findings identified in this current study: participants did not want to bother the health services or staff due to their general awareness of the crisis that surrounds NHS provision and EDs in particular, having absorbed these continuous negative messages.

Appropriate utilisation of services was an important factor in how the participants in this study appraised their need to attend the ED and called upon them to make decisions whether their needs were genuine and worthy of the urgent and emergency care services. Questioning whether their problem was legitimate enough to warrant emergency care, of being a 'genuine' patient, led many participants in this study to contemplate what constitutes an emergency need. Similarly, Considine et al (2010) descriptive qualitative study on older people's experience of accessing emergency care found that older people were reluctant to access care and waited until they thought their problem was severe 'enough'**.** However, for some participants in this current study, interpreting what constitutes an emergency was challenging with some unable to recognise when to seek help promptly from emergency care services. Care-seeking for acute emergency needs among older adults was found to be problematic and complex in a grounded theory study by Lutz et al (2018). This was due to the difficulties in interpreting what is normal and what is life-threatening. Consequently, this posed barriers to older people seeking help for their medical complaint. Historical studies by Leventhal and Prohaska (1986) revealed that older people are more likely to attribute their symptoms to ageing, even when they perceived their symptoms as severe. More recent studies report that attributing symptoms to aging continues to be a barrier to accessing services (Canvin et al. 2018, Wurm et al.2013, Richards et al. 2002). Normalisation of symptoms to ageing is a significant finding from this current study and draws attention to the need for further research on improving older people's ability to recognise and differentiate between the symptoms of ageing and life-threatening conditions.

Delays in seeking help for their urgent and medical care needs found in this study were also attributed to doubts by the participants about the severity of their illness, fears of wasting HCPs' time, and being seen as a nuisance. Isaksson et al (2011,2013) work on why older people delay seeking help for their myocardial infarction may be useful to inform our understanding of help seeking behaviours when older people are faced with emergency health needs. The qualitative interviews with older people revealed many of the individuals believed they were not ill enough and were more likely to downplay and neglect their symptoms, only seeking help when the pain became too unbearable. Significantly, such delays in seeking help for myocardial infarction are associated with increased morbidity and mortality in older people (Ryan and Zerwic 2003, Tullman et al.2007). Similarly, the participants in Isaksson study (ibid) also identified fear of wasting time and of being a nuisance as significant factors in avoiding seeking help for their acute emergency needs. These findings resonate with many of the experiences of the participants in this current study. Thus, understanding why older people delay seeking help, and the risks associated with these delays has implications for HCPs in how they educate older people about the signs and symptoms of serious health conditions that warrant urgent medical attention, to support older people to seek help promptly and reinforce health promotion and prevention messages on optimising health and well-being.

Relinquishing of difficult decision-making to HCPs or family members due to the previous mentioned factors associated with delayed seeking help was common amongst some pf the participants. As in other studies, these findings highlight older people's dependency on others such as GPs or family members to support their decisions to attend the ED (Considine et al. 2010, Marr et al.2019) with endorsement from paramedics, GPs or family members a significant factor in persuading them. This strategy of deferring decision-making to others lessened participants' concerns of being a burden (Henson et al.2016) whilst reassuring and validating their medical needs. It also provided the participants with a sense of permission to attend the ED due to others appraising their needs as severe, thus supporting the appropriateness of their emergency need. This had significant meaning for the participants as it was associated with been a legitimate patient, particularly when the current health discourse strongly emphasises the need for attendance at the ED requires you to have a genuine emergency.

Current health culture and public health campaign messages ask patients to choose the best service for their needs and only use emergency services in a 'genuine emergency' (Walters et al. 2001, Hillman, 2014), focusing on trying to dissuade patients from using the ED for non-urgent needs (Lutz et al. 2018). The crisis in the NHS and the ensuing rationing of care (Vassy, 2001) discourages illegitimate patients from making inopportune visits, reiterating that emergency care services and staff must only concentrate on those patients with severe illness (Wamsiedel, 2018). However, such messages have strong moral overtones, resulting in many participants feeling under a moral obligation to choose appropriately and only seek help in a genuine emergency. However, the previous discussion established that many older people struggle to define a genuine emergency (Lutz et al, 2018, Hillman, 2014) so unintentionally, these messages may deter older people needing emergency care from seeking help, as well as assuming that older people can make those complex decisions over their emergency needs: this positions the patient as an expert with a strong understanding of their health needs, able to make judgements about what is normal and abnormal, and when to seek help (Hillman, 2014). However, Lutz et al. (2018), asserts it is unrealistic to expect older patients to have the requisite knowledge to determine if their symptoms require emergency care.

Anxiety over entitlement and worthiness to be in the ED caused participants in this current study to go to great lengths to justify their need to staff. Research by

McDonald et al (2007) on individual's decisions on accessing healthcare is particularly useful to explain the behaviour of 'justifying need'. They coined the phrase 'the ethical consumer' (p.439) to illustrate how in times of competing demands on health services, patients are more inclined to demonstrate their appropriate use of health care resources by only accessing services when necessary. As previously discussed, this view may resonate with older people who feel stigmatised and blamed for high usage of services, and regulate their health-seeking behaviour accordingly in order to be deemed genuine users of health care services. Attempts by participants to assert their legitimacy to access emergency care can be explained by the theoretical concept of 'candidacy'. Candidacy describes the ways in which people's eligibility for medical attention is determined by their appropriateness which is influenced by economic and organisational factors, alongside policy imperatives (Dixon-Wood et al. 2006). Arguably, individuals must perceive themselves as legitimate first to access services. Key to understanding their legitimacy is the ability to recognise their symptoms as constituting a need for medical attention or intervention (Canvin et al. 2018, Dixon-Wood et al. 2006), however this is challenging for older people as previously identified.

Anxiety over feeling a fraud or an imposter in the ED was a finding that many participants reported in this current study, doubting they were 'unwell' enough, that their symptoms were not genuine or worthy enough to receive care and treatment from this service. Consequently, participants were fearful that their reason for attendance at the ED may be viewed by staff as inappropriate or undeserving. An observational study by Dingwall and Murray (1983) found that staff judged patients on their entitlement to care by categorising them based on their priority of needs through a triage system (Hillman, 2014, Wamsiedel, 2018). This helps identify those patients who place inappropriate demands on the service (Llanwarne et al. 2017), and prioritises those with urgent needs. The practice of 'moral labelling' is ascribed to the legitimacy of patients' symptoms and the appropriateness of their health needs (Hillman 2014, Llanwarne et al. 2017). Hillman's (2014) ethnographic study of categorisation in a large UK emergency department (ED) revealed that to claim legitimacy, patients feel the need to provide reasons and justifications for their attendance. Where staff in this study validated the participant's need to be in the ED provided strong reassurance that they had made the right decision in seeking help and affirmed to them that they were appropriate users of the health service. This study contributes to our current understanding of the importance to an older person of being recognised and validated by HCPs as a ‘genuine’ patient, endorsing that individuals took the right steps in seeking help for their urgent medical needs.

However, despite seeking reassurances from staff that they had genuine needs to be in the ED, nearly all the participants downplayed the extent of their medical needs and their entitlement to emergency care, viewing other patients’ entitlement as more worthy than theirs (Hillman, 2014). As previously discussed, this may reflect the discourses on older people that are presented through negative stereotypes of ageing and blame for the chaos in NHS hospitals. Additionally, participants referenced ‘taking up space’, implying other patients were more worthy of space than them. The use of the word ‘space’ by the participants is interesting since with the lack of beds and resources in the current NHS, space is viewed as a valuable commodity (Maguire et al.2015), and may reflect the participants’ awareness of this. Furthermore, the vocabulary of managers and staff in the NHS still includes the derogatory term ‘bed-blocker’ which translates into stigmatisation of older people (Oliver, 2008, McMillan,2005). Some participants were strongly aware of this term. Sadly, this suggests a health culture that blames older people for the pressure on services, rather than addressing the deficiencies in care for older people (Thwaites et al.2017, RSPH, 2018, Landeiro et al.2019). Therefore, it is unsurprising to learn how older people’s sense of worth is influenced by the apparent stigmatisation and ageism inherent within our health culture.

It is important for HCPs to fully understand the complexity and challenges older people face in their decisions to attend the ED: how older people internalise both public and social discourse of ageing and associated burden and its impact on their self-esteem and self-worth, and how validation by staff that they are genuine users of emergency services provides positive reassurances and reinforces their sense of worth. HCPs can use this knowledge to explore with older people their help-seeking behaviour and use interventions that promote and prevent ill-health, even in fast-paced environments like the ED and AMUs. This shifts the emphasis of an emergency care model that is disease-specific to a patient-centred approach that captures the unique needs of the older person accessing these services. Policy makers need to appreciate how their messages may be perceived by older people, and explore approaches which do not alienate and stigmatise them. This means that the language of care should enable older people to live well in ageing by empowering them to engage with services to maintain their independence, rather than dissuade them from doing so. How older people view themselves as less worthy than others for care is of particular relevance to the broader organisational delivery of care in the ED and urgent care environment, pointing to the need for the humanisation of care to promote self-worth and an inclusive culture of care for older people and their families, which otherwise may be missed due to the busyness of these environments.

The Dichotomy of Safety in the ED- Feeling safe versus Feeling abandoned

Feeling safe was found to be an overarching need during their ED and acute hospital stay and this current study identified the factors that provided participants with an overall sense of safety when receiving emergency care. Mollon, (2014), Lasiter, (2011) and Melby, (2005) also found feeling safe as a feature of older people's ED experiences. Fear and uncertainty about the severity of their illness was a driving factor that brought them to the ED, which was viewed as a place of safety for many participants. Delays in seeking help until many of the older people's symptoms were severe identified in this study heightened their sense of fear and they viewed the ED as a place where they could receive reassurances and support with their acute medical needs, despite their reluctance to attend identified in the previous section. The positive experiences of being monitored and attended to was aided by the quality of interactions with staff, whose knowledge, skills and competencies gave positive reassurance. In contrast, fears of abandonment in transitions of care caused distress and increased the participant's vulnerability.

A retrospective cohort study by Kennely et al (2014) examined the characteristics of 500 older people over the age of 65 (mean age 77) who attended the ED of a large urban teaching hospital, and found the drivers for attendance were comorbidity and acute illness severity. This suggests that when older people present to the ED, many are acutely unwell with increased severity of illness. Additionally, Rising et al (2016) observational study explored older people's motivations to attend the ED and revealed that fear and anxiety about the severity of their illness were also key factors, and Parke et al. (2013) found fear was one of the main reasons for attending the ED. This may reflect the nature of perceived severity of illness and associated levels of stress (Melby, 2005, Lutz et al. 2018). Severity of illness may also explain why many participants were at their most scared and vulnerable when they presented to the ED (McCabe and

Kennely, 2015, Melby, 2005), inferring a strong link between the severity of illness and feeling fearful.

The ED was considered a place of safety, where participants sought reassurances and explanations for their symptoms with the hope of securing a diagnosis and to alleviate their fears and anxieties (Rising et al.2016). Accordingly, participants looked to staff to alleviate their concerns about their condition and how it would be managed, which helped reduce their levels of stress. However, some participants did not convey their concerns to staff and therefore they were ‘unspoken’ and ‘unheard’, enduring these worries throughout their stay. These findings are consistent with an ethnographic study by Olthuis et al. (2014), which explored the concerns of patients who visited the ED and determined their fears were most heightened when they first arrived in the ED. Therefore, these worries, if not observed or managed by staff, may go unnoticed in the chaotic environment of the ED where there is an increased emphasis on the technological and operational aspects of patient care (Rising et al. 2016).

Unfamiliarity with a busy, noisy hospital emergency department created an environment that was threatening and left the older person struggling to meet their basic needs or to have these met. This current study found high levels of stress and anxiety when participants were exposed to unfamiliar hospital environments (see also: Lasiter and Duffy, 2013, Joanna Briggs Institute, 2012). EDs have been described in the literature as ‘war zones’ (Mc Connell et al.2016). Many participants in this current study drew attention to the busy, chaotic and unfamiliar ED environment (cf. Considine et al. 2012, Fry et al, 2014), stressing how the noise levels, cold, windowless rooms, hard trolleys, the height of beds and trolleys and distance from toilets compounded their stress and anxiety, at a time when they were already fearful about the seriousness of their condition. This highlights how the design, layout and physical environment increased participants; vulnerabilities, causing them concern and discomfort. Other studies have recognised that the ED environment of care is not always optimal for older people (Joanna Briggs Institute, 2012, Considine et al, 2012, Fry et al, 2014, McCabe and Kennely, 2015, Goodridge et al. 2018).

Some participants in this current study reported their fundamental care needs were not always met around comfort, toileting, hydration and nutrition, all which added to their concerns and anxieties, and impacted greatly on their dignity. A qualitative, descriptive study by Goodridge et al. (2018) explored older people's risk of emotional harm in the ED found many of the participants experienced negative outcomes due to the lack of attention to their physical and emotional needs, contributing to a suboptimal experience, leaving them feeling dehumanized, despite several studies emphasising the important role the ED plays in caring for older people (Johanna Briggs Institute, 2012, Considine et al, 2012, Fry et al, 2014, Lasiter and Duff, 2013).

This study has provided insight into the emotional/psychological and physical factors that make older people feel unsafe. Many participants' fears and anxieties about being in the ED were poorly recognised by staff, leaving many emotional and psychological needs unaddressed. Although improving the patient experience has recognised patient safety as an important dimension of quality of care (Darzi, 2008, DH, 2010, Lasiter, 2011,Hearn et al. 2017, NHS, 2019, Jamalimoghadam et al. 2019), few studies have explored the emotional or psychological safety of patients (Mollon, 2014), and rarely examine older people's feelings of safety in the ED (Lasiter, 2011) in comparison to the policy drivers to improve physical safety (Darzi, 2008, DH, 2010, NHS, 2019).

Although feeling safe is an abstract concept (Mollon, 2014), definitions can be found in the literature which offer useful insights about how patients experience this phenomenon. Feeling safe has been described as an '*existential feeling of security that, if absent, leads to anxiety'* (Sandler and Sandler, (1998),cited in Kenward et al. 2017, p.143). Russell (1999, p.758) defined feeling safe as an: '*emotional state during which it is perceived that there is no imminent danger of psychological or physical injury'.* Both definitions are relevant to the experiences of the participants in this study, in how they framed perceptions of feeling safe in the ED environment. Moreover, Mollon (2014) states that feeling safe is different from being safe. Using concept analysis to examine the phenomenon of feeling safe, Mollon (2014) identified key defining attributes: trust in the nurse/patient relationship, feeling cared for, and the presence and knowledge of staff together with the relationships with staff, and the environment. Similarly, the current study also found these attributes were valued by the participants to alleviate their feelings of fear and anxiety. However, this study also highlighted that close monitoring and observations of staff strengthened their feelings of safety, and the importance of HCPs in providing reassurance, should a participant's condition deteriorate. Similar studies found that continuous monitoring of patients through observations and technology, such as ECGs and blood pressure monitors, were another means by which participants found reassurance (Maben, 2015, Elmqvist et al. 2012). Patients felt these interventions would alert staff to an immediate risk of danger (Lasiter, 2011, Maben, 2015). Whilst obtaining physiological measurements is an essential factor in prioritising patient care, the literature indicates that there is a tendency for HCPs working in the ED to focus more on technological and operational aspects of care (Considine et al. 2012, Fry et al. 2014) rather than a holistic approach to care, including both the physiological and psychological components of feeling safe which acknowledges the individual needs of the older patient.

This study identified that positive encounters with staff that made participants feel safe correlated strongly with how much participants felt cared for. In addition to the proximity of staff, participants who felt that the full attention of staff was on them gave a real sense of reassurance and comfort that *'someone was there for them'*. At a time when older people are most vulnerable and dependent on others for their needs, Lasiter (2011) noted the significance of presence of staff on older people's experiences of feeling safe in ITU, in her grounded theory study. Furthermore, she found responsiveness and timeliness in meeting the older person's physiological and informational needs created a strong feeling of assurance and safety in patients. This is particularly relevant for acutely unwell older people in the ED, who may not be able to care for themselves or meet their own needs. Furthermore, the presence of staff assured participants that they were not forgotten or ignored, and that their care was personalised (Lasiter, 2011). Thus, positive actions by staff to make older people feel cared for met their hierarchy of needs to feel safe (Maslow,1987). Using Maslow's humanistic theory of motivation and personality as a theoretical framework, Nyden et al (2003) explored the needs of older people in the ED and found that overall, safety was the dominant, yet often unsatisfied need. Therefore, this study findings indicate that the actions of staff to fully attend to the needs of older people was an important aspect of feeling safe in the ED and contributed positively to their experiences of emergency care (Parke et al. 2013).

Although, participants in the current study perceived that staff's full attention was on them, the interactions were brief due to the competing demands and pressures of the ED (cf. Forsgärde et al. 2015). However, the value of these interactions during the monitoring and taking of physiological measurements cannot be underestimated, giving the opportunity to build therapeutic relationships, enhancing the patient-centred approaches which underpin HCPs' practice. Reassurance during these brief moments of interaction can address their care and information needs, providing comfort in the busyness and chaotic environment of the ED (Welch, 2010). Innes et al (2018) study found that therapeutic engagement by ED nurses reassured and calmed patients and their families, while also enabling prompt commencement of treatments through close monitoring and assessment and detection of any deterioration. This demonstrates that it is not necessarily the amount of time spent managing the older person's needs but the quality of engagement that maximises the caring, allowing for provision of optimal care (see also Frank et al, 2009, Conroy et al. 2014, McCabe and Kennely,2015).

Contributing significantly to the participants' sense of safety were the perceived competencies and skills of the urgent and emergency care staff. Knowledgeable staff who used their expertise contributed to patients feeling safe (Lasiter, 2011, Kenward et al.2017). Staff who demonstrated not only their technical competency, but their communication skills and information-giving to update participants on their results or tests, provided valid reassurances that they were safe in their care. Other recent studies also support these aspects of care by staff (Lasiter, 2011, Mollon, 2014). Additionally, the findings of this study clearly indicated the importance to participants of timely relaying of information about their condition, the ED processes of care, confirmation of their diagnoses, and affirmation that their condition was stable. Earlier studies that have shown that timely information to patients in the ED is critical to reducing patient anxiety and increasing patient satisfaction with care (Russell, 1999, Watson et al. 1999, Wassener et al. 2012). In the current study, receiving information promptly gave participants the impression that the staff treating them were professional, knowledgeable and competent.

In contrast, the findings indicated that some aspects of care made participants question the competency of staff, leaving them feeling unsafe. Primarily this was around safe medication management during their hospital stay, and the inattention of staff to their prescribed medications and allergies resulted in some participants being prescribed medication that was contraindicated or to which they were allergic. Furthermore, poor aftercare information and lack of clear instructions at discharge left some participants unintentionally non-adhering to their newly prescribed medication. Ultimately, the participants' narratives suggest there were clear issues of communication breakdown over prescribed medication and allergies of patients. Significantly, participants were particularly vulnerable to medication errors during transitions in care, with admission and discharge being the most critical points. With some participants in this study having up to three transitions in care, the risk of miscommunication and changes to medicine is potentially a significant problem (Rutter et al. 2017). A recent report by the World Health organisation (WHO, 2017) on medication safety stressed the importance of improving communication at transition points as vital to avoid medication-related harm. A qualitative study by Patterson et al (2019) using focus groups of staff including nurses and pharmacists explored medication safety during and after acute care and identified that poor communication was a major contributing factor to medication errors and one which caused harm to patients.

Inaccurate recording of patient medication at both admission and discharge has been found to be an extensive problem, gaining much attention in the area of patient safety (Hellström et al.2012), Recent studies have shown the importance of recording accurate medication history, specifically at the initial ED admission, to prevent adverse drug reactions and interactions (Hellström et al.2012, Basey et al.2014). Poor medication management including incomplete documentation of changes in medication for older people during or immediately after hospital increases the risk of readmission within a month (Wheeler et al. 2017, Rutter et al.2017). A study by Hastings et al. (2011) to identify interventions to reduce medication errors for the older person in the ED found that discharge is also an important transition in care, with patients requiring specific care and education around their medication. Many of the participants in this study had changes to their medication or were prescribed new medications and clear communication is required to support patient adherence and improve patient safety. Poor attention to patient education and lack of clear instructions on the labelling of newly prescribed discharge medication contributed to non-adherence in some of the participants and left them feeling vulnerable on discharge (Hastings et al.2011).

The environment of care contributes significantly to medication errors (MEs) (Manias et al.2014) and numerous studies have identified that MEs in the ED are problematic and frequent (Eshani et al.2013, Mitchell Scott et al.2014, Dormann et al.2018), with older people being particularly vulnerable (Dormann et al. 2018). Moreover, they are at higher risk of MEs than any other patient group due to the number of medications they take (Cohen et al, 2008). Factors contributing to these errors are the busy and often overcrowded EDs, high patient caseloads, increased patient complexity, the volume of medications administered and the time critical nature of medication administration (Mitchell Scott et al.2014, Weant et al. 2014). These factors strongly suggest that older people have specific needs around medication management to keep them safe. To improve medication safety, recent studies advocate that staff must have comprehensive understanding and knowledge of medications and their interactions, including allergies, for the management of older people in the ED (Di Simone et al, 2018, Melby, 2005). Therefore, knowledge and understanding of medication management is crucial to medication and overall safety of the older person.

Contrastingly, this study did identify that some nurses maximised their opportunity to engage in education strategies with participants to ensure understanding of their medications. Nurses who spent time ascertaining the participant's medicine history, took time to listen and understand their medication usage, and checked that they understood their medication resulted in positive experiences of safe medicine management. Furthermore, the use of validation to confirm that participants were taking their medications appropriately instilled confidence in their knowledge, made participants feel safe knowing they were taking them correctly and promoted self-management strategies to manage their condition (Nunes et al. 2009, NICE, 2009). Multidisciplinary approaches to the care of the older person in the ED ,such as using pharmacists, doctors and nurses was found to play an important role in comprehensive assessment of medication in the older person, improving patient safety and education (Verloo et al.2007, Rhalimi et al.2006). Thus, comprehensive assessment of medication is an essential area of older person's management in the ED, which might otherwise be neglected due to the busyness of the environment and the competing demands on staff.

Promoting self-management in the ED was a valuable resource, enabling participants in the current study to understand and manage their condition, providing them with a sense of security that they were doing the right things to maintain their health and well-being. However, some participants did not experience any such approaches, which suggests variability in the frequency of delivery. Attitudes to health promotion and patient education were surveyed through a study using a questionnaire with ED nurses (Taggart, 2009). The results identified that although nurses believe that health promotion and patient education are important, it is the perceived importance that is the strongest variable in whether nurses carried it out. Further, patient education is not necessarily practiced due to barriers, most notably time to perform it (Taggart, 2009). A culture of health promotion and prevention within the ED should be encouraged as part of the provision for older people, but organisational constraints must be removed so HCPs have the time to give it the attention it deserves. The participants' experiences of feeling safe and unsafe around medication management in the ED and on discharge provide powerful messages around safe medication management in the ED.

Transitions in care was an important area where participants in this study felt vulnerable which threatened their sense of safety. Key areas were long waits in the ED without meaningful interaction from ED staff, moving from high levels of monitoring in the ED to lower levels on the wards, and following discharge. Participants reported feeling abandoned, feeling uncared for, isolated, lonely, fearful, anxious, concerned, worried, invisible, and vulnerable. For many participants, following the initial assessment involving brief interactions with staff in the ED, they were then left alone for long periods which generated feelings of abandonment and isolation, increasing their sense of vulnerability. According to Wiman et al. (2007) abandonment and dissatisfaction occur once the patient's physical condition has been assessed. This is further explained by Elmqvist et al (2012) lifeworld study where they interviewed14 patients and their family members who attended the ED about their initial encounters with staff. The research identified that once the initial assessment and priority work was completed, the patient finds they are in an 'empty space' waiting for the next encounter to occur, with long waits which can be uncertain and unpredictable (Elmqvist et al.2012, Forsgärde et al, 2016). Feeling abandoned and unsupported exacerbated participants' fears and worries about their condition.

Moving in the middle of the night from the sense of safety in the ED, to wards and side rooms also instilled feelings of fear and isolation, with the lack of connection and visibility of staff leaving some participants feeling distressed and vulnerable. Contributing to this was their awareness that they had moved from high levels of monitoring to lower levels. For some participants being left alone in a side room made them feel isolated, that no-one cared and that they didn't matter. Recent mixed-methods studies exploring the use of single rooms in health care for older people looked at both patient safety and experience (Maben et al, 2015, 2016). The authors found that that there was an increase in falls, medication errors and the risk of adverse events due to the lack of visibility by the staff. Furthermore, patients who felt disconnected from staff were more likely to report feeling isolated.

Some participants experienced multiple moves in a twenty-four-hour period , which left them participants feeling particularly unsafe and vulnerable. A Kings Fund Report, (2013), on continuity of care for older people in an acute hospital. with a focus on emergency care, recommended that frail older people should be moved as little as possible, unless clinically necessary. The report further elaborates on the disruption caused to older people due to breakdowns in continuity of care and lack of relationships with staff, all of which lead to damaging consequences for health and well-being. Campaigners such as the Patients' Association (2011) branded the practice of moving patients at night 'dehumanising'. A freedom of information act requested by The Daily Telegraph in 2014 (www.telegraph.co.uk) to several NHS Trusts found the practice of moving older people in the middle of the night had increased by 20% over the preceding five years.

The working ED model of care for this current study involved multiple moves: typically, participants could be moved from the ED into AMU, and from there to an older persons' ward, with many moves occurring in the middle of the night, or discharged home. Increased pressure on emergency care departments has sought to increase patient throughput and achieve four- hour ED waiting time targets in a system where there is an ever-increasing demand on beds; this leaves hospitals struggling and such movement of patients is inevitable (Maben et al.2012). It is therefore unsurprising to hear patient's narratives where they feel dehumanised, and likening themselves to parcels, as revealed in two Kings Fund Reports (Goodrich and Cornwell, 2008 and Maben et al. 2012). These narratives resonate strongly with the accounts in the current study.

There is limited research specifically on the lived-experiences of older people from the perspective of moving from high level of monitoring in the ED to lower levels on wards, or the effect of being moved in the middle of the night so it is difficult to make inferences from the emergence of this finding. However, this study finding suggests that multiple moves and moving in the middle of the night are key issues for older people. Continuity of care mattered to the participants at each stage of their journey, with arrival at the ED, being in the ED and at discharge being particularly stressful for older people. Bate and Robert (2006 p.308) likened these to 'touch points' and sometimes refer to them as 'moments of truth' where patients experience heightened anxiety and stress and suggest that these are points in the care journey that shape their subjective experience. It is at these points of care the authors stated that emotional and human connection needs to be made with health care staff.

In addition, the move from hospital to home identified lack of follow-up care, support and help, particularly from the participants' GPs as a factor that caused deep upset and fears about safety, with some participants reporting a sense of abandonment at this crucial transitional care point. Worryingly, some participants felt uncertain as to how either to manage their conditions or how to take medication that was prescribed in the hospital. Often this was because of poor understanding of discharge information and lack of appropriate instructions about how to take the newly prescribed medication. Therefore, there was a reliance on the GP to fill those gaps in care, so when there was no continuity of care from the GP, participants felt discarded and helpless. This finding concurs with the existing literature, that suboptimal information transfer of medication, limited or no written instructions and poor patient understanding are problematic in care transitions for the older person (Calares et al, 2018).

Shortcomings in transitional care at discharge risk medication errors and drug related problems for the older person. Furthermore, unintentional non-adherence to medications (NICE,2009, O'Quin et al, 2015), as evident in the participants' narratives, increases the potential for readmission This key area of risk is supported by several studies (Calares et al.2018, Rutter et al.2017, Wheeler et al.2018, Aminzadeh and Dalziel, 2002). Older people are at particular risk of re-admission and adverse outcomes after hospital discharge (Aminzadeh and Dalziel, 2002), therefore the findings from this study would infer that safer discharge practice is essential to improve the outcomes for older people. A safe discharge process is an important component of high-quality patient care in the ED (Hall et al. 2018). A safe discharge ensures that patients understand their diagnosis, prognosis, are alerted to symptoms which may indicate a deterioration in their condition, and clear instructions about how, when and where to seek help and support. This suggests that stronger mechanisms are needed to improve older people's understanding of their care and after care instructions and highlights the need to accurately identify any misunderstandings before discharge (cf. Engels et al.2009).

Once home, many participants found they had to wait for long periods before securing a follow-up appointment with their GP and even then, there was lack of information, due to the absence of discharge summaries or test results. Therefore, for these participants, follow-up care was deficient for their needs. Participants who appeared more vulnerable to these gaps in care were those who were directly discharged from the ED. This finding concurs with a grounded theory study by Cadogan et al. (2016), who conducted nine focus groups with ED staff to examine from their perspective the factors that influenced quality and safety of transitions home from the ED for vulnerable older adults. They identified that transitions of care for older people discharged directly from the ED are highly problematic, with high rates of adverse effects and increased risk of repeat attendance at the ED. All participants in this current study who were discharged directly to home lived alone. Some had family, others did not, and the lack of family or carers has been recognised as a major barrier to effective transitional care following an ED visit (Cadogan et al. 2016).

A few participants in the current study had positive experiences of aftercare following their discharge, where GPs proactively contacted patients with appointments. This intervention has been identified as a successful approach that has been used in ED-to-home transitional care models (Caplan et al.2004). Other examples are scheduling both nurse and telephone follow-up appointments for patients before they leave the ED (Caplan et al.2004, Cadogan et al.2016, Lewis et al.2017). These have been found to reduce ED visits and provide timely referrals if needed, as well as providing comfort and allaying fear.

The findings strongly suggest that participants viewed feeling safe as an important aspect of their care and that this is an underappreciated need which ED staff may overlook when their attention is on prioritisation of acute medical emergencies. Moreover, there are distinct transition points in care when participants feel most vulnerable and abandoned. Leaving older people to wait for long periods without any meaningful interaction with staff, inattention to medication safety and lack of high-quality discharge processes all point to poorly managed transitions in care, indicating significant gaps in care. Greater continuity of care through the older person's journey and development of clear integrated pathways of care to support better outcomes will lead to improved patient experiences. Where there is evidence from the participants' experiences of attention to their individual needs, quality engagement, awareness of their concerns and worries, and making them feel comfortable and cared for greatly enhanced their sense of safety.

Relationships with Staff

How older people are supported to manage their medical crises is significant to their positive experiences of urgent and emergency care. This current study has revealed deeper knowledge of the role of HCPs in these positive experiences through their interactions with participants and attention to their individual needs. The patient-centred approaches focusing on the little acts of kindness were significant to participants , making them feel connected to staff and that they belonged in the emergency department. Relational skills and effective communications were fundamental to understanding participants' individual needs, and more importantly for the participants, addressing their basic care needs when they were unable to do so themselves, due to being acutely unwell. Lack of meaningful interactions with staff left some participants feeling disconnected, isolated and uncared for. Therefore, this study highlights the coexistence of person-centred and non-person-centred care within the ED.

Patient-centred care is considered the cornerstone of high quality care (DH, 2008, The Health Foundation 2012, McCormack and McCance, 2016). McCormack et al. (2010) describe person-centredness as:

'*An approach to practice established through the formation and fostering of therapeutic relationships between all care providers, people and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self- determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.'* (p.13).

However, delivering person-centred care can be challenging within the organisational constraints of busy EDs (McCormack et al.2013) where there is a tendency to focus on the technical and objectively measurable tasks of patient care (McConnell et al.2016, Elmqvist et al.2012). While such aspects of care are important, this study highlights the significance the human acts of kindness displayed by the ED staff in making participants feel genuinely cared for and that they mattered in all the busyness around them. These acts of kindness refer to the relational aspects of care which fostered positive interactions between HCPs and participants (Kennedy et al.2017).

Relational care concerns interpersonal aspects of care that treat patients with dignity, compassion, respect, empathy and emotional support (Kennedy et al. 2017, Arthur et al.2015). This aspect of care has gained prominence since the publication of the powerful narratives of ten older people who experienced dehumanising care under The NHS (The Ombudsman, 2011). Their harrowing accounts presented an NHS that failed to provide safe and compassionate care to older people or recognise their humanity or individuality. Sadly, despite, these significant failings, the Francis report (2013) on the Mid Staffordshire NHS Trust again illuminated major deficiencies in the care of older people, with an emphasis on the lack of attention and due accord to patient dignity and respect. Key recommendations were made to transform older people's experiences by creating positive organisational cultures to deliver high quality patient care. Central to reform was the promotion of dignified care for the most vulnerable individuals. What followed was a stream of national and local policies, initiatives and service developments to improve the care and experiences of older people who access health care (Williams et al.2015). This backdrop to the gaps in older people's care was introduced in Chapter 1 and was a major driver for this study.

The growing recognition of the significant problems in the care for older people, particularly in acute hospital care and EDs (Tadd et al. 2011, Bridges and Nugus,2010) pointed to the need to get the basics right. The Kings Fund Point of Care Report (2008) recognised the importance of seeing the person, not just the patient, and getting the basics right was the stand-out message. This view resonates strongly with the experiences of the participants in this current study. Staff who got the basics right made them feel genuinely cared for, by treating them as an individual with kindness and respect.

Crucial to their positive experiences of care was the meeting of their basic needs, which fostered a real sense of staff's authenticity to care. Furthermore, identifying and anticipating the participant's care needs demonstrated staff's ability to recognise their individual requirements (Bridges et al 2010). Consequently, staff who were pro-active in addressing those needs without being asked heightened participants' sense of being cared for. Thus, these were clearly attributes the participants valued, given the unpredictable environment and busyness of the ED (Olthuis et al. 2014). Moreover, the ‘little acts of kindness’ by staff had a profound and lasting impact on participants, for example, when staff anticipated the needs of the participant by offering them a blanket when they were cold, showing them genuine kindness and empathy when they were at their most scared and vulnerable. Being sensitive to their fears and anxieties when they were acutely ill in an unfamiliar environment and importantly, maintaining dignity by meeting hydration and toileting needs are just a few of the examples of the ‘little things’ that humanised their care experience (cf. Galvin and Les Todres, 2014).

The seemingly ‘little things’ that may go unnoticed in busy EDs were what some participants struggled with the most, such as going to the toilet or reaching for drinks and call bells to request help, getting on and off beds, assistance with dressing/undressing. Congruent with the literature, the ‘little things’ often became the ‘big things’ (Williams et al.2016, p.786, Bridges and Nugus,2010, van der Meide et al.2015) and were most important in participants’ perceptions of receiving dignified care. Importantly, personalised attention to individual needs and awareness of the emotional and physical impact of the environment induced feelings of comfort. This finding is reflected in a large qualitative study by Bridges and Nugus (2010), incorporating 31 sites across England to explore older peoples and their relative’s experiences of urgent and emergency care services. The authors found that older people highly valued staff who were able to support their wide range of needs, specifically those which were psychological or around activities of daily living, as reflected in this current study. This is echoed in Maben et al (2011) qualitative study on older people with acute care needs, which also highlighted the significance of the ‘little things’, evoking a strong sense of being cared for. These too focused on the relational aspects of care, staff who demonstrated interest in the patient, compassion, kindness and timeliness of care, particularly around toileting needs were what really stood out for older people. According to Cornwell et al. (2011) the smallest actions on the part of staff can make a huge difference to patients’ experience of care and are received with gratitude. This growing body of evidence suggests that the relational aspects of care are what older people value the most (Bridges and Nugus, 2010, Bridges et al 2010), so it is unsurprising that the ‘little things’ are synonymous with the universal need to feel cared for.

