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Voices of Ill Frail Older People: Personal Resources and Experiences of Health Care Services

Theresa Westgård[1,2*], Katarina Wilhelmson[1,2,3], Synneve Dahlin-Ivanoff[2,4] and Ulrika Lagerlöf Nilsson[2,5]

[1]Department of Health and Rehabilitation, University of Gothenburg, Sweden

[2]Centre of Aging and Health-AGECAP, University of Gothenburg, Sweden

[3]Department of Geriatrics, The Sahlgrenska University Hospital, Sweden

[4]Department of Psychiatry and Neurochemistry, University of Gothenburg, Sweden

[5]Department of Historical Studies, University of Gothenburg, Sweden

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Corresponding author:
Theresa Westgård,
Department of Health and Rehabilitation, Institute of Neuroscience and Physiology, The Sahlgrenska Academy, University of Gothenburg, Arvid Wallgrens backe, House 2, Box 455, 405 30 Gothenburg, Sweden,
Email: Theresa.westgard@neuro.gu.se

ABSTRACT

Background: For many older people, ageing may become associated with frailty. Frequently reduced physical functioning and health are common in frailty; however, this is only one part of the big picture that may affect a frail older person's well-being. To understand a frail older person's unique capability, the study aimed to identifying their personal resources' to comprehend how they experienced receiving health care services.

Method: Ten participants aged 75 or older, screened as frail were interviewed one month after discharge from the hospital ward practicing the Comprehensive Geriatric Assessment.

Result: Frail older people have personal resources established earlier in life and these remained intact and useful when receiving health care services. These personal resources were service: being service minded, having confidence in organizing and conversing and negotiating; and inherent abilities: being resilient and being hopeful and optimistic.

Conclusion: Even though people have, personal resources it does not mean that they could use them, since it was dependent upon a collaboration between a person's social networks, physical environments and person resources. Identifying personal resources could give frail older people the boost they need to experience that they are still competent and capable when needing and receiving health care services. This would require that the health care staff and the health care organization support frail older people by practicing integrated care that is person-centered.

Trial Registration: Clinical Trials ID: NCT02773914. Registered 16 May 2016, retrospectively registered

INTRODUCTION

For many older people, ageing may become associated with frailty. Being frail is not a disease or a diagnosis but rather a term used to describe the accumulation of biological ageing process occurring in a person [1]. Many problems experienced by frail older people may not be amenable to medical solutions alone but require an understanding of the social aspects of ageing, comorbidities and available resources

[2]. Although reduced physical functioning and health are common in frailty [3], this is only one part of the big picture that may affect a frail older person's well-being. One way to understand how people can maintain their well-being could be to use the capability approach. Sen's capability approach [4], focuses on the possibilities and type of life people are able to live, which is their capability, or their real opportunity to do and be what they have reason to value. Sen's capability approach provides a basis for including the experiences that frail older people have regarding health care services [4]. Theoretically, in order to understand a frail older person's unique capability, identifying their personal resources' could be one way to comprehend how they experienced receiving health care services. Several studies have identified personal resources as the within-person capacities [5,6] that make up each individual. Personal resources are unique and valuable for each person but are usually an underutilized viable source [6]. While much research has been done exploring the outcomes of health due to frailty, frailty research has traditionally evolved without considering the perspective of the patient [7,8]. This could be in part due to the how old age has been historically constructed, which continues to impact the lens in which older people are viewed today in society [9]. However shifting the view to include how frail older people might achieve capability with the use of personal resources when receiving health care services, could help to further understanding of how frail older people might maintain their well-being.

Frail older people have complex needs, and a competency in health care workers trained to understand frailty including their personal resources would further strengthen the care they deliver [2,10]. When ill and frail, older people require frequent health care services [7,11], and despite that frail older people are high consumers of health care, their care is greatly impacted by procedural and policy decisions across all settings of health care sector [12]. Health care services should be broad and take a holistic approach, considering the preferences and choices that the frail people express, so that they can experience remaining in control of their life despite frailty and chronic illness [8].

