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Seeking support after hospitalisation for injury: a nested qualitative study of the role of primary care

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Seeking support after hospitalisation for injury:

a nested qualitative study of the role of primary care

Abstract

Background
In the UK, studies suggest that the transition from hospital to home after an injury can be a difficult time and many patients report feeling inadequately prepared. Patients often use primary care services after hospital discharge. These consultations provide opportunities to consider problems that patients experience and to facilitate recovery. Little is known, however, about how patients and service providers view care after hospital discharge and the role played by primary care services, specifically GPs.

Aim
To identify good practice and unmet needs in respect of post-discharge support for injured patients.

Design and setting
Qualitative study using semi-structured interviews at four sites (Bristol, Leicester/Loughborough, Nottingham, and Surrey).

Method
Qualitative interviews with 40 service providers and 45 hospitalised injured patients.

Results
Although there were examples of well-managed hospital discharges, many patients felt they were not provided with the information they needed about their injury, what to expect in terms of recovery, pain control, return to work, psychological problems, and services to help meet their needs. They also described difficulty accessing services such as physiotherapy or counselling. Service providers identified problems with communication between secondary and primary care, lack of access to physiotherapy, poor communication about other services that may help patients, GP service and resource constraints, and difficulties in providing information to patients concerning likely prognosis.

Conclusion
Discharge from hospital after an injury can be problematic for patients. Changes in both secondary and primary care are required to resolve this problem.

Keywords
general practitioners; injury; patient discharge; primary health care.

INTRODUCTION

Unintentional injuries are common, resulting in more than 668 000 hospital admissions in England in 2012/2013,[1] or an average of 84 per GP practice per year.[1,2] Around half of admissions involve people aged 16–69 years. The main causes of injury are falls, transport collisions, and other injuries such as those caused by sharp objects, heat/cold, and poisoning. Falls were the most common cause in those aged >45 years, with striking against objects being the most common cause in 16–44-year-olds. Transport collisions and other causes of injury were more common in males, whereas falls were more common in females.[1] Increased survival rates[3] and reduced lengths of hospital stay[4] are shifting care for injured patients, some of whom have complex needs, into the community. Recovery is often prolonged or incomplete:[5,6] only 49% of injured adults are fully recovered 12 months after injury[7] and two-fifths of working-age adults have not fully returned to work 4 months after injury, with pain, mobility limitations, anxiety, and depression being commonly reported.[8]

Discharge home after an injury can be a difficult time and many patients report feeling inadequately prepared.[9] Contributory factors are: poorly coordinated or long waiting times for care,[10] inadequate pain control,[8,11] psychological problems,[12–14] lack of access to services,[10,11] and significant gaps in information provision.[9] Post-injury, most working-age adults consult a GP in the first month and over a third consult between 1 and 4 months.[8] Little is known, however, about patient and service provider (SP) experiences and views about post-hospital care and the role of GPs. This study aimed at identifying good practice and unmet needs in respect of post-discharge support for injured patients.

METHOD

A multicentre longitudinal quantitative study was undertaken, with a nested qualitative element, assessing the impact of injuries on physical, psychosocial, and occupational functioning. A total of 668 adults aged 16–70 years, admitted to acute NHS trusts after an unintentional injury in Nottingham, Bristol, Leicester/Loughborough, or Surrey, participated. Semi-structured interviews were conducted with a subset of patients ($n = 45$) with lower-limb, upper-limb, or multiple injuries, their carers ($n = 18$), and providers of services used by study participants ($n = 40$) (Table 1). The SPs interviewed had not necessarily cared for the patients interviewed. Limb injuries were

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How this fits in

Many patients consult GPs and practice nurses after injury, and the ever-reducing length of hospital stays means that patients are increasingly being managed in primary care. This study found examples of well-managed hospital discharges, but also found that many patients experienced problems transitioning from hospital to home. The study makes recommendations for improving this transition, which will be of interest to primary care clinicians and commissioners of acute services.

chosen to reflect the most common injuries experienced by study participants and multiple injuries to represent more complex injuries requiring greater coordination of care. Patients were interviewed at one of three points post injury (1–4, 5–8, or 9–12 months). Maximum variation sampling was used, based on injured participant characteristics ascertained from self-completed questionnaires at recruitment into the quantitative study and at 1, 2, 4, and 12 months' follow-up as described in the published protocol.[15] Patient and SP sampling is described in full elsewhere.[9,10]