The relational aspects of care fostered interactions with participants that made them feel connected to staff and that they belonged in the ED, rather than feeling they were a burden or nuisance to staff, and the more meaningful these encounters were, the more connected participants felt. Therefore, this study highlights the meaning of ‘connectedness’ for participants in urgent and emergency care environments. Despite the short timeframe that staff have to engage with participants, and the demands of their workplace, it is evident that building meaningful rapport with older people is a fundamental skill that needs to take place throughout their urgent and emergency care journey (Cooney et al.2014). The participants in this current study highly valued the relationships they had with staff which made them feel connected, such as taking the time to understand their needs, not rushing them, and supporting them to maintain independence and agency. In a systematic review of studies on older people’s experiences and relatives in acute hospital care, Bridges et al. (2010) found that being connected to staff demonstrated strong reciprocal relationships, meaning that staff recognised the older people as human beings with distinct care needs. Therefore, feeling connected assumes respectful reciprocity. Conversely, in a review of studies on the meaning of connection for older people, Cooney et al. (2014) found that when there is a lack of connection, individuals can feel an ‘outsider’ and disengaged when the fundamental need to belong is unmet. Hence, the absence of connection can increase anxiety and feelings of exclusion. Thus, the authors stress that HCPs have an essential role in building rapport with the older person to facilitate a strong sense of connection and belonging.

The organisational structure and processes of the ED can present challenges to fostering a person-centred environment, providing both the technical and relational aspects of care (Watkins et al.2019, Dewar and Kennedy, 2016). However, the current study findings have highlighted key elements of care that, despite these challenges, make a significant difference to the participants’ experiences when attending the ED. These findings can be considered in the context of the existing literature on patient-centred care that encompasses understanding the patient as a unique human being, to be treated with kindness, consideration and as an individual (Fix et al.2018, Hung et al.2017). A literature review by McConnell et al. (2013) explored person-centredness, specifically in EDs, and the predominant finding was the need for HCPs to develop relationships and behaviours that support patient-centred approaches which put the patient at the centre of care delivery. Thus, improving patient experience in EDs is not only the provision of good clinical and technical care, but is also about treating older people with ‘kindness and compassion’ (McCance et al.2016, Dewar and Mackay 2010, Goodrich and Cornwell,2008).

In contrast, the quality of the interaction with staff was experienced differently between participants (cf. Maben, 2015, Olthuis et al. 2014). In the current study some participants reported a lack of meaningful interactions with staff where the technical aspects of care superseded relational care (see also Watkins et al.2019, Nyström et al.2003). Hence for staff, managing the acutely ill patient was a priority and due attention was not given to the holistic care that was important to the participants to provide a sense of being cared for. Therefore, these current study findings highlight the incongruence between that which participants valued the most, and what staff felt were priorities of care, resulting in some of the participants basic care needs and emotional care not been met. Consistent with the existing literature, fostering relational care may be a challenge in the ED, where the culture of care places high value on the medical technical tasks over caring (Elmqvist et al. 2012). Furthermore, several studies found that the majority of ED staff’s interactions with patients occurred only when undertaking these technical tasks (Nyström et al.2003, Elmqvist et al.2012, van der Meide et al.2015). Thus, it is easy within the ED environment for technical skills to dominate. Maben et al (2015) assert that the focus on the technical aspects of care reduces the visibility of the participants as individuals. This lack of visibility resonated with some of participants’ experiences in this current study where they felt disconnected from staff who they perceived as too busy and in a constant state of rushing (cf. Maben, 2015). Moreover, the predominantly task-driven interactions reduced participants to objects of measurement. Accordingly, participants were disinclined to ask questions, seek information about their care and did not make their needs known, which resulted in unmet needs. The feature of rushed care has been identified in other studies as a barrier to person-centred care, becoming more impersonal, the more rushed the staff (van der Meide et al.2015).

Despite a lack of connectivity with staff reported by some, all participants in this current study spoke of their positive experiences of staff and gratitude for the care they received, with a reluctance to criticise staff or question ED processes.

Similarly, a study by Richardson et al. (2007) found that older people aged 80 and over were reluctant to say anything that would be perceived as complaining about the staff or their hospital care. This appears to be associated with participants' empathy for staff who they feel are overworked in an overstretched NHS. However, some participants recounted negative experiences, which did not represent person-centred care or connection to staff. Thus, they framed and justified these contradictory experiences by indirectly blaming the organisational demands of the service in which the staff had to work. Where there were unmet needs, participants made allowances for staff due to their workloads, and in general had unconditional acceptance of the care they received. Accordingly, unwilling to burden staff they sometimes asked little from them. This often resulted in participants not making their needs known, sometimes taking risks which compromised their own safety, for example, not calling for assistance to go to the bathroom or not expressing their concerns if they felt they were not ready for discharge. This is also echoed in Bridges and Nugus's (2010) qualitative study, which found that older people were reluctant to ask for help for their psychological and physical needs, often downplaying these needs. The authors felt this reflected the older person's diminished sense of significance. This was also a significant finding in this current study and was explored and discussed under entitlement and legitimacy and will be discussed in how participants adopt disempowering approaches in receipt of care.

A study by Coyle and Williams (2001) on valuing people as individuals in health care, found the busyness of staff prevented older people seeking help. This corresponds to the findings of several previous studies (van der Meide et al.2015, Bridges and Nugus, 2010, Bridges et al.2010); however this current study extends our understanding by illuminating the strength of the older person's reluctance to seek help, their concern about adding to the staff's workload and worryingly taking risks which may compromise their safety. Given existing concerns that the ED is not a safe and enabling environment for older people (Boltz et al.2013), this current study has highlighted an area of further risk due to older people not seeking help for their toileting and nutrition needs. This has implications for improving the quality of care for older people in the ED, where patient-centred interventions to encourage older people to seek help will contribute to improving their sense of safety in the ED and without fear or worry that they are a burden or a nuisance to staff.

This current study provides further evidence that encounters with older people need to entail much more than the technical and diagnostic aspects of care and must be complemented by the relational and personalised approaches that older people value. It also shows differences in priorities of care between staff and older people, which can lead to unmet needs for the older person. Ultimately, this current study reveals that the relationships older people have with staff need to be strengthened so that they feel better able to convey their needs and feel comfortable to express concerns if they occur. Staff need to develop communication skills to detect unspoken concerns, encourage patient participation in the evaluations of their needs, and develop facilitative strategies to enable older people to share their concerns, so their needs are met (Hestevik et al.2019). Understanding how older people feel connected is helpful for HCPs to identify areas to focus on within the urgent and emergency care environment to facilitate person-centred care.

Maintaining a sense of being valued

This current study revealed the meanings ascribed to experiencing an acute medical emergency can significantly alter participants' personal identity and autonomy. Crucial to their care experience was the importance they placed on their personal identity, as an individual with a past, present and future. Central to their personal identity was to feel valued, to have a sense of worth, to feel they belonged and had a purpose in life. At times of acute illness, their established identity was disrupted which affected their sense of worth, their autonomy and independence. Essential to their care experience was to regain their identity so they could return to normal. Hence, relationships with staff were key to supporting participants to maintain their personal identity, autonomy, independence and self-worth, especially when there were numerous threats to these during their urgent and emergency care stay. However, some interactions with staff left some of the participants feeling devalued, with a diminished sense of worth. Therefore, the participants personal identity, autonomy and self-worth can be enhanced or diminished by how they perceive they are treated by staff.

This current study highlights the determination of participants to maintain a sense of self, despite the challenges faced when they became acutely ill, requiring emergency care. The impact of illness on the 'self' disrupts the personal constructs of one's life, past, present and future and is changed as a result of illness (Bury,1982). The concept of self is positioned as a central part of our identity as a person (Ricoeur,1992). Goffman (1990) introduced the term ‘personal identity’ to represent the uniqueness of a person that allows for the differentiation of individuals from each other. Our sense of ‘self’ and ‘identity’ is widely accepted and constructed through *‘reflexive interaction with others’* (Clarke and James, 2003, p.1388). Thus, identity is shaped by how one views oneself, by the relationships they have with others, and their social interactions (Pierce, 2003, Karnilowicz, 2011). However, self and identity are not static and can be changeable, for example, ageing is a social process that is not the same for everyone (Charmaz, 1987, Nikander,2009). According to Parfit (1984) maintaining a continuous personal identity is challenged by the many obstacles a person may experience across their life-course. Parfit (1984) argues that there are certain times in our lives where there will be a loss of identity, and therefore, there are degrees to which identity will be present or absent. Schechtman, (2003, p.255), acknowledges that at these times of loss of identity, one may feel disconnected from the ‘self’ but the processes used to manage change are important so that one can remain ‘feeling part of’ our identity. Therefore, in this current study, the findings highlight the sense of loss, disconnect, and efforts to retain identity which framed the participants’ experiences of urgent and emergency care.

Disruption to the participants’ established sense of identity arose from a sense of their impending mortality and the vulnerabilities of ageing. This saw the participants dependent on others for support and management of their medical needs. Charmaz’s (1983) concept of ‘loss of self’ can be applied to many of the participant’s experiences in the current study because of threats to identity due to their acute illness. Charmaz (1983) further noted threats can manifest when participants experience acute medical emergencies, bringing to fore such feelings of impending mortality and awareness of the physical deterioration in their bodies due to the ageing process. According to Higgs and Gilleard (2016, p.45), fear of a failing body brought on by ageing, the risk of falling and poor hearing undermines any claims to ageing well, with the greatest threat being that of losing one’s ability to represent oneself. The development of frailty symbolises risks which affect the ability to exercise embodied agency (Higgs and Gilleard, 2015). Embodied agency is rooted in phenomenology. The philosophy of Merleau-Ponty (1968) believed that the physical body is an important part of our self and remains until death. The body is a living self, which, through ageing, may be threatened. For older people, an awareness that their body is failing may impact on their everyday agency. The body becomes inseparable from the ageing process, so their experience of being-in-the-world relates to bodily decline and burden (Heidegger, 1962). Therefore, for many of the participants in this study, serious falls and illnesses imposed by ageing affected their embodied agency and threatened their identity. This is an important consideration in older people's care in order to understand their experience of loss and decline which impacts on their view of self.

Moreover, the need to attend the ED due to a failing body, and severity of their illness further challenged the participants' sense of identity. Furthermore, this drew their attention to the limited extent to which they could exert their autonomy, which they perceived as due to their dependency on others for care. An ethnographic study (Tadd et al.2011) exploring older people's experiences of dignity in acute care found that having to request assistance could result in low self-esteem, further threatening older people's sense of identity. According to Lloyd et al. (2014) many older people viewed their functional decline and dependency on others as a prelude to the end of life, hence their sense of loss of agency and independence is exacerbated when depending on others (Lloyd et al.2014, p.4). This sense of loss resonated strongly with some participants in this current study where the combined effects of ageing and acute illness called their personal identity into question. The participant's sense of their former autonomous identity altered due to their reliance on others such as family members or HCPs., with some perceiving they were a burden to others. Added to this is the societal view of older people as burdensome, which Lloyd et al (2014) argue adds pressure to demonstrate their self-reliance and self-sufficiency. According to Phelan (2010) the social construction of older people as a burden contributes to healthcare delivery that is generic, rather than individualised, focusing on stereotyping the older person as dependent. This perpetuates the negative discourses around ageing and dependency and fails to recognise individualism and personal identity. However, Held (2006) in her 'ethics of care' work asserts that conditions of dependency such as ageing should not be seen as unusual but as integral to human life, thus advocating a shift from the concept of dependency being equated with burden, to one where there is acknowledgement that there will be a need for dependency on others at some point in the older person's life course. For example, accepting identity in old age may include more relationships with HCPs and carers (Lloyd et al.2014, p.5).

This suggests that successful ageing can be determined by how older people are able to create meaning in their life by effectively coping or adapting to the age-related changes of increased dependence. This indicates that HCPs have a key role in helping and supporting older people with the experience of adjusting to age-related illness and its impact on their sense of self, enabling them to exercise their self- determination, to maintain their identity and autonomy, despite these age-related challenges.

Autonomy or agency is a central value in the delivery of patient-centred care (McCormack, 2001, Mc Connell et al. 2016, McCormack and McCance, 2016, Lyons, 2013) due to its emphasis on individualism (McConnell et al. 2016, Morgan et al. 2006, McCormack, 2001). Autonomy and independence were perceived by the participants in this current study as valued components of their identity, with participants wanting to be involved in their care and decisions about them. Sometimes a lack of information or staff not involving them in their care resulted in them feeling devalued, leaving them with a diminished sense of worth. Within healthcare the principle of autonomy is associated with enabling patients to make their own decisions about which healthcare interventions they will or will not receive (Entwistle et al.2010). Others describe autonomy as the capacity to make choices or decisions (Morgan et al.2006, Sherwin and Winsby, 2010, Barclay, 2016). However, for older people, particularly if they are dependent on others to make decisions for their acute medical needs can lead to an erosion of personal identity (Coyle, 2001, Bridges et al. 2010,). Therefore, this study makes a valuable contribution to illustrating the relationship between dependency and autonomy.

This current study has revealed staff's actions and interventions which either promoted or inhibited personal identity and agency. Successful and positive experiences of maintaining identity were associated with actions of staff who respected and valued the person as an individual, recognised their care needs and vulnerabilities and acted accordingly, thus,reinforcing to participants their sense of worth. This confirms the findings of other work on autonomy (McCormack and McCance,2006, Chochinov, 2007, Jocelyn, 2014) and reflects the significance of the relationships which staff form with older people which promote and maintain their identity and autonomy. Additionally, this current study highlights that staff who fostered reciprocal relationships with participants, actively involved them in decisions about their care, provided them with information, and encouraged choice, enabled a strong sense of personal agency.

Positive relationships with staff provide meaning to the older person in how they are valued as an individual and are important dimensions of relational care (Nolan et al.2006). Hence, recognition and being valued by staff was important relational aspects of care for the participants in this current study, strengthening their feelings of belonging and being accepted and increasing their sense of self-worth. Feeling connected to staff (*section : relationships with staff*) and being valued by staff highlight the interrelatedness of the relationships the participants formed with staff.

In this current study the experiences of the participants have identified care approaches that supported them to maintain a positive sense of self, improving their well-being. Many participants reported positive experiences of compassionate care and that they were treated with respect and dignity during their acute care episode. Barclay's (2016) work on dignity underscores the challenges older people face when they are vulnerable due to sickness, deteriorating health and dependency on others, threatening their ability to maintain their dignity. This is heightened when there are high levels of dependence in washing, dressing, eating and toileting, which undermines their self-worth (Barclay, 2016). This may explain why many of the participants in the current study put high value on staff who met the basic and private care needs fundamental to maintaining their sense of dignity .This current study highlights the significance of maintaining dignity as an important component of retaining the participants' sense of self-worth and value.

Attentiveness of staff in getting to know the participants as a person, and what mattered to them as individuals with their own identity, was central to their positive experiences of care. In contrast, some participants felt staff only had a snapshot view of who they were and did not see 'the person'. The importance of person knowledge has emerged in recent years as a crucial aspect of patient-centred care (McCormack and McCance, 2006, Dewar and Kennedy, 2016). Person knowledge recognises *"what is known" about a person (e.g., age, condition) and "knowing the patient" as a person (e.g., what matters to them, their past experiences)* (Dewar and Kennedy, 2016, p.1471). In the ED this means recognising the vulnerabilities of the older person (Watkins et al. 2019), gaining their views and insights about involving them in their care, awareness of the distress that the busy and chaotic environment of the ED may cause and ensuring that the older person is always heard even when they are silent.

Knowing the person can be enhanced through ‘caring conversations’ which Dewar and Kennedy, (2016) and Dewar et al, (2010) state are the foundation of compassionate care. Asking questions to understand the needs of the older person from their perspective should be part of everyday practice, even in the briefest of encounters in the ED. Through these caring and supportive relationships, staff enabled participants to be involved in their own care, and express their individual needs. This enabled staff to recognise the importance of the individualism of the older person, which may otherwise be eroded in an environment where technical aspects of care can supersede relational care. By ignoring the individualism and uniqueness of the older person, it could be argued that person-centred care is largely absent from the approaches and interventions used in the ED to support the care of the older person (McCormack & McCance, 2016). Ultimately, person-centred approaches to care are proffered as central to promoting autonomy in the older person in the ED (McConnell et al, 2016).

Contrastingly, this current study also highlighted that for some participants, lack of patient-centred approaches by HCPs threatened their sense of identity and being valued by lack of inclusion in their care, not addressing their individual needs and feeling they were not being listened to, heightening their diminished sense of worth and compromising their autonomy. According to Wilson et al. (2005) when personhood is not affirmed, patients are less likely to perceive they are being treated with dignity and respect (Wilson et al., 2005), which can undermine their perceived sense of worth or value (Chochinov et al., 2002) and exacerbate feelings of becoming a burden to others (Chochinov, 2007).

Furthermore, there were challenges faced by participants when they perceived they had to justify their sense of worth as valued recipients of care, undermining how they felt they were valued as an individual. This resulted in some participants needing to assert ‘self’ about their own beliefs of their personal worth in response to how they felt they were perceived by others. An observational study (Harrison et al.2015) on why patients with COPD decline pulmonary rehabilitation during hospitalisation found that their’ beliefs regarding their own personal worth were challenged by both comparing themselves to others who they felt were worse than them, and fear of how they may be perceived by others, particularly during a time of vulnerability. That this group felt blamed for their own demise due to lifestyle behaviour lends credibility to the current study findings in that marginalised populations see themselves as unworthy of care.

Therefore, this current study demonstrates a great deal about the physical, mental and emotional efforts the participants made to maintain their sense of identity and be valued as an individual in receipt of care (Lloyd et al 2014). Understanding how older people view their sense of worth should enable HCPs to be mindful of how dominant these views are, particularly at a time when they are most vulnerable. According to Harrison et al (2015) expressing empathy and reassurance to patients who feel unworthy of care is important even in the face of the demands of a pressurised and demanding health service.

Whilst, this current study identified the significance of autonomy for participants in exercising choice and independence, the findings also conveyed how some participants, when faced with the challenges of an acute medical emergency, were happy to relinquish control and defer decision-making to others. Consequently, they did not exert their personal autonomy due to their reliance on HCPs and family to make decisions for them (Hillman, 2014). According to Sherwin and Winsby (2010) who conducted a critical philosophical review of the concept of autonomy in older people, found that personal autonomy runs into particular risk when there is increased dependence and vulnerability that accompanies illness. In addition, Jacelon (2004) found that many older people willingly gave up control, especially when their condition was being stabilised, as they were too ill and weak to engage in decision-making. However, they were more willing to resume autonomy when they were recovering and moving towards discharge. This suggests there are stages through which older people may need to progress to maintain their autonomy, which is applicable to emergency care as they move from the acute emergency state to recovery and discharge. HCPs must try to help patients achieve as much autonomy as possible based on their individual circumstances. Hence, this current study provides a unique insight into the tension between the participants' desire to exert their autonomy, with having to adjust to dependency on others for care.

Pivotal to their urgent and emergency care experience were some individual's focus on recovery and management of their condition so they could return to normal, re-establishing their identity. This highlights the participant's attempts to return to everyday life and functioning as key components of their sense of self. Jacelon (2004) grounded study on dignity in hospitalised older people drew attention to the importance of 'self-dignity' (p.546) which is based on an individual's past accomplishments and is built over time. Hence, although the older person enters hospital with an established sense of self-worth. initially this is diminished in the acute stage of illness when they are reliant on others for care. The individual then works to restore their 'self-dignity' as they move to discharge. Therefore, once the medical emergency was managed, many of the participants in this current study were able to return to their everyday life, which strengthened their personal identity.

Continuity of self, role preservation and maintaining normalcy were found in a qualitative study on older people receiving palliative care treatment in hospital to be important components of preserving identity, shaping their lives with meaning and worth (Chochinov, 2012). These findings could be applied to this current study in that participants' identity was central to who they were as people. They had a strong desire to continue to maintain this, despite periods of acute illness and dependency posing serious threats to their sense of self and personal agency. Through the relationships they had with staff, participants could envisage returning to their previous way of life and resuming their identity and independence. Understanding this will enable staff to see the central role they play in maintaining identity and agency by supporting a patient to adjust and adapt to an acute crisis.

Empowering older people through their urgent and emergency care journey

The findings of this current study identified the extent to which some participants felt inferior and lacked the knowledge and confidence to engage with HCPs about their care and the decisions made about them. This resulted in negative stereotyping, self-stigmatising behaviour and created barriers to engagement in shared decision making (SDM). Furthermore, many participants adopted a stoical approach to care, which saw them very accepting of care and at times acquiescent to the care they received, feeling they had little power to change it. Consequently, they were very reluctant to complain. Therefore, this current study has identified key areas in the participant's journey to maximise their involvement in their care and improve their patient experience.

The previous discussion on 'maintaining a sense of being valued' revealed those empowering interventions by HCPs which actively engaged some participants in shared decision-making (SDM) increasing their sense of self-worth and self-esteem (Tadd et al,2011). Contrastingly, other participants disengaged from SDM, applying negative stereotypes to themselves, resulting in dependency on others, such as HCPs and family to make the decisions for them (Schoenfeld et al.2018). Other participants held back from involvement in their care, remaining silent even when they felt decisions made about them by others were not in their best interest (Perry et al.2011). Thus, there was tension between empowering and disempowering processes in the ED which affected participants' experiences of care and involvement in SDM. Thus, a deeper understanding of these disempowering approaches will enable HCPs to maximise older people's engagement in decisions about their care which may help meet their unmet needs.

How older people view themselves and their SDM capability needs to be understood, particularly in the environment of the ED where, because decisions need to be executed quickly and are deemed a priority (Hess et al.2015), older people may be more vulnerable to being omitted from decisions about themselves by HCPs. Gilleard and Higgs, (1998) states that older people are marginalised in healthcare, being at risk of being deemed too frail, lacking capacity, or assumed to be lacking interest in participation, which can exclude older people in decision-making. However, Flynn et al, (2012) argue that decisions in the ED benefit from patient involvement, despite this setting being least conducive to SDM. It is acknowledged that staff engagement with SDM in the ED environment can be a complex and challenging aspect of practice, due to time pressures and the need to manage critically ill and unstable patients (Petriwskyj et al.2014). Nonetheless, it is recognised that older people in the ED have multiple health and social care needs, making it even more important to understand the unique perspectives of their experiences of SDM in this environment (Schoenfeld et al.2018). Despite a growing emphasis on SDM in healthcare and in the ED, there is little known of the older person's experience of their involvement in this practice (Schoenfeld et al.2018, Petriwskyj et al.2014) and the findings from this current study add to this small body of evidence. This additional knowledge is important for HCPs caring for older people in urgent and emergency care environments if they are to understand the self-disempowering processes they apply, which inhibit their capacity to engage in care decisions about them. Consequently, many of their individual needs go unmet. Thus, there is a need to move away from the task-orientated approaches that are apparent from many of the participants' narratives in this current study towards a patient-centred approach which actively involves older people in their care and treats them as equals in care decisions.

SDM is characterised by active patient involvement and has several key features: a sharing of information by both patient and HCPs, and offering treatment and support packages which build a shared consensus about preferred patient's preferences, priorities values and goals (Coulter and Collins, 2011, Hess, 2015, Schoenfeld et al.2018). SDM has the potential to actively involve older people in their care, rather than them be passive recipients of care (Petriwskyj et al.2014, Gilleard and Higgs, 1998). According to McAllister et al. (2012) empowerment is a process where patients become self-determining, with some control over their health and healthcare, rather than assuming passivity. Therefore, empowering older people to have more control and choice over their care to make individualised decisions to meet their needs would be desirable in the ED (Hogan et al.2016). Thus, an SDM approach would equip the older person with a better understanding of how best to proceed with managing their care, based on the relevant medical factors, whilst appreciating their individual needs and preferences through a shared understanding. To support and enable older people to participate in their care the Johanna Briggs Institute (2012) developed a best practice information sheet on age-friendly nursing interventions in the management of older people in the ED. Based on this evidence they identified that an age -friendly ED environment should support and empower individuals and their carers to be actively involved in decision making. (Pearce et al.2011).

However, achieving self-determination for some of the participants in this current study was challenging because of the negative view they held of themselves, which strongly affected their ability to engage in SDM. According to Petriwskyj et al., (2014) fundamental to understanding engagement processes in SDM is how older people are positioned, both by themselves and others, which they contend is a key starting point in developing engagement. A recent realist synthesis (Dunn et al.2018) was conducted to identify interventions that might help involve older people with multiple health and social care needs in SDM. The authors identified that a key factor in developing a culture of SDM in practice is firstly to understand the willingness or ability of older people to participate in it. Therefore, this current study findings would suggest that HCPs in the ED play a pivotal role in assessing how older people view themselves to establish how best to involve them in their care, the extent to which they wish to be involved, and as appropriate for the clinical situation (Flynn et al. 2012).

Even though this current study found many of the participants wanted to be involved in decisions about their care, they did not actively seek out participation in SDM. Similarly, Bunn et al. (2018) found that older people want to be involved in decision-making, but they were "*not encouraged, or enabled to participate in SDM"*: (p.11). Several studies have identified that the reasons for HCPs not involving older people in SDM include limited time, organisational barriers, and not believing that older people want to be involved in decisions in an emergency care setting (Schoenfeld et al.2018, Schoenfeld et al.2016, Penney and Wellard, 2007). However, revealed in this current study is that many of the participants held back from being involved in their care and consequently did not make their needs known, so posing challenges for staff to meet them. This points to the need for a shared understanding of the older person's needs and preferences, to improve their health outcomes when being cared for in the ED, with HCPs needing to recognise the barriers older people face when making decisions about their care.

This current study revealed the barriers participants faced which inhibited their participation in their care, including lack of confidence in their own knowledge and feelings of inferiority. These findings are consistent with other studies that suggest that patients' involvement in decision-making is linked to their confidence, and perception of their knowledge and self-efficacy to engage in SDM (Dunn et al,2018, Williams et al, 2014). Furthermore, a recent qualitative study on patients' perceptions of SDM in the ED found that those who perceived their knowledge as being inferior in comparison to HCPs felt their involvement in SDM was inappropriate or unwanted (Schoenfeld et al. 2018). Their view of the HCP as the expert disempowered them from feeling they had a role in SDM (Schoenfeld et al 2018). A qualitative study using IPA methodology (Perry et al.2011) exploring older peoples' experiences of discharge following orthopaedic surgery found that older people believing that they are inferior, doing what they are told without complaint resulted in their exclusion in SDM. This perpetuates paternalistic approaches to care which ignore older people's valuable contributions to participation in care and creates power imbalances. Using a critical ethnographic design to explore older people's participation in their care in acute hospital settings, Penney and Wellard (2007) supported this view, finding that tensions can arise around those who perceive the professional as the expert with knowledge, resulting in power imbalances in care (Petriwskyj et al.2014). Moreover, this limits opportunities for older people for full participation in SDM, leaving the power dynamics between HCPs and patients unchallenged (Petriwskyj et al., 2014, Gilliard et al.,2005). Thus, the medical-paternalistic model remains embedded in practice, with HCPs remaining 'experts' (Petriwskyj et al.2014). This would suggest that knowledge and power influence an individuals' capacity to engage in SDM, illustrated by the participants in this current study who wanted to be involved in their care or seek information feeling disempowered to engage, due to their own feelings of inferiority when comparing themselves to HCPs. This view of the professionals as 'experts' gave participants a profound trust in the professionals, often deferring the decision-making to them, as they 'knew best', as reported. Consequently, this belief that HCPs know best conflicts with patients' desire to be more involved in their care (Penney and Wellard, 2007).

Further barriers to engagement with SDM revealed in this current study were environments of care where the participants observed the staff to be rushed and feeling unable to ask for information or exchange their views and opinions for fear of being a nuisance. Significant empathy for staff's workload resulted in many participants not wanting to bother them with their information needs. Rushed staff was recognised as a barrier to SDM as it prevented patients from engagement and exchange of information with them (Schoenfeld et al, 2018). Furthermore, Penney and Wellard (2007) found that busy environments influenced HCPs' approaches to care, with them assuming the dominant, paternalistic role, relying on their expert knowledge to make decisions on older people's behalf, thus limiting engagement and involvement of patients in decision-making.

This paternalistic approach to care was in opposition to how many of the participants in this current study wanted to be involved in decisions about their care, highlighting the importance for them to have knowledge and information to participate actively in their care. Despite wanting to know more about their condition, how to manage it, and self-manage once home, some participants revealed how poor understanding of what had happened to them during their episode of care, and lack of information provision leading to uncertainties in how to manage their condition(s) or how to take medication that was prescribed from the hospital. Often this was directly due to poor understanding of discharge information and lack of appropriate instructions about how to take the newly prescribed medication.

Particularly concerning was lack of involvement reported by many participants in discharge decisions, highlighting issues over their readiness for discharge. Despite some participant narratives clearly articulating their concern over being discharged, their perspective and view appeared not to be considered. This resulted in them feeling anxious, frightened and worried how they would cope once home. Notwithstanding, some participants remained silent, unable to voice their opinion as they felt powerless to change the situation. A recent literature review on older people’s participation in transitions of care (Dyrstad et al.2014) found that they felt neither heard, seen nor involved in the discharge planning process. This was particularly evident when HCPs took a task-orientated approach to discharge planning, rather than an inclusive patient-centred approach. The review also identified how many older people felt resigned and powerless when the decision about discharge was made without their involvement. Edahkl et al. (2012) conducted a qualitative study on older people’s experience of discharge from an acute hospital and found that they were seldom invited to participate in decision–making regarding their discharge, with the decision already having being made between the doctor and the nurse. Consequently, the older person was merely informed of the decision, having been excluded from the discharge process. However, the finding in this current study of lack of information and participation in the discharge process is not new and is consistent with several studies exploring the patient’s perspective on discharge planning (Benten and Spalding, 2008, Edahkl et al.2012). Failure to involve older people in discharge decisions causes fear and distress. Moreover, not actively involving older people in their care makes them passive recipients of care and may lead to disempowerment (Benten and Spalding, 2008). Sadly, many participants felt the reason for their discharge was to free up beds, or that they may be ‘bed blockers’. This finding is consistent with other studies (Benten and Spalding, 2008, Edahkl et al.2012).

The findings of this current study revealed that participants used different approaches to deal with barriers preventing their participation in their care, with many passive and uncomplaining, some stoical, and others acquiescent due to feelings of powerlessness to change the processes of care. Edahkl et al (2012) found that many older people in hospital were subordinate to decisions they did not agree to, with most adopting a pragmatic approach, hoping that the right decisions had been made for them. Moreover, this current study suggests that the apparent stoicism of many of the participants masked feelings of anxiety and loss of control over the decisions made. Moore et al (2013) explored stoicism in health and illness, noting that often the stoic attitude of older people is reported as a coping mechanism. However, they advocate that silence in older people is not necessarily a marker of stoicism, but warrants further scrutiny to understand how they cope and manage illness.

In addition to being silent, there was a general reluctance in participants in this current study to criticise or question the process or procedures they experienced. In the most part, they expressed sincere gratitude to the staff; not wanting to complain about their care in case they were viewed as ungrateful for the care they received. The reluctance of the participants to complain or question ED processes raises some concerns as it suggests that older people are disinclined to complain. According to Bridges et al (2010) this highlights care challenges when older people do not disclose their concerns as this leads to unmet needs. Furthermore, the authors state that the lack of complaints from those who are most vulnerable and at risk in our hospitals increases the potential to miss opportunities to improve services. The idiographic and interpretative approach of IPA used in this current study allowed for a deeper analysis of the participants' reluctance to complain, and brought to the fore the implications of this in relation to managing their care needs. Many of the participants' narratives provided accounts where they were left for long periods without interaction from staff, information about their care was not shared with them and they were not included in decisions made about them. Despite these care gaps, there was a stoical acceptance of the situation they were in, which at times led to acquiescence. Cornwell et al (2012) report on continuity of care in older people revealed older people tend to complain less and are less critical than younger people. A later survey carried out by the Parliamentary and Health Service Ombudsman (www. Ombudsman.org.uk, 2017) found older people and their relatives less likely to complain when they receive poor care, and when they did complain, they felt it made no difference. This survey also revealed wider concerns, echoed in this current study findings, about limited communication with older people and their families, who were not kept informed or given enough opportunities to discuss their care and treatment, and lack of involvement in decisions about them.

Therefore, this current study recommends that further research is required to understand the deeper nuances of why older people don’t complain, and to get richer descriptions to inform service delivery. Further research would complement this current study and develop understandings of the phenomena previously not investigated from the perspective of the older person themselves.

Knowledge and understanding of how the participants felt involved in care decisions reflects the need for interventions to engender older people’s confidence in their ability to engage in SDM. This requires the HCPs to foster trusting relationships with older people to reach a shared understanding of SDM (Dunn et al.2018). Creating an environment in which older people have confidence to ask questions, are given time to discuss their concerns and options without fear of being a nuisance or taking up the HCPs’ time is pivotal to engagement with SDM. Actively inviting patients to be involved in the SDM process was found to be a positive experience by participants in a recent qualitative study on SDM (Schoenfeld et al 2018). Thus, this simple action of inviting older people in SDM conversations can create relationships which optimise mutual involvement, communication and information exchange to overcome SDM barriers.

The power relations identified in this current study suggests they are implicit rather than explicit. Nonetheless, the paternalistic model of care was apparent within the participants’ narratives and was recognised by their passive acquiescent acceptance of the HCPs’ decision-making and authority (Perry et al.2011). Closer attention to engaging older people in SDM needs to be driven by practice, and inherent power relations need to be challenged. HCPs recognition of the power imbalance should be addressed by more proactive engagement with older patients (Schoenfeld et al.,2018), enabling them to focus on more favorable, patient-centred and approaches which are inclusive and representative of the OP population in the urgent and emergency care environment (Coulter and Collins, 2011). Importantly staff attitudes and their use of empowering approaches play a key role in engaging older people in decisions about their care. This study found empathy and compassionate care were the fundamental principles of engagement with older people. Attitudes that neglected the individual choice of the participants undermined their autonomy and rights to

SDM. Ultimately, empowering approaches will drive the development of equal partners in care between older people and the health care professionals.

Summary

Having to attend urgent and emergency care services had enormous impact on the lives of the older person and their loved ones when faced with the uncertainties of their medical need and the seriousness of their condition. The first steps to accessing urgent and emergency care services were fraught with difficulties, specifically, in their decision-making about whether to call the emergency services or attend the ED. Absorption of the messages portrayed by the media around the public and social discourse of ageing as a ‘burden’, saw older people internalise these messages and apply negative stereotypes to themselves. Hence, they too viewed themselves as a burden, which affected their help-seeking behaviour for their medical needs. Disruption to their established sense of identity is altered by threats to their own mortality and the vulnerabilities of ageing that see them dependent on others for support and management of their medical needs. Furthermore, a visit to urgent and emergency care services engendered significant feelings of anxiety, fear, inferiority, low self-esteem and lack of personal autonomy. Unfamiliarity with a busy hospital ED, an environment that can be noisy and threatening which leaves the older person struggling to meet their basic needs. Moreover, feelings of inferiority saw older people adopt disempowering approaches which inhibited their engagement in shared decision making about their care. However, making an improvement to these experiences are staff whose positive interactions make them feel safe and cared for. Staff who are supportive, empowering and attentive to their needs make them feel valued and respected. Moreover, staff who actively build positive connections with older people develop relationships that foster inclusivity in shared decision-making and information giving. Thus, these actions by staff validated older people’s contribution to care. recognising them as a unique population within urgent and emergency care services.