To explore how personal resources influence frail older people's experiences of health care services, knowing how the Swedish society views health care services is useful. Sweden has a long history of officially organizing, managing and controlling services for the poor, sick, and frail older people [13]. Since 1928, laws have steered Sweden's county councils giving them responsibility for public health care, including hospital care services, for all its residents [14]. This law has been rewritten numerous times during the past 90 years, most recently in 2017 and is now titled the Swedish Health and Medical Services Act (SFS 2017:30) [15]. The purpose of this most recent act is to declare that good health care is care that is equal for all the people and must consider an individual's unique values [15].

However, despite this act, the health care system remains mainly designed to address one medical issue at a time, and is not equipped to meet the complex needs of frail older people [12]. Health care services could benefit from learning about people's resources and life-stories, to support better understanding the vulnerable, ill and frail people as they are transferred between and cared for multiple health care branches. Frail older people require a well-coordinated response by multiple professionals addressing their health and social care needs [16], and this coordination should include sharing the information learned about care needs as well as resources and life-stories [17]. Furthermore, frail older people want to have their life histories recognized and through their histories, staff might better elicit what people value so that their care can be personalized, according to people's wants and wishes [18].

Previous studies exploring how older people make use of their personal resources are sparse [17,19]. These studies identified the personal resources that older people perceived they needed in order for them to maintain their independence to live at home, or to be able to continue employment after retirement. Physical well-being and psychosocial factors; such as having purpose in life, being useful to others and to society [17], or being more likely to succeed while using personal resources and if discrimination against them was experienced as low [19] were the main findings. Another study exploring community dwelling people at risk of becoming frail focused on the strengths of their participants and found that balancing factors were used to maintain quality of life, which included their coping strategies, resilience and personality traits [20].

To the best of our knowledge, no studies have explored how personal resources might influence frail older people experiences when receiving health care services. Personal resources for the purpose of this study are the resources that are at a person's disposal, which they make use of when receiving and working towards achieving their health care goals, which gives them satisfaction with their life. Personal resources will include, but are not limited to occupational backgrounds, wisdom/knowledge and life experiences. For these reasons, the aim of this study was to explore how personal resources influence frail older people's experiences of health care services.

METHODS

Analytical framework

When attempting to uncover a person's life history and social identity comprised of their personal resources a biographical approach is a feasible framework to employ [18]. The approach emphasizes the historical experiences accumulated during a person's lifetime [18], which further facilitates learning about the person by re-evaluating their past, present and future plans [21]. By taking a biographical approach the historical connections unique to each participant became illuminated, because people are historical and they keep with them their previous life experiences [21].

Analytical method

We chose a narrative method to allow the participants to express their experiences of [22] of receiving health care services. Through narratives, the information obtained contained aspects of the frail older person's life experiences, which made up their personal resources. People's life story experiences were then coupled with an aspect of time to support an understanding of how participant in their reflections used their personal resources to find meaning in how the present health care services were experienced. With this focus of inquiry, the interviewers used a semi-structured interview guide with open-ended questions. The questions were formulated by the authors and were organized to address two themes: 1) personal experiences and background and 2) recent health care experiences. Theme 1, focused on how the participants experienced growing up, their family situations, their education and previous occupations. Theme 2, focused on their most recent hospital admission and the care services they received prior to and after their illness.

In order to better understand these stories and the data which the participants narrated as causally linked events, happenings and actions [21], we employed the narrative structure procedure of three-dimensional space (Table 1), to produce explanatory stories [22]. The three-dimensional space is defined as the interaction; a personal and social experience, the continuity; the past, present and future dimension, and the situation/place of the dimension [22,23]. After transcribing the interviews, the data was manually sorted in accordance to the interaction. The participant's personal experiences were then analysed in relation to the interactions they had with other people in their social environments. These fragments were data that reinforced the participant's interaction in their three-dimensional space. Secondly, the continuity; the past, present, and future, was then analysed in the action and experience and/or as how the participant would have liked an action or experience in the future to occur. Lastly, the situation or place was then analysed, since specific situations or landscapes give additional meaning to the participant's narrative, as they can impact and shape people's experiences [24].