Patient interview schedules explored experiences of care post-injury while SP interviews explored experiences of providing care and individual and organisational barriers to better provision. Patient interviews were undertaken in the participant's home or by telephone. SP interviews were conducted at their place of work or by telephone. Interviews were conducted by researchers with varied academic and clinical backgrounds (social science, nursing, and medical) and lasted from 30 minutes to over 2 hours; their content was audiotaped, transcribed, and thematically analysed using NVivo 9 (version 10). An initial coding framework was developed by researchers from the four study centres and a lay research adviser. Initial coding was followed by further coding cycles to test the codes assigned, produce broader themes, and identify relationships and patterns in the data and divergent cases. Continuous discussions took place to ensure discrepancies and disagreements were identified and to refine emerging major and minor themes. Inter-coder reliability was assessed on 10% of the data.

RESULTS

A total of 169 injured patients were invited to participate: 72 agreed and 45 were interviewed. A total of 542 SPs were invited to participate from acute trusts/ambulance trusts (n = 163); community/primary care (n = 333); the private sector (29); social services (n = 15); and the voluntary sector (n = 2). Sixty-one managers were also asked to invite their staff to participate. Forty-seven SPs agreed to participate and 40 were interviewed. Tables 1 and 2 show the characteristics of injured patients and SPs respectively.

Patient quotes exemplify themes and include sex, age, and unique code. SP quotes include unique code and occupation. This study does not describe patients' accounts of their needs as this will be the topic of a separate study.

Patient perspectives on post-discharge and primary care

Positive patient experiences were described in terms of GPs being proactive about visiting, listening and showing empathy, access to timely appointments, providing information, and arranging physiotherapy:

'They are nice doctors my doctors. They listen, very much so. I mean I don't often go but when you do go, they're very good.' (Female, 64, P67)

'She printed some leaflets off for me off the computer and she's been so good and understanding. And apparently after a trauma or an accident, you can go into depression.' (Female, 69, P143)

'When I got this problem with my leg swelling up and throbbing, she made the phone call and he was there ... literally without exaggeration, within half an hour and ... gave me a full check-up. And every time I've been down to see him, he's asked me how I am and talked it through with me and examined me and asked me if I'd got any issues so, yeah, I'm very happy with my own doctor and the access I've got to him as well.' (Male, 59, P158)

Negative experiences with GPs were described in terms of a lack of contact, difficulties in accessing appointments, or failing to listen to requests for counselling. Some patients felt a GP's first-line response to psychological issues was to offer sleeping pills or antidepressants, when the patient felt they needed 'talking therapy'. One patient recalled a GP describing a request for counselling early on in her recovery as 'ridiculous'. A second patient injured as a result of a road crash requested counselling to overcome fears about travelling. She reported her GP saying 'just go out for short journeys in your car and you'll soon be

Table 1. Characteristics of injured participants (*n* = 45)

Characteristics	*N* (%) (unless stated otherwise)
Study centre	
Bristol	10 (22)
Leicester/Loughborough	8 (18)
Nottingham	18 (40)
Surrey	9 (20)
Sex	
Male	21 (47)
Female	24 (53)
Median age (interquartile range)	56 (46–63)
Median index of multiple deprivation (interquartile range)	13 (7–22)
In paid employment at time of injury	27 (60)
Type of injury	
Lower-extremity injury	26 (58)
Upper-extremity injury	8 (18)
Multiple injuries	11 (24)
Cause of injury	
Falls/stumble/trip/jump	25 (56)
Road traffic collision	12 (27)
Other	8 (18)
Median number of days in hospital (interquartile range)	6 (3–10)
Time between injury and interview	
1–4 months	13 (29)
5–8 months	17 (38)
9–12 months	15 (33)
Health, service use, and employment in the 12 months post-injury	
Consulted GP or practice nurse [5]	36 (90)
Used other community services [5]	25 (63)
Met case definition for anxiety[a]	10 (22)
Met case definition for depression[a]	9 (20)
Severe post-traumatic distress[b]	6 (13)
Self-reported complete recovery at 12 months [4]	10 (24)
Employed and working at 12 months [1][c]	19 (73)