Chapter 7: Health Care Professionals Findings

Introduction

The data from the focus group discussions with the Health care Professionals revealed three overall themes: **Challenging Care Environment, Understanding Older People Needs** and **Improving the Care Journey**. Each major theme had three to six minor themes (See Fig 12).

Thematic analysis has highlighted the consensus amongst Health Care Professionals (HCPs) that they were doing the best they could, caring for older people within the constraints of the urgent and emergency care environments they worked in. They identified a range of factors that either supported or impeded their capacity to care for older people. Factors that impeded care were: working in a time pressured environment, the volume of patients accessing services and the organisational processes of care. HCPs identified that the organisational processes of care had a poor fit with meeting the needs of older people in comparison to other patient groups. This lack of fit centred on a current system they felt was broken and that failed to recognise older people as a distinct group with unique needs within the ED. To address this, they described the need for comprehensive assessment of older people’s needs, but acknowledged that this requires more time to *‘get to the bottom of their problems’* (HCP03 FG2) to improve their health outcomes. In the absence of time, tensions arose in trying to balance their professional responsibilities against these restrictions. However, this often resulted in care in which the technical aspects of care superseded relational care. In doing this, they recognised that ‘the little things’ that mean so much to the older person can frequently be forgotten. Whilst this further fuelled their frustrations, they recognised that they still needed to manage their time against the organisational constraints and spoke that ‘*the art and the skill of the ED professional’* (HCP04 FG2) was to make every contact they have with patients productive in the time limitations they have.

Furthermore, the HCPs drew attention to the media and how the damaging messages about urgent and emergency care had a negative impact on older people and the professionals who worked in these services. In that, for older people they felt the media acted as a barrier to seeking help or asking questions when they were in the ED due to the portrayal of an overstretched NHS.

Whereas, HCPs revealed, they felt the effects of the media headlines that consistently highlighted the deficiencies in ED and urgent care systems. For professionals these attacks felt *'personal'* (HCP06 FG2), especially when they considered that they were doing 'their best' (HCP05 FG2) in a system which they had no power over the processes of care.

The themes will now be discussed to illustrate the views and perspectives of HCPs based on the vignette of an older person's ED journey.

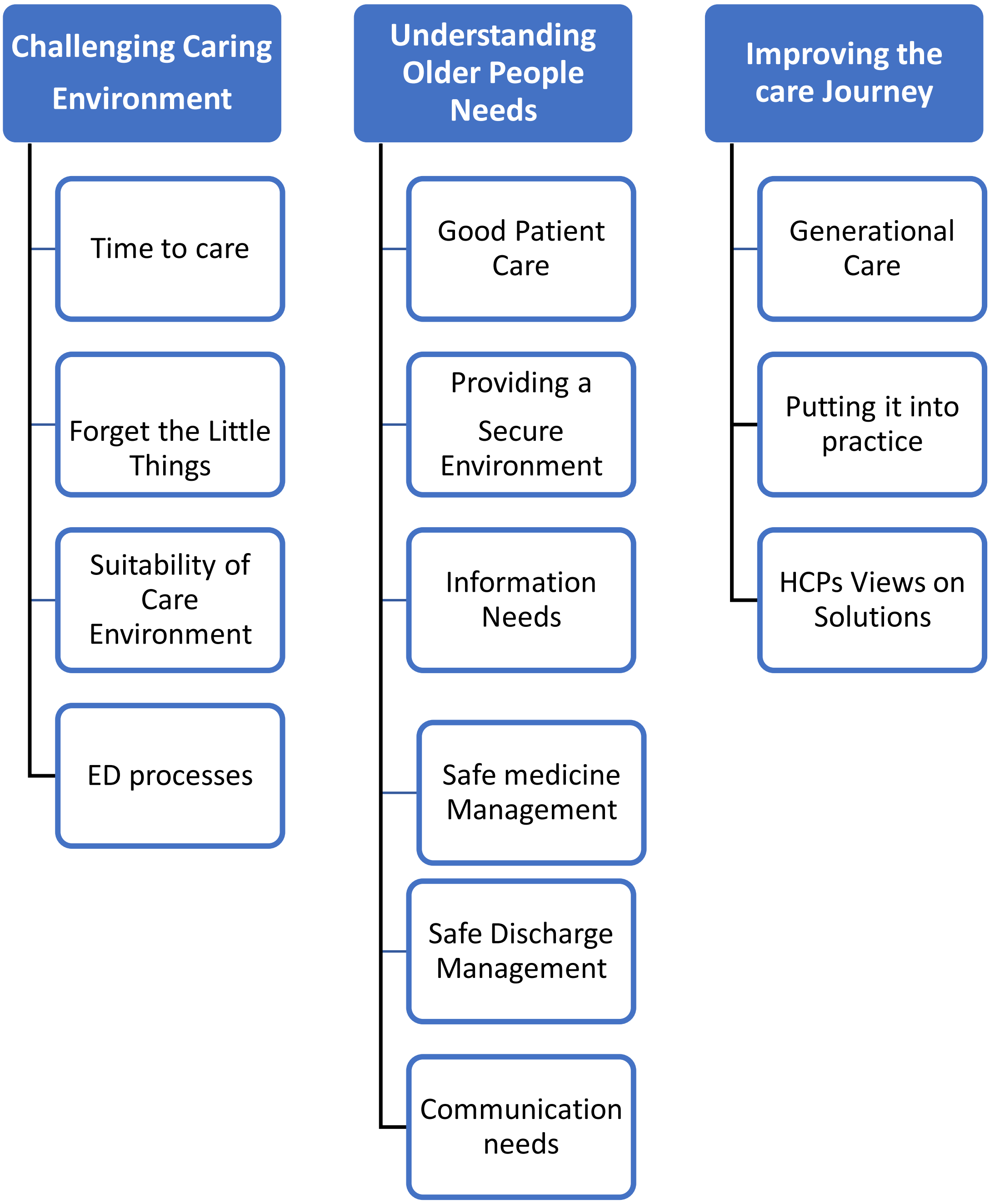


Fig 12: Thematic Overview of Focus Group Themes

Challenging Caring Environment

This theme reflected the HCPs perceptions of the challenging working environments in which they worked and how this impeded their abilities to care for older people. Tensions occurred when they felt they were not meeting older people's needs due to the organisational processes of care and the increased demands placed on the service. Often this left HCPs feeling frustrated and disappointed when the care they aspired to did not match their expectations when delivered. This highlights the emotional struggles for HCPs when involved in working with older people in fast paced acute environments of care.

Time to Care

The majority of the HCPs who participated in the groups were aware of older people's individual needs, yet time pressures within the ED inhibited the amount of time they could spend with individuals. Lack of time was a key factor cited by HCPs in providing the levels of care required to manage the multiple needs of the older person in the ED. Most HCPs acknowledged that more time was needed for older people in the ED, which could have a positive impact on older people's experiences. However, in recognising the importance of time, HCPs were also aware of how the lack of time had a profound impact on quality of care provision. They described how this meant that it was challenging to fully assess the individual needs of the older person.

> **'You've got to be a specialist at looking at a wide range of things haven't you, you've got to be a specialist at looking at all the different systems of the body and that takes time. We need more time with that patient group and I'm not sure that's fully recognised across the Trust, across the country'. (HCP03 FG2)**

Consequently, the older person's basic care needs were often compromised due to time constraints. Although, some HCPs felt that basic care needs were met, they wholly recognised that these were only met at the very most to a minimal level.

> **'Because everybody is running from patient to patient and she's basing that, she understands and can see how busy everybody is, but she still feels she's been given time but on a very basic level of**

> **care rather than the higher level of the medical explanations of what's happening with her'. (HCP02 FG1)**

This lack of time meant undertaking care quickly, without involving the patient, or prioritising certain aspects of patient care

> **'And you know, because of the time restraints sometimes you talk to somebody but then you don't have the time to say do you understand, do you know what you're doing' (HCP01 FG1).**

HCPs spoke of their frustration about the lack of time to provide quality patient care for older people due to competing priorities of managing acute emergencies, waiting time targets and the volume of patients they had to see. They all felt they came into their respective professions to care but believed organisational processes impacted on their ability to provide care to their own high-quality expectations. Thus, there was incongruence between how staff wanted to care and the reality of the working environment of the ED.

> **'At the end of the day we all come into this profession because we care, if not you're in the wrong job. But, it is the processes and the fact that you are very busy that gets in the way of that. It is frustrating because you are trying to do everything you can' (HCP04 FG1).**

From the vignette, HCPs recognised and showed concern that everyone was too busy to spend time with the older person to provide information; however they were very aware that time invested in patients, could prevent readmissions.

> **'Nobody quite had 10 minutes (laughs). Either too busy or you know, busy as an excuse to not. Because they think no, they won't understand or they are concerned that she won't understand and ask me questions it's, we are all busy, but at no point did anyone take that 10 minutes total. It is 10 minutes because it does stop people bouncing back and further problems and it saves yourself further work down the line'. (HCP04 FG2)**

Participants emphasised that due to time constraints it impacted on their ability to get to the bottom of the older person's individual problems. However, key to managing this was to work efficiently and effectively in the brief time that they did have with the person

> **'You might not feel like you have time to really get to the bottom of their individual problems, but you need to portray that and make those few minutes worthwhile, and that's what experience teaches you isn't it'. (HCP03 FG2)**

Forget the Little Things

Forgetting the 'little things' was something that HCPs felt happened frequently; however, they recognised that for the older person meeting their basic needs was important to them. They acknowledged that the 'little things' (HCP06 FG1) were usually superseded by other priorities and that they were working in an environment where they were always rushing from one patient to the next.

> **'Sometimes I think because we are so busy we forget little things like that don't we and we forget to turn around and say, because I can honestly say that I've forgotten at times' (HCP01 FG1).**

HCPs acknowledged that understanding the importance of the 'little things' was valued by the older person and improved their experiences of care. However, the harsh reality was that the HCPs intentions were usually superseded by the priorities of more urgent cases.

> **'You go in intending to have a nice conversation with this patient and put their mind at rest, half way through doing that your phone goes or you suddenly realise that actually there are another 6 patients that are priority one's that day and you end kind of like rushing through it a little bit and you come out thinking did I actually say XYZ, did she understand it that you got to move on to the next one' (HCP02 FG1).**

Suitability of Care Environment

An awareness of how unwelcoming the ED was for an older person due to its busyness was something that the participants recognised. They felt that this not only acted as a barrier to them seeking advice and/or help but also to them making their needs known.

> **‘Maybe it’s like they don’t feel very welcome to the hospital because everyone is busy and not paying much attention to them’. (HCP07 FG2)**

Furthermore, the majority of HCPs expressed there was a lack of fit between the ED and the meeting of an older person’s needs due to the physical and chaotic environment of the ED. For example, the following extract illustrates how a HCP stated they explained to an older person why they had to be moved from the ED to a ward area.

> **‘That A&E isn’t a suitable place for you and we are going to move you somewhere where more appropriate care will be delivered’ (HCP05 FG2).**

The HCPs also identified how the environment may make the older person feel like a fraud due to being aware of how busy the environment and staff are and when they compare themselves to other patients in the ED.

> **‘ I think if they are in there for a while as well and they are laying on a little bed and looking around at everything and can see there’s a lot going on over there and a lot going on over there and when they are alright they can get up and go to the toilet and things like that they feel alright actually and ‘I don’t need to be here because everyone else is a lot ill-er’, so don’t need to be there, but it’s just, you know, reassuring them really, making them feel….’(HCP01, FG2)**

HCPs accepted that they have a ‘*battle’* in trying to address many of the organisational demands of urgent and emergency care. They discussed how this situation was due to the lack of resources and just how busy and pressurised the environment was to work in. This resulted in the HCPs feeling frustrated due to the constant pressure in which they worked.

> **‘When they (older person) had a negative experience, it’s just yeah, disheartening. And I think we have got a bit of a battle in that it’s a very difficult environment obviously because of resources etc. that’s a huge part of it’(HCP05 FG2)**
>
> **‘It’s been like this for ages I think, it’s more and more because it’s so pressurised’ (HCP06 FG1)**

ED processes

The organisational processes involved in meeting four-hour targets, pathways of care that involved multiple transitions in older people’s care journeys and the push to discharge from hospital all negatively influenced the care and continuity HCPs felt they could provide. The majority believed that ED processes of care were aimed at discharging the patient from hospital as quick as possible, rather than aiming for high quality patient care. In this context, there was an overwhelming agreement about the huge pressure HCPs felt in respect of needing to discharge patients. This pressure is further compounded by a backlog of people waiting in ambulances and the continuous pressure to free up beds and trolleys. They suggested that the focus of care in the ED was to ‘*fix todays problem’* (HCP03 FG2) and get the older person out of the door as quickly as possible. Staff attention was constantly on finding the next bed for the other patients coming through the door. This led to a pressurised environment to work in.

> ‘**They’ve got three trolleys with numbers up on the walls, so they are affectively acting as unofficial trolley bays and have got so many people coming through, then we have got to clear A&E out but we get patients put on these trolleys waiting for beds’ (HCP02 FG1).**

HCPs also spoke about how they felt they were working in a system that was broken with some questioning the ED processes of care when this had the potential to cause harm to the older person.

> **‘Your mortality is going up by the minute by your moving her- confusion and delirium is going to up and in the middle of the night I think she was moved, why are we moving patients, we’re failing if we are moving patients. Ok they have got to come from AMU to**

> **somewhere in the middle of the night, but why are we moving patients off AMU in the middle of the night?' (HCP06 FG2)**

System delays, multiple handovers and transitions in care were common experiences for older people. HCPs acknowledged the potential for things to get missed during these processes which increased the risk of adverse events. Consequently, they reluctantly accepted that these processes could result in poor patient outcomes.

> **'She's lucky she was only moved once, I know it's a horrible thing to say. But she's lucky she only went once. People move multiple times especially when we are opening escalation areas if you're medically fit for discharge and you are then moved into a day area, day procedure area unfortunately at the moment because there is nowhere for emergency cases who need to be in the emergency area to go. And then normally a lot of those discharges fail because they have been moved and everything goes wrong'. *(*HCP06 FG2)**

> **'Old people, being moved around a lot, and to a new place, new staff, where, like what you were saying, confidence, having confidence to talk out. If you're meeting new staff every four hours and you're going to a new part, I think patients feel a bit pillar to post.' (HCP05 FG1)**

However, they also recognised that despite these concerns the patient's outcome in the vignette was good and thus they felt reassured.

> **'I think care appears good, outcome appears good, process is the problem isn't it. You got a good outcome with a questionable process, and that is, the process is the important thing, the outcome will be the outcome if the process is always ok '(HCP04 FG2)**

Understanding Older People's Needs

Understanding older people's individuals' needs played a key role in providing good quality patient care and a safe environment. However, the HCPs agreed that there was a need for different pathways of care for older people in order to be fully able to identify and address their needs. There was strong agreement amongst HCPs across the two focus groups that there was a necessity to give voice to the older person by empowering them, so they are facilitated to ask for their needs to be met.

Good Patient Care

This subtheme identifies clearly HCPs views about what good patient care should look like by ensuring that older people's physical, psychological and social needs are met. They recognised that older people have different needs and require different approaches to care than other patient populations that visit the ED.

> **'As people get older you have to look at more different areas, more different dimensions to their presentation and discharge planning.' (HCP03 FG2)**

The HCPs agreed that recognising the unique needs of the older person required a complete holistic approach to care, that not only appreciated the needs of the older person, but those of the whole family and carers. This was fundamental to good patient care for older people in the urgent and emergency care environment.

> **'In OPM they've got families, they've got husbands. John, her husband was very, very worried about her so that's something you got to consider as well like the husband he's also part of the patient who's also worried how's he going to get home how's he going to cope'. (HCP02 FG2).**

Humanising care was identified by HCPs as a universal approach to care that was appreciated by older people and one where '*the little things*' (HCP01 FG1) made a difference. These moments of care were memorable and truly valued.

> '**The language he used (Dr), it's not medical, it reaches everyone on that level, everyone understands that language don't they whether you're a doctor or a person who's got no medical understanding' (HCP03 FG2)**

However, some HCPs felt that whilst the care they provided at times was good it was at a basic level. A number of HCPs felt concerned and saddened that they were not fully meeting the needs of the older person. The majority of HCPs acknowledged the frustration they felt in being unable to provide optimal care.

> **‘I do feel sometimes that the care that I provide to elderly patients definitely could be better because of the fact that we spend a lot more time with other patients’ (HCP04 FG1).**

Many participants also recognised the need to understand the vulnerabilities of older people, particularly in the ED setting. Furthermore, they expressed concern for the older person’s dignity in the ED when there were long transfer waits until beds became available on the wards.

> **‘Also, as a patient, how undignified is it to be waiting for a bed on a trolley on a ward’ (HCP4 FG1).**

Providing a Secure Environment

The HCPs understood the need to keep older people safe in the ED, however they spoke of obstacles to achieve this posed by the challenging physical environment. Their empathy for older people is clearly demonstrated as they recognised how overwhelming the noise and bustle of the ED and ward environments could lead to a very ‘*scary*’ environment (HCP02 FG1). They acknowledged the hearing and sensory problems older people could have which makes them vulnerable within these environments.

> **‘Also, the noise and the bustle of the ward and the fact that they are hard of hearing and maybe their sights not so great, and it becomes very overwhelming and quite a scary thing’ (HCP02 FG1).**

The importance of being sensitive to an older person’s fear, anxiety and vulnerability due to the chaotic and noisy environment was acknowledged by HCPs. They understood how important it was for older people to be reassured; in particular they recognised the transitions in care where older people may feel more vulnerable due to being left for long periods or being moved to side rooms. However, they recognised that they did not fully meet the older person’s expectations of continuity of care and safety needs.

> **‘It was probably really scary for her because she was put in a side room as well. She didn’t really know what to expect so I think we didn’t manage her expectations. But we didn’t give her that confirmation that she was and so you know, then put in a side room’ (HCP04 FG1).**

Information Needs

The lack of information provided to older people was recognised by the HCPs who explained that this was largely due to professionals making assumptions that other professionals had already informed them about their care.

> ‘**Maybe we assumed that somebody else had told her. Because there are a lot of people in the process’ (HCP05 FG1).**

However, many of the HCPs identified that there were assumptions made about the perceived generational needs of the older person. This included assumptions that older people did not want to know as much information in comparison to younger people. Some HCPs did not want to unduly worry older people with too much information. Subsequently, they made judgement calls on how much information to reveal to them.

> ‘**So, assuming that someone has already told them or assuming that they wouldn’t understand because they are an old person ‘(HCP05, FG1)**

HCPs recognised that not involving older people in their care or providing them with sufficient information contributed to poor patient outcomes. Furthermore, it resulted in older people having limited understanding of what was happening to them because HCPs don’t check their understanding or invite them to ask questions. Thus, HCPs acknowledged that such approaches allow older people to succumb to being passive recipients of care.

> **‘Maybe she hasn’t heard and understood and they just continue to go through their journey without having that basic information. It’s probably something else that everybody needs to be aware of. (HCP02 FG1)**

However, many HCPs acknowledged the need to make decisions in different ways to meet the needs of the older person as there were stark differences between older and younger people's needs. HCPs revealed that the timing and readiness of older people to receive and absorb information was important in the approaches they used to involve individuals in their care. In particular, they recognised that in an ED crisis older people need time to process the information. However, they also identified that there were limitations in how much they could do to fully enable older people to understand their diagnosis and management, and that a more integrated approach between primary and secondary care was required.

> **'I think it's about the timing, I was going to say the timing of when we do that as well. Because when you are in a crisis in ED and might not be able to think clearly to ask the questions about the situation of your diagnosis so I think that's where for example community trusts have such an important role and following people up when they've calmed down and they've stabilised and when they aren't in crisis and asked them about that experience' (HCP03 FG2).**

Safe Medicine Management

Worryingly, HCPs acknowledged concerns over poor patient education about discharge medication from the vignette, which they felt could negatively impact on an individual's safety and recovery once home.

> **'The fact that she left hospital with a tablet and didn't understand what to do with it, that's quite scary. And if she was taking something she didn't understand and ends up straight back in again, which is what happens a lot as well and I think that bit stands out quite a lot' (HCP01 FG2).**

> '**Really we shouldn't be starting new medicines on people without discussing that, because it's something we are doing to them' (HCP05 FG1)**

HCPs recognised that many older people do not fully understand their medication. They acknowledged that not enough time was provided for older people to discuss their discharge medication with them or allow them sufficient time to invite them to ask questions. However, they accepted that when time was spent with the older person explaining about medication, they were grateful, and they felt this should be an integral part of their role.

> **‘They seem really, really grateful that you took the time to explain every tablet to them, because they have been taking it for years and didn’t know what each tablet is for. Then at the end they seem very thankful.’ (HCP02 FG2).**

Yet, they also recognised that some older people had a general acceptance of what they were told and did not actively seek further information about their medication.

> **‘When I know a patient is going to a ward or I’m discharging them, I’ll say to them do you have any questions and a lot of people say, what elderly people say is no, I’m fine. You look at them and think, are you sure, yes I’m fine and you just think (sharp intake of breath) are you really, or are you just… (HCP01 FG1).**

Many of the HCPs felt that fully addressing older people’s education needs about new medication could not always be achieved due to the short time frame prior to discharge. In particular, this was more notable for those older people who were directly discharged from the ED. Additionally, HCPs identified that they would like to spend more time with an older person to comprehensively explain new medication, as they recognised that they might not have the support once home in the community.

> **“Doesn’t surprise me though. I think this is what we anticipate can happen when people leave hospital and I think sometimes that’s why we feel or fight an inclination to keep people in hospital a little bit longer sometimes because we are aware that they haven’t got that support all the time when they leave. There isn’t that transition of care, not consistently and certainly not in the older patient population’. (HCP03 FG2)**

Safe Discharge Management

Participants acknowledged that the rush to get older people discharged from the ED compromised a safe discharge. Minimal time therefore was spent on comprehensively providing the older person with information on follow up care and management. There was also recognition from HCPs that many older people are unsure about their follow-up care and that this may negatively impact on their health and be a subsequent cause for readmission.

> **‘The discharge decision was communicated by a nurse and the follow up decision, but no clear plan to follow up regarding her angina is probably a fairly typical thing that happens in all forms of emergency that actually the big rush is to get to the discharge decision - once the discharge decision is made people have moved on to the next one because they have a whole barrow load of people to admit or discharge and sometimes the intricacies of the discharge are not communicated would be my impression of what happened really (HCP04 FG2).**

Some HCPs acknowledged the importance of ‘*wrapping it up’* (HCP03 FG1) with the older person before they are discharged from the hospital. This involved providing the older person with an overview of their care management, the x-rays, blood tests they had and checking their understanding of this and their follow up care. This facilitated the older person to understand the discharge process. Good discharge information enabled the HCP to be perceived as a competent professional, which was valued by the older person.

> **‘I am at the exit of the, I’m helping patients to leave the hospital so I find that actually, wrapping it up at the end then, starting with why are you here, do you know what happens to you, what happened, what investigations did you have and giving them a little bit of a background would almost start my assessment with a bit of a, more peace of mind and they kind of know and they relax. Your fracture, your x-ray is ok, you don’t have a fracture, your bloods are ok’ (HCP03 FG1)**

Communication needs

> HCPs reported that they felt in general, older people leave hospital with only a basic understanding of their care journey. Thus, they recognised they were not working collaboratively with the older person in their care. This, they felt was a significant barrier to meeting the needs of the older person, as they acknowledged that older people can hold back from asking questions and affirmed that many rely on their family members to communicate to the professionals and make decisions on their behalf.
>
> **'I think we're not necessarily providing basic care in this situation because we haven't communicated what's going on to the patient and I think we assume a lot of knowledge in others, and we forget perhaps that not everyone understands, and I think communicating what's wrong with someone and what's happening is basic care.' (HCP03 FGD2)**
>
> **'There's not a lot of joint decision making going on. At no point did anyone say would you like to be further investigated, do you know what I mean, are you coping with your medication, or it wouldn't appear any way' (HCP04 FG2).**

Lack of involvement of older people in their care was seen by the HCPs as being disrespectful to older people. Whilst some HCPs identified that they felt the older person was treated with respect, kindness and compassion from the narrative of the vignette, other HCPs argued that the lack of inclusion of older people in their care or communication with them about their care demonstrated a lack of respect towards them. They felt that this was largely due to HCPs acknowledging that they were making assumptions about their level of understanding and need for information. As a consequence, they don't explain or involve the older person in their care.

> **'I think that shows a lack of respect of her understanding to, we are assuming that she wouldn't be able to understand her clinical presentation' (HCP05 FG1).**

Moreover, some HCPs identified an apparent hierarchy of information-giving which results in assumptions about information being conveyed to older people. This initially starts off with the Doctors and Consultants. This process leads many

HCPs to assume that information about what is happening to the patient and test results have already been relayed to the person.

> **‘We sometimes get asked by the patient do you know what’s happening with my results or when can I expect these, or why am I here or something like that. We either don’t have or aren’t in the position to explain something we don’t have access to. So it does happen where the assumption is that the doctors or the consultants first start the process when they have and spoken to the patients. So, that does get missed out of the process’. (HCP02 FG1).**

Some HCPs acknowledged barriers to communication that could be created by talking too fast in busy and noisy environments which might impede a patient’s understanding of care management and discharge planning. However, they recognised the important role that family members have in the ED, especially when older people have memory or communication problems.

> **‘Also I mean sometimes, I must say that, I must be speaking quite fast in an accent they don’t understand, but maybe the patients don’t understand or they have memory problems; I try to let the next of kin know or a carer or somebody know what the plan is or what happens because the patients go home with no information and nobody knows what happens. So for me, it is important to let the patient or somebody know what happened.’ (HCP03 FG1)**

HCPs conveyed the importance of communicating effectively with the older person to maintain their sense of worth and identity throughout their hospital care journey. In particular, they stressed that older people should feel ‘*important*’ (HCP01 FG2) all the time and not feel they are being ’shoved out’. In particular, there was a perceived over emphasis on: ‘needing a bed’, which the HCPs felt had the potential of diminishing an older person’s sense of worth in the ED.

> **‘Because we need the bed but I just think it needs to be put across in a different way, and not feel like you’re shoved out the way because somebody else is more important they should all be really important no matter whether they are waiting to go home or in respiratory failure’ (HCP01 FG2)**

Improving the Care Journey

This theme highlights the generational aspects of older people's care that makes their needs unique to them. Whilst many of the HCPs demonstrated awareness of these needs, which were further enhanced by recent educational courses, putting this into practice was difficult due to the challenges of the working environment. Despite these challenges HCPs were in a strong position to suggest possible solutions that they felt would improve an older person's care journey. Furthermore, additional influences, other than organisational barriers were identified; more specifically, these were the impact of the media on how older people perceived their level of burden on services and how HCPs internalised the constant berating of the services in which they worked.

Generational Care

The majority of the HCPs spoke of their awareness that older people sometimes will just *'go with the flow'* (HCP03 FG1) and attributed this to be a *'generational'* thing (HCP02 FG1, HCP05, FG2).They recognised that older patients were more accepting of care and in general are reluctant to complain even when they experience care they perceive as poor. Consequently, from the HCP perspective this makes their work in the ED easier. Furthermore, HCPs acknowledged that '*quiet*' (HCP04 FG1) older people tend to be overlooked due to the demands of the more vocal patients and the general busyness of their working environment. Whilst the HCPs were sensitive to the older person's needs and conscious that they need more care input, many HCPs did not act upon it due to competing challenges within the ED.

> **'She does see things that she may not agree with but she seems to be going with the flow. So, which makes it, it makes it as a typical patient, it makes it an easier patient for us in the sense because you have the opposite patient that does do these things and are very vocal and make it more challenging for the staff working in A&E' (HCP03 FG1)**

> **'Doris she's obviously quiet she didn't say anything she was like 'oh no, I'll just let them get on with it' so and then you have the very vocal people and they are the ones you have to go to because, and I**

> **find that really frustrating because Doris is the one that probably needs more'. (HCP04 FG1)**

In addition, the majority of the HCPs identified generational aspects of care that they experience in everyday practice such as older people feeling a burden and assigning their symptoms to ageing. Understanding these perceptions highlighted to the HCPs how older people view themselves as a service user and the challenges older people have in assessing their own symptoms and long-term conditions. The HCPs also pointed out that listening to the older person's story made them consider how their sense of worth may diminish as they get older.

> **'The times an older person will say, as a therapist it happens to me quite a bit, they will say I don't want to be a burden or I don't want to be a nuisance to my family; you're not, you're a person just as much as the person standing next to you. Yeah, they perhaps value themselves less as they get older'. (HCP05 FG2)**

> **'And obviously ill health as ageing. They don't consider hypertension, diabetes, that's not an illness, it's just because I'm old. So, you ask people their past medical history and like cramps and all that, and you go any diabetes, oh yeah, diabetic, high blood pressure, they're not illnesses are they, it's just what happens when you get to old age.' (HCP04 FG2)**

Putting it into practice

Many of the HCPs provided examples of evidence-based practice that should be used when caring for older people. This was derived from recent knowledge and understanding gained by attending educational modules at the local university. However, they recognised the challenges of aligning their clinical practice with their theoretical knowledge, due to the time pressured environment and organisational restraints.

> **'So, using the Calgary Cambridge model for assessment (of) patients they talk about joint decision -making process and it's really difficult to actually field that into working in A&E; it's not how we are taught and it's not the culture, and then when you go and**

> **read about the models. I have to actively think about involving the patient in the decision-making process instead of it just being natural, does that make sense' (HCP05 FG1)**

HCPs Views on Solutions

There was a general consensus that clear pathways of care for the older person are needed, that require different ways of working to ensure that the older people's journey is improved. Of importance was the recognition that older people's medicine is a speciality field.

> **'We recognise older person's medicine as a speciality like we never really used to. Actually, we recognise more now that they do need a different pathway, a different way of working to get better experience so that's a change that you can build on and move through, isn't it, it never used to happen.' (HCP04 FG2)**

> **'It needs to have the recognition that it is a very specialist area' (HCP05 FG2)**

The HCPs also identified transitions in care as important and they felt the older person was more vulnerable and these stood out as areas for room for improvement from the vignette, specifically around discharge processes and medicine management and safety.

> **'There isn't that transition of care, not consistently and certainly not in the older patient population. And so, looking at it from a helicopter view you know, you got to look at the whole patient admissions/re-admissions and it's that gap, there's gaps in care and that's why people get re-admitted again' (HCP03 FG2)**

Furthermore, there was a recognition that a comprehensive specialist approach to older people's care was required to meet their individualised needs. However, they acknowledged that care that was individualised needed a certain level of skill.

> **'It's making someone feel like an individual and not a number. Like you say xxxx, that's a skill in itself, you might not feel like you have time to really get to the bottom of their individual problems but you**

> **need to portray that and make those few minutes worthwhile, and that's what experience teaches you isn't it (HCP03, FG2)**

The HCPs acknowledged that older people can hold back from asking questions about their care. To address this, as professionals they felt, they need to be more pro-active in inviting older people to ask questions and to participate in their care. This requires empowering approaches to care that in essence gives the older person permission to ask questions, therefore, they are given a voice to ask for their needs to be met. Inviting older people into care conversations, HCPs suggested would enable older people to make their needs known and ensure that they fully understand their care and follow up management. This would recognise them as equal partners in shared decision making about their health care needs.

> **'They'll tell you and you'll say 'did you tell the doctor that' and they'll say 'no I didn't like to' or something similar and I think we need to perhaps look at it a way of empowering patients more so that they can keep everything going on with their health' (HCP05 FG2)**
> **'We just need to say do you understand what's happening, do you need to ask me any questions and just spending some time with them' (HCP01 FG1)**

However, despite the multiple solutions that HCPs proposed, they also accepted that they had an uphill task in trying to address many of the organisational demands of urgent and emergency care. Exacerbating this battle was the media portrayal of ED services, which reinforced any existing negative beliefs and perceptions about the care that was or would be provided.

> **'I think the media doesn't help I think the media just working against us, they catastrophise everything so everybody has this pre-conception before they come in anyway.'(HCP05, FG2)**
> **'The media portrays such a rush fitting environment' (HCP03 FG2)**

'For some of the HCPs they internalised the attacks by the media and felt they were personal. This did not reflect the everyday experiences of the HCPs who work to do their best every day for all patients they encounter.

> **‘And that’s personal, that feels personal, because that’s a system failure going on not an individual failure going on and that feels personal when you read it because actually we come to work and try our best every day and then you read that and think oh’.(HCP06 FG2)**

Summary

The use of the vignette in the focus group allowed the HCPs to express their perceptions and views of older people’s care in the environment in which they worked. They identified several factors that they felt were pressing issues and challenges in how they care for older people, as shown in the themes that were derived. These factors centred on organisational processes of care and a need for new ways of thinking and working in order to meet the needs of older people within a contemporary health service. Fundamentally, the HCPs acknowledged that older people have unique needs that encompassed generational views about how they perceive themselves as recipients of care. This requires a specific skill set, translated into actions and interventions that fostered involving older people in their care to maximise optimal outcomes of care for this patient population.

Chapter 8 Synthesis of Findings

Introduction

This chapter will comprise a synthesis in relation to the findings from the interviews with older people and the focus groups undertaken with health care professionals and older people. This will be achieved by also comparing and contrasting with the wider literature. The similarities and differences between older peoples' perspective and those of professionals highlighted will underpin the discussion (see Box 2). Furthermore, the discussion will capture the distinct views of health care professionals through the narrative lens of the vignette to illuminate how they contextualised the care experiences of older people, and in doing so, bring to light their experiences on caring for this unique patient group. The focus will be on how each group has understood the experiences of the ED and urgent care for older people. Significantly, this synthesis will provide further understanding about what the experience of attending urgent and emergency care may be like for an older person. As a result of drawing on both perspectives, recommendations for practice can be developed and these are presented clearly in Chapter 9.

Similarities in older people and HCPs views on older people's experience of care

- ➢ Many older people are left with unmet needs during their emergency stay
- ➢ Little things make a difference to the older person's experience in the ED
- ➢ Positive relationships helped them to feel connected.
- ➢ Active engagement in building rapport enabled a deeper understanding of needs
- ➢ Unsuitability of the ED environment to meet need which increased vulnerability
- ➢ HCPs work hard for all their patients despite organizational constraints

Differences between older people and HCPs perspectives on experiencing care

Older People

- Priorities of care which are important are understood differently
- Concerns are not raised or spoken about
- The ‘little things’ often get overlooked
- Basic needs for physical comforts were not met
- Specific environmental needs and meaningful relationships with staff make them feel cared for
- Avoidance of communicating needs for fear of wasting time or being a nuisance
- Lack of involvement in decisions
- Feeling abandoned during transitions
- Lack of continuity in care after discharge transition

HCPs

- Assumptions made about the perceived generational needs of the older person
- Incongruence between how staff want to provide care and reality of the ED environment leading to frustration and disappointment
- Disconnect between theoretical knowledge and practical application

Box 4: Key similarities and differences between older people and health care professionals

It was evident from the older people’s findings chapter (see Ch 5) that they were generally positive about their experiences of care and valued the service of the ED and the efforts staff made to care for them. Nonetheless, they faced numerous challenges whilst they were recipients of urgent and emergency care. These highlighted areas of concern regarding the management and delivery of care for older people. Moreover, these concerns were also echoed in the health care professionals’ findings. Accordingly, health care professionals thought the challenges reflect the pressures faced by urgent and emergency care services in delivering patient-centred quality of care to this patient population. The challenges centred around organisational constraints, care pathways, suitability of the environment and the lack of time for staff to engage in meaningful relationships with older people to identify their needs. Ultimately the concerns identified acted as barriers to providing patient-centred care to meet the unique needs of the older person.