Using a narrative method and the three-dimensional space to analyze our data, a concentration on the stories told by the participants about their health care experiences enabled the researchers to organize the stories into categories related to their personal resources. The categories were then further analyzed until emerging sub-categories were identified. This dynamic process of connecting disconnected data elements in a coherent, interesting and explanatory way was the goal of assembling this study's findings [21]. Keeping in mind the unique historical stories of the participants, methodological concerns for the three-dimensional space [23] surrounding the health care experiences became the lens we used to view and organize the participants' personal resources. This was achieved with the narratives the frail older participants discussed in their health care experiences that were connected together like a puzzle, with their previous life experiences and personal resources. This allowed the researchers to parallel what the participants experienced, understood and envisioned regarding their health care services, and compared it with how they described their personal resources and life experiences.

Table 1: Narrative structure procedure of the three-dimensional space.

Interaction		Continuity			Situation/Place
Personal	Social	Past	Present	Future	
Look inward to internal conditions, feelings, hopes, aesthetic reactions, moral dispositions	Look outward to existential conditions in the environment with other people and their intentions, purposes, assumption, and points of view	Look backward to remembered experiences, feelings, and stories from earlier times	Look at current experiences, feelings, and stories relating to actions of an event	Look forward to implied and possible experiences and plot lines	Look at context, time and place situated in a physical landscape or setting with topological and spatial boundaries with characters' intentions, purposes, and different points of view

(Inspired by Clandinin and Connelly [24]). The three-dimensional space narrative structure [25] used with permission according to the Creative Commons Attribution 4.0 International License (http://creativecommons.org/licenses/by-nc-nd/4.0/).

Table 2: Demographics of Participants.

Participant	Age	Gender	Education	Previous Occupation	Self -Rated Health*
#1	88	Male	Trade school	Electrician	Good
#2	92	Female	High School	Grocery store: cashier/Painter	Fair
#3	95	Female	Attended Elementary School	Shoe store: salesperson	Good
#4	85	Female	High School	School secretary	Good
#5	91	Female	Elementary School	Fishmonger, bus driver, street kitchen owner	Poor
#6	86	Female	Elementary School	Bakery: salesperson, bus driver	Fair
#7	77	Female	College	Schoolprinciple, politician/member of parliament	Very Good
#8	86	Male	Attended High School	Ambulance staff/Fire station dispatcher	Fair
#9	82	Female	Elementary School	Women's clothing: salesperson	Good
#10	91	Male	Elementary School	Supermarket: executive	Poor

*Self-rated health asking "how would you rate your health: excellent, very good, good, fair or poor" at the one month follow-up after their hospital admission.

SETTING AND PARTICIPANTS

Participants were selected from an acute geriatric medical ward practicing Comprehensive Geriatric Assessment (CGA). Ten participants aged 77 or older and screened as frail using the FRESH screen [24] were selected for this study one month after discharge from the CGA ward. Eight participants who had partaken in Comprehensive Geriatric Assessment for Frail Older People in Swedish Acute Care settings (CGA-Swed): a Randomized Control Trial [26] and were eligible for inclusion in this qualitative study if they scored a 25 or higher on the Mini Mental State (MMS) [25]. Two participants who were not part of the study but received the CGA were declared cognitively intact by a physician on the ward and were contacted and asked if they were willing to be interviewed and recorded after discharge from the CGA ward. All participants signed informed consent forms and received both written and verbal information about the study prior to being included and interviewed. This study is part of the CGA-Swede RCT [26] at a University hospital in Western Sweden, registered at Clinical Trials (ID: NCT02773914), and approved by the Regional Ethical Review Board in Gothenburg (EPN Gothenburg Drn: 899-15).