[ ] missing values. [a]Based on Hospital Anxiety and Depression Scale subscale scores of ≥11. [b]Based on Impact of Events Scale score of ≥44. [c]Only reported for those employed and working at time of injury (n = 27).

better'. Some patients felt that counselling would have helped them to know whether their feelings were normal, and to 'get it out of the system' and 'move on'. Some felt having someone outside their social network to talk to was important because they wanted to protect family or friends from their low emotional state or felt ashamed of their inability to cope:

' ... that was one of the biggest blows to me, that I didn't get any help that way ... somebody to talk to because no matter how you're feeling, you do try to protect your family ... And if I was coming down here in floods of tears and saying "I'm really depressed today", then (partner) worries. If I'm quiet, he's saying to me "are you hurting?" and most of the time I'll say yes, but I'm not hurting. It's because I'm so, you know, upset about things.' (Female, 68, P6)

The importance of accessing physiotherapists. Patients repeatedly identified physiotherapists as providing information about their injury and support and encouragement with recovery. Some physiotherapists had 'taken the place of the counsellor' and allowed patients to 'gauge' their recovery progress:

' ... it would have been important to see a counsellor and I haven't seen one. So the only other person that I can say is the physiotherapist that I saw probably quite soon after the accident who I was able to talk to, who sort of took the place of a counsellor ....' (Female, 66, P38)

Problems accessing physiotherapy and limitations on the number of sessions were reported. One patient was on a 26-week waiting list, delaying his return to work:

'I rang up and spoke to the fracture clinic receptionist and basically she was saying "well it's 26 weeks, (name), the waiting list is" ... I've got an employer that's wanting me to get back to work.' (Male, 29, P14)

Lack of continuity of care. Some patients felt abandoned by the health service post-discharge, which adversely affected their mental state and coping:

'I started going loopy to start with ... getting depressed and that and like. I thought "I can't have this, I've got to do it for myself because no one is going to do it for me." Because I weren't getting no help from no one at all.' (Male, 48, P146)

Most patients felt there was a lack of continuity and that, despite responsibility for care transferring to their GP, initiating contact and subsequent care coordination were left up to the patient:

'I think it would be good if someone took charge of your case ... If we didn't ring the GPs, if I didn't make an appointment myself, nobody could have cared less if I got better or not.' (Female, 66, P38)

' ... hospital got me sorted, sent me away with medicines and so on but, as I say, where I felt it probably fell between two stools ... There was no link or feedback from the GP ... to see what state I was in.' (Male, 57, P176)

GPs' perspectives on patients' needs post-discharge and within primary care

The three GPs interviewed had limited experience of dealing with injured patients, reporting that most care was provided by community nursing teams and physiotherapists. They acknowledged their role, however, in pain management, psychological problems, certification for time off work, and dealing with insurance and court-related claims and solicitors. GPs recognised that psychological problems might arise as a consequence of pain, disability, or disfigurement, and distinguished between 'reactive mental health issues', which were 'not necessarily an illness', and more persistent problems. GPs provided support for short-lived symptoms and referral when symptoms were not improving:

'People are going to be miserable for 6–8 weeks when they've done some injury and it's going to hopefully get better ... I think they've just got to cope with it you know, we can't medicalise unhappiness.' (GP 1)

'If they are having psychological issues secondary to their injury it is likely to be reactive in nature from the injury so it's hopefully going to be short-lived and those sorts of things we can often support patients through ... Those are the types of patients we would offer a longer appointment to give them a bit more time to be able to talk to us ... Perhaps after a few months if the psychological issue was ongoing we would start to think about "is this developing into depression or chronic anxiety?", in which case we would then ... direct them appropriately either to a talking therapy or, if we were very concerned, psychiatry obviously and the crisis team.' (GP 2)

GPs felt they had an important role in

Table 2. Characteristics of service providers (*n* = 40)