Reality Versus Aspiration for Care

Healthcare professionals (HCPs) faced daily challenges to meet older people’s needs. Working in a fast-paced environment under the pressure of organisational constraints and processes of care resulted in tensions between care aspirations and the reality of the practice environment. These findings are in line with previous studies acknowledging the constant pressure HCPs are under to provide quality of care for older people (Nolan, 2007, Nugus et al.2011, McConnell and McCance, 2015). Using a focused ethnographic approach, Taylor et al (2015) explored ED nurses’ experiences of caring for older people, which found they had to assess and juggle care-giving against competing priorities. This was undertaken in a time-pressured setting, resulting in an environment that was unpredictable and with changing priorities of care (Taylor et al. 2015).

In this current study, HCPs worked hard with compassion to meet the needs of older people within the overall environmental and organisational constraints. Furthermore, they wanted to make a difference with their care and provide high quality patient-centred care. These views resonate with a mixed-methods study by Bulut et al. (2014) who explored nursing perspectives of caring for older people. The study identified that nurses aspired to provide patient-centred care to ensure that older people’s physical, psychological and social needs were met, and highlighted the need to keep older people safe. However, a similar qualitative study exploring nurses’ experiences reported multiple challenges in trying to achieve quality nursing care and maintain their safety , such as the diverse and complex health needs of older people (Lennox et al.2019).

HCPs in this study spoke of their frustration at not being able to provide appropriate and personalised care for older people in the ED. They acknowledged their tendency to focus on the presenting problem, rather than on all aspects of older people’s health. There was minimal assessment of any psychosocial issues, limited time on comprehensive medication review or polypharmacy issues. Consequently, this resulted in the needs of older people being inadequately addressed. A systematic review by Shankar et al (2014) identified similar themes and found the absence of managing these needs caused increased distress for older people. Further issues that stood out for HCPs from use of the vignette were gaps in care around communication and shared decision-making, meeting basic care needs, medicines management and comprehensive discharge assessment. These gaps in care clearly highlight areas for quality improvement in the delivery of care for older people and have been recognised in the literature as areas that affect patient health outcomes (for example, Lowthian et al.2016, McCabe and Kennelly, 2015, Taylor et al.2015). Moreover, these gaps in care saddened the HCPs since they all wanted to make a difference and provide the best care for the older person. However, the stark reality was an organisational culture of constraints and ED processes that impeded their ability to provide patient-centred care. As a result, comprehensive assessment and management of the older person was replaced with care they felt was good enough, but not what they aspired to.

The inability of staff to meet their own expectations of what care should be for older people left them feeling frustrated and disappointed. This highlighted the emotional struggles experienced in caring for older people. Consistent with previous study findings, emotional struggles and moral angst are common experiences for HCPs when they are unable to meet the needs of the older person (Kelley et al.2011, Bulut et al.2014, Goodrich et al.2018). This is in line with Taylor et al. (2015) study, which found that the pressure of continuous reprioritisation of care often resulted in older people’s basic care needs being seen as less important and subsequently overlooked. This left HCPs distressed, knowing they could not meet fundamental needs. Thus, managing older people’s unmet needs and their own personal distress simultaneously were common occurrences HCPs. Mackintosh (2006, p.959) states that professionals have to develop some degree of *‘emotional hardiness’* to cope with their ability to work in the ED to meet all patients’ needs appropriately.

This current study identifies the dichotomy between the professionals’ aspirations to care and the reality of a work environment which lessens their capacity to provide the essential care older people need. Based on the findings from the HCPs’ experiences, it is clear that attention needs to be paid to their emotional needs within the context of their practice.

Understanding the complexity of older people’s needs

Caring for older people required more time to assess their individual needs, however the reality was that insufficient time was provided. Significantly, for HCPs in this study the complexity of older people’s health and social care needs as well as the urgency of their presenting problems warranted more time. Time to care is a consistent finding from previous research in order to assess and manage the complexity of older people's needs, achieve optimal care and to have a positive impact on their experience (Rawson et al.2017, Taylor et al.2015, Ellis et al, 2015).

Older people present with serious acute illnesses such as cardiac, respiratory and neurological problems (Steinmiller et al.2015; Ellis et al, 2015; Taylor et al.2015) and many individuals have at least two or more long-term conditions, polypharmacy and social care issues (Aminzadel and Dalziel,2002, Samaras et al.2010, Downing and Wilson, 2005) and concomitant functional decline (Conroy and Turpin, 2016). Thus, older people are a more complex group than other patients in the ED (Taylor et al. 2015; Bulut et al.2014). The interplay of multiple comorbidities, functional decline and social care needs can predispose older people to poor health outcomes and greater care needs (Ellis et al. 2015; Conroy and Turpin, 2016). Additionally, older people may present with vague, atypical symptoms combined with poor history-telling, resulting in challenges or delays in attaining a diagnosis (Taylor et al.2015). Thus, older people have unique needs posing challenges for ED staff (Shankar et al.2014). This highlights the necessity for HCPs to understand both the complexity and urgency of older people's needs (Nugus et al. 2011, Ellis et al. 2015). However, managing these components of health in an environment where acute medical needs are a priority and time is limited is highly problematic. The traditional models of care in the ED have tended to focus on managing the acute emergency and not complexity (Conroy and Turpin, 2016) presenting a potential mismatch between the emergency priority and the multifaceted nature of older people's needs (Conroy and Turpin, 2016).

In this current study lack of time gave HCPs little time to make meaningful connections with older people. This resulted in assessments being undertaken too quickly and care that did not include the older person. Competing pressures, priorities of care and the volume of patients limited the time available to spend on comprehensive assessment of the older person's needs (Taylor et al. 2015). These factors all combine to illustrate the challenges of providing care in a time-pressured environment (Ellis et al.2015). Conversely, for the older people in this current study, time was what they wanted from HCPs. They wanted professionals who were not in a hurry, willing to listen and talk to them and keep them involved in relevant decisions about them. Lack of quality time with HCPs left older people feeling the underlying cause of their problem was not identified, and that their other health issues which they felt could be the cause of their problem were not explored. Missed opportunities to recognise the severity of older people's symptoms were identified in an ethnographic study on nurses' experiences of caring for older people (Taylor et al. 2015). This was mainly due to their attention being on the presenting problem identified on the triage letter, often resulting in the comprehensive assessment of older people's needs not being initiated. Accordingly, older people in this study wanted time for health care professionals to get to know them as a person, thus providing them with permission to tell their story about all their symptoms and concerns. This would enable health care professionals to have a comprehensive understanding of their needs, which includes psycho- social assessment and not just management of the presenting physical health problem(s). Consequently, this highlights the risks associated with rapid assessment of older people which has the potential to miss serious illnesses that if left untreated, can lead to sudden and serious deterioration in health (McCabe and Kennelly, 2015).

Rushing from one patient to the next -forgetting the little things

Little things that could make a difference to the ED experience can get overlooked. Struggling with the amount of time they could spend with older people; the HCPs in this study described an environment of care where they were '*rushing from one patient to the next'* (HCP2, FG1). This left little time to talk, explain care and/or diagnosis or involve older people in their care. Taylor et al (2015) study on nurses' experiences of caring for older people in the ED found that nurses work rapidly to assess, treat and discharge, then move on to the next patient. In contrast, the pace for older people was slower, extra time was required to support them with ambulation, speech and thought processes. Consequently, the nurses found it difficult to slow their pace to match the older person's needs. This suggests the speed of the environment is out of line with the pace of older people's requirements.

HCPs in this study recognised that the 'little things' that older people value were often overlooked, resulting in barriers to care. However, they accepted that maintaining comfort and physical needs could not take precedence in an ED culture where they had to prioritise treatment for the sickest patients. Prioritisation of emergency medical need is a consistent finding in many studies (for example, Kihlgren et al.2005, Elmqvist et al. 2011) and highlights the tension between managing complexity, urgency and the basic care needs of the older person. Lennox et al (2019) qualitative study on health care perspectives of meeting older patients' needs further emphasised how the fast-paced and time-constrained environment acted as a barrier to address older people's complex needs, as well as relational care.

Being rushed meant HCPs in this study felt they were unavailable to respond to older people when needed, such as requests to go to the toilet, help with dressing, providing food and drink and support with mobility and getting on and off the high beds. However, such rushed care had a negative impact on the older people's experience and the quality of care they received. For example, an awareness of how busy the nurse was, stopped them from seeking help for their needs and they often felt abandoned. Similar findings were reported in van der Meide's (2015) phenomenological study which found that hospitalised older people who perceived staff were busy, struggled to evaluate whether they needed to seek help or not.

In this study, providing a blanket for an older person when they were cold, bringing them to the toilet when needed, helping with mobility and making sure they had something to eat and drink when they had been waiting long hours in the ED demonstrated to them that they were genuinely being cared for. Regretfully, meeting these important needs was often neglected because of the pressures on staff to meet other urgent medical needs. This was a similar finding in Cetin-Sahin's (2019) study on older people's experience in the ED, which found that physical needs, such as maintaining comfort, mobility, and providing timely assistance when required were often poorly addressed. This highlights the differences in prioritisation of needs and what matters most to the older person. Despite being a priority for the older person, health care professionals recognised they tended to focus on technical care over relational care. This supports the findings in how older people experienced care that lacked the relational support that they valued the most. This is a significant finding as it illustrates the value placed upon meeting relational needs for older people which is in opposition to the technical medical priorities of HCPs.

Some HCPs indicated deep concern regarding a lack of basic care and dignity to the older person to which vignette drew attention, for example older people being left without water, or for long periods of time without interactions from professionals. It was evident that all the HCPs strived to deliver dignified and compassionate care, nonetheless there were many factors at an organisational and environmental level that inhibited this. Yet there are few studies exploring dignified care from the perspective of the HCPs themselves. Accordingly, Kinnear et al (2015) qualitative study sought to understand how dignified care is understood and delivered by HCPs. The main findings from interviews with HCPs were that positive staff attitudes, team working and a culture that adopted initiatives to promote and facilitate dignified care provision were most successful. However, there were multiple barriers hindering their ability to deliver dignified care. These centred on organisational factors such as high patient turnover, meeting targets, time and resources and environmental restrictions around space and facilities. Similar findings are consistent in this and other studies (for example, Gallagher et al.2008, Boltz et al.2013, Tadd et al.2011, Kinnear et al.2014). This identifies the many threats affecting the delivery of dignified care at both organisational and individual levels.

In contrast, HCPs recognised that there were also examples of dignified care which demonstrated kindness and compassion which made positive differences to the older person’s experience and respected them as an individual. Smith et al (2016) work on compassionate care by nurses, which used reflections to gain insight on their perceptions of compassion, identified that not only did the ‘little things’ make a massive difference to those who received care, but also to those who provided it, suggesting that delivery of dignified and compassionate care benefits both the patient and the HCP. A further study exploring the experiences of hospitalised adults showed that small actions of staff mitigate against the disruption caused by their hospitalisation (van der Meide et al. 2015). Thus, the ‘little things’ can positively influence health and well-being at a time of great personal disruption.

This study highlights the importance of the little things that are highly valued by older people. Significantly it demonstrates that respectful and dignified care can be achieved through the small actions by staff which have a positive impact on older people’s experience of care. However, it has also identified the many factors hindering the HCPs’ ability to provide the care they aspire to. Therefore, the findings acknowledge the pressures under which HCPs are working to do their best to care for older people, which may offer some insight into why they may forget the ‘little things’.

The Art of Patient-Centred Care in the ED

Holistic and empowering approaches were identified by the HCPs as being central to meeting the needs of the older person. However, supporting and empowering older people is only likely to take place when HCPs have meaningful connections which foster valuable patient-professional relationships (Flynn, 2016, Dewar, 2016, Nolan et al 2004). Thus, there needs to be a common understanding between the patient and the HCP to constitute care that is meaningful (Larson, 1984). Otherwise, discrepancies will arise between what the patients and the HCP see as important, leading to unmet needs and poor experiences of care.

Patient-centred care was a holistic approach advocated by the HCPs to support the development of therapeutic and meaningful relationships with older people. One professional emphasised that achieving patient-centred care was down to the *‘art and the skill of the ED professional’* (HCP04, FG2) to make every contact count within the constraints of time that they have with patients. There was a consensus from the HCPs that this was an important aspect of care for older people. This view is consistent with findings from previous research on nurse-patient interaction that suggests professional relationships can be formed over a relatively short duration (Shatell, 2004) and even in the ‘*fleeting of an interaction’* (Bramley & Matiti, 2014 p.2795). Dewar’s (2011) work on compassionate care in nursing defines the importance of developing meaningful relationships with patients to highlight the centrality of relationships between human beings. She identifies the importance of recognising another person’s vulnerability, which requires an emotional response that is meaningful to the person. Importantly, these responses to care acknowledge that compassion in nursing is experienced by the patient and the nurse in partnership. Therefore, professionals in this current study who recognised the older person’s vulnerability at a time of crisis and responded in meaningful ways were highly valued and equate strongly to the human dimension of caring (Galvin, 2018, Todres et al, 2009).

In this study both participants and HCPs acknowledged that where caring behaviours were present, these were positively received during interactions and were significant to older people's positive experiences. Perceptions of caring by the older people centred on a sense of '*presence*' and *'genuine'* interest from HCPs in them as individuals. These caring elements contributed to a strong sense of being cared for and feeling secure. A recent mixed-methods study by Flynn (2016, p.8) on professionals and patients' perspective of caring found the '*assurance of human presence'* significantly influenced both health and well-being. Presence included professionals' behaviours of sensitivity and understanding towards patients, spending time with them, talking to them, showing concern and allowing them to express their feelings. These behaviours showed patients the dimensions of caring which treated them as individuals with unique needs. Similarly, these behaviours were also identified by participants in this current study to highlight the caring interactions of professionals. Hence, essential to achieving a positive sense of connection with professionals are the caring behaviours valuing older people as recipients of care.

Although HCPs articulated values associated with patient-centredness in discussing their experiences of caring for older people, this study identified that these espoused values are not always translated into care delivery. This view is supported by Flynn (2016, p.34) who found that *'caring may not translate into everyday caring behaviours or practice'.* Achieving person-centred care in the ED may be problematic because priorities of care focus on rapid assessment, diagnosis, management and quick discharge (Kilghren et al.2005). Numerous studies have identified the challenges of delivering patient-centred care in the ED (for example, Dewar et al. 2016, Kitson et al.2013, McCance and McCormack, 2010).The often crowded and chaotic environment (Shankar et al.2014) combined with the increased number of patients to treat (Goodrich, 2012) makes patient-centred care difficult to achieve. Despite patient-centred care being promoted in health care policy and practice to improve the quality of care for older people (NSF, 2001, DH, 2008, NHS England 2019), little attention has been paid to how frontline staff are supported to transfer these policies to the practice setting (Innes et al.2006). Thus implementation of key areas of patient-centred values such as participation and involvement and therapeutic relationships between the patient and professional have the potential to be ignored (Kitson et al, 2012, Nolan et al. 2004).

Understanding the role humanities play in caring may bridge some of these policy-practice gaps. Recently there has been increasing impetus on the value of humanities for HCPs to understand human experience (Lim and Marsaglia, 2018). Caring professions are in a unique position to gain understanding and insight from patient experiences and narratives through the empathetic interactions they have with them (Lim and Marsaglia, 2018). The pioneering work of Carper (1978) in this area proposed the importance of knowing and understanding human experience. This would assist professionals with the development of empathy to be more effective in the care they provide to patients and improve overall experience. Furthermore, Lim and Marsaglia, (2018, p.121) assert '*when we understand human experience, we become more empathetic'* and thus highlights the role professionals have in making positive connections with older people to understand their illness and frailty and which encompasses that which makes us human (Todres et al.2009).

Compassion and empathy have been identified as important components of patient-centred care (McCormack and McCance, 2010) and pertain to all caring professions. For example, early literature emphasised the need for medicine to know the whole patient (Peabody, 1984); additionally, physiotherapists and occupational therapists strengthened their roles in empowering patients and building therapeutic relationships (Shatell, 2004). Thus, there is a recognition of the need to move away from intervention-focused care of 'doing', to the concept of 'being' (Teo, 2009). This puts the patient back into the centre of all professionals' efforts to search for meaning on what it is to be human. For many of the older people in this current study, caring attributes and behaviours they perceived as positive experiences were from all HCPs they had contact with. Therefore, caring is not unique to any one profession, which highlights the significance of caring from an individual perspective.

Emotional and Psychological Needs of Older People

Through the narratives of both the participants and HCPs it was evident there were gaps in meeting the emotional and psychological needs of older people. HCPs did not explicitly identify how they supported emotional and psychological needs. However, there was increased awareness of individuals' increased vulnerability due to fear and anxiety and the stress of being in a chaotic environment. HCPs also recognised how frightening a visit to the ED was for an older person. Despite their awareness of these emotional needs, emphasis was mainly on managing the presenting problem and the acute medical emergency. This would suggest that although professionals recognise the psychological and emotional needs affecting older people in the ED, they do not necessarily act upon them. Tendency to focus on the presenting problem in the ED has been reported in many studies (Goodridge et al.2018, Mc Connell et al.2016, Boltz et al.2013) which can lead to neglect of the important psychological and emotional aspects of care. A recent mixed-methods study (Ross et al.2017) exploring how paramedics meet the psychosocial needs of older people found that often they are so focused on the clinical findings and presenting illness, they overlook the psychosocial cues and questioning required to assess and identify such needs.

Older people in this current study described care where opportunities were missed to address their psychological and emotional needs. For example, participants experienced a heightened need to feel safe and cared for, to be reassured, to feel able to express concern about self and feel connected to staff. Of significance in this study was the need for participants to have a strong sense of security due to their awareness of how acutely unwell they were and their impending mortality. Initially, becoming acutely unwell may involve appraising the threat or meaning of the illness which can trigger emotional responses of feeling vulnerable, loss of identity and autonomy and becoming helpless (Currid, 2012). Additionally, emotional harm can be experienced by older people (Goodridge et al. 2018) when there is a lack of support in developing meaningful relationships with professionals , enabling them to speak up and ask for help (Edmonson and Lei, 2014). Risk of emotional harm can also be heightened when organisational constraints and pressures impact on a professional's capacity to respond sensitively to their needs (Vaes and Muratore, 2013). This view concurs with the experiences described by the HCPs in this study. They would like to do more but given the multifaceted nature of older people's needs, they had neither the time or resources to do so. Additionally, Butterworth and Shaw (2017) assert that professionals lack the confidence and skills to provide the complex psychosocial and interpersonal support required to care for people in emotional distress.

Compassionate and humanising care helped reduce the older people's feelings of fear and anxiety by reassuring them that they were safe and cared for. This current study has shown that those HCPs who demonstrate attributes of caring and compassion can have a greater impact in their brief interactions with older people to support their psychological and emotional needs. Ross et al (2017) suggest that HCPs are in a unique position to observe and assess all the determinants of a patient's health by paying due attention to their psychosocial needs. This will assist professionals to treat patients holistically and provide best quality care. Philosophically, adopting a biopsychosocial model (Engel 1977) will enable professionals to understand how illness and disease are affected by multiple variables and allow them to appreciate the subjective experience of the older person (Currid 2012). It permits connection to understand what makes us human and the meaning of illness and frailty. Being responsive and actively engaging in strategies to address psychological and emotional needs will contribute to improved health outcomes and humane care for older people (Currid 2012; Goodridge et al.2018).

This current study has highlighted the absence of adequate psychological and emotional support necessary to manage older people's distress. There is a recognised need for HCPs to be aware and educated on the emotional and psychological needs of older people in the ED to better align with holistic care and practice. Going beyond the management of physical needs and adopting assessments of psychological and emotional need will enable a more responsive approach to these unmet needs. This can greatly impact on the older person's overall well-being and experience, resulting in better quality of care that moves away from the biomedical model. According to Currid (2012) no matter how high professionals' standards of physical care may be, if they do not address the psychological and emotional aspects of patient care, their care will continue to fall short.

The absence of assessment of these psychological and emotional needs is a significant finding from this current study as it highlights that fundamental needs central to the practice of holistic assessment are not being met. Thus, older people should be provided with care that meets their physical, psychological, emotional and social needs and that encompass holistic practice.

Improving the Care Journey

HCPs recognised the need to improve the care journey for older people. Additionally, they drew attention to the challenges they believed impeded their delivery of patient-centred care. In particular, they attributed this to the lack of alignment between the suitability of the environment and the existing pathways of care which did not meet the individual needs of older people. They recognised that the noise and busyness of the ED increased the vulnerability of the older person, combined with multiple transitions in care which they felt caused the older person fear, anxiety and distress. This mirrored many of the older people's experience of their care journey. Whilst the HCPs identified improving the care journey through age-friendly pathways and integrated care, they were sceptical of how change could occur due to present organisational constraints and processes. Nonetheless, a clear consensus from both older people and health care professionals about gaps in care points strongly to the need for different pathways of care to improve older people's experiences of care.

Pathways of Care

The need for clear pathways of care to better meet the individual needs of the older person in the ED was a dominant feature in the HCPs' discussion. Aligned to this was a central requirement to recognise older people's care as a speciality, which necessitates specialist teams with the appropriate knowledge and skills to improve their health outcomes. This view is supported by Kelley et al. (2011) who claim that older people's needs are not being met in the ED because professionals are ill-equipped to manage the challenges and complexities of older people's care. Additionally, there is an underlying assumption that older people are not considered a *'specialist population*' and therefore EDs lack the specialist skills and resources to manage their complex needs (Kelley et al. 2011, p.9). The needs of older people are multi-faceted, and many studies recognise that older patients have distinct and complex needs that are not suitable to existing episodic and emergency-focused care systems (Aminzadeh and Dalziel, 2002, Ellis et al.2015).

Current traditional ED models of care focus on rapid discharge, treatment and throughput does not address the needs of many older people (Kihlgren et al.2005). To improve the care for older people recommendations for alternative pathways of care have been suggested in many studies (for example, Salvi et al.2007, Kelly et al. 2011, George, 2011). In the USA, dedicated spaces for older people in the ED have been developed that are elder-friendly. Other centres have EDs designed especially for older people (Kelley et al. 2011). The argument for specialist centres is not only about the environmental benefits, but also the potential to foster best practice and the development of expertise (Ellis et al. 2011). Whilst there are limited date on their effectiveness, those centres in the USA which have evaluated their specialist geriatric services identified fewer adverse effects, decreased hospital readmission rates and an increase in patient satisfaction (George, 2011). Importantly, supporting this infrastructure are highly trained staff who provide specialist geriatric care for this group of patients (George, 2011). In contrast, lack of training for ED staff has been identified in several studies and reported as a barrier to safe and effective care for older people (for example, Boltz et al.2013, Bulut et al. 2014, Burger et al.2018).

Although the development of EDs for older people is well -established in the USA (George, 2011), similar developments have not existed in the UK until recently, when the first older people's ED was opened in December 2017 at a large university teaching hospital trust in East Anglia. There are those in the UK who question the introduction of such EDs for their feasibility and sustainability in meeting the needs of the growing population of older people (Conroy and Turpin, 2016). However emergency provision in this new specialist service is neither 24/7 nor 7 days a week, which limits the capacity to provide a streamlined one-stop service for older people with urgent and emergency care needs. Nonetheless, in the absence of such specialist services, older people will still rely on the traditional access to the ED. Therefore, many studies suggest improving the existing pathways of care between the ED and other inter-related care processes through adapting current organisational models to optimise the quality of care for older people (Salvi et al.2007, Conroy and Turpin, 2016).

Multiple transitions were identified by both older people and HCPs as being challenging for the older person and highlighted gaps in pathways of care. Some participants experienced moves in the middle of the night. HCPs accepted that these experiences occurred and recognised them as problematic and not conducive to providing holistic patient-centred care. They also acknowledged that these transitions can increase the vulnerability of older people by causing fear, anxiety and unfamiliarity with their environments. Previous studies (Kelley et al. 2011, Sykes et al.2017) highlight how frequent moves impact negatively on older people's experiences of care and worryingly they are more vulnerable to health risks during transitions in care. Pathways of care should focus on minimising the extent to which older people have to move in one care episode with consideration of its impact (Kelley et al.2011). Multiple transitions were associated with poor quality of care for older people in Taylor et al (2015) study, with frequent moves attributed to accommodating more acutely ill patients. Thus, this finding highlights that the practice of multiple transitions negatively affects older people's experiences, which causes stress and puts their safety at risk.

Although existing pathways of care at the research site appear to provide structured transitions in care through integration between ED, AMU and OPM, this current study has identified that the multiple transitions older people experience in one care journey negatively affects the quality of patient care and development of meaningful connections with staff. This is an important finding as it questions existing care delivery practice and whether it is actually designed to meet the needs of the people it serves the most. Thus, the experiences of both the HCPs and participants point to the need to further examine the multiple transitions older people experience during their acute medical emergencies.

Poor discharge transitions were highlighted by many participants as a negative experience, which also affected their follow-up care and ability to manage their condition once home. Lack of involvement in discharge decisions, poor discharge information and documentation, inability to arrange appointments with GPs and feelings of no support from GPs were just a few of the challenges participants experienced around and following discharge. Despite research, health service policy and practice, all promoting the involvement of older people in decisions about their care transitions, this remains problematic in practice (Allen et al.2018, Bauer et al.2009). The lack of involvement of older people in their care decisions is not new and has been identified in several previous studies which also make reference to the reasons for this (for example, Allen et al.2018, Rustad et al. 2016, Coleman et al.2005). Allen et al (2018) identified a number of barriers, including limited support by professionals to engage in conversations with older people about their care requirements, and the need for fast throughput and fragmentation of services. This also relates to continuing concerns around the quality of care transitions post hospital discharge, given the risk of adverse events following discharge.

Growing evidence suggests that many older people experience high rates of adverse outcomes including re-attendance, functional decline, admission to a nursing home and even mortality following discharge from the ED (Lowthian et al, 2015, p.761, McCabe and Kennely, 2015). Additionally, a systematic review of older people following ED attendance found there were higher rates of dependency for ongoing support and help with activities of daily living due to functional decline and cognition (Aminzadeh and Dalziel, 2002). A further study by Altfeld et al (2013) found older people reported altered and new needs shortly after discharge. These studies support the current study findings to indicate the difficulties older people face with participation in their discharge decisions and the challenges they face to maintain independence once home.

A significant challenge for older people identified in this study was their understanding of discharge instructions. Particularly problematic was information on how to manage their illness and expectations around what to anticipate in relation to recovery, where to seek help and understanding of how to take newly prescribed medications. These findings are consistent with the work of Hastings et al. (2011) who reported that a significant number of older patients did not understand aftercare instructions, how long their symptoms would last, the cause of their problem, self-care instructions and did not receive the necessary discharge information. Worryingly, those older people who were prescribed new medication received little instruction either on how to take it or its intended purpose . Regrettably, this was also a finding from some of the participants in this current study. In contrast, time spent on medication reviews in the ED has been shown to improve patient outcomes such as adherence, but also has the potential to identify opportunities to support older people in the community once home (Ellis et al.2015). In this current study, where staff spent time explaining and reviewing medication, older people had experiences that were more favourable, enhancing their capacity to self-manage their medications once home. Thus this study highlights the variability in meeting the holistic needs of older people relating to discharge needs and follow-up care, and suggests potential lack of continuity across the interface of primary and secondary care.

The HCPs acknowledged issues with inadequate discharge planning for older people. However, they attributed lack of time as a key factor in their inability to comprehensively assess older people’s discharge needs and provide detailed information on their follow-up treatment and care. Often the decision to discharge was rapid, presenting challenges for the HCP. In particular, organisational processes of care, the push to discharge patients within the four-hour target, and lack of integrated services to support older people in the community were barriers to effective discharge planning. Similarly, Dystrad et al (2015) observational study on older people's participation in their admission and discharge found that organisational and time pressures greatly affected how HCPs involve older people in their care, often resulting in hurried decision-making practices that were not sensitive to individual' 'needs or wishes (Drystad et al. 2015). Rustad et al (2016) qualitative study on older people's experiences of discharge transitions found managing discharge and continuity of care was complex and challenging for health care professionals. The findings of this current study suggest that discharge decisions do not always meet the needs of older people and often the pace of the decision to discharge does not proactively involve older people's participation in the decision, strongly suggesting that care revolves around the needs of the organisation rather than the patient.

The key organisational constraint identified by many of the HCPs was the need to meet the four-hour standard (RCEM, 2018). This requires that 95% of patients attending the ED should be admitted to hospital or discharged within four hours. It was first introduced to NHS emergency departments in 2004 to address waiting times to be treated and discharged, and in response to the growing number of attendees. The aim was to improve the overall experience and quality of care in the ED (DH, 2000). Significantly, this study found HCPs felt pressured to discharge patients quickly, maintain patient flow and find the next bed to place patients in. Ultimately there was a strong feeling from the HCPs that meeting the four-hour standard was at the sacrifice of patient care. Although recent studies have shown patient flow and patient experience may have improved, this has happened at the expense of HCPs being able to engage in quality of time and treatment with patients and treatment (Vezyridis and Timmons, 2014, Mortimor and Cooper, 2007). Vezyridis and Timmons's (2014 p.7) qualitative study explored the impact of national targets on EDs and found '*the busier the ED got, the need to speed up clinical performance got'.* This resulted in increased pressure being put on staff to move patients on, hence the target became the focus, rather than the patient and their actual illness.

Increased activity around twenty minutes before the four-hour cut-off time has been reported in previous studies (Mason et al, 2010, 2012). This may explain some of the multiple transitions in the care journey found in this current study and questions for whose benefit this is and at what expense. Furthermore, Vezridis and Timmons (2014) suggest that the intense and consistent pressure under which HCPs work under in the ED to meet four-hour targets is often overlooked.

Thus, this study builds on existing research to highlight the impact of such pressures on HCPs in response to organisational processes of care. This important finding from the current study highlights the pressures HCPs are under to meet operational standards and demands and recognises the need for further research to understand staff support needs when working in challenging clinical environments.

Through the vignette, the HCPs in this current study identified gaps in integrated and holistic approaches to care, such as co-ordinated services and maintaining continuity of care from hospital. Thus, current pathways of care did not support continuity between acute and community care. The National Service Framework for older people (NSF) (2001) first identified the need to reduce fragmentation and ensure a more co-ordinated approach to care that met the needs of the older person. Attention was placed on more holistic, streamlined care to improve integration of health and social care. Yet, some nineteen years after the NSF was introduced, this study identified evident gaps in achieving personalised care for older people following discharge from an acute hospital/ED. To improve integrated approaches to care, specifically around discharge, Nugus et al (2010) ethnographic study explored coordination processes and decisions made by physicians and nurses in the ED. The study identified the crucial role these professionals have in discharge planning, particularly if there were home or personal difficulties. Importantly the awareness by the decision-makers of what local services were available to support patients on discharge was stressed. However, the study also acknowledged the challenges faced by professionals to meet the different needs of all the client groups who access the ED and provide continuity of care across the patient’s care journey. Many studies identify that the main priority is to provide safe transitions of care into the community (for example, Allen et al. 2018, Lowthian et al 2015, Atfield et al. 2013). This usually requires the efforts of a multidisciplinary approach (Nugus et al.2010). To operationalise such an approach, these professionals were required to manage the underlying complexities of organisational processes and external services to deliver integrated holistic care (Nugus and Braithwaite, 2010).

Given the increased risk of adverse outcomes for older people following attendance at the ED (Taylor et al.2015, Lyons and Paterson, 2009, Boltz et al. 2008), this current study underscores the need for greater collaboration with other services across the interface of primary and secondary care. This suggests more targeted interventions to meet individual needs and to receive the right support from the most appropriate professionals in ways that are both timely and efficient. Opportunities to improve older people's care should focus on providing the relevant information on after care that are particularly worrying for older people, such as follow-up arrangements, initiating effective and timely communication from GPs and nurses in primary care and medication review. Targeted interventions such as supportive discharge, home care, comprehensive geriatric assessment, multidisciplinary intervention, and personalised telephone support have been shown to increase patient satisfaction, adherence to follow-up arrangements and medication and reduces the risk of re-attendance, further functional decline and mortality (Ellis et al, 2011, O'Connell- Francischetto et al.2016). It is clear that HCPs have difficulties in providing detailed patient education in a busy and challenging care environment (Dunnion and Kelly, 2007,Boltz et al.2013). Nevertheless, good quality discharge planning is recognised in many studies as essential to provide the continuum of care older people need (Lowthian et al.2015, O'Connell Francischetto et al.2016). A recent health service report identified the importance of knowledge-sharing, which requires effective communications and collaboration between health and social care to provide a safe discharge for patients (Waring et al.2014). Thus, to achieve a high-quality discharge it is fundamental to have meaningful follow-up care that is appropriate, timely, and enhanced by effective communication by all professionals across the primary and secondary care interface.

This study has identified several transitions in care that impact negatively on an older person's experience. These highlight the need to minimise multiple transitions in care, involve older people in decisions about their discharge to meet their needs and preferences, provide comprehensive discharge information, perhaps in particular if they have been prescribed new or different medication. Follow-up care that is personalised and timely and greater communication between services to ensure continuity of care are also needed.

Environmental Design Considerations

The HCPs in this current study identified the unsuitability of the care environment to meet the needs of the older person. This related to the physical layout of the ED, the noise and the busyness, which they acknowledged was likely to be overwhelming for the older person. Furthermore, they recognised the fast-paced environment increased the stress and anxiety the older people endured, heightening their sense of vulnerability. This view is consistent with the older people’s experiences in this current study as they frequently spoke of the impact of the noise and busyness, which made them feel more vulnerable. Such factors create an environment that is chaotic and unpredictable (Mc Cabe and Kennelly, 2015, Shankar et al.2014) and combined with a lack of fit of the physical design, this results in challenges for HCPs to meet the needs of older people.

The findings about the unsuitability of the physical environment for older people is not new. Previous studies have highlighted problems with overcrowding, noise and limited space (Kelley et al. 2011, Ellis et al.2015). Some of the older people in this study spoke specifically about having difficulty accessing food and drink, keeping warm, beds that were too high, bathrooms not in proximity and interrupted sleep due to the noise. This was particularly problematic for those who had mobility problems and were dependent on HCPs for their care needs. Cetin-Sahin et al (2019) qualitative study about older people’s and family experiences of the ED found that the physical care needs of older people were not always addressed due to the busyness of the environment. This led to delayed responses relating to comfort, toileting and food and drink. Ellis et al. (2015) identified that busy and complex ED environments are particularly difficult for those older patients with hearing and cognitive problems and can cause undue stress. Hence, they highlighted that simple solutions such as ambient light and reductions in noise levels can minimise these stressors. However, in the context of a chaotic environment, the ability to reduce noise is questionable. Burton et al (2014) identified that difficulties in adapting to the unfamiliar environment of the ED are particularly challenging for those older people with hearing and vision impairments. Crowded and built-up areas can cause difficulties in navigation, which can cause disorientation (Parke et al.2019). Frail older people are particularly vulnerable to falls in the ED (NHS thermometer, 2013). Older people are at higher risk of developing pressure ulcers due to long waits on hospital trolleys and immobility, while waiting for diagnostics or transfer to wards (McCabe and Kennelly.2015). Thus, this presents numerous difficulties with both the environmental design and physical spaces of the ED, which do not take account of the unique needs of older people who are acutely unwell.