DATA COLLECTION

Ten face-to-face interviews were conducted using open-ended questions. All interviews were performed in the participant's home and were carried out from June 2016–May 2018 by the first author. The interviews were recorded digitally and lasted from 21 to 64 min. Seven of the interviews occurred individually, one had their spouse present and two were married and were interviewed at the same time. The researcher asked the participants about their life experiences as open ended questions which allowed for them to interpret the question freely. Furthermore, general questions about hospital and health care experiences were explored and further developed according to the participants' responses. The participants were aged 77–95 years old and included: seven

women and three men. The participants are presented as individual cases below in text and are shown by the demographics in Table 2.

RESULTS

The participants' experiences of health care services were influenced by their personal resources. The categorical themes of personal resources identified were: 1) service and 2) inherent abilities. Service surfaced frequently as the participants discussed how in their lives they had worked in the service sector or had wisdom and knowledge about how service should be delivered. This service category focused on how the participants viewed and experienced health care as a service. Within the category of service three sub-categories were identified where the participants had: personal resources of being: service minded, having confidence in organizing and conversing and negotiating. Secondly the category of inherent abilities surfaced as the participants explained that when their service personal resources did not suffice in healthcare, they made use of their innate attributes. Within the category of inherent abilities two sub-categories were identified where the participants were identified as being resilient and being hopeful/optimistic.

PERSONAL RESOURCES

Service

Participants in this study were experienced in providing services. They viewed service as an action of helping or doing work for or with someone, which made up the three subcategories of: being service minded, having confidence in organizing services and conversing and negotiating services.

Being service minded: Being service minded was the personal resource pronounced by participants who in their previous work and life experiences were motivated to give good service, which required that they had social skills. Being service minded meant to them that instructions were followed, questions could be answered, time was respected and that one was attentive and flexible. The participants discussed how they experienced the staff; who either had or lacked being service minded when providing them with their health care services. In addition, some participants offered suggestions and recommendations, using their past experiences and personal resources while sharing their wants and wishes for the future, describing how they would like health care services to be framed and improved, when experiencing staff who were not service minded.

One 95 year old widowed female recalls how it was to grow up living in a poor family of 12 during the 1920s. They had cramped living conditions, which resulted in five of her siblings being removed by social services. She was only able to attend school for five-and-a-half-years because she had to work and help out at home. She was responsible for teaching her younger siblings to read, and made milk deliveries in the mornings. In her narratives, she described how at the age of 16 she landed her first paid job in a shoe store. The shop owner told her that she had to "change my dialect and speak properly to serve the important and wealthy customers, since we were selling the best Italian designer shoes. I had to appear educated." She gained the personal resource of being service minded by being flexible, respectable, and practicing good social skills, as she provided good service to her customers for over 40 years. However, when she was acutely ill at the age of 95, she did not experience that staff in the emergency department were service minded. She explained how in the emergency department, during her 23-24 hour wait for a bed on the geriatric ward, she was placed "very far away from reception. They put me behind a folding screen. I couldn't get in contact with them. I couldn't yell… there was no bell…I didn't receive water, food or supervision from anyone. Nothing! Zero!" She continued, "But my great-granddaughter helped me file a formal complaint against the emergency department…they can't treat people this way."

Having confidence in organizing: Having confidence in organizing was described as a component of service learned by participants from their previous work experiences. Having this personal resource, required that a person felt competent and was motivated to bring together the necessary and available resources required to solve the problem with which they were faced. Participants described how when they used this personal resource it meant that they knew how to access resources or find others who could. It also required a sort of efficiency and understanding of the task they were assigned to. With this confidence came responsibly to see that the organization of services were carried out proficiently. The participants who had the personal resource of having confidence in organizing made use of this in their narratives, as

they described observing how the logistics of their health care and the staff providing the care was experienced. Using these skills they observed and made suggestions as to how staff and health care services could be better or differently organized and restructured based on their life experiences, to secure a better organization in the future.

An 86 year old married male describes how he spent his entire career working in the public sector for the ambulance and fire department. He explains as an ambulance staffer (nearly 70 years ago), he had diversity in his job, driving ambulances and carrying patients on stretchers. For the majority of his working career, he was employed at the fire station as a dispatcher. He developed the personal resource of having confidence in organizing, as he assumed responsibility for making decisions, organizing logistics, telephoning, and forwarding information associated with the fires and emergencies. He explains, "[I had to make sure] that the right people were in the right place at the right time...I sat like a spider in the net to make sure that the right strength was sent to the right place at the right time to save that which was able to be saved. That was then."

