ORIGINAL ARTICLE

Factors influencing the decision of older people living in independent units to enter the acute care system

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Factors influencing the decision of older people living in independent units to enter the acute care system

Aims and objectives. This South Australian-based study explored and described the factors influencing the decision of older people living in the community in independent living units to enter the acute care system.

Background. Community-based older Australians, an increasing population segment, make choices about support needed to optimize health and well-being. This includes when to enter the acute care system. Entering this system has potential risks as well as benefits. The current South Australian Department of Human Services policies of 'keeping older people out' of the acute care system has implications for prevention and early intervention measures and requires an understanding of how and why older people enter the acute care system.

Method. In-depth interviews were conducted with older people (N = 31) and their families (N = 10), drawn from three South Australian aged care organizations providing independent living unit accommodation, and focus groups (N = 14) were conducted with stakeholders to identify factors influencing the decision of older people living in independent living units to enter the acute care system.

Findings. Analysis of the data revealed eight facets influencing this group of older people's decision-making with respect to entering the acute care system; they were: expectations of support in the independent living unit not being met; the presence/absence of safety nets; lack of after-hours support; the desire to remain independent; the general practitioner as pivotal; the influence of others; perceptions of the emergency department; and having access to information.

Relevance to practice. These facets provide insights into entry processes, links and relationships that form an interface between primary care, community care, the aged care industry and the acute system. Analysis of these insights highlight prevention and early intervention responses that can promote the health and well-being of older people, potential ways to streamline services, as well as gaps in current services.

Key words: acute care system, decision-making, older people, qualitative research

Introduction

Older people make choices about where they live and the degree of support they require to optimize their health and well-being. They make these choices with the help and advice of aged care organizations, health professionals, community and consumer advisers, and family and significant others. Healthy ageing must provide a balance between independent living and social support; physical and emotional health; adequate financial and healthcare resources to sustain the later stages of life; and a place in which to feel safe and comfortable (McMurray, 1999). In an effort to achieve such balance in Australia, some older people choose to live in an independent living unit (ILU). An ILU is a housing option for older people, which can be rented or leased, and which is frequently managed by an aged care organization in the not-for-profit sector. Buys (2000) found that the six key reasons for older people moving into an ILU were: health care and support, low maintenance needs, personal security and security of tenure; company of other older people; lower costs; and proximity to family.

However, even if they choose to live in an ILU, as older people age there is a likelihood of an increase in their need for acute care services. In Australia, as in many Western countries, older people are increasingly the core business of the acute care system (Department of Human Services: DHS, 1999; Gibson *et al.*, 1999; Bishop, 2001; Cheek & Gibson, 2003). The acute care system is not easily defined. A search of the literature reveals that terms such as acute care, the acute care system, and acute care setting are assumed to be understood and their meaning is implicit rather than made explicit. Our study adopted a broad working definition of the acute care system. As Cheek (2004, p. 53) argues, acute care sites 'have traditionally been places of cure – that is, it is assumed that patients who enter the acute system get better'. Acute care, its settings and its systems have been 'organised around notions of curative, defined episodic care' (Cheek, 2004, p. 59). With this in mind, 'the acute care system' for the purposes of this paper has been broadened to include not only the hospital/emergency department itself but also associated points of entry including general practitioners, ambulance and outpatients who interface with the acute care facility and form part of the acute care system (DHS, 1999; McMurray, 1999). Older people may either choose to enter the acute care system, or medical emergencies may be such that they are required to enter the acute care system despite not choosing to do so.