The fast-paced environment also poses challenges for HCPs in their assessment of older people’s needs. High turnover of patients may lead to professionals missing symptoms of recognisable illnesses in older people because of the busyness (Deasey et al.2016, Kilghren et al.2005). Additionally, Cehin-Sahin et al (2019) stress the importance of the necessity for the physical space to be compatible with older people's needs, increasing HCPs' ability to perform safe and holistic care. Examples include easy access to bathrooms, beds and chairs that are adjustable and comfortable, space to support mobility and prevent functional decline. Thus, the importance of the physical space to support the physical needs of the older person was an important finding in this current study, also relating to the maintenance of older peoples' dignity and autonomy.

Education and training

Many of the HCPs identified that older people's care was a speciality that required specialist skills and competencies, underpinned by best practice. For some of the HCPs this was a dominant feature of the discussion and stemmed from recent engagement in ongoing professional development modules at their local university. They acknowledged that participation in learning facilitated a deeper understanding of evidence-based practice to support the care of the older person. However, they stressed that putting that knowledge into practice in the fast-paced environment of the ED was a challenge and some HCPs felt this was unachievable.

Although the HCPs articulated the value of evidence-based practice, this study identifies that despite such awareness of its importance, there are barriers such as attitudes and environmental challenges that affect making it a reality in practice. The translation of theory to practice is not a new concept and at times is contentious (Zieber and Wojtowicz, 2019, Labeau, 2019, Ousey and Gallagher, 2007). Drawing from nursing, many theorists argue that whilst there is an abundance of theory development, there remains a consistent struggle to reconcile theory with the reality of practice (Zieber and Wojtowicz, 2019, Scully, 2011, Ousey and Gallagher, 2007). Zieber and Wojtowicz, (2019, P.1) emphasise the *'theoretical realities and the practice realities of nursing are somehow in tension with each other',* thus highlighting a disconnect between the two. Furthermore, professional socialisation may provide some explanation to the disconnect between the theory and practice gap. The work of Mackintosh (2006) explored nurses' attitudes and views of becoming a professional. It found that over time, socialisation to the environment occurs and affects the way in which nurses care about patients. Attitudes to caring changed and its importance reduced, with allowances being made for environmental and organisational constraints. This may explain how busy clinical environments may overshadow the HCPs' previous ethos of caring in order to manage the demands of the workplace. Consequently, despite new knowledge, professional practice remains unchanged. Moreover, the influence of environments on the application of evidence-based practice is supported by Al Ghabesh's (2015) study, which found that implementation barriers related to both lack of time and the setting. This finding is consistent with the HCPs' experiences in this current study where time and the unpredictable environment impeded their ability to apply their learning from the classroom to practice.

Despite the challenges of translating learning to practice, guidance from the Institute of Medicine (2010) states that patients should receive care that is based on the best available scientific knowledge, identifying core components of health that should be patient-centred, timely and efficient. It is clear from the experiences of older people in this study that there were care practices that would benefit from the implementation of evidence-based practice. Older people identified care where they were put at risk by incomplete assessment of their needs, delayed diagnosis, failure to act on allergies to medication and lack of inclusivity of the older person in their own care. It has also been established that the complexity of older people's health and social problems poses important challenges, in terms of assessment and management of those needs from admission through to discharge (Salvi et al.2007). In response, there is a growing awareness of the need for education and training to build HCPs' geriatric competency and evidence-based practice (Conroy and Turpin, 2016, McCance and Kennely, 2015).

The literature promotes specialist skills and expertise as a requisite for the care of older people (Bridges et al, 2010, Rawson et al.2017, Goodridge et al.2018). However due to the increasing numbers of older people who access EDs, there is an argument that care should not solely be in the domain of specialist gerontological practitioners (Deasey et al.2016). In the ED there are emergency care professionals as well as specialist geriatric teams who care for older people; however, there may be different emphases on their approaches to care. The model of care for emergency professionals is based on life-saving, acute and rapid response (Kilghren et al.2005). Technical skills take precedence over basic nursing care and assessment of psychosocial needs (Kilghren et al.2005). Thus there is incongruence between how emergency care professionals prioritise and manage care, and the holistic and essential care that is fundamental to meet older people’s needs.

Whilst HCPs have a duty of care to deliver evidence-based practice, this can be difficult for professionals in the ED due to the complexities and co-morbidities older people present with (Deasey et al. 2016). Furthermore, lack of specialist training in gerontology and awareness of the unique needs of older people poses challenges in their management, which results in unmet needs and the potential for adverse outcomes (Taylor et al.2015, Boltz et al. 2008, Lyons and Paterson, 2009). Hence it is argued that all professionals who work with older people require a comprehensive knowledge of ageing and gerontology to provide safe and effective care (Bridges et al. 2012, Rawson et al.2017, Watkins et al. 2019). A self-report study conducted by Rawson et al (2017) on nurses’ gerontological knowledge found that patient health outcomes improve when they are cared for by nurses with specialist training in geriatric care. However, frequently cited in the literature is the lack of geriatric knowledge and competence to meet the needs of the older person (Melby and Ryan, 2005, Taylor et al.2015, Conroy and Turpin, 2016). This view is supported by a literature review on emergency nurses’ knowledge of ageing and attitudes to older people (Deasey et al.2014).The authors found that nurses were not equipped with the specialist knowledge and skills required to care for older people in the ED. Additionally, the pressurised environment coupled with lack of gerontological knowledge inhibited professionals’ ability to recognise and manage the atypical presentations exhibited by older people and thus put patients at risk (Taylor et al.2015). However, this contrasted with their competence in managing acute emergencies (Deasey et al. 2014).

To support professionals who care for older people in urgent and emergency care, best practice guidelines were established (The Silver Book 2012). The aim was to improve older people’s experiences through continuous advancements in the standards of care they received. Tools such as comprehensive geriatric assessment (CGA) were developed to support multidisciplinary approaches to care. Fundamental to the principles of CGA, the aim was to shift from the predominantly medical perspective, and towards a more holistic patient-centred perspective (Salvi et al.2007). CGA has been shown to benefit older people in the acute hospital (Parker et al.2017, 2018, Ellis et al.2017). CGA can assist HCPs in identifying older peoples' needs by assessing a range of health and social care domains that contribute to vulnerability and adverse outcomes (Taylor et al.2015). It can promote improved decision-making by professionals and delivery of tailored interventions specifically to meet the needs of the older person (Ellis et al.2017). However, completion of a CGA is time-consuming and may pose challenges in the time-pressured environments of the ED (Kocman et al.2019,). Furthermore, Kocman et al. (2019) conducted a mixed-methods study to see if CGA could be delivered outside non-specialist geriatric services. The authors found that effective CGA can only be delivered by professionals with a high degree of geriatric competence. This suggests that comprehensive geriatric assessment requires specialist skills and knowledge. However, the aim of CGA is to deliver multidimensional assessment of older people by multidisciplinary specialist care teams (Ellis et al. 2017). This implies that a level of expertise in geriatric assessment and competencies is required and points to specialist geriatric teams to manage this approach to assessment. Yet in the ED older people are managed by both ED professionals and specialist geriatric teams, which suggests the need for consistency in expertise in geriatric assessment across the disciplines of emergency care and gerontology.

To strengthen holistic approaches to care, Conroy and Turpin (2016) emphasise the need to develop shared competencies to improve patient outcomes. This has important implications for the educational and training needs of staff so that they are equipped with the knowledge, skills and competencies to deliver the expertise required to manage the complex needs of older people (Salvi et al, 2007). The Silver Book (2012) recommends that professionals working in the ED need to develop their understanding and confidence in managing the complexity of older people's conditions and in common frailty syndromes. Thus, improving health care professionals' knowledge of the ageing process and gerontology with an emphasis on providing holistic high-quality care would enable better recognition and response to the management of atypical presentations, complexity of illness and psychosocial needs. This would support the necessity for more specialist education and training, tailored to meet the needs of professionals caring for older people in urgent and emergency care environments. Targeted education has been recommended as a model of care to support HCPs working in the ED so they can provide best practice care to older people (Rawson et al 2017). Increasing knowledge of older people's needs should enable HCPs to provide care for older people that combines the management of the acute medical emergency with their fundamental care needs.

Generational Needs

The HCPs in this study recognised that many older people view themselves negatively as recipients of healthcare, such as being a burden, not wanting to waste staff’s time and are generally uncritically accepting of the care they receive. Dionigi (2005) affirms that stereotypes play a powerful role in shaping both how we interact with individuals and see ourselves. Therefore, how the participants in this study viewed themselves was significant in relation to how they interacted with HCPs. Those individuals who felt they were a nuisance, or a burden had reduced confidence to engage with HCPs to alert them of their needs or if they were dissatisfied with their care. Despite the HCPs in this study having awareness of these generational tendencies, they acknowledged that often they did not engage with older people to identify their individual needs as there was an assumption that these were being met.

The findings from the older people interviews highlighted their need for more information about their diagnoses and management of their illnesses and that they wanted more say in the decisions made concerning them. However, there was evidence that some HCPs made assumptions about the level of information and involvement older people wanted. Thus, there were contrasts in the perception of information needs of older people by HCPs, with what older people want. This minimises the extent to which HCPs involve older people in shared decision-making about their health. Kane and Jacobs (2018) assert that HCPs may possess significant knowledge and skill, but they may not be correct in their assumptions about what is right for an older person. Assumptions about older people’s information needs often resulted in HCPs in this study providing less information to individuals about their condition for fear of causing them undue distress or worry. Studies have shown that older people receive less information than younger patients do, when in fact they would like to receive more to meet their individual needs (Lyttle and Ryan,2010, Wyman et al ,2018).

The findings of this study suggest that through their interactions with HCPs, older people may be exposed to negative stereotyping, however unintentional. This involves the perception of involvement in the care and information needs of one group over another; for example, the assumption that older people require less information than younger people do. To decrease the impact of such stereotyping, Scholl and Sabat (2008) argue that older people need to experience a sense of perceived control over their situation. This can be achieved by supporting older peoples' autonomy over decisions about their health according to their needs. Furthermore, Kane and Jacobs (2018) advise that it is essential that older people decide the level of information required about their needs and preferences, so that they can make choices supported by the HCP. Given that older people are at much higher risk of sudden illness and are the largest users of urgent and emergency care (Conroy et al. 2014, Bridges et al. 2010), Turner et al (2018) state that it is all the more important that older people are prepared and able to communicate their needs and preferences to HCPs.

Awareness of how older people see themselves as a burden or a nuisance is an important finding about how they seek information on their emergency health needs. This requires HCPs to deepen their understanding of the self-stigmatisation that prevents older people from seeking information and making their needs known. Additionally, this study highlights the impact of HCPs' assumptions about older people's levels of informational needs, which resulted in them receiving less information about their acute medical emergency. Thus, it is evident that there are discrepancies in perceptions of information needs between the HCP and older person. An increased understanding of these discrepancies would enable HCPs to understand the needs, values and beliefs of older people and then provide them with information that fits with those preferences and expectations. This would then enable older individuals to be more autonomous about decisions that matter to them. Furthermore, increasing awareness of unintentional stereotyping can promote changes in HCPs' attitudes and behaviours which can benefit older people's care by actively providing information based on their individual needs and involving them in their care and associated decisions.

Understanding the meaning of silence through the busyness

The HCPs recognised that many older people do not voice their care needs or concerns when they experience an acute medical emergency and thus remain silent. They identified multiple factors that might contribute to this, such as the frightening setting in which older people find themselves, particularly the noisy, fast-paced, busy environment of the ED and fear of being a nuisance or wasting staff time. Thus, these elements prevent many older people expressing their needs. This can be challenging for both the HCP and the older person, which subsequently contributes to poor experiences of care and unmet needs.

However, a key finding of this study found that the meaning of silence can be interpreted differently between the patient and the HCP. Many older people remained silent, yet many had significant care needs requiring support and attention; however, their concern about other patients and staff led them to believe their needs were less deserving and unworthy of attention. Interestingly, the meaning of such silence to the HCPs was interpreted as indicating that the older people were satisfied with their care and their needs were met. They therefore spoke about the quieter older patient who made their *'jobs easier'* *(*HCP3,FG1*)* to enable them to attend to those '*more vocal'* (HCP4,FG1) patients. Thus, the meaning and understanding of silence needs to be recognised so that HCPs can respond differently. This requires appreciation of the importance of what is not said, to think about caring in a different way in order to understand the silences. Kawatata and Gastaldo's (2015.p.5) work on interpreting silence in qualitative research provides a useful explanation by stating: '*silence is not an absence of communication but rather a communication strategy'*. Recognising silence as an invitation to pick up cues from patients would enable health care professionals to listen sufficiently to acknowledge needs and understand it from the patient's perspective. It would also facilitate caring conversations that involve shared experiences. Such conversations have been shown to have a positive impact on patient experience(s) and improve outcomes of care (for example: Dewar, 2017, 2016, Smith et al.2016, 2010, Nolan et al.2004, www.caringconversations.scot). Rydenlund et al (2019) work on caring conversations in mental health found that these enabled practitioners to develop a deeper understanding of the patient experience by giving them a voice, through paying careful attention to their needs. The authors advocate a hermeneutic approach to such conversations as this means the professional must understand the ‘whole’ experience as well as paying attention to the different parts. This is an important approach particularly for emergency care, as it tends to focus on the ‘part’ such as the presenting problem without looking at the other elements. Therefore, important aspects of the patient’s illness are missed. However, they argue that this takes time, space and a commitment to a caring attitude. Showing such attitudes through little of acts of kindness like holding an older person’s hand provides opportunity to holistically assess and unravel what appear to be a jigsaw puzzle of older people’s needs. Barritt’s (2005) work is aimed at HCPs to enable them to understand human experience. It also claims the power of compassion conveys empathy and a deep understanding of human need. Now, more than ever before, HCPs in urgent and emergency care face many challenges and pressures and building on their existing approaches to care such as caring conversations can assist them to put these skills into practice to provide personalised care for older people. Actively engaging in caring conversations, which invites older people to share their concerns, needs and opinions will facilitate a deeper understanding of their experiences and allow professionals to hear through the silence.

This study has clearly identified that the meaning of silence has different interpretations from the perspectives of the older person and the HCPs and highlights the apparent incongruence between how HCPs and older people experience care provision.

Summary

HCPs in this study were able to articulate both what constitutes good patient care, and equally what was not so good about how care is provided to older people in urgent and emergency care. However, the study also suggests that HCPs are aware of the challenges of delivering patient-centred care in the ED to older people and work hard to meet these within the limitations of the environment in which they work. Strong views and beliefs about their positive role in caring for the older person were evident; however, participants felt impeded by the organisational constraints and ED processes of care that prevented them from providing individualised patient care. Consequently, there was tension between how they aspired to care for the older person and the stark reality of what they could deliver. This also highlighted the emotional struggles they had to endure when caring for older people. Central to this was their recognition that the ED environment failed to meet the needs of older people, due to the noise and busyness, which the HCPs saw as overwhelming and stressful for older patients. They also felt that older people had unique needs requiring different pathways of care, and fundamental to this was the time to care, rather than acceptance of the push to discharge. Solutions to improving the older person's care journey were provided, however they were sceptical of how realistically these could be put into practice within current traditional systems of care.

The study also established that delivering care to older people in such settings is complex and is often constrained by limited time to focus on the holistic needs of older people. Furthermore, a tendency to concentrate only on the presenting problem left many older people's physical and psychosocial needs not being assessed or addressed. Moreover, HCPs identified that barriers of competing emergencies and the constant push to discharge older people to free up beds contributed to not fully meeting older people's needs. Consequently, they recognised that this resulted in inadequate assessment of older people's individualised needs, limited involvement of older people in their care journey and poor discharge planning and follow-up. Worryingly, lack of involvement of older people in their care, in particular around the decision to discharge, highlighted significant gaps in quality of care and opportunities to maximise optimal care were often missed.

The pressures under which HCPs professionals are working to deliver patient care to the growing population of older people have been highlighted in this study. These pressures are recognised in NHS reports on the need to transform urgent and emergency care (NHS England, 2013,2014, RCEM,2015). The current landscape exposes an emergency system that lacks funding, a shortage of consultants and staff, reduced bed numbers, fragmented care outside of hospital, all of which are problematic, particularly with the increasing complexity of older people's care needs (Rees et al.2019, Ham, 2017). These factors combine to reveal a challenging working environment and an emergency service in crisis (Ham, 2016). Despite these struggles, it was evident from the study that the ED staff work hard to meet the demands of care delivery and the 4-hour target to reduce waiting times. However, the study also questions the cost of meeting these targets have on patient care and staff well-being. Additionally, pressures from the media portrayal of an overstretched NHS and an emergency service in crisis significantly impacts on ED staff morale and negatively influences older people's view of themselves for causing the crisis.

This study is important as it explored the perspective of how care is understood from the perspective of both older people and HCPs in an urgent and emergency care setting. It considers the central aspects of care that matter most to older people, against the challenges and complexities HCPs face in their ability to deliver such care. It clearly identified the unique needs of the older person in the context of a clinically demanding environment. This study demonstrates fundamentally that both older people and HCPs have a similar understanding about which aspects of care are the most important, and where there are differences, how they are understood. Together the similarities and differences highlight caring practices that positively influence experiences of care that value older people. Knowing about care practices which negatively affect older people can enable a deeper understanding of their impact which can inform and challenge future practice.

The insights gained from this synthesis will now be explored in the next chapter and discussed in recommendations and implications for practice.

Chapter 9: Reflexivity, limitations, strengths, recommendations and conclusion

Introduction

This research study was designed to explore older people's experiences of urgent and emergency care to gain an understanding of how they made sense of these experiences and capture what it is like for older people to receive care within such settings. The experiences of HCPs working in these care environments were also examined to provide context and perspective to the organisational and processes of care that influence the care of older people.

The aim of the study has been met through an in-depth analysis of the participants' experiences and thus new insights and knowledge were gained to inform and improve the quality of care for older people. Findings from this study both support existing understanding of older people's experiences of urgent and emergency care and contribute new knowledge to this important area of healthcare practice. In order to consider application to practice, the strengths and limitations of the study will be explored before providing recommendations for practice developments, policy and further research.

The chapter will start with the value and importance of reflexivity in IPA and its impact on the research design and methodology used in the study. Reflexive accounts on research design processes are presented throughout the chapter so others can appraise the trustworthiness of the study and to highlight specific aspects of the methodology and study design that would be useful for future studies. Personal reflexivity on the position and potential influence of the researcher on the research process plus the growth of the student as a researcher are also provided. Personal reflexivity will be presented in the first person as "I". Goldspink and Engward (2019, p.93) recommend this approach '*to present the focus, the thinking, and doing of IPA*'.

Reflexivity

Reflexivity is an important element of qualitative research and Willig (2013) suggests that the researcher adopt a reflexive stance, which requires them to question the research design, methodology and analytical processes in how they construct the findings and shape the research. Therefore, each stage of the research will be discussed considering these questions. Finlay (2002) argues that most qualitative researchers will make attempts to be aware of their role in the (co)-construction of knowledge and will make explicit their influence, their biases and responses to the different elements of the research process in an effort to enhance the trustworthiness, transparency and accountability of their research. Furthermore, Smith et al (2009) highlight the importance of reflection and reflexivity as measures of quality and validity in all qualitative research, including IPA.

Reflexivity through self-examination can also open the researcher to new insights within the participants' accounts (Sutton and Austin, 2015, Attia and Edge,2016). Thus, any previous knowledge and assumptions are challenged, and new insights gained to bring the researcher closer to understanding the subjective experiences of the participants (Smith et al.1999). I believe the result of my reflections and reflexivity from the identification of IPA and throughout the process of research design has resulted in a study that has closely adhered to the fundamental theoretical underpinnings of IPA, phenomenology, hermeneutics and idiography to achieve the research aim.

Methodology

Initially I found phenomenology challenging, due to the difficulties in understanding the complex philosophy, the multiple and diverse approaches with each having their own distinct features. However, this is not uncommon for novice researchers and I was aware of these challenges when I embarked on reading the literature around the methodology chapter (Chapter 3) (Finlay,2009, Gelling,2010). Exploration of my philosophical stance and orientation of the study facilitated a greater understanding and discernment between descriptive and interpretative phenomenology. I considered the approach most suitable to answer my research question was interpretative phenomenology., feeling Husserl's and the newer descriptive phenomenology constrained the development of the deeper meanings from the experiences of the older person. Therefore, the choice of IPA with its focus on phenomenological enquiry was felt to be the appropriate choice as it prioritises the voice of participants (Reid et al.2005). Understanding older people's experiences of care from their perspective was significant to the aims of the study to gain deeper insights in order to inform and allow HCPs to practice what matters most to them. I believe capturing the lived experience via the individual's voice from those who have directly experienced urgent and emergency care (in this case older people) is crucial, and a key aim of IPA. Seeking the viewpoint from the participants' perspective, encompassing the challenges and issues for this patient population is an important feature of IPA due to its focus on understanding their view of themselves in the world, in this case the viewpoint of older people (Clancy,2013). According to Davis (2009) gaining a range of views and perspectives from older people, especially from those seldom heard, has the potential to illuminate areas of practice leading to improvements in the quality of care and patient experience.

Through IPA, my role was to search for and understand the meanings and essences of the experience from the patients' perspective in order to inform and improve their care experience (Crotty, 2000). The idiographic features of IPA enabled rich descriptions of each participant's experiences. My interpretations of these narratives allowed me to identify key themes and connections between themes, to capture sufficiently the experiences. Gadamer (1960) emphasises the significant role the interpretative approach has in making sense of participants' narratives to convey understanding. Additionally, reflexive engagement with the data and applying deeper interpretation resulted in thinking about the older people's experiences from different viewpoints to gain insights and make conceptual links to the broader and organisational processes of care. Applying the hermeneutic circle and having a clear audit trail of how I arrived at the themes before reaching a consensus with my supervisors contributed to the rigour of the work and enhanced the quality of the research. Each stage of the research will now be explored to highlight the reflexive approaches the researcher engaged with to ensure the credibility of the work and the personal journey as a novice researcher.

Recruitment

Recruitment of older people participants posed one of the main challenges in this study and my focus will be on how I overcame these challenges. When I commenced recruitment of the ten older participants, my pre-conceived assumption was that it would be easy to recruit older people, given their increasing numbers accessing urgent and emergency care. This assumption proved wrong; it turned out to be one of the most challenging aspects of the study, causing considerable delay to its progression. The inclusion criteria required participants to have experienced the different pathways of care for older people, to include those who presented to the ED and subsequently admitted, and others who were discharged from the ED. Many of the older people were admitted from the ED to AMU or OPM. Therefore, access to those older people who were directly discharged home from the ED became problematic.

Successful participant recruitment is essential to conducting qualitative research (Newington and Metcalfe, 2014). My awareness of the need to recruit participants who had experienced all the urgent and emergency care journey became a source of anxiety and frustration, with my biggest fear being unable to complete the study due to failure to recruit the requisite sample population. There followed a lengthy few months working with the gatekeepers at the research site to identify potential participants. A further problem was the time gatekeepers were able to commit to recruiting participants in the ED due to the pressures of working to the four-hour standard, meaning that often identifying participants was not a priority for them. To overcome this challenge, I communicated and visited the gatekeepers regularly to update them on the status of participant recruitment numbers. I also prompted with gentle reminders the need to recruit three participants who only received ED care and were discharged home. It was important to be sensitive in order to avoid staff feeling pressured (to recruit participants). Eventually this approach worked, highlighting the importance of the role of collaboration with gatekeepers for successful recruitment. However, through reflexivity, I questioned my position in the recruitment process and the dynamics required between the gatekeeper and the researcher. At times, I felt powerless in gaining access to my target population and was aware of my increasing anxiety as the study and time progressed. McAreavey and Das (2013) aptly identify these negotiations with gatekeepers as a delicate balancing act and I was careful not to show my anxieties. I realised that developing and maintaining meaningful relationships with gatekeepers was crucial to gain access to the participants. I was also very aware of the time pressures the gatekeepers were under and was careful to acknowledge this in my empathetic discussions, developing rapport and building trust in the gatekeeper-researcher relationship. They were aware of my positioning in the study not only as as a researcher seeking to explore patient experience within their practice setting, but as a lecturer in nursing, so it was clear that there was a mutual understanding of the challenges they faced in the ED. Savage (1995) highlights the importance of a shared embodied understanding to develop trusting and respectful relationships in the field and I feel that this was satisfactorily achieved.

Further challenges to recruitment related to how participants perceived their role in the research. For example, there were many older people who gave permission to be contacted about the study, but when contacted, declined participation, feeling they had nothing to say or contribute. Initially I was taken back by this, but as I moved back and forth with the data from interviews with the older people, I began to appreciate and understand how older people viewed themselves in the world and the impact this had on their identity and self- worth. The experience of trying to recruit older people helped me positively to unfold the layers of meanings older people ascribe to their self-worth.

Other potential participants felt their experience was positive and that they had nothing to complain about, despite being informed of the remit of the study. This view was shared by many potential participants who declined, but did provide rich insight into not only older people's reluctance to complain, but also how they may view research. For example, it could be possible that they viewed research as only looking to find faults in the health care system and they did not necessarily want to contribute to this. Therefore, identifying barriers to successful recruitment to this study required me to rethink how I approached the follow-up telephone conversations following expressions of interest to participate: subsequently I strengthened my emphasis on the importance of hearing their story about their experiences.

Recruiting older people successfully to this study highlighted important considerations and understandings in how older people value their contribution to research studies. Other barriers to participation related to older people's continued substantial health problems, specifically, recruiting older people who experience acute illness which may make it difficult for them to focus on study information communicated to them by researchers or gatekeepers. Additionally, McMurdo et al (2011) stress the importance that staff or gatekeepers understand good research practice and the eligibility criteria , and have a belief that the study will benefit patient care in order to facilitate successful recruitment. In this study, the gatekeepers were supportive of the study and were clear that patients who were severely ill did not meet the established inclusion criteria.

Successful recruitment of older people in research is crucial to inform healthcare practice (Mody et al.2008, McMurdo et al 2011), although there are important challenges to consider in the recruitment of older people, as highlighted in this study. Nonetheless, there is a growing willingness from older people wishing to be active participants, not only in policymaking but in service provision (Walker,2007). Therefore, as researchers and gatekeepers there must be concerted efforts to work together to achieve the end goal of quality care and improved service delivery for older people. Further research on why older people are reluctant to participate in research is worthy of exploration.

Focus Group Recruitment

From the initial meetings with staff who work in urgent and emergency care, and replies from the recruitment posters, there was a very positive response to the study. As a result, there was a lot of support for the study and many HCPs from all disciplines in urgent and emergency care were recruited to the two focus groups. Purposive sampling was employed to ensure the sample encompassed the diverse range of individuals with specific knowledge and understanding of the culture of care and the patient population (Patton, 2002, Creswell and Plano Clark, 2011). However, despite the willingness of all HCPs, the range of disciplines available on the day of the focus groups was reduced due to their work commitments: for example, no emergency care consultant, older people's medicine consultant or social worker were available to share their knowledge and understandings from the vignette. Initially, I was disappointed, as I considered the impact of this on the range, diversity and rich narratives of participants. However, as this happened 'in the moment', I had to put aside my disappointment and focus on my interviewing role, asking the questions and exploring the thoughts and views of the HCPs based on the vignette. It was important that I approached the interviewing with a freshness and that I bracketed my assumptions that the interview may not provide the rich narratives I hoped to capture. This was to avoid the risk of steering the focus group in a direction that moves away from the participants accounts to my subjective assumptions about the potential data.

Nonetheless, the two focus groups still achieved maximum diversity across the range of disciplines which achieved the aim of the focus groups.

Reflecting on my challenges to recruit maximum diversity of participants highlighted some important lessons about recruiting HCPs: firstly, the importance of 'buy in' from managers and gatekeepers to release staff for the study. Secondly, despite all efforts to recruit from the rich mix of HCPs, the practicalities of releasing staff to attend focus groups held within work time can be problematic, although equally holding the groups outside of work schedules would have been challenging. The difficulties for healthcare participants to participate in focus groups have been reported in qualitative studies as being due to time burden and clinical schedules, as with the experiences of the HCPs in this study (Tausch and Menold, 2016). Therefore, this is an area for further careful consideration when planning for future studies targeting participants working in high demand clinical settings.

This unexpected narrowing in the range of focus group participants allowed me to examine my reflexivity, both in relation to my positionality as an interviewer, and the impact this may have on the research process. Awareness of my disappointment and the need to bracket my underlying concerns enabled me to conduct the focus group with full attention on the experiences of the HCPs. Feedback from the scribe who was my supervisor also confirmed the positive way I conducted the focus groups and that the narratives provided a rich source of data stemming from the participants accounts of their experiences. Furthermore, it also highlighted some of the challenges of recruiting HCPs to focus groups which may be useful for future researchers when considering recruitment for their study.

Sample-Older People

Purposeful sampling for older people was employed in keeping with the tenets of IPA. This type of sampling was appropriate as it selects individuals who have experienced the phenomena, and therefore, this allows for an understanding of the lived experience (Tapp, 2008). The aim of IPA is to create a homogenous sample, so that the participants can each reveal something of their experiences and convergence and divergence can be examined in some detail within the sample (Smith et al. 2009). As IPA is committed to deep examination of each participant’s experience, smaller sample sizes are required. The sample recruited for this study was ten participants based on an inclusion criterion (Ch 4- Table 4) developed to enable deep exploration of their experiences of care. The demographics of the participants were mostly similar in age, ethnicity and gender (five males and five females) and reflected to some extent the population of older people within that geographical locality who would experience the phenomena under exploration. The small sample size enabled me to gather in-depth and meaningful insights from the participants' narratives (Patton, 2015). Maintaining the idiographic features essential to IPA can be achieved in the smaller number of participants, whilst attaining depth through the rich narrative data yield (Smith et al.2009). The rich yield of data from the individual narratives supports the use of smaller samples as it required detailed examination of the transcripts for meaning through higher levels of interpretation. However, it was very time-consuming to achieve a case-by-case analysis in order to end up with the in-depth examination of the phenomena under investigation (Pietkiewicz and Smith, 2014).

Data Collection-Older People

IPA is best suited to data collection methods that offer participants the opportunity to provide rich and detailed accounts of their experiences (Smith et al.2009) and are the most widely adopted method for IPA research (Reid et al.2005). Therefore, semi- structured one-to-one interviews were chosen enabling participants to tell their stories and speak freely about their experiences. The interview guide evolved from its initial conception, with interview questions more in line with closed questioning and the potential for yes/no answers, precluding the detailed responses required to explore lived experiences. Refining of the interview guide progressed to questions allowing for deeper responses through the objective *'can you tell me your experiences…'?.* Discussion with my supervisors and colleagues who had previously used IPA offered valuable insights to develop my thinking around the construction of the interview guide. During this construction phase I was critically reflective to ensure the questions were explicitly focused on maximising the participants' ability to tell their story in their own words (Reid et al.2005). I was mindful that paramount to the aim of IPA was not to lead the participant or emphasise the questions I thought were important. Therefore, through thoughtful and considered revisions, I refined the interview guides with my supervisors and colleagues to see how they interpreted the questions. Eventually developed a guide that I was happy had the potential to elicit the rich narratives that would achieve the aim of the study.

During the interviews with older people the schedule was not followed rigidly or asked in the exact order set out in the guide, since participants were encouraged to talk as freely and reflectively as they wanted to. Their answers directed the flow of the discussion and I was careful not to lead the discussion or impose any of my beliefs, conceptions or knowledge about the phenomena. It was important that my experience and ‘insider experience’ as a nurse did not lead to imposition of my beliefs and assumptions about older people’s care, and that I did not share my views, remaining impartial.

Smith et al (2009, p.57) describe the interview process as a ‘conversation with a purpose’ which is informed by the research question. Therefore, I acknowledge that if there were times when the participant was steering away from the aim, I quickly redirected the participant back to the aim. The use of prompts and probing also encouraged the older people to talk more in depth and elaborate on points that were of interest and worthy of exploration to address the research question. Following each interview, I reflected on the interactions I had with participants and wrote up field notes and the reflexive research diary highlighting my feelings, thoughts and any assumptions that may have arisen during or from the interviews. Some of the experiences shared by the older people as noted in my research diary and field notes affected me emotionally. For example, in Agnes’s interview (see, p.263) having an elderly mother myself, I could relate to the importance of the meaning she ascribed to family and why it was important to restore her identity and maintain self-worth. However, as a researcher I have not shared her experience and each participant’s experience is unique to them and should not influence my interpretations. It is common for researchers to feel emotional following interviews with participants and some have described how unprepared they were for the emotional impact of listening to their stories (Pellatt,2003).

I also questioned my interview skills, their quality, and the outcome of those skills to see if these did encourage the rich narratives I was hoping to achieve. Transcribing as soon as possible after the interview facilitated deep engagement with what the participants had said, whilst paying due attention to how and what they said. I have discussed this further in this chapter in the section on my personal research journey.

Data Analysis

Data analysis proved extremely time-consuming as I transcribed all the older people interviews and focus group transcripts. However, this enabled me to get even closer to the participants' narratives so I could hear each of their distinctive voices come through, and individually transcribing their words enabled deep immersion in their experiences. Moustakas (1994) highlights the importance of the researcher in transcribing and analysing the data for themes to allow the experience to be fully understood. Transcription has been described as '*a process that is theoretical, selective, interpretative, and representational'* (Davidson, 2009, p.36). Therefore, your approach to transcription will depend on your theoretical and methodological positions. IPA requires deep engagement with the text to unfold the essences of the participants' experiences. Smith et al (2009) framework offered me a flexible approach to the analysis as a novice researcher. This allowed movement from the focus on the individual to a more shared understanding of experiences, progressing from a descriptive level to a deeper interpretative one. However, the process of deep interpretation and searching for meaning was challenging and these have been discussed in more depth in my personal research diary (see Box 5, p.259).

It was at this point I became somewhat challenged in developing the conceptual and deeper interpretation levels required for IPA. Moving to abstraction and naming of themes has been identified as a challenging process which requires considerable engagement with the data (Fade et al.2004). Identifying themes and making connections within and across themes requires higher order thinking. Smith et al (2009) asserts that a limitation of IPA is reaching the levels of interpretation to convey meaning of the experiences. The use of a research diary enabled me to reflect on the older people's perspectives and my own thoughts and views following the interviews. This facilitated an active engagement in searching for meaning through this resource. According to Shaw (2010) journaling (I referred to it as the research diary) fosters integrity due to the researcher's consistent use of the participant's perspective to challenge and lead their thinking. To reach the levels of interpretation needed to identify the essence of the experiences of participants required exhaustive attempts at searching for meaning. This caused me to work hard to pursue meaningful superordinate and subordinate themes to build a picture/story of the wholeness of the participants' experience whilst preserving the individual accounts of the participants. However, this was difficult to achieve and took time to attain.

Reflexive account of conducting the analysis - Digging Deeper

As a novice researcher, the initial unpacking of the data was daunting. I found the iterative process of analysis challenging in how to avoid the themes becoming too generalised whilst aiming to illuminate the meanings attached to older people and their experiences of accessing urgent and emergency care. To give 'voice' to their experiences was always at the forefront of my interpretations and the extent that I captured this, I found myself consistently/constantly/continually questioning.

Initial interpretations during supervision sessions suggested that my analysis of the participants' accounts was overly descriptive, and the essence of meaning attached to the narratives was being lost and I needed to 'dig deeper'. There was a sense of my own uncertainty in how I was going to develop rich descriptive and conceptual accounts of experiences that would capture this essence and shed light on current and future research and implications for practice.