This participant's personal resource of having confidence in organizing was still intact despite retirement and old age, after his 11-12 hour wait in the emergency department. He described his observations and questioned the logistics on the CGA ward was when he finally arrived to the ward and got a bed. He immediately noticed that there were many empty beds. "There was space here and there. It seemed like they were hiding a few spaces so that when you come up [to the ward] and are admitted you can see that there are extra beds. But they said that they were reserved for this and that. One can feel that they make it difficult when you can see there was actually space…one could have been admitted to the ward sooner for observation." Yet after spending 5 days on the ward, he then praised the logistics and organization on the CGA ward stated, "For older people, if they are going to have good care, they should follow the system they had on the CGA, with a few modifications, it was marvelous. If they can follow that system...but it's probably expensive." He added that the only modification would be to "have more open beds."

Conversing and negotiatin: Being able to converse and negotiate while providing services and when interacting with others was a personal resource described among participants. These people earlier in their lives through work experience and social clubs were used to talking with customers, fellow members and others because of their involvements and experiences. Conversing with other people for them involved sharing knowledge and learning new information. When conversations did not go as planned there was sometimes times a need for negotiations, since people will not always agree. This skill of settling differences was used throughout the participant's lives and in their business experiences. The participants who had the personal resource of conversing and negotiating wanted to make use of their skills when receiving health care services. However, this was not always possible, which could be because the person chose not to demonstrate their abilities or because the organization and situation restricted conversations that invited negotiating when delivering health care services.

A 91 year old widowed male with the personal resource of conversing and negotiating explained that after attending elementary school, he started working in sales. This path led him to enroll in additional courses to develop his working skills and career within retail. He climbed the career ladder and developed the personal resource of conversing in his retail grocery store executive career before retiring. He described how he enjoys discussing and negotiating face to face, and that these skills placed him on the board of several unions and organizations. A career of buying, selling, and negotiating are the business that makes up much of his life experiences. Now that he is older and in need of health care, the use of his personal resource of conversing seems to be less relevant to support his bad heart and needs with activities of daily living. He explained that "health care resources have shrunk...the resources that used to be earmarked for older people, including the staff and administration, have organized themselves in such a way that they prefer to chat via Skype... There is no longer a personal conversation and it has already been decided what they are going to offer, so there is no real negotiation."

Furthermore, he described how he experienced being forgotten and rejected, and how health care made him feel that he had no ability to make use of his resources to get the kind of health care he wanted. "I have help four times a day, and recently the evening staff that prepares my dinner told me that the

night staff will give me my medication before bed, [which is locked in a safe]…but they never arrived...at midnight I locked the door and shut off the light. They never came, so I missed my medication." Despite him being dependent on home health care, the staff constantly told him that he is too healthy to receive care in a nursing home. "I've made numerous efforts to be moved into a nursing home, but they reject me." He rhetorically asks about his future, "How sick and old do I have to be before I get a space?"

Inherent Abilities

The participants in this study displayed inherent abilities described through their stories, which were defined as those inseparable qualities or characteristics that exist in someone. These abilities were identified as being learned or existing early in life, and were often used out of necessity when resources were limited or unavailable as explained by the participants in their narratives. Inherent abilities were subdivided into two subcategories of being resilient and being hopeful and optimistic.

Being resilient: Being resilient was the personal resource described by the participants who in their narratives discussed how throughout their earlier lives they confronted difficult situations, where they had to find solutions and were able to bounce back despite having limited support and or resources. In their storytelling, the participants described facing hardship situations and explained how they overcame by being creative, flexible and adaptive. Being resilient throughout life is the personal resource participants described as helping them to survive a difficult situation, which allowed them to maintain a level of independence and wellbeing. The participants who were resilient, used this personal resource when health care services were not experienced as meeting their needs. Being resilient supported the participants to overcome and survive despite experiencing that they were marginalized or excluded. Using their resilience lens they informed others and formulated how they would like health care services to be delivered in the future to better meet their and other's needs.