Characteristics	*N* (%) (unless stated otherwise)
Study centre	
Bristol	12 (30)
Leicester/ Loughborough	6 (15)
Nottingham	15 (38)
Surrey	7 (18)
Profession/specialism	
Nurses	14 (35)
Physiotherapists	9 (23)
Hospital doctors	5 (13)
GPs	3 (8)
Ambulance service staff	3 (8)
Occupational therapists	2 (5)
Osteopaths	2 (5)
Psychologist	1 (3)
Voluntary sector manager	1 (3)

orchestrating services, arranging hospital follow-up, or signposting to voluntary services such as the Red Cross for assistive aids. Patients also sought reassurance and GPs found themselves providing supplementary information about the nature of the injury, self-management, exercises, prognosis, and a timetable for recovery:

'So they want to know when they are going to get better? ... Is this going to leave them with any long-standing problems? ... Pain, restriction of movement, scarring, and those sorts of things.' (GP 2)

In terms of meeting patients' needs, GPs felt they had a limited range of options and were not always able to provide the kind of support patients needed or expected. This in turn meant managing patients' expectations about services:

'I think the fracture's dealt with, but the impact of the fracture and what that means to you I think you get very little help. But I can tell you now we don't want that work in general practice, because we can't do it. So it's almost like we need a link nurse there to help everybody with that sort of advice I think.' (GP 1)

'I think they come hoping that or expecting that we have almost a magic wand and can arrange for the reconstructive surgery they need very quickly or physiotherapy they would like or they've been told that they should have very quickly. And then we're trying to manage their expectations down.' (GP 2)

Lack of continuity of care. Like patients, GPs viewed the discharge process negatively, stating that patients often felt abandoned. One GP had experienced the fracture clinic as a patient and had felt 'flung out' of the system and reported a lack of advice, particularly in relation to pain control. They described a lack of 'joined up' care, exacerbated by poor communication across the secondary–primary care interface, and reflected on the consequences for people with little social support, such as elderly people living alone, or others for whom accessing care was difficult:

'I think a big thing for us is communication. Not knowing what's gone on so somebody may have an accident on Friday night, be in hospital Friday, Saturday, come out on Sunday and we may not get a discharge letter at all or we may not get one for a couple of weeks.' (GP 2)

'I had a Polish gentleman ... he came to see me with the interpreter because he had ongoing problems with pain and restrictive movement but I had no documentation from A&E or the fracture clinic. I assessed him as best I could, couldn't see anything overt that meant that he needed to go back into hospital that day ... then got one of our secretaries to go through the online system to ... get the summary and realised he had actually got a dislocation of his acromioclavicular joint so the reason he couldn't lift his arm up was because of that which is a quite significant piece of information ... I felt bad for the patient who had made the effort of having a double appointment with an interpreter to come and see me, and I really didn't feel I could make the most of that time because I didn't have that background information.' (GP 3)

Barriers to care. GPs acknowledged the gap between the services they could provide and those they would provide in an ideal world, such as better signposting to other services, case managers to coordinate care, and better information to help manage patient expectations:

'You'd have the management of your injury, you would prepare people, give them good information about how to manage their injury, how to cope socially and psychologically and then you would follow them up and make sure that they were all kind of better ... We haven't got that. We could be much better at signposting people to things that are going to help them because you can anticipate. You've got a broken right arm, these are the things that are going to be difficult. We can signpost you. Ring that number, you can get one of these guard things, you know, so you can have your shower ... and you can just help people out a bit more I think. You could do more to help.' (GP 3)

Funding was considered the main constraint on providing physiotherapy services, with GPs considering the impact of their referral decisions on resources:

'I think we do try and do our best and I think perhaps where we struggle is, you know, it would be really nice to perhaps get an opinion from somebody or get some physiotherapy here, there and then you're constantly thinking resources, resources.' (GP 2)

Difficulties accessing physiotherapy, including long waiting times, were seen as barriers to care, with GPs feeling it was 'chance' whether or not patients see a

physiotherapist and implying the waiting list was too long to provide effective care:

'… the health service is not meeting the need, but I actually think it's gone down, you know, because obviously I've been a GP for a long time. Whereas virtually every plaster off they'd see the physio then and there and now that doesn't happen. But it's interesting because some patients get to see the physio and some don't … what are the criteria and who discusses that?' (GP 1)