Moving to deeper nuanced understanding of experiences led me at times to doubt my analytical interpretations and prevented progression of my thoughts as I became (un)stuck. The complexity of the task in hand required me to self-question, to come to a deeper understanding of the narratives and to ensure the eventual themes were conceptual enough. The preliminary themes (Fig 13) acted as a foundation and through reflexivity and feedback from my supervisors, colleagues, presentation of my work and attending the regional IPA research network, valuable insight and understanding on the next steps required in the analytical process was eventually gained. Feedback consistently centered on the themes being too general and requiring more analytical unpicking. The consistent search for meaning eventually enabled me to provide the depth required for IPA analysis and being true to the epistemological positions of hermeneutics and phenomenology.

Box 5 : Research Diary -Reflexive account on conducting the IPA data analysis

The use of the participants' own quotes were chosen to give voice to their experiences, to keep as close to their personal experiences as possible, enabling their thoughts and feelings to be accurately represented, thus highlighting the trustworthiness of this approach to data analysis. On reflection, whilst this was a lengthy journey, the benefits are rewarding in how, through deeper interpretation, the older person's experiences unfolded to provide meaningful accounts which could then inform practice. Capturing the essence of what participants experience is a skill that has developed my competence in qualitative data analysis and has also allowed me to identify some of the essential features of older people's experiences of urgent and emergency care that can be of value to healthcare practice.

Personal Journey

Embarking on this research journey and conducting a research study has given me much insight into research design and methodology. Being a novice researcher with no previous involvement in research projects enabled me to start the journey with an open mind about what my learning needs were and a curiosity in developing a sound understanding of my research focus. As an experienced lecturer with a background in long-term conditions management, embarking on a research question fundamental to my area of teaching fuelled my interest in a topic with the potential to inform and change practice for older people. Along the way there have been highs and lows where I questioned my competence in my capability as a researcher which affected my confidence. Despite these challenges and obstacles. I worked hard to develop the requisite skills to grow as a researcher through the personal and professional skills development programme, with support from supervisors and colleagues. Learning the process and rigour of IPA has also allowed me to understand a new methodology and gain a deeper understanding of the value of qualitative approaches to explore lived experiences.

Through undertaking this research, I have gained much in my personal understanding of human experiences. The older people I encountered welcomed me into their homes and I recognised my privileged position in hearing their stories. Interviewing participants in their own home enabled me to appreciate

their meaning-making from a different perspective in relation to the context of time and place. Dodgson (2019) emphasised that all qualitative research is contextual as it occurs within a specific time and place between two people.
I had a strong awareness that I needed to do justice to their narratives, paying due attention to the words of the participants to capture accurately and legitimately their experiences (Pringle et al.2011). I was also aware of my insider and outsider positions, with the potential to draw on these experiences to fully understand these narratives. My previous role as a nurse practitioner working with older people with long-term conditions exposed me to the impact of their illness on physical, psychological and social levels, and currently as a lecturer, an appreciation of the conceptual and theoretical positioning of long-term conditions management. Although these understandings helped me to better recognise the nuances of older people's experiences, I also appreciated I have neither shared their experience nor worked in urgent and emergency care. The choice of IPA methodology asserts that the researcher can only gain an understanding of the participant's experience through what the participant says, as they have not directly shared that experience (Oxley, 2016). Thus, the researcher must make sense of those experiences through engagement with the hermeneutic circle, which requires any preconceptions or knowledge to be challenged (Smith et al.2009). As a researcher whose aim was to get as close to the experience as possible, I chose not to disclose to the ten older people participants that I was a 'nurse' or a 'nursing lecturer' to avoid the interviews veering off in a different direction. This way the role of the researcher was always made clear to the participants. How researchers position themselves in the research is important to avoid causing undue influence. The work of Ballinger and Payne (2000, cited in Finlay, 2002, p.216) highlights this point about how participants can view the researcher as a *'professional with some kind of authority and influence',* which can affect the researcher/participant interaction. Furthermore, Johnson and Mcleod Clarke (2003) stated that if the participants have awareness that the researcher is a nurse, there may be pressure on them to step out of the researcher role and into the role of the nurse. Therefore, my positioning as a researcher was central to the interactions with these participants so they had a clear focus in their role in the interview.

To understand experiences, Husserl called on the use of reduction which involves 'bracketing' or 'suspension' of our pre-existing knowledge and preconceptions to try and get to the essence of the phenomenon (gil- Rodriguez

& Hefferon, 2015). However, Heidegger's hermeneutic phenomenology recognises that the *'researcher's* views *of the world are inextricably inter- twined with the way in which they interpret the participant's experiences'* (Oxley, 2016, p.56). This allows the researcher to draw on their position to get as close to the phenomenon through their interpretation (Smith et al. 2009). Therefore, the importance of the researcher to engage in continuous reflexivity and acknowledge their previous preconceptions and knowledge about what it brings to the phenomenon is central (Smith et al. 2009). Through engagement in these processes I acknowledged my positioning in the study as both an insider and outsider and used the research diary and field notes to highlight how my insider/outsider knowledge influenced how I arrived at the themes. Hayfield and Huxley (2015) propose that the position of insider or outsider can bring a number of benefits to the research. The researcher can take an active role in describing and presenting those populations with marginalised voices. This was central to the aim of the current study, to give 'voice' to the older person's experiences of how they received care. Hayfield and Huxley (2015) also highlight the positive role the researcher has in shaping the production of knowledge through the research processes they use. Thus, use of IPA with its emphasis on interpretation and 'meaning making' allowed for the positive positioning of the insider/outsider perspective to shape and guide the study.

Developing research competence

The most challenging and daunting part of this study was the IPA data analysis, which at times left me feeling overwhelmed. Ensuring that I remained true to the epistemological positions of hermeneutics and phenomenology and doing justice to the older people's narratives proved more complex than I had anticipated. I was uncertain that I was ever going to achieve the interpretative depth required which led to self-doubt and questioning my research capabilities and competence, all of which I had to overcome in order to progress with my analysis. Thus, it took me a considerable amount of time to eventually come to grips with the underpinning methodology of the research study in relation to the IPA analysis. A reflexive account of my journey with IPA analysis illustrates these challenges and the steps taken to overcome these barriers in order to move forward with my study (See Box 5, p.259). My growth in using and applying IPA has enabled me to provide the rich descriptions of the experiences of older people, so that their 'voices' can be heard to inform practice.

Digging Deeper in IPA

To help me with digging deeper in relation to the analysis, I used the meetings with my supervisors and other colleagues to discuss the themes I identified and how I arrived at those themes. These were valuable experiences, calling on me to develop my analytical thinking to make the conceptual links and justify my assumptions and connections to the meanings I ascribed to the participants' narratives. Given the intricacy of interpretative analysis, Hefferon and Gil-Rodriguez (2011) and Smith et al (2009) stress the importance of supervision for novice researchers to support them with reaching the conceptual level of analysis required. I also used my research diary and field notes to recall the interviews with the older people, to explore my initial thoughts/impressions and relate these to how I interpreted the data of the individual participants (Box 6, p.263/264). According to Nadin and Cassell (2006) the use of a research diary is to aid reflexivity in the research process. Furthermore, it is a valuable tool to prompt insights and inform methodological and theoretical decisions (Nadin and Cassell, 2006). Thus, keeping a research diary made me aware of my thoughts and feelings about the research, including the interviews with the participants. The diary enabled me to examine these encounters with the participants in the environments in which I interviewed them and the influence that these social situations had on my interpretations. Using reflexivity, I was able to explore my epistemological position, which provided me with a clear focus about the purpose of my study to explore the participants' experiences and through these steps allowed me to construct new analytical insights.

Interview with Agnes, I thought I was made to feel so welcome in her home and how she was so willing to be involved in the study. I noted there were pictures all around her kitchen of her family and grandchildren and she told me about them all and that she was very proud of her grandchildren who went to university. She also talked highly of her community and her neighbours who 'all look out for each other'.

Field Notes: Agnes Visit (Date:06.12.16)

When I commenced transcribing Agnes' interview, these thoughts became apparent to me in how through her narrative, the importance of her identity as a mother, a grandmother and a neighbour was clear. When she was at home in her environment **this is who she is** and the significance of these identities were threaded through her dialogue with me in how she was cared for in the ED, how she felt valued, what the emergency admission meant to her and how she was so full of gratitude for the staff who saved her life, so she could be around for many more years for her family.

Listening to the audio-recording

I listened to her voice in how she lovingly referred to her family members and, in the frequency with which she mentioned them in the interview. This left me with a strong sense of how significant her family were to her and that she needed to be there for them. I made a note of the words she used in her quotes:

'she treated me like she was my own daughter' and how she felt she was worth saving so she could live for her family. (Agnes)

My thoughts

I wondered how as an outsider she was able to share those identities with me, those private family photos, which provided me with an understanding, of how much those family members meant to her. I then wondered whether these identities were shared with staff when she presented to the ED, whether the staff sought to understand what it meant for Agnes to be a patient in the ED, and how they involved her daughter in their discussions seeing she was such an important person in Agnes's life.

Personal thought
I can relate to Agnes's experience, being the daughter of a parent who is elderly and can appreciate the significance of family to her. However, I am aware that it is an experience unique to Agnes and therefore the focus is on her story.

For me this interview identified two striking thinking points for me as a researcher:

1. Personal Identity
2. Sense of worth

Box 6: Example of field notes and reflexive practice-excerpt from research diary

The idiographic approach of IPA helped me to pay close attention to the participant's individual accounts and how they made sense of those experiences (Smith et al.2009). This provided valuable insights which helped me interpret the meaning attached to each participant's experiences and then build connections across the participants' narratives. Moran (2000) states that interpretative work is required to understand the meaning of what is disclosed. However, there are many challenges identified in the literature around interpretation of the participants' narratives (Brocki and Weaden, 2006, Smith et al.2009, Eatough and Smith, 2014). Critical evaluations of IPA have pointed out that it can be '*mostly descriptive and not sufficiently interpretative'* (Brocki and Weaden, 2006, Tuffour, 2017, p.4). Furthermore, Biggerstaff and Thompson (2008) argue that the move from a descriptive level of analysis to a conceptual level is complex and can often be problematic. Another challenge acknowledged is the difficulties that researchers can have interpreting what the participant has said based on the participant's perceived experience (Oxley, 2016). However, Oxley (2016, p.55) states that this is part of the 'methodical stance', where the researcher positions themselves as 'meaning makers'. Initially, these challenges were evident in my interpretations, as seen in my attempt at the preliminary themes (See Fig 13). Therefore, active steps (discussions with supervisors, colleagues, IPA Network, research diary and field notes) were taken to move to deeper interpretation and meaning making which has been demonstrated in the final themes identified (See Fig 5 Ch 5, p.109).

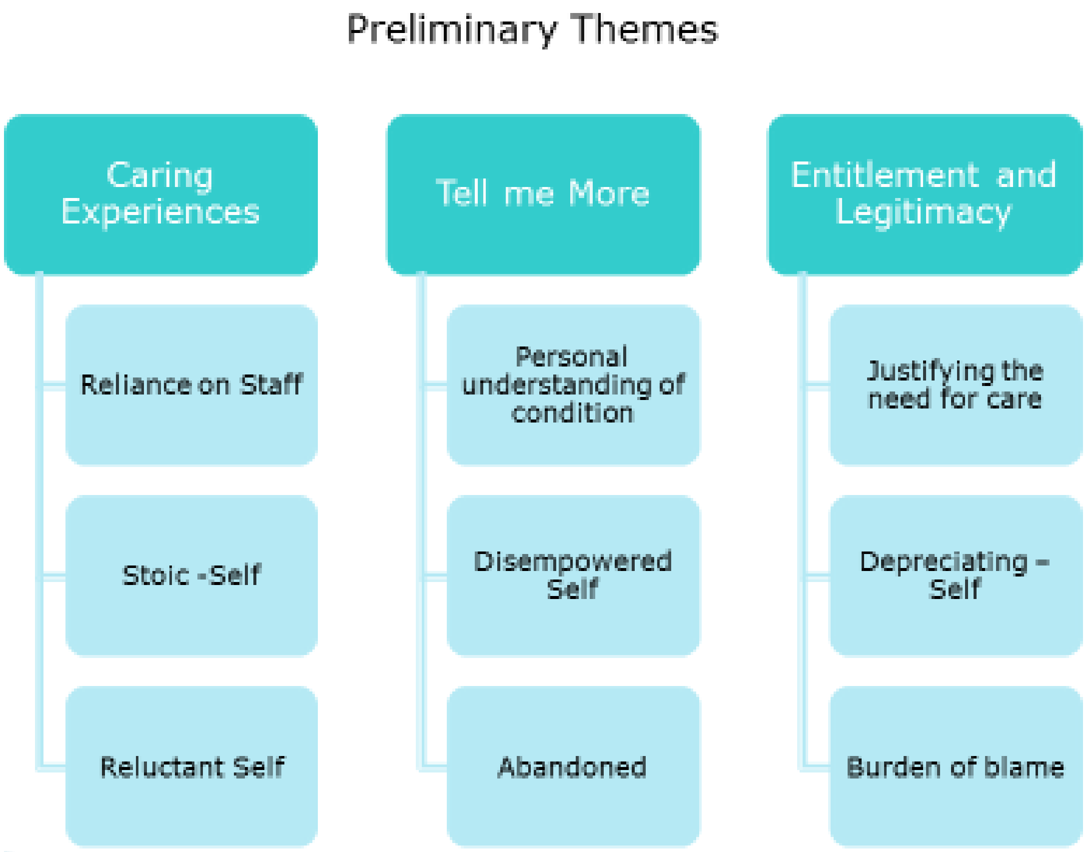


Fig 13: Preliminary Themes

Reflections on interviews with older people

Initially I put a lot of pressure on myself to get the interviews right and to ask the 'right' questions, so they were in keeping with IPA methodology, using the interview guide (See Appendix F). This resulted in some missed opportunities where I didn't 'dig deep' with the participant when they identified an area of discussion that required greater exploration and depth (See Box 7a, p.266 : annotations highlighted in blue). Smith et al (2009) advise that improving the researcher's interview techniques is another way to 'dig deep' to gain rich data. Transcribing the tapes as soon as possible after each interview allowed me to reflect on my interview approach and how I interacted with the participants. This identified areas for improvement in my interview techniques and acted as a monitoring tool through my field notes, as I progressed through the interviews (See Box 7b, p.267). Awareness that the participant takes the lead allowed me to step back from my over-concern to follow the topic guide and enabled me to develop my questioning in response to the participant's narrative. This enabled a freer style of questioning and it was evident as I progressed in skill-development that I said less and the participants said more. Through engaging with the interview transcripts reflexively, I was able to gain new insights in how I used the skills of questioning, which subsequently produced better interviews that yielded rich data. Therefore, engaging reflexively with the data and through self-awareness of my skills as the interviewer enabled me to appreciate my influence on the direction of the interview.

James	I, I think because of I've already been seen in that room before, there was nothing to do, I couldn't put any pressure on anybody, I have no right to ask for any special treatment. So grin and bear it really, there was nothing else to do. Could have developed this point about why he felt 'powerless'- didn't follow up with a question – could you tell me more? **Normalising the ED process**	Nothing I could do No right for special treatment Grin and bear Powerless to change things Feeling disempowered Made to be submissive Feeling of lack of influence Why does he feel he needs special treatment- should older people have special treatment in the ED Just because I'm old doesn't mean I will get special treatment **Acceptance** **Powerlessness** **This was the ED process** **Why does he feel like that?**

Box 7a : Digging Deeper- Questioning

Field Notes

Following transcribing James interview (my first interview) I note some missed opportunities. Looking at the transcript I could see my line of questioning was influenced by the interview guide. James made an important point on feeling powerless, but I didn't probe further. There was an opportunity to use my prompt questions – Can you tell me more? I am left thinking why he felt powerless. Is this how older people feel?

Action Point

- Listen carefully to what the participant says
- Act upon important nuances and probe deeper

Box 7b: Field Notes - James interview

Quality of the Research

Evaluating the quality of qualitative research is an important process in order to examine the claims researchers make about their findings (Mays and Pope, 2000). There are many ways to improve validity with a number of guidelines developed to assist in this process. However, Smith et al (2009) suggest Yardley's 2000 and 2008 guidelines for assessing the quality of qualitative work as one that is particularly suitable to IPA research. Yardley's (2000, 2008) criteria for judging quality are sensitivity to context, commitment and rigour, transparency and coherence and impact and importance

Sensitivity to Context

Sensitivity to context can be achieved through many aspects of the research process. Initially this was demonstrated in the early stages of the study by identifying IPA as the most appropriate method to explore the experiences of the older person. This involved immersing myself in understanding the theoretical underpinnings of IPA and its potential application to the planned study. The next step was to situate the study within the extant literature and develop awareness of the wider political and social discourse that influences healthcare for older people within the environment and context of care. Building theory and conceptual links were significant in making connections and understanding the whole experience of older people as I moved through the data analysis. Engaging in the relevant literature and policy enabled an understanding of the different perspectives relating to the area of focus.

I was aware of my role as the researcher and the patient population I would be working with. This commanded careful consideration of ethical and research processes, with particular attention to recruitment and the conduct of the interviews. At all stages of recruitment and interviewing, participants were provided with comprehensive information about the study to gain informed consent. All the older people interviews bar one took place in the participants' home and the researcher was aware of their role in reassuring the participants and to manage any sensitive issues if they were discussed or raised.

Making sense of what the participants say and working through unfolding their narrative is an important feature of data analysis that demonstrates sensitivity to context (Smith et al 2009). Care not to impose any of my preconceived ideas or assumptions on the data demonstrates sensitivity to the data by grounding the findings in the accounts of the participants. These were then substantiated by the provision of verbatim extracts to support the arguments made (Smith et al. 2009, Pringle et al. 2011). Careful consideration of the interpretations of the data was undertaken to ensure that these represented the voice of the older person (Yardley, 2000).

The use of patient and public involvement (PPI) strengthened the study in the early stages of the research, especially in relation to the research question, writing the participant information documents in lay language and most importantly obtaining the views of older people on the relevance of the research to the population whose care it was intended to improve was an essential part of the process. Bagley et al (2016) assert that involving PPI is good practice so that patients and the public have a say in research decisions that may affect them. Therefore, the perspective of older people for whom this research was intended was used, demonstrating my commitment to ensuring the validity of the research. Furthermore, it also supported the socio-cultural and linguistic context of research that Yardley (2000) advocates to determine sensitivity in context.

Commitment and rigour

In-depth and prolonged engagement with the topic are characteristics of commitment and rigour to the work (Yardley, 2000).Transcribing and analysing all the interviews enabled me to get closer to the participants' narratives which, although this was a slow process, allowed me to scrutinise meaning, context and understanding of what had been said. Braun and Clarke (2006) support this approach as they posit that this develops a far more thorough understanding of the data. Additionally, Lapadat and Lindsay (1999) recommend that paying closer attention to the data through transcription may also facilitate the interpretative skills needed to analyse the data. Intense persistence at working to a higher interpretative level also demonstrated my commitment to getting IPA right and doing justice to the participant’s story so that their voices could be heard. Smith et al (2009) argue that the analysis should be thorough, complete and interpretative, I have achieved this through the range of participant quotes used to illustrate the themes. The range of participants was supported by the purposive sampling employed. Hence, only those participants that would be the most suitable to answer the research question were included as per the inclusion criteria that were established. Thus, reasonable homogeneity was achieved in line with IPA research.

Moving from initially identifying emerging themes to eventually arriving at the final themes involved a prolonged step-by-step analysis process. This involved testing and justifying my themes with my supervisors to establish the credibility of the findings. Further discussion of possible alternative themes and hearing different perspectives of interpretations was explored until a consensus was reached. Yardley (2008) advocates this process to enhance the credibility of the findings to demonstrate rigour.

The combination of two different methods: IPA with older people and focus groups with HCPs was used to gain different perspectives of the phenomena under investigation. This demonstrated triangulation of data to provide a multifaceted understanding of the topic (Yardley, 2008).

Transparency and coherence

Transparency relates to the clarity of the stages of the research processes in the write up (Smith et al. 2009). I have attempted to be clear in my approach to the thesis by providing a systematic approach to each of the chapters, clearly describing the question, how the participants were selected, how the interview guide was developed and applied and how the interviews were conducted and analysed (Smith et al.2009). Detailed information was provided about how I conducted the analysis. This was supported by my research diary that provided accounts of the development of my skills of interpretation, so I could provide deeper conceptual meanings to the participants' narratives. The older people findings chapter required several attempts at rewriting until it finally was consistent with the underlying principles of IPA. Hence, by giving clear descriptions and accounts of the steps in the design, methodology, analysis, and presentation of the results have maximised my attempt to demonstrate transparency to the reader.

According to Yardley (2000) transparency requires the researcher to demonstrate clearly how their interpretations were derived from the data. This was achieved by providing a sufficient number of compelling quotes from the participants' narratives to illuminate the themes. These were supported by tables and figures at the beginning of each superordinate and subordinate theme, so there was transparency and signposting to the reader of the journey taken to arrive at the themes. The findings were then related back to the literature to make connections to context and theoretical and conceptual underpinnings, whilst establishing for the reader how this related to the research question. Therefore, acquisition of IPA methods and the interpretative skills has afforded me the ability to examine and theorise the conceptual links made.

The reflective diary and field notes offered a way of achieving transparency by detailing the decisions made and the thoughts and feelings concerning why things were done and what actions were taken. These reflexive stances were discussed with the supervisory team at all stages of the PhD journey which helped to reflect and justify the methods used.

The double hermeneutic employed in IPA recognises that different researchers may interpret the data differently; therefore Yardley (2007) argues that current interpretations may not be the only ones, due to the subjective nature of interpretation. However, this is an established view and steps were taken to strengthen the transparency of the work to increase the credibility of my findings by regular discussions with supervisors and linking the findings to the existing literature.

Impact and importance

The final aspect of Yardley's (2000, 2008) assessment of quality is that the study provides a sense of impact and importance to the reader. The literature review established the limited qualitative research on the experiences of urgent and emergency care from the perspective of older people themselves. Furthermore, very few studies on this area of healthcare practice have been explored from both the perspective of the older person and multidisciplinary professionals, and to that end it is novel. Therefore, this study has provided findings of value that will inform and contribute to new understandings about how we care for older people in these environments of care. The study also brings to light several conceptual insights around personal identity, autonomy and connectivity that will enable HCPs to understand how older people view themselves as recipients of care. Importantly the study reinforces that older people have unique needs and are a distinct group within the ED setting and therefore this strongly suggests that they require age-friendly services more attuned to their needs. The study also highlights several new understandings around the organisational and processes of care affecting HCP's capacities to deliver patient-centred care and the emotional struggles they can face when the quality of care they aspire to give cannot be delivered. Several areas for future research have been identified as a result of this study which demonstrates the positive role research has in the identification of gaps in care, thus, continuously seeking to improve the quality of care for older people. The study also highlights the significance current public and social discourse has on the representation of older people in society and the impact this has on their sense of worth, identity and help-seeking for medical needs. Furthermore, the study also highlights that the language used in policy which should protect older people may deter them from seeking help for their emergency needs, in opposition to the promotion of health and well-being in older age such policy aims to achieve.

Reflections on the decisions made regarding methodology, study design and the research process, with emphasis on the role of reflexivity and the personal journey of the researcher and consideration of the overall quality of the study, has provided several areas for the reader to scrutinise and make judgements on. This study has afforded me the opportunity, through interpretative phenomenology, to explore and analyse the experiences of older people to identify the essential features of the phenomenon to provide new understandings about an important area of healthcare practice.

Following on from this aspect of the work I will now be discussing the limitations and strengths of the study with recommendations for future developments in practice, research and policy.

Study limitations

While this study may provide important findings regarding older people's experiences of urgent and emergency care, there are several limitations to acknowledge.

The IPA qualitative method used makes it difficult to generalise widely from the results of the study due to the small sample size used (Oxley, 2016), limiting how the data and findings can be generalised to a wider population. However, Smith et al (2009, p.4), emphasise that the key concept of IPA is to understand the part to illuminate the whole, therefore the researcher uses their existing professional knowledge to make the connections to the evidence, which they identify as 'theoretical generalisability'. As seen in the strengths of the study, the commitment to an idiographic approach to the participants' narratives enables a much richer and deeper analysis of the participants' experiences. Therefore, the purpose of IPA is not to generalise, but rather to provide deeper insights and understandings of participants' accounts of their experiences (Drummond et al.2011, Gil-Rodriguez and Hefferon,2011, O'Mullan et al.2017).

The sample of participants was purposefully homogenous, in that they all experienced the phenomena under investigation and were able to provide their perspective of their experiences, although these were individual and distinct. Furthermore, they were homogenous in that they were similar in age, ethnicity and gender, and thus achieved a representative sample to meet the aim of the study (Smith et al.2009). The sample size of ten participants was also small enough to ensure an idiographic approach could be used.

The focus of the study was on providing the participants' perspective of older people's experiences, with the researcher illuminating these insights through their interpretation. However, it is acknowledged that IPA is fundamentally a subjective approach where there may be different interpretations depending on the researcher that collects and analyses the data.

The study was limited to one single ED and urgent care service in an acute hospital located in the East of England. Although the findings could be transferred to other similar settings, caution would clearly need to be used. The study sample also represents an older patient pathway of emergency care specific to the research site and therefore other EDs may have different age limits through which older people can access their pathways of care.

While participants described presentations to the ED which are broadly representative of a British general practice population, it is recognised that these representations are based on the participants' self-reporting narratives about their reasons for attendance at the urgent and emergency care and are not confirmed or corroborated through a recorded diagnosis. However, the focus of the study was on older people's experiences of urgent and emergency care and therefore a documented diagnosis was not central to the inclusion/exclusion criteria that were developed for the study.

The acute and urgent nature of the older person's medical illness in this study provides insight into their perception of their experiences of urgent and emergency care. However, it should be acknowledged that many of the older people's experiences may be related to their levels of vulnerability and dependency on HCPs for their care needs. Thus, older people who are less dependent may experience care differently and provide quite different accounts of their experiences.

It was noted that many of the patients identified by the gatekeepers as wanting to participate in, or who requested further information on the study, when contacted by the researcher, subsequently declined to participate, providing reasons such as they felt that they would not have much to contribute to the study or they had had good experiences of care. Others felt that since they had no complaints about the service, nothing would be gained by their contributions, and others feeling they were still too ill to participate in a study. Therefore, the sample of participants interviewed were those who were most willing (and able) to share their stories. Thus, as described above, the sample cannot represent the views of all older people about their experiences of urgent and emergency care. Additionally, understanding why older people feel they have nothing to contribute is worthy of a study on its own and would throw light on how older people may be engaged in research.

All the participants expressed satisfaction with the care they received from the urgent and emergency care services and wished to make it clear that they were not complaining. However, it could be said that this strong desire not to complain about or appear ungrateful for the service or staff may have impeded some of the deeper nuances of what it was like to receive care in an urgent and emergency care environment.

All of the participants in the study sample were White British, over the age of 80 years, who lived in their own homes and the exclusion criteria specifically excluded those people with cognitive impairment or who were too ill to participate. Therefore, the study findings are limited to older people who (broadly) share the same characteristics.

Despite these identified limitations, it is hoped the findings from the study will inform practice, policy and future research concerning this important area of older people's healthcare.

Strengths of the study

This study has a number of strengths. Firstly, the analytical approach of IPA offers strengths in the idiographic approach and deeper interpretation of the data necessitating a 'dig-deeper' approach to find out what it was like for the older person to experience care in and urgent and emergency setting. Thus, the interpretations were grounded within the narratives of the participants, which directly generated the themes. Furthermore, the richness of the data from all ten participants and the resultant themes suggests that IPA was a suitable and appropriate method to achieve the aims of the study.

The sample of participants was purposefully homogenous, in that, they all experienced the phenomena under investigation and able to provide their perspectives on their experiences; furthermore, in that they were similar in age, ethnicity and gender, and thus achieved a representative sample to meet the aims of the study (Smith et al.2009). However, the sample size of ten participants was also small enough to ensure an idiographic approach. According to Smith et al. (2009), one of the challenges of IPA is keeping the sample sizes small in order to provide the detailed individual accounts of the participants. This requires considerable skill to remain true to an idiographic focus; if not, can run the risk of resembling a thematic analysis (Smith et al.2009, p.107).

The use of semi-structured interviews with older people and focus groups with staff supported by a vignette generated multi-layered accounts of healthcare experience from the perspectives of both the patient and staff, thus offering deeper and robust narratives about older people's experiences. Furthermore, few studies have explored older people's experiences of urgent and emergency using both perspectives, therefore this approach is novel to the phenomenon under investigation.

The study used a vignette to explore and discuss healthcare professionals' views and perspectives of caring for older people within an urgent and emergency care setting. A limitation is that the focus group may only represent a snapshot view of these views and experiences and may not reflect how individuals actually respond in reality (Hughes and Huby, 2004). However, the vignette was constructed based on the original accounts of the older people's experiences and were not wholly hypothetical representations. Therefore, attempts were made to make it as near to the older person's 'real life' experiences as possible. Thus, the aim was to actively use the hitherto relatively silent voice of the older person to uncover views and perspectives from the professionals who care for them in order to gain different or similar perspectives of care. Hence, this was a strength of using such a vignette in the study. This was acknowledged by the HCPs to represent the 'typical' older people they see in their routine care provision. Another strength of using a vignette was that the focus groups had a clear focus for the discussion (Hughes and Huby,2004). This study acknowledges the limitations and strengths of using a vignette, however overall, it strengthened the aim of the research by exploring elements of older people's care that we seek to understand and learn more about.

Additionally, the literature confirms that the participants' experiences discussed within the emergent themes are relevant and supported.

The interviews with older people were conducted within a short time-frame from their discharge from the urgent and emergency care services, thus enabling greater recall and freshness of the events and experiences they had.

Contribution to Knowledge

This study provides a valuable contribution to the understanding of older people's lived experiences of urgent and emergency care through the lens of both the older person and health care professionals. It provides a unique insight into how the older persons displays of silence in the ED can be interpreted differently by healthcare professionals, resulting in them not voicing their needs or concerns and as a consequence, individuals are overlooked and their needs unmet. It contributes new evidence of the impact that transitions in care have on older people; moving from areas of high-intensity monitoring in the ED to lower levels of observation on wards and side rooms, can significantly increase their sense of fear and anxiety. Alongside this, it crucially identified how multiple transitions, particularly when being moved in the middle of the night, often resulted in heightened feelings of isolation, vulnerability and uncertainty. Ultimately, this study asserted the power of the relational aspects of care that were fundamental and vital for the older person to have a sense of belonging and connection. Correspondingly, it was also found that key to their experiences was receiving validation from health care professionals, to legitimise the older persons use of urgent and emergency care services and contribute to a sense of self-esteem and self-worth. Of significance, this study has found that maintaining a sense of identify and autonomy for the older person is reliant on health care professionals' attitudes and behaviour which can help address the negative impact that the social and public discourse of ageing can cause. However, health care professionals need time to care to prevent them feeling frustrated and disappointed when the care they aspire to did not match their expectations when delivered, often leaving them struggling emotionally.

Recommendations

This study enables the older person's voice to be heard and contribute to shaping and informing healthcare services. Thus, the findings are important in highlighting the challenges and issues specific to older people, so that these can be acknowledged, especially in relation to the provision of age-appropriate health services. Consequently, the study has important implications for HCPs and service providers to improve understanding about how older people experience care. It is crucial to understand and consider how both organisational processes of care, and interactions with staff influence those experiences and illuminate what matters most to older people when they access urgent and emergency care services when evaluating and developing service provision in this area of healthcare.

IPA has allowed a deeper understanding of how older people make sense of their experience of urgent and emergency care, identifying important and new understandings of what matters most to older people when they are recipients of such care. These understandings provide rich insights and contextual information relating to how policy and health care practice shape those experiences. The findings also provide important considerations to inform changes stemming from the perspective of those older people for whom it has the most impact. Implications and recommendations for future policy, practice and research that have been derived from the study thus follow, although it is acknowledged that this is not an exhaustive list.

Recommendations for Practice

Achieving patient-centred care in the ED.

Fundamental to the positive experiences of care were the relational aspects of care which fostered interactions so that participants felt connected to staff and that they belonged in the ED, without feeling they were a burden. The '*little things'* that illuminated moments of caring and kindness, which can sometimes be forgotten in the busyness of the setting are what mattered most to older people. It is these aspects that made a key difference to older people's care. This study highlights the power of relational care and the key role professionals have in making this an integral approach to their everyday practice. Hence there is a need for greater emphasis on relational care as well as technical care in the ED. This fusion of the relational and technical dimensions of care will enhance and develop the culture of caring in the ED.

The study draws attention to the impact that feeling a burden has on older people, from a diminished sense of worth and self-esteem to self-stigmatisation about living longer. There is a need for health care professionals to be aware of this sense of burden since it may prevent older people from seeking help. Additionally, when they are recipients of care, older patients felt they must justify that they are legitimate users of health care services. Staff need to be sensitive and aware of the significance and meaning that older people attach to feeling a legitimate patient.

Therefore, understanding how older people internalise such feelings of burden will facilitate HCPs use of validation and reassurance in order to convey to older people that they are legitimate users of care. Thus, this study recommends the use of empowering approaches to enable older people to seek help when needed and to feel reassured that they are genuine users of health care, which will also promote their sense of self-esteem and self-worth.

The study also highlights older people’s fear of wasting HCPs’ time which prevented them from seeking help or making their needs known. This deserves attention as it acts as a barrier in communication about their needs. However, the lack of involvement of older people in their care further alienated them from expressing their needs. Thus, there is a need to formulate patient-centred approaches that enable staff to better understand their health needs and their current problem. Greater emphasis on building meaningful relationships and shared decision-making will facilitate more active involvement of older people in their care. Such approaches would also support older people to express their needs more freely, and without experiencing guilt.

Attention to the psychological and emotional needs of older people was largely missing from older people’s care, with the emphasis primarily on managing the presenting urgent need. Whilst this focus is understandable in an emergency care environment, the result left older people feeling insecure and with a heightened sense of fear due to their sense of impending mortality. Therefore, there needs to be a fundamental shift from the medical model of care to one that encompasses all aspects of human need and holistic care.

Pathways of Care

The findings draw attention to the need for alternative pathways of care for older people to meet their urgent and emergency care needs. Current pathways of care identified multiple transitions in care, inadequate assessment of older people’s needs and poor discharge transitions, which ultimately left older people with unmet needs, and which also affect their dignity and autonomy. Additionally, environmental and organisational factors further constrained the delivery of effective care to this patient population. However, a whole system change is required so organisations understand and recognise the unique needs of the older person. This suggests a transformation of services that are aligned to older people's needs, and which promote better processes of integration of care to improve health and social care outcomes. Where age-friendly pathways have been introduced in the USA and UK in recent years, these have shown positive health outcomes and improved patient experiences. However, this study has acknowledged that further research is required to assess their effectiveness. This study lends support to new ways of thinking to develop more inclusive and age-friendly practices which treat older people with respect and dignity

Managing Care Transitions

This study has gained a deeper understanding of the affect multiple transitions have on older people who access urgent and emergency care. Notably, these heightened older people's fear and anxiety when moving from high areas of observation to the relative isolation of the wards and side rooms. This has highlighted a number of issues with this pathway of care that leaves older people feeling vulnerable, fearful and isolated and suggests greater consideration needs to be paid to minimise the number of transitions in ED care journeys, to alleviate undue stress. The literature lent some support to explain an increase in transitions just before the 4-hour target cut off time. Therefore, the study findings advocate (or advise) that such care delivery practice is not conducive to patient care as it negatively affects the quality of care older people receive and perceive and prevents the development of meaningful relationships with staff. Approaches to care need to meet the needs of the older person and not the organisation.