A 91 year old female describes how she became a widow in her mid-30's after her husband died unexpectedly. She never remarried and raised two boys on her own. They were school aged at the time of their fathers passing but she described the wonderful home and life they have shared, always in agreement. She speaks fondly of how she has always worked and was employed as a fish monger, bus driver at the airport and even owned a roadside café. Stating that "work was really fun…met lots of people. I think I have had a fun life with my work... I've never thought I'll stay home today." The personal resource of being resilient throughout her young adult life continue to support her as she now lives alone in a service apartment adapted for her daily needs, where she remains independent in grocery shopping and frequently bakes. Other free time hobbies include meeting her neighbors in the same senior apartment building daily for lunch, afternoon tea and social events. They chat and discuss daily events keeping each other informed.

This participant describes how she was forced to use her personal resource of being resilient during her illness after the home alarm services informed her that they could not help her because she was not being treated by home health services. She found herself in a situation where she had to make use of the limited resources available to her. She relied on her ability to adapt and use her social network (e.g., her sons), as she stayed in bed for the week until she regained her strength. "I was nauseous and vomiting; I stopped drinking…I used the medical alert alarm…I called because I was so ill…but there is no point, if you don't have home health, no one cares about you…a man came and the first thing he asked me is do you have home health services. No, I have home help, just cleaning. Then we can't do anything for you he said … at night there isn't anyone. Primary care demands that I go there. I couldn't manage that. It wasn't possible you have to book an appointment with primary care if you need care." With limited resources, she relied on her ability to adapt and manage with the support of her sons, until her stomach flu had passed and she was able to regain her strength. "But now (after 10 days) it is wonderful and I have started going out again but my legs are like jelly…when I go out, I meet people and I get around. It is dangerous to lie still and have pity on yourself." This participant describes in her story how being resilient helped her to manage her illness without health care services until she could bounce back and recover to her previous daily routine. She reports furthermore openly sharing her story with her neighbors, so they will know what to expect if they too are ill and need home health services.

Being hopeful and optimistic: Being hopeful and optimistic surfaced as an inherent ability and as a personal resource amongst the participants who described having sureness about the future or that a successful outcome of something that was going to occur. This favorable outlook was related to the participant's confidence in the health care system; and the optimism that they would receive the health care they needed so that they could maintain their health. Participants described being hopeful and optimistic, because they had a genuine interest in the continued development of their own health and future. However, some narratives support that despite participants having inherent abilities of optimism and being hopeful, if they continuously experience that they are forgotten or marginalized when receiving health care services, it can negatively impact their future optimism. In some cases, participants who were optimistic and hopeful, described feelings that were diminished and replaced with despair and uncertainty towards their health, when not receiving support and information about their medical concerns.

An 86 year old married female described in short her life as being married for over 45 years and having worked in different service sectors with her husband. Rather than divulging information about those experiences, she chose to discuss her hobbies during the interview. She explained how she always wanted to be a pilot, but her vision wasn't good enough, so she traveled a lot instead. She explains how age and illness have now limited her flying, traveling and exercise routines. This participant possessed the personal resource of being hopeful and optimistic as she described how she would love to get out into the forests and pick mushrooms again, but that it wasn't possible right now due to her use of a walker and her dizziness. She is hopeful that the physicians would find out what is causing her dizziness and cure it. Despite her experiencing that the doctor "doesn't seem to read my journal or know what is going on after I've been discharged from the hospital… I want them to remove my dizziness, so I can go out and walk and do things again." This participant describes in her story how being optimistic and hopeful helped her to manage her illness when health care services and staff were unable to meet her wants and wishes.

DISCUSSION

Ill, frail older people living with comorbidities are also living with personal resources, which are their assets. Personal resources related to services and inherent abilities were identified in this study. They were internal assets that were obtained through earlier life experiences, and were proven to remain intact for people when they needed health care services.