'Now some do seem to be discharged and there's a physiotherapy follow-up, but it seems to be rather random whether they do get that … And the other issue is patients don't go because they have to wait so long and by the time they get the appointment through, they're back at work or they think "well what's the point?" (GP 2)

Other service providers' perspectives on post-discharge and primary care

Other SPs recognised that primary care was stretched to meet the needs of patients. A potential consequence of this was lack of follow-up and inadequate pain management leading to negative consequences for patients and their families:

'When you start talking to them [patients] *you start to realise actually they're not coping very well … Their GPs, they're massively overworked and I don't always know how sympathetic they are to the cause.'* (SP 21, Physiotherapist manager)

'GPs are not very forthcoming in responding to requests to look at issues like unresolved pain problems and medication, especially neuropathic type pain … sometimes it's difficult to get them into that system and it takes a long, long time. And that's holding up rehabilitation a lot of the time.' (SP 12, Occupational therapist)

SPs felt that poor continuity may arise from GPs being unaware of what services existed, lack of mutual understanding, poor communication, and a lack of GP follow-up:

'We need to have a better working relationship with the community. The community needs to have a better working relationship with us in terms of giving us information about their patients when they get admitted into hospital. We don't have that contact at all.' (SP 1, Ward matron in trauma and orthopaedics)

'It's very confusing for people … knowing what we can offer, because I think the awareness definitely from GPs is probably very poor.' (SP 12, Occupational therapist)

'GPs need to take some responsibility around how they follow those patients up and not just adjust the pills and potions they're on, but maybe take some time and give us feedback around the health and mental wellbeing of those patients and families.' (SP 34, Matron neurology)

GP and other SP recommendations to deal with identified gaps

SPs acknowledged that patients experience gaps in health care and have unmet needs with some falling between services, potentially delaying recovery and return to normality. Strategies were suggested to deal with these gaps. These included providing accessible sensitive verbal/written information about injury management and the range of 'normal' consequences and a written discharge management plan. Health advisers could assist in explaining the injury and potential difficulties patients might experience, and providing information about accessing services.

Communication between services could be improved by trauma nurses informing GPs of the patients' discharge, highlighting potential issues, and improving electronic data sharing between primary and secondary care. GPs could be provided with more information about available services so they could refer or signpost patients appropriately. Secondary care or rehabilitation services should provide GPs with information on likely prognosis to help them guide patient expectations of recovery. Care coordination could be improved through the use of case managers, trauma discharge nurses or outreach services, and development of care pathways. Access to some services (particularly counselling and physiotherapy) could be improved by expanding services and provision within GP practices. Screening those at greatest risk of psychological problems would allow early identification and management.

DISCUSSION

Summary

The transition home from hospital after injury can be problematic for patients. Although this study found examples of well-managed hospital discharges, many patients felt they were not provided with the information they needed concerning their injury, prognosis, pain control, return to work, psychological problems, or services to help meet their needs. Patients also described difficulty accessing services such as physiotherapy or counselling. SPs

identified problems with communication between secondary and primary care, lack of access to physiotherapy, lack of information about other services, limitations on the care GPs can provide, and difficulties providing information and support to patients regarding the recovery process and likely prognosis.

Strengths and limitations

This study included patients and SPs from four geographical areas, capturing views of a substantial number of patients with a wide range of injuries and sociodemographic characteristics; varied psychological problems post-injury and degrees of recovery; and a wide range of SPs in secondary and primary care. It is likely that these experiences are pertinent beyond the four study centres. Interviews were undertaken and analysed by researchers with varied academic and clinical backgrounds, enhancing validity and transferability of the findings. A wide range of SPs was interviewed to obtain a broad overview of the care provided after an injury, but there were difficulties in recruiting some types of SPs, for example, social care and counselling services, and the study sample included only three GPs. It is possible that interviewing a larger number of GPs would have produced differing views from those expressed by the GPs interviewed. The congruence, however, of patient, GP, and other SP views suggests that the findings reflect broader experiences of receiving and providing care post-hospital discharge. Responders in some staff groups were identified by managers who may have selected those with particular views. All service providers expressed both positive and negative views, however, suggesting that this may not have occurred.