Strengthening integrated care pathways

The findings also propose a strong case for better integration between primary and secondary care, specifically follow up care after discharge. This would mean strengthening and developing the integration of health care services, initiating comprehensive assessment and advanced care planning for those most vulnerable and at risk. The aim would be to prevent readmissions and maximise adherence to treatment plans and medication following discharge from the ED. Targeted interventions are advocated to facilitate transition from hospital to home and ensure timely follow-up, alongside ongoing community support as necessary, to enable older people to feel safe and reduce the risk of adverse events. These suggested strategies will work towards improving the quality and continuity of care delivered to older people following discharge.

Environment of Care

There is an apparent lack of fit between the environment of care and the needs of the older person. Older people have specific needs to maintain their comfort and physical needs, such as easy access to toileting, comfortable beds and trolleys, access to food and drink and keeping warm. The noise and fast-paced environment of the ED is often at odds with the pace of the older person, which can increase their sense of vulnerability. Awareness of the busyness and the high workload of staff left many older people feeling reluctant to ask for assistance, with some taking risks that compromised their safety in order to meet their care needs. This suggests that many older people are left with unmet needs concerning basic care and an environment that does not respect their dignity. HCPs felt the fast-paced and time-constrained environment acted as a barrier to address older people's complex needs as well as preventing appropriate levels of relational care. Thus, there is a persuasive argument for an environment of care that is safe and comfortable in order to meet the individual needs of older people. This study lends further evidence of the specific environmental needs of older people to enable them to feel safe and secure as part of their care experience in health settings. Therefore, age-friendly environments, more attuned to older peoples' needs should be an essential feature of their care, also maximising the maintenance of independence. Commitment from organisations is required in the planning and delivery of care to design environments with a clear understanding of the specific needs of older people, allowing comfort and safety. This will also improve HCPs' ability to assess, treat and provide individualised and holistic patient-centred care.

The Culture of Care

The ED culture was described by HCPs as one where organisational processes of care, in particular the push to get patients discharged within the four-hour target, took precedence. It would appear that government initiatives aimed at reducing waiting times deflect emphasis on individualised patient care to one that is target driven. Consequently, this poses significant threats to the delivery of dignified and patient- centred care at both an individual and an organisational level. Within this culture older people were left for long periods without any connection to staff and were not involved in decisions that mattered to them, so were effectively silenced. This significantly impacted on their sense of self-worth and autonomy. The study findings highlight the need for organisations to rethink their current processes of care to create a culture that prioritises and reflects the needs of the older population. Moreover, the organisation needs to support staff with sufficient time, space and resources to succeed in providing the care to older people, to which they aspire. Therefore, this study strongly suggests the need to transform older people’s care by creating positive organisational cultures that respect the needs of older people and enables HCPs to deliver high quality care.

Staff Support, Knowledge and Training

The study underlines the challenges of caring for the needs of older people in the fast-paced ED environment. However, older people appreciated those HCPs who were knowledgeable and used relational skills to make them feel connected and valued. Therefore, this study draws attention to the need for support and training of HCPs in brief interventions which maximise the positive outcomes of care achievable through such patient/professional interactions. Complexity of older people’s care was also recognised by HCPs, whilst acknowledging having insufficient time to assess these needs due to the focus on the presenting urgent problem. Further, this study highlights the need to better understand the complexity of older people’s health care needs to improve patient care outcomes. This indicates the need for more holistic and comprehensive approaches to assessment, recognising the multifaceted needs of older people. Whilst many of the HCPs had positive experiences of attending education courses related to their jobs, they reported difficulties in applying their new learning within the organisational constraints of their working environment. Therefore, this emphasises the need for organisations to identify approaches to support HCPs in translating their new skills, knowledge and competencies to the practice area.

Recommendations for Policy

Language - impact of policy terminology on older people’s perceptions of accessing urgent and emergency care

Based on the findings of this study, some important policy considerations are apparent in order to enhance older people’s appraisal of their need to access urgent and emergency care. The study identified how many older participants had concerns over their legitimacy as a genuine user of urgent and emergency services. Therefore, comprehension of how participants make sense of having a genuine emergency and the need to access services must be understood from a policy and practice context. Current health policy may expose older people to messages implying they are overstretching health and care services by living longer. As seen, such messages make it difficult for older people to assess whether their needs are genuine, and as a result, sometimes delaying their seeking support for urgent and emergency needs. Consequently, even those older people for whom the ED service is appropriate perceive that they must justify such use. Policy makers have an important role to improve access to urgent and emergency care services through the language used in policy terminology, so older people do not feel they are a burden on health care services. Further, policy makers need to understand older people's perceptions of these messages and the role and impact of the language used on those who are most vulnerable and at risk of harm (through non-utilisation of health care). The study indicates that the negative language on ageing used in current health and government policy, together with the requirement for individuals to interpret their own emergency are often misinterpreted. Moreover, they fail to convey the intended messages for promotion of health and well-being for this important patient population.

Older people's utilisation of urgent and emergency care

Current healthcare policy is focused on reducing inappropriate use of urgent and emergency services, whilst also promoting to individuals the need to receive care from the most appropriate service. The study has identified that when older people visit the ED, their reason for attendance is generally appropriate, which is supported by the wider literature. Understanding that older people will only seek help when they feel they are legitimate users of urgent and emergency care will help policymakers to develop effective ways of targeting older people, so they access the right care in a timely way.

Redesign of urgent and emergency care for older people

The experiences of the older people were largely positive; however, this study identified several challenges they faced due to the organisational and processes of care which increased their vulnerability and even threatened their dignity. Therefore, this study also advises to policymakers that there is a case for redesigning existing urgent and emergency care services in order to fulfil the care needs of older people.

Recommendations for further research

Older People

Research in older people’s health is a priority, given they are more likely than any other population group to utilise health care services. The study findings offer ideas for future research to improve the care for older people in urgent and emergency care settings and target and respond to their unmet needs by understanding the impact of the physical environment and care processes on older people’s health and well-being. Areas to consider would include exploring the adaptation or redesign of current urgent and emergency care services to develop age-friendly practices that reflect a life-course and population approach to ageing.

Further research is also required on age-friendly interventions to identify how to best and more effectively involve older people in shared decision-making.

Transitions in Care

Environmental factors associated with emergency care, particularly around the appropriateness and necessity of moving older people in the middle of the night, and the impact these have on patient safety and vulnerability should be considered as a future area of research. A better understanding of these experiences for older people will enable the development of ways to avoid such disruptions to individual care. Additionally, there is a need to explore and develop interventions to improve transitions in care, specifically managing transitions for older people who are discharged directly from the ED.

Media portrayal of ageing

The impact of the media portrayal of older people on their experiences and expectations of health and care is also an under-researched area of health care practice. Further examination of the findings in this current study about the emotional impacts of being portrayed as a burden and older individuals’ lowered expectations of care is also warranted. There is clearly potential for future research into this area of health.

Raising older people’s awareness of the signs and symptoms of ageing

Normalisation of symptoms to aspects of ageing is a significant finding from the current study and draws attention to the need for further research on increasing older people’s understanding about how to recognise and differentiate between symptoms of ageing and life--threatening illnesses. Often the older person attributed their illness to ageing processes and delayed seeking help, which may put them at increased risk of further deterioration or exacerbation of their condition. Older people welcomed positive steps taken by HCPs to explain and inform them about what was normal, and which abnormal symptoms could be experienced. Interventions to empower older people to develop competence in their own skills of assessment and seek help earlier for their needs is an additional area worthy of future exploration.

Engaging older people in research

Successful engagement and recruitment of older people in research is crucial since by exploring from their perspectives what effective health care practices would comprise for older people, we can both positively shape how they experience care. and inform healthcare practice.
However, in this study many older people were reluctant to participate, feeling they had nothing to contribute. This perception is worthy of investigation as a study in its own right and would throw light on how we might more effectively involve older people in research.

Healthcare professionals

It was evident from the findings from the HCPs that they experienced emotional struggles when caring for older people, as they were unable to provide the care they aspired to for this patient group. Therefore, a deeper understanding of such difficulties from the perspective of HCPs themselves would provide deeper and richer insights on how best to support them when working in challenging and fast-paced environments.

Dissemination of Findings of the Study

The study findings have been presented locally at the research site and nationally at the British Society of Gerontology (BSG) Annual Conferences. These presentations have afforded the researcher valuable opportunities to disseminate IPA as an appropriate methodology for exploring older people's experiences of care, as well as the key findings of the research about what matters most to older people when they access urgent and emergency care. Edwards (2015) asserts that engaging in research offers the opportunity to improve the lives of patients, through the translation of research into clinical practice. However, if HCPs are unaware of the research, then a change in practice cannot occur, hence the focus of the key dissemination of my research were target audiences who were HCPs, researchers and experts in the field of gerontology. This has provided a platform to reach those who would most benefit from my research and can be pivotal in adopting it and making necessary changes in practice to improve care for older people.

I have also presented the research at the East of England IPA research network group to explore and discuss the use IPA as a methodology to examine patients' experiences in health care research. This also served to provide a critical approach from others who had a shared interest in IPA and offered valuable feedback on the process of theme development and the application of the principles of IPA epistemology and the scope of my research. Furthermore, it also offered peer support and exchange of ideas and experiences of IPA in different research areas and disciplines.

I also submitted abstracts and presented through poster and oral presentations at the university's annual postgraduate research conferences. Attendance at these conferences has offered the opportunity to share my research journey at the different stages of my research, for example initially presenting IPA as a method and then presenting preliminary emerging findings and subsequently my final findings. Meeting other PhD students has enabled knowledge translation with peers who are also on a similar research journey. Additionally, it supported my critical thinking and appraisal of the work undertaken to identify what were the key findings and messages and the knowledge contribution of the study.

Attendance and presenting at local and national conferences and older people's medicine and emergency care research and practice meetings have been important first steps on the path toward knowledge transfer and the potential change to practice. I now intend to publish the findings of this study in peer-reviewed journals to maximise the audience who would benefit most about learning about the research. Relevant journals that I would consider submission to include: Age and Ageing, Ageing and Society, Journal of Clinical Nursing, Journal of Emergency Medicine, International Journal of Emergency Nursing, and Emergency Nursing. I also would aim to submit an abstract to an international conference such as the International Association of Gerontology and Geriatrics (IAGG), so that my work could be reviewed at an international level, thus having the potential for practice change to reach many countries where older people's urgent and emergency care experience could be enhanced.

Summary

This study offers valuable insights into how older people experience urgent and emergency care. In general, older people had positive experiences of care and were grateful for the care they received. However, their expectations of care were low, and they faced many challenges to have their needs met. Moreover, HCPs found it demanding and difficult to meet older people's needs due to the complexity of their illnesses and organisational constraints. This creates an environment where older people are at increased risk of their needs being unmet. Seeking legitimacy and validation that they are genuine users of urgent and emergency care was an important feature of their care. The findings uncovered how political and social discourse portraying longevity as a burden both stigmatises older people and puts pressure on them to choose the right health care service. Consequently, older people often resort to self-assessing their own needs for care and can make decisions which delay seeking help or lead to neglect of their health care needs. Furthermore, there were various aspects of the care journey that were identified as more challenging for older people. In particular, older people were more vulnerable in transition processes, moving from high levels of intensity to lower levels of monitoring on wards and at discharge. Therefore, it is very important that they are reassured and supported by HCPs at these vulnerable points in time and care and that their voices are heard in the decisions that are being made about them. This will help equip

HCPs with the necessary skills to identify any worries or fears and gain greater insight into how best to meet older peoples' needs.

Existing research findings that older people have unique needs that make them a distinct group within the urgent and emergency care environment have been reinforced by this study. The complexity of their needs combined with an environment that does not support either their comfort or physical needs can pose significant threats to individuals' dignity, autonomy and self-worth, as well as their health. Therefore, this study emphasises that older people have specific needs to maintain their comfort and physical requirements as well as maintaining their autonomy and sense of significance. Attendance at the ED can cause significant disruption to older people's established sense of identity from threats due to their impending mortality and some associated vulnerabilities of ageing. This highlights the need for HCPs to understand the specific and individual vulnerabilities experienced by older people when they attend the ED. Person-centred approaches underpin more positive experiences of urgent and emergency care. Such experiences are shaped by the interactions with staff, the environment of care and interventions that foster inclusivity in shared decision-making and information giving. Valued reassurances from staff who met all their needs, supported them as individuals needing care and treatment, and made them feel safe were all highly sought attributes of staff and had positive influences on experiences of care. These attributes of staff made older people feel they had a strong sense of belonging and personal agency and that they mattered in the context of ED and urgent and emergency care services. Thus, the importance of relational skills during the brief interactions with older people in the ED cannot be undervalued.

This study can inform policy and practice as the more knowledge and understanding we have of what it is like for older people experiencing urgent and emergency care the better we can meet the unique needs of this patient population. This can help us to develop individualised holistic approaches to care that acknowledges the multidimensional needs of older people. The findings of the study contribute to the understanding of what it is like to receive care when experiencing an acute medical emergency from the older patient's perspective. It is clear that older people have distinct needs that often go unmet in fast-paced environments of the ED. Importantly, older people need to feel a sense of connectedness and belonging so they can be involved in decisions about their care to meet their needs. The study also contributes to the policy agenda by understanding the patient experience to transform services built around the needs of the older person. Furthermore, this study has illuminated the struggles HCPs experience to meet the needs of older people at an organisational level.

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Appendix A

Authors and Country of Study	Aim of Study	Sample Population	Design and Data Collection Methods	Key findings
Spilsbury et al (1999) "The little things count". Older adults' experiences of A&E care **UK**	To gain more insight into how patients felt about the care they received in A&E	N=12 6M 6F Purposeful sampling Over 75	Qualitative methodology (not specified) One to one interviews with older people initially in ED (open ended questions) Observational - observations of interactions between participants and health care professionals were made. Follow-up interviews were conducted at 48 hours and one month after A&E contact to explore issues further Inductive data analysis	8 Themes: The Little things count Lack of Assessment Lack of information giving Unacknowledged waiting times Ignoring sensory/physical problems Inappropriate Comments Lack of Privacy, safety and comfort Concerns for the future
Watson et al (1999) Elderly patients' perceptions of care in the emergency department **USA**	The purpose of this study was to describe elderly patients' perceptions of care in the emergency department.	N=12 6M 6F Over 65 Range of 66 to 86 years	A qualitative, descriptive design One to One Interviews Content Analysis	5 Themes : Needs for information Observations of waiting time Perceptions of professional competency and caring service Concerns about process and facility design Personal tolerance .

Nyden et al (2003) Unsatisfied basic needs of older patients in emergency care environments – obstacles to an active role in decision making **Sweden**	To analyse older people's basic needs in the emergency care	n=7 2M 5F Over 65 age range: 65-88 years,	Life-world interpretative Approach One to one interviews Open ended questions Interpretative analysis Maslow's hierarchy of needs used as a framework	5 Themes: Physiological Needs – desire to be comfortable and something to eat and drink while waiting Safety Needs-Being in hospital gave a sense of security Affection and Belonginess Needs-desire for relationships with staff, they wanted to be respected and accepted as appropriate clients in the ED Self-Esteem needs-Need for affection and Belonging Self-Actualisation needs-wanting to know information but did not have expectations to be involved in discussions about themselves
Kihlgren et al (2004) Older patients awaiting emergency department treatment **Sweden**	The aim of this study was to describe the conditions at the emergency department (ED) and the events that took place during the waiting period	n=20 14F 6M Over 75 years and their relatives (n=15)	Qualitative-Grounded Theory Non-participant observations and interviews Grounded Theory Analysis	6 Themes: Unnecessary waiting Unpleasant waiting Lack of good routines during the waiting stage Suffering during the waiting stage Bad feelings during the waiting stage Nursing care during the waiting stage- medical technical care

Richardson et al (2007) Following the patient journey: Older persons' experiences of emergency departments and discharge **New Zealand**	This study was designed to examine the experience of the older patient (aged 80 years or over) admitted to an in-patient bed via the ED of a major tertiary level teaching hospital.	N=13 6M 7F Over 80 Range 80-102	Mixed Methods Quantitative- patient flow audit Qualitative – (not specified) Semi structured one to one interviews Follow up telephone interview 2 weeks following discharge Thematic Analysis	3 Themes: Relinquish control to the 'system'. Reluctance of participants to criticise or question the process or procedures they experienced. Acceptance , trust, relinquishment and deference
Bridges (2008) Listening makes sense: understanding the experiences of older people and relatives using urgent care services in England **UK**	What are the experiences of older people and their carers in urgent care? What are the different elements of services that older people and their carers identify as significant influences on their experiences? How can the experiences of older people and their carers be improved?	N =96 64 F 25 M aged over 75 and their relatives 69 older people 27 relatives Range 75-95 Multi centre study - 31 sites across England	Narrative Methodology Discovery interview – semi structured interviews Thematic content analysis	6 Themes: Older people can delay seeking help and often need help deciding what to do Older people may feel they do not matter The urgent care setting can provoke fear and anxiety Older patients highly value'personal touch' from staff and help with activities like going to the toilet Continuity of care and discharge planning are important Relatives accompanying patients have an important role

Bridges & Nugus (2010) Dignity and significance in urgent care: older people's experiences. **UK**	To explore the role that a sense of significance plays in the experiences of older patients in urgent care settings and the factors that influence these experiences.	N =96 64 F 25 M aged over 75 and their relatives 69 older people 27 relatives Range 75-95 Multi centre study - 31 sites across England	Narrative Methodology Discovery interview – semi structured interviews Thematic content analysis This study was derived from the same study by Bridges (2008)	4 Themes Threat to a sense of significance Primacy of technical medical care Imbalance of power Subordination of patients' non - medical needs
Lyons and Paterson (2009) Experiences of older people in emergency care settings **UK**	The aim of the study was to explore the aspects of emergency care that are important to the older patients who received treatment at the Royal Infirmary of Edinburgh and to establish whether their specific needs were met.	N=20 F11 M9 Over 65 Range 64-94	Qualitative grounded theory In-depth, face-to-face interviews Open coding and constant comparative method Systematic analysis	5 categories Attentiveness Staff competence Communication Waiting times Overall care needs
Considine et al (2010) Older peoples' experience of accessing emergency care	The aim of this study was to describe older people's perspectives of accessing ED care	N =27 participant interviews and 1 N=12 care-giver interviews Over 65	Qualitative Descriptive Descriptive approach Observation of participants and caregivers	4 Themes Variation in Ed use by older people Reluctance to access ED care Mixed experiences of waiting Perceived factors influencing access to emergency care

Australia		mean age 77	Semi-structured face-to-face interviews Inductive Thematic analysis	
Lawrie & Battye (2012) Older People's experience of emergency hospital readmission **UK**	To understand the issues of urgent readmission from the perspective of those most affected – older people who have experienced an emergency readmission	N=18 4 senior stakeholders Over 75 Semi-structured interviews with stakeholders	**Qualitative (not specified which methodology used)** qualitative interviews with older people semi-structured interviews with stakeholders Content Analysis	4 Broad Themes Over half of older people experience poor care, dignity not preserved, communication issues, environment poor Older people generally accepting of challenges facing staff in the ED Desire to have more personalized care and more say about their own care Readmission negative impact on the older person
Maben et al (2012) Poppets and parcels: the links between staff experience of work and acutely ill older people's experience of hospital care	To examine the links between staff experience of work and patient experience of care in a 'Medicine for Older People' (MfOP) service in England	N=13 patients N=5 relatives N=18 staff (age not specified - other than MfOP ward)	Mixed Methods One to one semi structured interviews and analysed using Staff and patient survey questionnaires Non -participant observation Thematic analysis	3 Broad Themes Generally positive experiences of care reported Variations in pt. experience is significantly influenced by staff work experiences, e.g. poor staffing, poor leadership, poor co-worker relationships Often more complex patients receive less personalized care

Olofsson et al (2012) During and beyond the triage encounter: Chronically ill elderly patients' experiences throughout their emergency department attendances **Sweden**	The aim of the study was to explore and describe the experiences of a group of chronically ill elderly patients' during their triage encounter and subsequent ED stay	N=14 M5 F9 Over 70 Range 71 and 90 year	Qualitative Descriptive phenomenological open-ended interviews Descriptive analysis	5 Themes Prompt and competent care establish confidence. A personal touch and sincere interest contribute to a feeling of being at the centre of attention. Inattentive attitude and indifferent behaviour cause a feeling of exclusion. Lack of interest in the patient contributes to a feeling of being neglected and ignored. Failure to listen contributed to frustration and disappointment.
Stein-Parbury et al (2015) Expectations and experiences of older people and their carers in relation to emergency department arrival and care: A qualitative study in Australia **Australia**	To explore the expectations and experiences of older people and their carers leading up to and following presentation to the ED	N =10 6M 4F N= 10 Carers Over 65 Ages ranged from 65–94 years	Qualitative-interpretative One to One semi structured interviews. Interviewed within one month of discharge from the ED. Interpretative analysis	5 themes Exacerbation of symptoms lead them to see care from the ED. Uninformed about Ed procedures Family/carers feel they need to act as advocates for information and basic services Grateful for the care they received Mindful of the busy environment

Glasby et al (2016) Who knows best? Older people's contribution to understanding and preventing avoidable hospital admissions The Experiences of Older People **UK** Two-year study funded by the NIHR Research for Patient Benefit programme	To explore the older patient perspective utilisation of emergency services	N=104 people N =91 older people N=13 relatives) 51M 53F Over 65 Over 65 Across 3 trust sites across three trust areas	Qualitative Interviews with older people Focus groups with staff Thematic Analysis	3 Broad Themes Most older people were admitted to hospital appropriately Delayed seeking help and ended up at hospital as a last resort Fear of being a burden on scarce public resources

Appendix B

CASP Qualitative Check list (2018)	Spilsbury et al (1999)	Watson et al (1999)	Nyden et al (2003)	Kihlgren et al (2004)	Richardson et al (2007)	Bridges (2008)	Bridges and Nugus (2009)
1.Was there a clear statement of the aims of the research?	✓	✓	✓	✓	✓	✓	✓
2. Is a qualitative methodology appropriate?	✓ specific methodology not stated	✓ qualitative descriptive	✓ Lifeworld interpretative approach	✓ Grounded theory and non-participant observations	✓ Mixed methods audit interviews semi-	✓ qualitative, narrative discovery approach questionnaires	✓
3. Was the research design appropriate to address the aims of the research?	✓ semi-structured interviews and observational interactions follow up interviews 48hrs and one month	✓ interviews (does not state what type of interviews)	✓ interviews	✓ Pilot Interviews observations	✓ structured post discharge telephone interview	✓ Interviews with older people	✓ used same sample as Bridges 2008
4. Was the recruitment strategy appropriate to the aims of the research?	✓ approached at site and when informed appropriate by ED staff ? fear of OP feeling if said no may jeopardise treatment with this approach	X not stated	✓ Nurse recruited at site but cannot tell how they were approached	✓	✓	✓	✓
5. Was the data collected in a way that addressed the research issue?	✓ open ended questions	✓	✓ open ended questions	✓	✓	✓	✓
6. Has the relationship between researcher and participants been adequately considered?	X Cannot tell	X not stated	X not stated	✓	✓	✓	✓
7. Have the ethical issues been taken into consideration?	✓	X not stated	✓	✓	✓	✓	✓
8. Was the data analysis sufficiently rigorous?	✓ inductive analysis coding does not state who coded?	✓ not fully stated	✓	✓	✓	✓	✓
9. Is there a clear statement of findings?	✓	✓	✓	✓	✓	✓	✓ similar write up of findings to Bridges (2008)
10. How valuable is the research?	✓	✓	✓	✓	✓	✓	✓
Quality Score	80% (High)	55%(Low)	85% (High)	100%(High)	100%(High)	100%(High)	High (100%)

CASP Qualitative Check list (2018)	Lyons and Paterson (2009)	Considine et al (2010)	Lawrie amd Battye (2012)	Maben et al (2012)	Olofsson et al (2012)	Stein-Parbury et al (2015)	Glasby et al (2016)
1.Was there a clear statement of the aims of the research?	✓	✓	✓	✓	✓	✓	✓
2. Is a qualitative methodology appropriate?	✓ Grounded methodology	✓ Descriptive	✓ Not fully described	✓	✓ Qualitative descriptive phenomenology	✓	✓
3. Was the research design appropriate to address the aims of the research?	✓	✓	✓ Qualitative interviews	✓ Mixed methods Explored both staff and older people's experiences	✓	✓ One to one semi-structured interviews	✓ One to one semi-structured interviews
4. Was the recruitment strategy appropriate to the aims of the research?	✓ member of nursing team identified eligible patients	✓	✓ Not fully described	X Not described	✓ Not fully described	✓	✓
5. Was the data collected in a way that addressed the research issue?	✓	✓	X Cannot tell	✓	✓	✓	✓
6. Has the relationship between researcher and participants been adequately considered?	x	✓	X Cannot tell	X Not described	✓	x	x
7. Have the ethical issues been taken into consideration?	✓	✓	✓ Not fully described	✓ Not fully described	✓	✓	✓
8. Was the data analysis sufficiently rigorous?	✓ greater use of quotes to align with themes- some lacked fit	✓	✓ Not fully described	✓	✓	✓	✓
9. Is there a clear statement of findings?	✓	✓	✓	✓	✓	✓	✓
10. How valuable is the research?	✓	✓	✓ More applied to policy	✓	✓	✓	✓
Quality Score	95% (High)	100% (High)	60% (medium)	75% (High)	95% (High)	90% (High)	90% (High)

Appendix C

Criteria		Yes (2)	Partial (1)	No (0)
1	Question / objective sufficiently described?			
2	Study design evident and appropriate?			
3	Context for the study clear?			
4	Connection to a theoretical framework / wider body of knowledge?			
5	Sampling strategy described, relevant and justified?			
6	Data collection methods clearly described and systematic?			
7	Data analysis clearly described and systematic?			
8	Use of verification procedure(s) to establish credibility?			
9	Conclusions supported by the results?			
10	Reflexivity of the account?			

Appendix D

NHS
Health Research Authority

21 September 2015

Miss Marie McGee School of Health Sciences Edith Cavell Building University of East Anglia NR47TJ

Dear Miss McGee

East of England - Cambridge South Research Ethics Committee

The Old Chapel Royal Standard Place Nottingham NG1 6FS

Tel: 0115 883 9428

Study title:	Older People's Experience of Urgent and Emergency Care in an Acute Hospital
REC reference:	15/EE/0268
IRAS project ID:	178620

Thank you for your letter of 11 September 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Assistant Nicola Kohut, nrescommittee.eastofengland-cambridgesouth@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Copies of advertisement materials for research participants [Poster Invitation HCPs]	1	02 June 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [certificate of indemnity]	1	24 June 2015
Interview schedules or topic guides for participants [Interview schedule : Older People]	3	08 June 2015
IRAS Checklist XML [Checklist_11092015]		11 September 2015
Letters of invitation to participant [Participant Invitation Letter : Older People]	4	11 September 2015
Other [Consent Form : HCP]	1	08 June 2015
Other [Topic Guide : HCP]	1	08 June 2015
Other [CV Secondary Supervisor]	1	23 June 2015
Other [reply letter to cambridge south ethics committee]		31 August 2015
Other [invitation Letter : HCP]	3	11 September 2015
Other [PIS : HCP]	3	11 September 2015
Other [Participant Consent Form Oldr People]	5	11 September 2015
Participant consent form [Participant Consent Form : Older People]	3	11 September 2015
Participant information sheet (PIS) [PIS Older Prople]	4	11 September 2015
REC Application Form [REC_Form_18062015]		18 June 2015
Research protocol or project proposal [Proposal : Older People's Experience of Urgent and Emergency Care]	3	07 September 2015
Summary CV for Chief Investigator (CI) [Older People's Experience of Urgent and Emergency Care : Proposal]	version 1	08 June 2015
Summary CV for supervisor (student research) [CV : Primary Supervisor]	1	08 June 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- • Notifying substantial amendments

- • □Adding new sites and investigators
- • □Notification of serious breaches of the protocol
- • □Progress and safety reports
- • □Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at

http://www.hra.nhs.uk/hra-training/

With the Committee’s best wishes for the success of this project. Yours sincerely

15/EE/0268 Please quote this number on all correspondence

pp.

Dr Leslie Gelling Chair

Email:

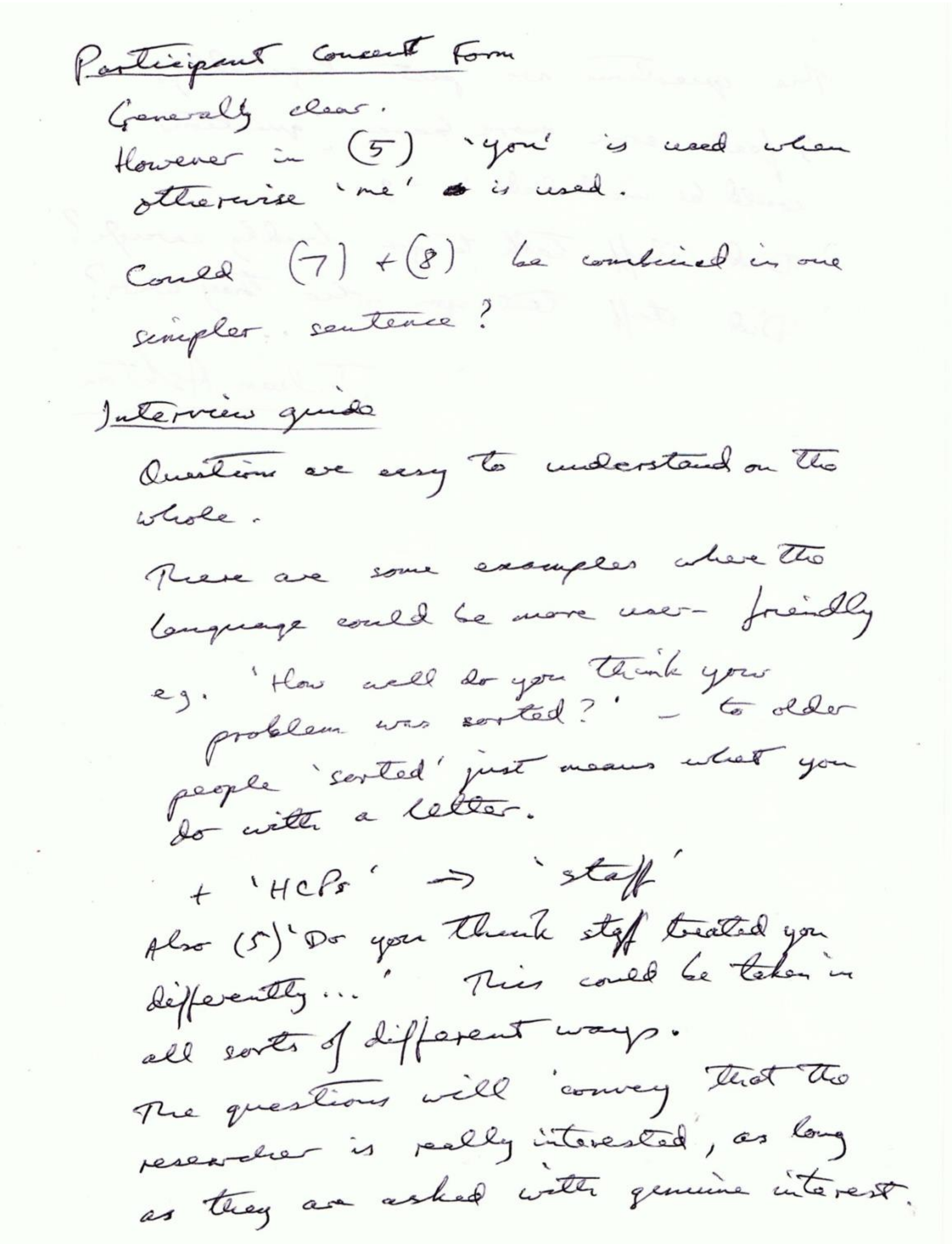
Enclosures: Copy to:

nrescommittee.eastofengland-cambridgesouth@nhs.net

After ethical review – guidance for researchers

Yvonne Kirkham, University of East Anglia
Laura Harper, Research and Development Office

Appendix E



Participant Concent Form

Generally clear.
However in (5) 'you' is used when otherwise 'me' is used.

Could (7) + (8) be combined in one simpler sentence?

Interview guide

Questions are easy to understand on the whole.

There are some examples where the language could be more user-friendly

e.g. 'How well do you think your problem was sorted?' – to older people 'sorted' just means what you do with a letter.

+ 'HCPs' → 'staff'

Also (5) 'Do you think staff treated you differently...' This could be taken in all sorts of different ways.

The questions will 'convey' that the researcher is really interested, as long as they are asked with genuine interest.

Appendix F

Interview guide:Version 3
Older People

Briefing statement:
Introduction of Interviewer:
As you are aware my name is Marie McGee and I am a student undertaking this study on 'Older People's Experience of Urgent and Emergency Care' as part of my Doctorate of Philosophy. Thank you again for agreeing to take part in this study and I look forward to you sharing your experiences with me.

The purpose of this interview is to find out how you felt about your recent experience of attending hospital urgently or in an emergency. It is important that you understand that I am not looking for right or wrong answers and I am not here to judge you in any way and actively encourage you to talk as freely and reflectively as you want to. I am interested in you and your experiences and therefore my questions will be guided by what you say, exploring your thoughts, ideas, feelings and concerns about your experience of urgent and emergency care. This interview ultimately is about your story of what happened to you?

If you would like to stop the interview at any time just let me know. We have got as long as you need but I do not anticipate it will take more than an hour. If you feel that you are finding it difficult to talk for an hour but would like to continue the interview at another time, please let me know and I can arrange this. If you do not want to answer a question or find it too difficult to answer please let me know?

Interviewer: Questioning should always channel the participant to their 'lived' experience.

Opening question:

Q.1 Please can you tell me about your recent experience of attending hospital urgently or in an emergency? *(interested in their experience to help set the scene)*

The interview will start with an open question to allow and enable the older person to talk freely and openly about their experiences of urgent and emergency care

Then the questions will move from general (open) to particular to explore experiences in relation to contextual and organisational aspects of care that influence/impact on experience if they have not been touched on in the opening question and subsequent discussion.

Starting with your stay in……..

<u>Experiences of Urgent and Emergency Care</u>
Can you tell me your experiences of the care you received?

1. Did you feel looked after?

2. What were your impressions of the staff that looked after you
3. How did you expect to be looked after?
4. Could it have been different?
5. Do you think staff treated you differently from other patients?

Experiences of the older person being involved in their own care

Can you tell me your experiences of being involved in your own care?

1. Did you feel that you were listened to when telling your story of what your problem was?
2. Did you feel that your views/decisions were taken into account?
3. Throughout your stay did staff tell you what was happening to you and why? And did you understand what they were saying to you? If not what did you do?
4. Were you involved in the decisions made about you? Dependent on the answer follow up with: would you have liked to have being involved? Or would you prefer to not to be involved? Can you tell me why?
5. How well do you think your problem was managed?

The following questions will be asked as the interviewer is interested in the participants' views of how their 'lived' experience may develop an understanding of what a good experience should look like.