One of the main personal resource categories was services. *Service* is an aspect of health care, and our participants weighted their care satisfaction heavily on whether they experienced the staff who cared for them were service minded or not. It is known that patients often define care in terms of service, since health care is a service [27]. Health care services should be designed to deliver care to patients. However when health care providers understand the patient's perspective, they improve their ability to meet patients' needs and enhance the quality of care experienced by the person [27]. Unfortunately, western health care still has paternalistic traditional practices and structures, thus limiting health care providers from seeing the person [27-30].

The participants in our study experienced health care through a service-minded lens and wanted to receive care from staff that was service minded. Previous research has shown that the dynamics between younger health care staff and older patients telling their life history retrospectively has been found to improve care [31]. However, despite being service minded, participants in our study struggled to receive services according to their goals. One clarification as to why this occurred, could be that the staff and the patient had different goals regarding their health care services. According to an earlier study, healthcare staffs' and the patients' agendas could be different as the staff may want to gather specific information from the patient about their medications and recent examinations, while the patient may have the need to or prefer discussing a wide range of health and life concerns with the staff [32].

Our participants described how they were confident in organizing services based on their life experiences, as they offered suggestions and made observations about how they perceived the logistics of health care and the staff's performance. They experienced that health care services were structured so they were sparse and limited. They offered

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suggestions about how logistics and organization could be improved, since they felt that the staff were not always able to support them in a timely manner. An earlier study found that patient satisfaction and the organization of resources are interrelated and at times may conflict one another; for example, patients may experience longer wait times and receive care from less responsive staff as a consequence of an organization's attempt to improve operational costs (e.g., less staff, fewer beds) [32].

Associated with patient satisfaction and responsive staff, the last service personal resource identified was conversing and negotiating. Our participants wanted to engage in conversations and to be part of making decisions, which might involve negotiating, when receiving health care services. However, this was not always experienced as occurring, despite being experienced and capable from their earlier life experiences. Participants at times experienced that they were ignored, forgotten, marginalized or lacked information, which could be interpreted due to gaps and inequalities in the health care process. Research into age discrimination has shown differences in health care services offered by age, with older people receiving less favorable treatment [33]. These breaches limited their capabilities to converse and negotiate, and were described as being due to the staff and physical location where health care services were being delivered. This supports our conclusion that when participants made comments to health care staff, these comments may have been missed clues as to who the person is and what matters to them when receiving care. This is best achieved when patients are prompted or invited to a conversation [27]. Patients want and anticipate that they will have the opportunity to discuss their values and main concerns with health care staff, however they rarely initiate the discussion, since they expect the health care staff will take the lead and initiate a conversation [27]. Learning about patients histories and involving them in their care can be challenging [27]. However when using a person-centered approach an acknowledgment of the unique expectations a person has for their care will be based on their understanding of the situation [28]. In this expectation and understanding, comprehension for a person's social history and resources must be made, while making allowances for the person's weaknesses as well as their strengths [28].

The second main category of personal resources was inherent abilities. The participants used these abilities when they were unable to achieve their goals. They experienced their lack of goal achievement due to the organization of health care services or because of the staff who were not supportive in meeting their goals and service needs. There were two subcategories of inherent abilities: being resilient and being optimistic/hopeful. Through these personal resources, people found alternative solutions in their social networks and physical environments, to uphold some level of health and well-being. An earlier study found that frail older people who are resilient have an inner strength to create well-being despite their frail and ill state [34]. To support frail older people needing care; their personal needs and assets must to be understood [35]. People's experiences, preferences, and values should be integrated and supported to optimize health decisions [36]. The interventions organized to support people however must also be accessible, available and goal oriented, so they do not merely focus on the disease approach to improving health [35]. When this organization does not occur, people may use their internal health asset, so they can remain goal directed, able to seek support and remain persistent with problem solving [37]. Frail older people who use their internal personal resources, were found to better cope with their changing bodies and health care needs by facilitating positive thinking and being hopeful [34].