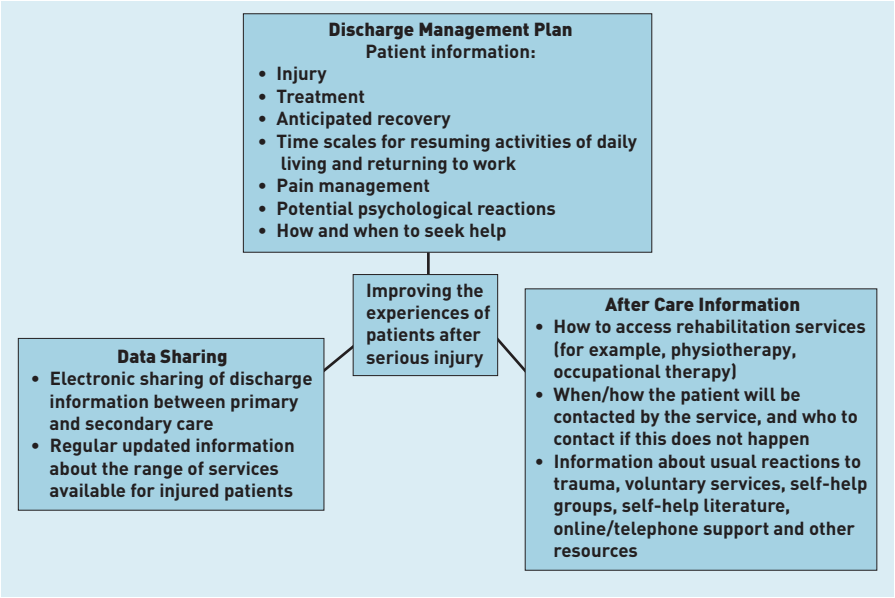


Figure 1. Proposed measures to improve services for patients discharged from hospital after serious injury.

Comparison with existing literature

Only two qualitative studies of general injury populations were found for comparison, but the present findings broadly concur with both. An Australian study interviewing 120 trauma patients post-discharge found that many felt the discharge process was stressful and provided poor preparation for returning home. Those patients reported unmet information needs, lack of access to rehabilitation services, and lack of coordination and continuity of care.[16] A UK study interviewing 89 injured patients also reported lack of access to physiotherapy, unmet information needs, inadequate pain management, and psychological problems.[11]

Implications for research and practice

Some services already have well-defined care pathways, such as those for hip fractures.[17] Although clinical guidelines on various aspects of major trauma are currently being developed, these may not cover the issues of post-hospital care highlighted in this study. The development of an injury care pathway, and concomitant quality standards, for general injury populations would potentially help streamline care, ensure problems identified in this study were resolved, and clarify expected care provision for the benefit of patients and SPs.

Some simple measures could improve patients' experiences post-discharge and GPs' provision of care (Figure 1). Although these are not resource neutral, many would be inexpensive. These include providing patients with a written discharge management plan including information on: their injury; treatment provided; anticipated trajectory of recovery and time scales for resuming activities of daily living; driving and return to work; pain management; psychological reactions after an injury; and how and when to seek help. Details of follow-up care (for example, physiotherapy, occupational therapy) including when or how the patient will be contacted by the service, whom to contact if this does not happen, and information about voluntary services, self-help groups, and other resources would be useful. Improvements in electronic sharing of discharge information between primary and secondary care and regular updated information about the range of services available for injured patients would improve continuity and access to care.

The present findings indicate that GPs

distinguish between early psychological responses to injury, which they regard as 'normal' or 'to be expected', and persistent or severe symptoms regarded as illness. They respond to early symptoms with reassurance and support, or in some cases with advice on gradually reintroducing feared activities. Patients report GPs' reluctance, however, to refer for counselling or other psychological support. Providing normalising information about the usual reactions to trauma, discussing the likely trajectory of symptoms, offering coping suggestions, encouraging social support (for example, self-help groups), and use of other sources of support (for example, self-help literature, online resources, charities) can help patients cope after injuries. Reassuring patients about ongoing support and discussing availability of psychological services, waiting times, and referral if symptoms are not resolving, may help patients to feel that their psychological needs are being considered. Research is required to evaluate the impact of these measures on patient-reported outcomes including satisfaction with care and measures of recovery.

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Provenance

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Competing interests

The authors have declared no competing interests.

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