Improving the Patient Experience for Older People

Can you tell me what would have improved your patient experience?

1. Thinking of your recent stay in hospital, is there any experiences that really stood out for you? If so, What?

2. Thinking of your recent stay in hospital is there anything that would have improved your experience as a patient?

3. Is there anything in particular that would have been helpful to you during your stay?

4. Was there any qualities that HCPs had that improved your urgent and emergency care experience

5. Finally, is there anything I haven't asked you that you wished I had?

Prompts/Probes follow-up questions: Going Deeper

- Are you able to tell me more about that?
- What happened when?
- Can you give an example of a time when that happened/ when you felt like that?
- Can you tell me about that particular experience and what you thought and felt?
- How did that make you feel?
- How was that helpful?
- Was that what you expected?
- Why do you think that happened?

- What did you think about that?
- Just talk about whatever comes to mind
- Can you describe what happened (next)?
- Can you tell me what you mean?
- Can I check that I understood what you mean?
- What about?
- Getting back to your experience of..?
- Is there anything else?
- Why?
- How?

Active Listening to encourage participant to tell their story and validate key experiences participants have identified:

- Silence
- Allowing the patient time to talk without interruption
- Pick up themes emerging/key words and use follow up questions

Topic Areas that arose from Literature Review:

- Individualised Patient Care
- Looked after
- Reason for admission not addressed and managed appropriately
- Shared decision making
- Dignity and Compassion
- Ageism
- Discharge Planning
- Organisational and Environmental impact on Care
- Communication
- Business of staff and impact on care

Appendix G

Marie McGee
11.09.15
Version 4 Participant Information Sheet : Older People

Participant Information Sheet

Title: Older People's Experience of Urgent and Emergency Care in an Acute Hospital

Researcher: Marie McGee
PhD Student, School of Health Sciences, University of East Anglia

I would like to invite you to take part in a research study. This research forms part of my postgraduate research (PhD) at the University of East Anglia. Before you decide if you would like to take part in the study you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and ask me any questions that you may have or if you would like further information. Talk to others about the study if you wish.

What is the purpose of the study?

The purpose of this study is to explore older people's experience of attending hospital urgently or in an emergency. I would like to explore this as we know that older people are one of the largest groups of people who use emergency services, yet little is known of their experiences of care in hospital during this time. Obtaining the views and opinions of older people is key to this study so that the 'voice' of older people can bring new understandings into how we could improve the quality of their care experience.

With this in mind I would like to talk to 10 older people to share their story of their experience in detail.

Why have I been invited to take part?

You have been invited to take part in this study because you have been identified as someone who has attended hospital urgently or in an emergency.

Do I have to take part?

It is important for you to know that you can choose whether or not to take part in this study. Understanding what the study is about and what it involves for you will help you make that decision and if there is anything you do not understand I am available to discuss that with you on my contact number provided.
Choosing not to participate **will not** affect your patient status in any way. If you do decide to participate in the study you can freely withdraw from the study at any stage of the process, even after you have started to answer any questions at the time of the interview. You **do not** have to give a reason. You also can stop the interview at any time or refuse to answer any of the questions that you do not wish to discuss.

What will happen to me if I take part?
If you agree to take part in this study, I will arrange an interview with you following your discharge from hospital to explore your recent experiences of attending hospital urgently or in an emergency. The interview will take place at a time and place that is convenient for you. It may be necessary to interview

you in hospital if you are admitted to a hospital ward. If this happens the researcher will ensure that a suitable private location will be found so the interview can take place. If you wish a family member, friend or carer can be present at the interview but only with your consent. I anticipate that it will not take more than an hour of your time however we have as long as you need for the interview but if you feel that this is too much for you I am happy to arrange a further interview. Before I start the interview there is still an opportunity for you to ask me further questions about the study before you sign the consent form. I would also like to audio record the interview with your permission.

However if you need to be withdrawn from the study all the information obtained from the interview will be retained with your agreement.

Why are the interviews being recorded?
I need to audio record the interviews to ensure I capture your experiences accurately and to help me understand your view and perspective. During the interview I may need to ask you to give me more information about some of the areas you have discussed.

What are the possible benefits of taking part?
The benefits of taking part in this study will provide you with the opportunity to share your experiences of care during your recent attendance at hospital. This information may contribute to new understandings of how older people experience care and may also be used to educate staff who works with older people in these settings to improve patient care.

There will be no direct benefit to you by taking part in the study and there will be no incentives or payments offered in return for your participation in the study. However you will be reimbursed for travel and parking expenses if you have to travel to the interview.

What are the possible disadvantages of taking part?
Sometimes talking about your experience of being unwell may possibly make you feel upset or uncomfortable. If this does happen please let me know as you may not wish to continue discussing that particular area with me. We can take a break if you choose or stop the interview at your discretion. If you need support I can provide you with contact details of services that may be able to support you or advise you to see your General Practitioner. You may prefer to contact services of your own choice also.

Will my taking part in the study be kept confidential?
The information you provide will be kept strictly confidential and your name will not be identified in the study in any circumstances. The interview will be audio recorded and following this the information will be typed up and all identifiable information removed. All data will be stored securely on a password-protected computer or kept in a locked cabinet and no one apart from the research team will have access to it.

Are there any exceptions that confidentiality can be broken?
All information is confidential unless you reveal something that would suggest harm or risk to yourself or others. If the researcher feels this is the case she will need to talk about this with you first before passing on any information to the relevant people such as the researcher's supervisor or a member of the supervisory team. If deemed appropriate, the information may be shared in accordance with local and NHS trust safeguarding policy.

How long is the information from the interviews held for?
The information I obtain from you will be held securely and anonymously for 10 years in accordance with the Data Protection Act (1998). Once the 10 years and the study have been completed and in accordance with the University and Hospital Trust Policy, the information will be disposed of in a confidential waste system.

The audio tape recordings from the interviews will be wiped clean and destroyed by the researcher following successful completion of their PhD studies.

All those with access to the information you provide during your interviews are bound by the Data Protection Act (1998), local NHS Trust Confidentiality Code of Conduct and/or by a professional code of conduct.

The people who will have access to your information that you provide are the following:
Researcher: Marie McGee
Supervisory Team: Bridget Penhale, Susan Campbell and Richard Sly

What will happen to the results of the research study?
The results of the study will be written up for research papers to be published in professional journals or presented at conferences, so that health care professionals and policy makers may learn from the views and experiences of older people.

The study will result in an academic thesis which will be made available through the University Library to other researchers and academics who are interested in older people's research and experiences of health care. The final study will contain direct quotations from the older people who participated in the study but these will be anonymised and no identifiable information will be used in the thesis, journal publications or professional conferences.

The results of the study will also be presented to the health care professionals who work in urgent and emergency care at the Norfolk and Norwich hospital. Older people who have participated in the study will be invited to attend these presentations should they wish to attend. A summary of the results/findings will be made available to the older people who participated in the study should they wish to know.

Who is organising and funding this research?
The University of East Anglia is organising and funding my research.

Who has reviewed the study?
This study has been reviewed by the local NHS Trust Research Governance Committee and the Cambridge South Research Ethics Committee to ensure that

the study meets the ethical standards to conduct a research study and to protect your rights, interests and dignity as a participant.
The study has also been closely reviewed by my supervision team at the university.

Who can I contact about the study?

If you have any questions or concerns about this study, please do not hesitate to contact me. I am happy to discuss any aspect of the study with you.

If you have concerns about the study that you do not wish to raise with me, you can discuss them with the following people:

- Ms. Bridget Penhale, Primary Supervisor and Reader, School of Health Sciences, University of East Anglia on 01603 597016
- Ms. Susan Campbell, Secondary Supervisor, School of Health Sciences and Lecturer, University of East Anglia on 01603 597102

Who can I contact if I have concerns over the care I received from the hospital?

If you have concerns about any aspect of your care, or the service you receive from the hospital you can contact the Patient and Liaison Service (PALS). This is an informal service and does not replace the NHS complaints procedure.

Contact details are : Main Telephone Number: **01603 289036**
Alternative Telephone Number: **01603 289045**
Fax Number: **01603 289046**
Email Address: **pals@nnuh.nhs.uk**

Thank you for your time.

Marie McGee
Postgraduate Research Student (MPhil/PhD)
School of Health Sciences
University of East Anglia
Norwich
NR4 7TJ

Email: m.mcgee@uea.ac.uk
Telephone (with voicemail facility): 01603 597103

Questions to ask the researcher after reading the participant information sheet:

Appendix H

School of Health Sciences
University of East Anglia
Norwich
NR4 7TJ

Invitation Letter to Participate in Study

Dear

Study title: Older People's Experience of Urgent and Emergency Care in an Acute Hospital

I am a postgraduate research student and I am interested in older people's experience of attending hospital urgently or in an emergency. I would like to invite you to be involved in a research study to explore these experiences.

This study will form the basis of my postgraduate research degree at the University of East Anglia.

I am inviting you to take part in this study because you have recently attended hospital for urgent care or an emergency.
A member of the team who cared for you during that time has identified you as a person who has expressed interest in taking part in the study. Please read the following information about the study to provide you with some understanding of what the study is about.

Older people are one of the largest groups of people who use emergency services, yet little is known of their experiences of care during this time. This study seeks to gather the perspectives of older people who have attended hospital urgently or in an emergency, and those staff who work in hospital who care for them.

After reading this and you feel this study may be of interest to you please do read the information sheet attached to find out more about me and what this research involves.

This information sheet can also be provided in larger print or in Braille if you need it?

If you would like any further information please phone me on 01603 597103 or email me at m.mcgee@uea.ac.uk

Many thanks for your help

Marie McGee
Postgraduate Research Student (MPhil/PhD)

Study title: Older people's experience of urgent and emergency care in an Acute Hospital

Permission Slip For Researcher To Contact Participant

Name: ____

I would like to know more about being involved in the above study ☐

I would like to participate in the study ☐

If you have indicated that you would like to know more about being involved in this study or would like to participate, I would appreciate it if you could provide the following information please:

Address: ____

____

Telephone Number: ____

Email address: ____

Appendix I

Participant Consent Form

Study:
Older People’s Experience of Urgent and Emergency Care in an acute hospital

Researcher: Marie McGee, School of Health Sciences, UEA

Please initial each box

1. I confirm that I have understood the participant information sheet dated 11.09.15 version 4 and have had the opportunity to ask questions about the study ☐
2. I understand that my participation is voluntary and that I can withdraw from the study at any time, without any reason and that this will not affect the care that I will receive now or in the future. ☐
3. I understand that the interview will be audio recorded for the purposes of the research and the information obtained from this will be shared with the research team and then written up as described in the participant information sheet. ☐
4. I understand that my name will not be identified in the study ☐
5. I understand that all my information is confidential unless I reveal something that would suggest harm or risk to me or to others. ☐
6. I understand that all information collected in the research will be stored securely and only accessed by members of the research team. ☐
7. I understand that direct quotations from the interviews maybe used in sharing the research but all names will be removed so the participant will not be identified ☐

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8. I understand that the results of the study will be used in the doctoral thesis, journal publications and to present at professional conferences and it will not be possible to identify me in these results. ☐

I agree to take part in the study

Name of Participant: …………………….. Name of Researcher…………………

Date: …………………………………….   Date: ………………………………….

Signature: …… ………………………… Signature: ……………………………..

Request for study summary findings

Please indicate if you would like to be sent a copy of the summary findings of the study

YES ☐

NO ☐

Name………………………………….

Address……………………………….

………………………………..

……………………………….

Appendix J

Vignette on OP experiences for HCP Focus Group

I would like to tell you a story about Doris, an 87 year old's experience of urgent and emergency care. Her journey starts in the Emergency Department (ED), then she moves to AMU and finally she ends up on an medicine for elderly ward. This journey lasts for 48 hours when she is discharged home.
This story will not focus on the reason for admission or a diagnosis – it is purely her personal narrative of her experience of attending the ED and her subsequent journey.

I went to see my GP at 5 pm about feeling faint when I was at church earlier in the day. She noticed I was breathing with difficulty and she promptly took an ECG and then said 'Oh we need to get you to the hospital quickly". I was very surprised and a bit reluctant, but she insisted on calling an ambulance and sending me in.

When I arrived in the ambulance to the emergency department I noticed people were coming in the ambulances all the time. They don't really know what's wrong with you so they don't know where to put you. They don't assess you quickly enough, that's the main problem. It all depends on what comes in on the ambulances which determines how quickly you are seen. There was a delay, but it wasn't a huge delay so I just thought there was nothing I could really do. When I looked around there was worse than me. There were lots of elderly people around.

When the nurse came it was all very busy, she took some details and showed me to a bed, then took some bloods and told me that a Doctor would come and see me and what was going to happen. They kept taking my blood pressure every half hour or so and I was wired up to the ECG machine. They kept monitoring me. Even though I was in a cubicle I was getting all the attention I needed and I wasn't left alone, one nurse in particular said **'here I am again'**. They were making me feel comfortable even though it was very busy. I couldn't see how busy it was but I could hear it.

The Doctor came and asked me some questions and told me he would be back when the results of the tests were available. I knew the system, I had been told what was going to happen and I decided to be patient and wait for things. I'm not very good at being patient. The only thing is I had to keep repeating things time and time again to this one and that one and it makes you a bit fed up.

It was quite some time before I realised what they thought the problem may be but I didn't want to ask the doctors and nurses what was wrong with me. I didn't ask questions because common sense says shut up and let them get on with it. I was just wondering what was going to happen. There was a lot of questions in my own mind about what was wrong with me.

I might have an opinion but it couldn't possibly be professional, so I kept my mouth shut and let them get on with it. I am very conscious of the fact that medically I am quite ignorant and I'm quite happy for other people to sort my problems out for me. I was quite content to lay there and let them get on with it
I did feel a fraud in the emergency department because I felt alright and a bit of a fool having to come in by the ambulance.

The nurses were brilliant, they never left me and one of them kept asking me was I alright and if I was having any pain or any discomfort and made me comfortable and everything. She made sure that I was alright. That just made me feel safe all the while. She could have been my daughter, how she looked after me. They didn't leave me on my own, they were backwards and forwards and keeping a good eye on me.

The staff are very busy, they are run off their feet and overworked, so I didn't want to press the call bell to ask them to bring me to the toilet so I took myself there. I was a bit concerned because I was frightened I weren't going to get my breath and I would go down.

Some nurses when you rang the bell they would come but others, it seemed too much for them and they would ignore the bell. The bells were going all the time, you know people weren't considerate enough for staff, I think they asked more. I asked as less as I can. They wanted to help you, but they didn't really have the time. You know, I, I felt sorry for them really, I really did feel sorry for them. It was quite cold in the cubicle but even though one Doctor was rushed he came in and said **"well you look cold",** so he got a blanket and wrapped it around me, he said "**you're like a little bug in a rug".**

I really wanted to know what was happening with me. I think you are always more afraid that it might be worse that you thought. I think as an older person you get more concerned because you feel closer to the end. My daughter came into the ED to see me as she got a call from my wife. My daughter had no problem with seeking out the Doctor to ask him a question about what was happening to me and I don't feel he thought she was a nuisance. She just felt you were entitled to do that. I just get very anxious about asking questions. The biggest difference of all, when I was young, you didn't ask nurses and doctors anything like that they were people up there, and you just did as you were told. But that's different now.

I was then transferred to AMU and the Doctors and the nurses were all there and they would come to me quite often while I was there, I wasn't left alone. The Doctor came in and saw me and took all kind of questions. They were willing to listen to you and everything, they didn't seem in a hurry at all and asked how I felt. I noticed they were rushed about and one thing and another, they got so many patients to look after, they can't just stop with one for a long while they got to look after everybody. However, there were times when I pressed the call bell they said "we'll be back in a minute, we'll be back in a minute" they kept saying, "back in a minute", but that minute turned into what seemed hours.

It was getting late and I had to stay the night. My wife was very worried about me but this nurse called 'John' said that she could go home and that he would keep a close eye on me, which they did. That really reassured her!

I got moved from AMU in the middle of the night to the ward and put in a side room. The whole lay out of the ward was a bit confusing. The only thing was I didn't really see anybody for quite a few hours. In the end I rang the bell as I wanted to use the toilet and a young man came to help me. I was a little bit concerned that nobody came to see me as they had kept a close eye on me before I came to the ward. But then I understood how busy they are, you know, and I expect they knew I was alright, so there wasn't any need for them to come and see me. In the morning they came and said I'd be moved because there was

somebody coming from A&E, which I was quite happy. I did feel like I was getting shifted from pillar to post though. They just want your bed.
When I was on the ward I noticed they were giving me this little brown tablet I asked the question what it is. They said it was ‘Lansoprazole’ and I said I was allergic to it and I had told the ambulance men and the Doctors. Somehow along the line it got missed, but see if I didn’t check, I might be getting the wrong tablet.
It was only when I was on the ward the consultant came to see me and told me my breathlessness and pain in my chest was due to angina. That was fairly reassuring actually and that I wasn’t a fraud.

When I was told I could go home, the staff said they would like to keep me longer but they need the bed. I was really worried about how I was going to be when I got home. I think they could have done a bit better telling me what to expect when I went home and explained more what had happened, why it had happened and how I was going to get better. There was a lot of waiting around before I was finally discharged from the time they said I could go home.

Now I’m home I’m still waiting for my GP to explain what they said in the hospital about what to do with my heart. It’s taking quite a long time for the information to filter down from the hospital to the GP. Its 3 weeks now. So you have to carry on and get on with your life. It’s when you are out of the hospital, that’s the problem.
The new tablet that was advised from hospital says ‘take as directed’, well I haven’t being directed. I don’t know if I have to take it or not. They didn’t really explain to me in hospital why I had to take this new medication or how to take it.
I have no complaints about my hospital stay. All I can say is while I was in the hospital I was treated as an older person that needed some respect.

Appendix K

University of East Anglia

Invitation to participate in a research study: ‘Older People’s Experience of Urgent and Emergency Care’

Marie McGee, PhD Student (School of Health Sciences, Edith Cavell Building)

What is required of you?

- Health care professionals are needed for a focus group to share your experiences of caring for older people in an urgent and emergency care environment.

Who is eligible to participate?

If you are a Doctor, Nurse, Healthcare Assistant, Occupational Therapist, Physiotherapist or Social Worker working in an urgent and emergency care environment, provide direct care to older people and can commit one hour of your time outside of your normal working hours, and wish to volunteer for this study, please contact me on the telephone number below.

Alternatively, do contact me to find out further information about the study

- Location and venue is within walking distance of your area of work.
- Compensation for travel will be provided as well as light refreshments.
- Parking will be available free of charge at the focus group venue.

Contact Details

Marie McGee,
School of Health Sciences,
Edith Cavell Building,
University of East Anglia,
Norwich Research Park,
Norwich
NR4 7TJ

Tel: 01603 597103
Email: m.mcgee@uea.ac.uk

This study has been reviewed and received ethics clearance and research governance approval.

Version 1 02/06/2015

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Appendix L

Participant Information Sheet – Health Care Professional

Title: Older People's Experience of Urgent and Emergency Care in an Acute Hospital

Researcher: Marie McGee
PhD Student, School of Health Sciences, University of East Anglia

I would like to invite you to take part in a research study. This research forms part of my postgraduate research (PhD) at the University of East Anglia. Before you decide if you would like to take part in the study you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and ask me any questions that you may have or if you would like further information. Talk to others about the study if you wish.

What is the purpose of the study?

The purpose of this study is to explore older people's experience of attending hospital urgently or in an emergency. I would like to explore this as we know that older people are one of the largest groups of people who use emergency services in hospital, yet little is known of their experiences of care during this time. Obtaining the views and opinions of Health Care Professionals who directly care for older people can contribute to our understandings on how we can improve the quality of care for older people who use these services.

With this in mind I would like to facilitate a focus discussion group with a minimum of eight to a maximum of 10 Health Care Professionals in each group. This group will consist of Health Care professionals from backgrounds such as nursing, health care workers, medicine, occupational therapy, physiotherapy and social work to share and explore their knowledge and experiences of caring for older people in an urgent or emergency care environment. The researcher will also be interviewing older people separately who have attended hospital urgently or in an emergency.

Why have I been invited to take part?

You have been invited to take part in this study because you are a Health Care Professional who has direct experience in caring for older people in an urgent or emergency care environment.

Do I have to take part?

It is important for you to know that you can choose whether or not to take part in this study and that participation is voluntary. Understanding what the study is about and what it involves for you will help you make that decision. If there is anything you do not understand I am available to discuss that with you on my contact number provided.

Choosing not to participate **will not** affect your employee status in any way. If you do decide to participate in the study you can freely withdraw from the study at any stage of the process. If the group discussion has already taken place you can request that the information provided by you may not be used in the research study. You **do not** have to give a reason.

What will happen to me if I take part?
If you agree to take part in this study, I will arrange to hold the focus group discussion at a location that is outside of the hospital premises but is in close proximity to your area of work. You will have the opportunity to indicate your preference for choice of location on the participant invitation reply slip. The focus group discussion will take place outside of work hours. It is expected that the focus group will last for up to an hour and will be facilitated by the researcher. There will also be a colleague of the researcher present to take notes of the discussion but will not be directly involved in the discussion.

There will still be opportunities for you to ask me further questions about the study before you sign the consent form. You will be asked to bring your signed consent form with you to the focus group discussion providing that you are in agreement with the information stated on the consent form. The researcher will collect the signed consent form from you prior to the focus group discussion and will also seek verbal consent prior to commencement of the focus group discussion. I would also like to audio record the interview with your permission

The focus group discussion will be facilitated by the researcher using a vignette to guide the discussion. The vignette or short stories aim to create as near to ‘real life cases’ of older peoples’ experiences of urgent and emergency care. In this case the vignettes will be created from the experiences of older people who have accessed urgent or emergency care that the researcher has interviewed already as part of this study. Prior to your attendance at the focus group I will send you some of the background questions so you can have an understanding of the areas to be explored during the discussion.

The researcher will make every reasonable attempt to ensure that all participants will have an equal chance to participate, to contribute and to be heard. There is no obligation that you need to participate in the discussion nor will you be pressurised to speak. You will not be asked to share personal beliefs or stories and you do not have to share any knowledge that you are not comfortable sharing.

Why are the interviews being recorded?
I need to audio record the interviews to ensure I capture the group’s experiences accurately and to help me understand the views and perspectives of the group.

What are the possible benefits of taking part?
The benefits of taking part in this study will provide you with the opportunity to share your experiences of caring for older people in an urgent and emergency

urgent environment care. This information may contribute to our understandings of how older people experience care and may also be used to educate staff who work with older people in these settings to improve patient care.

There will be no direct benefit to you by taking part in the study and there will be no incentives or payments offered in return for your participation in the study. However you will be reimbursed for travel and parking expenses if you have to travel to the interview.

.

What are the possible disadvantages of taking part?

Sometimes you may feel uncomfortable with sharing your views and experiences in a group. However the researcher will ensure that all members of the focus group are aware of the ground rules and expectations of the group. This will include what is expected from participants around maintaining group confidentiality.

If you do feel upset or uncomfortable you may not wish to continue discussing that particular area within the group. If this happens you can choose to take a break or stop participating in the group discussion. You do not have to answer any questions that make you feel uncomfortable and you do not have to give any reason for not responding or for refusing to take part in the discussion.

If you require further support regarding the area that is causing you upset, I will discuss this with my primary supervisor and if necessary signpost you to the relevant support services. You may wish to choose seek your own support if required.

The focus group discussions will take part outside of work hours and you will need to consider this in your decision to participate in the study.

Will my taking part in the study be kept confidential?

The researcher will inform the group at the beginning of the discussion about the ground rules and the expectations of the group regarding confidentiality. The researcher will ask you and others in the group not to talk to people outside the group about what was said in the group. The researcher will ask you to

keep what was said in the group confidential. However you should know that the researcher cannot stop or prevent participants who were in the group from sharing things that should be confidential. In that respect the researcher cannot guarantee confidentiality but will ask the group to respect confidentiality.

All information that you provide will be treated and handled with respect and in confidence. Your name and identity will not be disclosed at anytime and you can be reassured that when the study is published it will not be possible to identify you. The information that I collect from you at the group discussion will only be reviewed by me and my supervisory team.

The information you provide the researcher will be kept strictly confidential. The group will be audio taped and following this the information will be typed up. The audio recordings will be kept in a locked cabinet or on my password-protected computer in a secure office at the university. The typed interviews will not disclose your name or the name of anyone you mention as they will be changed or omitted to protect you and their identity.

Are there any exceptions that confidentiality can be broken?

All information that you provide the researcher is confidential however the researcher cannot guarantee confidentiality within the group if a participant chooses to share that information outside of the group. It is envisaged that group participants will respect confidentiality.

An exception where confidentiality can be broken is if a participant reveals something that would constitute poor practice or risk to themselves or others. If the researcher feels this is the case she will need to talk about this with you first before passing on any information to the relevant people such as the researcher's supervisor. If deemed appropriate, the information may be shared in accordance with local NHS trust policy and local and NHS trust safeguarding policy.

How long is the information from the interviews held for?

The information I obtain from you will be held securely and anonymously for 10 years in accordance with the Data Protection Act (1998). Once the 10 years and the study have been completed and in accordance with the University and Hospital Trust Policy, the information will be disposed of in a confidential waste system.

The audio tape recordings from the focus groups will be wiped clean and destroyed by the researcher following successful completion of their PhD.

All those with access to the information you provide during your interviews are bound by the Data Protection Act (1998), local NHS Trust Confidentiality Code of Conduct and/or by a professional code of conduct.

The people who will have access to your information that you provide are the following:
Researcher: Marie McGee
Supervisory Team: Bridget Penhale, Susan Campbell and Richard Sly

What will happen to the results of the research study?
The results of the study will be written up for research papers to be published in professional journals or presented at conferences, so that potential recommendations can be made to improve the care for older people who use urgent and emergency care services in hospital.

The study will result in an academic thesis which will be made available through the University Library to other researchers and academics who are interested in research on older people.

The results of the study will also be disseminated at local level through presentations. HCPs who have participated in the study will be invited to attend these presentations. A summary of the results/findings will also be made available to the HCPs who participated in the study should they wish to know.

Who is organising and funding this research?
The University of East Anglia is organising and funding my research.

Who has reviewed the study?
This study has been approved by the local NHS Trust Research Governance Committee and the Cambridge South Research Ethics Committee to ensure that the study meets the ethical standards to conduct a research study and to protect your rights, interests and dignity as a participant.
The study has also been closely reviewed by my supervision team at the university.

Who can I contact about the study?
If you have any questions or concerns about this study, please do not hesitate to contact me. I am happy to discuss any aspect of the study with you.

If you have concerns about the study that you do not wish to raise with me, you can discuss them with the following people:

- Ms. Bridget Penhale, Primary Supervisor and Reader, School of Health Sciences, University of East Anglia on 01603 597016
- Ms. Susan Campbell, Secondary Supervisor, School of Health Sciences and Lecturer, University of East Anglia on 01603 597102

Thank you for your time.

Marie McGee
Postgraduate Research Student (MPhil/PhD)
School of Health Sciences
University of East Anglia
Norwich
NR4 7TJ

Email: m.mcgee@uea.ac.uk
Telephone (with voicemail facility): 01603 597103

Please jot down any questions you may have to ask the researcher after reading the participant

Appendix M

Invitation Letter to Participate in Study : Health Care Professionals

Dear

Study title: Older People's Experience of Urgent and Emergency Care in an Acute Hospital

I am a postgraduate research student and I am interested in older people's experience of urgent and emergency care. I would like to invite you to be involved in a research study to explore the experiences of older people who have attended urgent or emergency care services in hospital. This study will form the basis of my postgraduate research degree at the University of East Anglia.

I am inviting you to take part in this study because you directly care for older people in an urgent or emergency care environment. It is important to capture the perspectives of those health care professionals who provide care. I will also be interviewing older people to share their experiences of having to attend hospital urgently or in an emergency.

You have identified yourself as someone who has expressed an interest in participating in the study or in receiving further information about the study. You have been provided with a participant information sheet

Please take your time to read through the participant information sheet. Before you decide if you want to take part in the study it is important that you understand why the research is being done and what it will involve for you. If you require further information you can contact me on the number provided or I can contact you.

If you have given permission for me to contact you I can discuss the study with you and address any queries that you may have. However if you have not contacted me within two weeks I will take it that you do not wish to pursue your interest in the study.

Thank you for your time.

Yours sincerely

Marie McGee
Postgraduate Research Student (MPhil/PhD)
School of Health Sciences
University of East Anglia

Email: m.mcgee@uea.ac.uk
Telephone (with voicemail facility): 01603 597103

Study title: Older people's experience of urgent and emergency care in an Acute Hospital

Permission Slip For Researcher To Contact Participant

Name:

____

I would like to know more about being involved in the above study ☐

I would like to participate in the study ☐

If you have indicated that you would like to know more about being involved in this study or would like to participate, I would appreciate it if you could provide the following information please:

Name:

____

Address:

____

____

Contact Telephone Number:

____

Email address:

____

Please state your profession :

____

Please state your preference for choice of location for discussion group from the following choices. There is parking facilities at both locations:

1. Bob Champion Research and Education Building
   University of East Anglia
   NR4 7TJ
   (located across from the Norfolk and Norwich hospital) ☐

2. Edith Cavell Building School of Health Sciences
   University of East Anglia
   NR4 7TJ
   (located across from the Norfolk and Norwich Hospital) ☐

3. No preference
   ☐

   ____

Appendix N

Study:
Older People’s Experience of Urgent and Emergency Care in an Acute Hospital

Researcher: Marie McGee, School of Health Sciences, UEA

Please initial each box

1. I confirm that I have understood the participant information sheet and have had the opportunity to ask questions about the study ☐
2. I understand that my participation is voluntary and that I can withdraw from the study at any time, without any reason and that this will not affect my employee status in any way. ☐
3. I understand that the group discussion will be audio recorded for the purposes of the research and the information obtained from this will be shared with the research team and then written up as described in the participant information sheet. ☐
4. I understand the procedures regarding confidentiality and they have been clearly explained to me, e.g. the use of names, pseudonyms and anonymisation of the data . ☐
5. I understand that confidentiality cannot be guaranteed outside the focus group for information which I might disclose in the focus group discussion. ☐
6. I understand that all my information provided to the researcher is confidential unless I reveal something that would suggest poor practice or harm or risk to me or to others. ☐
7. I understand that all information collected in the research will be stored securely and only accessed by members of the research team. ☐
8. I understand that the use of direct quotations will be used for the purposes of the research and for journal publications and at professional conferences. All names will be removed so the participant will not be identified ☐
9. I understand that the results of the study will be used for assessment purposes, journal publications and to present at professional conferences. The participant will not be identified ☐

I agree to take part in the study

Name of Participant: …………………….. Name of
Researcher…………………

Date: ……………………………………. Date:
………………………………….

Signature: …… …………………………. Signature:
……………………………..

Appendix O

Focus Group : Health Care Professionals (HCPs)

Vignette Based Interviews

Justification:
Interviewing both patients and Health Care Professionals (HCPs) will allow for a range of perspectives and provide context and deeper understanding of older people's experience of urgent and emergency care.

The two focus groups will be facilitated by the researcher using vignette(s) which are short stories developed from a collection of the experiences of the older people interviewed for the study. This is to reflect as near to 'real life cases' of older peoples' experiences to enable HCPs to identify with the cases and evoke feelings and aspects of themselves in the characters of the vignette (Young 2011).

Introduction of Interviewer:
As you are aware my name is Marie McGee and I am a student undertaking this study on 'Older People's Experience of Urgent and Emergency Care' as part of my Doctorate of Philosophy. Thank you again for your time and agreeing to take part in this focus group.

The purpose of this focus group is to explore your thoughts and feelings of your experience of caring for older people who use urgent and emergency care services in an acute hospital. It is important that you understand that I am not looking for correct or incorrect answers or that you should identify with any experiences associated with the vignette(s). We have as much as 60 minutes as a group to explore the vignette(s)(short stories). If at any time you feel that you cannot participate in the discussion please let me know? There is no obligation that you need to participate in the discussion nor will you be pressurised to speak. You will not be asked to share personal beliefs or stories and you do not have to share any knowledge that you are not comfortable sharing.

Vignette

Stage 1- Full details of vignette not disclosed

1. What struck you most about this vignette? (facilitate easy discussion)
2. In your experience what would happen in this situation?
3. In your opinion what changes could improve the older persons experiences identified in the vignette?

Stage 2 – Full details of vignette disclosed

1. How does this now sit with your original thoughts and feelings?

2. Is there anything that really stood out in this vignette- What was good about it and why?

3. In your opinion is there any further changes that would improve the experiences of the older person identified in the vignette?

4. As HCPs what would you find most valuable to support you more effectively in caring for older people in the area where you work? If so- What?

Closing Discussion

Having taken part in the discussion is there anything that strikes you as important?
If so, What?

Conclusion

Informal

- Value the work they have done
- Stress the value of the evidence they have produced
- Emphasise how it will add to the richness of the data collected for the study and the value of their perspective.

Thank you for coming and taking part in this discussion

Prompts/Probes and Follow up Questions

- In your experience what would make it easier to look after older people in this situation?
- In this scenario do you think older people's (over 80) care journey is different to other patients in an emergency and urgent care setting?
- Do you think in this situation Health Care Professionals perceptions may impact on the care that is provided (preconceived ideas, beliefs about older people?)
- What are your thoughts on whether older people's needs and expectations are met in an urgent and emergency care environment- if Yes- Why? If No – Why?
- Can you tell me about any barriers that may impact on looking after older people in an urgent and emergency care environment?
- Do you think health care organisation supports HCPs in managing and caring for older people in an urgent and emergency care environment?

- Are you able to tell me more about that point?
- What would happen?
- Can you give an example?
- Can you tell me about that particular experience and what you thought and felt?
- How did/would that make you feel?
- What did/would you think about that?
- Can you tell me what you mean?
- Can I check that I understood what you mean?
- Just talk about whatever comes to mind
- Why?

- How?

Active Listening to encourage participants the opportunity to share their thoughts and feelings about their experiences.

- Silence
- Allowing the HCP time to talk without interruption
- Pick up themes emerging/key words and use follow up questions

Note takers present at focus group – The researcher and another note taker experienced in focus group interviews

Appendix P

Background Questions for Vignette of Older People's Experiences of Urgent and Emergency Care

Q.1
How would you view Doris's experience?
Q.2
Do you feel this vignette reflects the older people you see?
Q.3
Doris describes having to wait to be seen because there are others more deserving of her
What is your experience of this?
Q.4
Doris ***feels reassured*** in the Emergency Department. What do you feel made her feel reassured?
Q.5
Doris describes **'feeling cared for'** for example, one Doctor said **"well you look cold", so he got a blanket and wrapped this blanket around me, he said "you're like a little bug in a rug -that really showed he cared'.**
What do you think made her feel cared for?
Q.6
Doris demonstrates lots of empathy for you and appreciates how you are all very busy. Sometimes this stops her from asking you questions or taking risks such as going to the toilet unaided- How do you feel about this?
Q.7
Doris states that the doctor/ nurse knows best and she prefers you to make the decisions for her – Why might this be?
Q.8
Doris describes feeling like a **'fraud'** being in the emergency department.
Why do you think older people feel like this and why?
Q.9
Is there anything in Doris's experience that really stood out for you and why?
Q.10
Are there experiences that you feel have not been covered in this vignette about how older people experience care in urgent and emergency care?
Q.11
What did you take from Doris's experience that you might make use of in how you care for older people?