Our participants have a timeline in history, where they grew up during and between times of war (1920-1945). During this time period Sweden was developing into a welfare state, to diminish poverty, by increasing access to resources and rights [38]. They have been part of, and experienced the transformation that Sweden has undergone, described as the "harvest time for welfare policy and medical progress" [38]. Living during a time of fruitage, society was flourishing, rights were established and advances in health care and living conditions, meant resources were available to its citizens. Sweden continues to have laws in place to safeguard health and medical services. The Health and Medical Services Act (SFS 2017:30) [15], is intended to assist and support people to vocalize their health care needs. People know that they are entitled to receive care which is supposed to be equal care, and the aforementioned publically-funded health care services

must consider an individual's unique values. However, despite health care services being universal in Sweden, they are not organized alike, nor do they have the same resources [39,40]. When people cannot draw upon all their resources, including their health care staff, their social network and the physical environment in which they are receiving health care services (e.g. emergency department, hospital ward, primary care, home health), they cannot achieve their full capability [41]. This meant that their resources were not always available at their disposal to be used when receiving health care. According to Sen [4], people's ability to achieve desired goals is reliant on what they have access to. Ill, frail older people could be enabled to use their personal resources to be who they want to be, and be capable to achieve what they value, when needing health care services. However, a frail older person with personal resources cannot do this on their own. It requires that all available resources be coordinated and integrated in supporting their capability. Integrated care programs are one way to improve the quality care for older people in primary care, as they are commonly founded on a multidisciplinary team approach, with tailored and personalized care based on CGA [42]. However, there is limited evidence for the effectiveness of these programs when the older person is also frail [41], which is further supported by the findings of a recent systematic review exploring the effectiveness of integrated care, highlighting that integrated care remains fragmented and limited [43]. These results support our findings, and make recommendations for future research which should focus on unravelling the heterogeneity amongst frail older people to better understand what can realistically be expected and achieved [43]. In doing so the authors of this study believe, discovering frail older people's personal resources would further support their capability. However, capability is not merely about what a person achieves in their health care, but that they are also part of the process in choosing the health care services that they value [44]. A person-centered care approach is care founded on a holistic approach of the patient and through partnership should result in personalized care planning and delivery [28,45] founded on what a person values. Based on our results, we suspect that the care our participants received was not always integrated care or person-centered, but rather may have been personalized medicine. This approach to care is medicine focused and describes how prescribed medications address a person's specific medical results, so the pharmaceuticals used are tailored to optimize a person's medical treatment [46,47]. Personalized medicine is a biomedical framework and typically lacks involving a person's personal narrative, collaboration and partnership, unlike person-centered care, since the focus is primarily on controlling pharmaceutical interactions in patients [46].

STRENGTHS AND LIMITATIONS

A strength to this study was the success in using a three-dimensional approach to make the connections between the participants past life experiences while identifying their personal resources. These personal resources identified could be useful in the present day and might be useful in the future, if people are capable, when receiving health care services. These findings may not have come to light with the same magnitude if we had excluded our participants historical life experiences, and might have weakened our discovery that resources from past life experiences remained present and intact when in need of health care services. On the other hand the approach is rather time consuming and requires thorough analysis of each narrative to find the connections between past, present and future. It is unclear if there are other approaches or methods that could have been used to arrive at the same result. Furthermore, our study is limited, since only a small group of Swedish participants with good cognitive status who had received care on a geriatric ward practicing a Comprehensive Geriatric Assessment were invited to participate. Our study is limited since no health care personal were included in the study, thus our results are only based on what our participants described and experienced. Lastly, because the benefits and outcomes of frail older people's use of personal resources together with staff who are informed about these assets is unknown, future and long-term studies are needed to further explore this initial finding.

CONCLUSION

People are historical beings, and regardless of being ill, frail and old; past life experiences influence the way people see and understand the world around them. We identified that even though people had personal resources it did not mean that they could use them, since it was dependent upon a collaboration between a person's social networks, physical

environments and personal resources. Identifying personal resources could give frail older people the boost they need to experience that they are still competent and capable when needing and receiving health care services. This would require that the health care staff and the health care organization are integrated and support frail older people's capability by practicing person-centered care.

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