The acute care system has potential risks as well as benefits for the older person, not least of which is that attendance at emergency departments may become a major pathway to institutional care for older people (Cheek & Ballantyne, 2001). To facilitate seamless care transitions and minimize the impact of the acute care system on the older person, hospital avoidance programmes, such as GP Home Link (a programme that works with GPs and emergency departments of hospitals to avoid inappropriate hospital admissions for people by providing short-term crisis intervention and complex care planning) are being developed, along with early discharge programmes, for example Hospital in the Home (a programme that provides an alternative to inpatient care for people who are acutely ill, but who would prefer to be cared for at home). These and other programmes collectively assist older people while they are 'in' the acute care system, and upon discharge, enhance their 'staying out' of the system. Indeed, the South Australian Department of Human Services, in recognition of both the impact the acute care system has on older people and that older people have on the acute system, developed a model for acute service provision for older people living in the community that emphasized three key principles: 'keeping out', 'being in' and 'staying out' (DHS, 1999). Essentially, 'keeping people out' of the acute care system means understanding how and why people enter the system, what points of entry they use, and what entry processes they could access. The aim of such understanding is to determine what prevention and early intervention measures could be utilized to re-direct the older person to more appropriate care or optimize care in the community. Thus 'keeping people out' means anything that stops older people being clients of the human service system including the acute sector and includes anything that promotes independence, supports decision-making and promotes health, safe housing and community involvement (DHS, 1999). As 'points of entry' involved with 'entry processes' for the acute care system, hospital emergency departments, and networks for pre- and post-acute care provision such as ambulance personnel, General Practice, social workers, allied health professionals, community pharmacists, and aged care organizations have a role to play in prevention and early intervention. Health promotion, prevention and early intervention have tended to be overlooked for older people in the past and not actively promoted (McMurray, 1999). Thus, there is a need to understand how and why older people living in ILUs decide to enter the acute care system in order to help older people remain in the community longer, optimize dignity, functional independence and well-being, yet minimize their use of acute care health services, which can reduce their independence, well-being and functionality. This said, there is little known about the decision to enter the acute care system. How and why older people enter the acute care system, and what influences their

choice and decision-making is a neglected area but one that has impact on resources and service delivery within the acute care system. Research investigating older people's (or others) decisions to enter the acute care system often is framed by understandings of presentation to the acute sector as appropriate/inappropriate or justified/unjustified, drawing on acute care derived premises of what appropriate/inappropriate and justified/unjustified mean (Cheek, 2004). For example, Padgett and Brodsky (1992) explore the concept of urgency in attendance and suggest 85% of attendance is not urgent according to the acuity of the person. Other researchers focus on the appropriateness of that decision-making and judge the appropriateness of the decision-making without including the perspective of the patient and their families, then make judgement about the decisions made (Walsh, 1993, 1995; Togi, 1997). Padgett and Brodsky (1992, p. 21) recognize the limitation of using information supplied only from the service providers' perspective and recommend that the social and psychological context of patients' decisions to go to the emergency department must also be considered.

'Keeping older people out' of the acute care system requires an understanding of how and why older people enter the system, what points of entry they use, and what entry processes they employ. Such an understanding can assist in determining what prevention and early intervention measures could be utilized to redirect older people to more appropriate care options, thereby optimizing care provided to older people.

Recognizing that older people are high users of the acute care system, and that the decision to enter is a complex process involving not only individuals but the context of that decision within their life and available resources, the study reported here focused on one group of older people in the community, namely those living in ILU. The impetus for this study was twofold. First from aged care organizations that are large providers of ILU accommodation and second from the South Australian Department of Human Services with its policy of 'keeping older people out' of the acute care system whenever possible. The research evolved from an interest of those dealing with older people and the acute care/ILU interface daily.

The study aimed to explore and describe the decision-making involved when older people living in ILUs to enter the acute care system. Specifically:

- why and how the decision to enter the acute care system was made;
- when and how the decision to enter the acute care system began;
- important factors involved in the decision-making;
- the efficacy of the entry/decision-making process.

Method

A qualitative exploratory and descriptive design was chosen as the most appropriate methodology for addressing the research question. As Sandelowski (2000, p. 339) states, 'such a study is especially useful for researchers wanting to know the *who*, *what*, and *where* of events'. In order to probe the who, what and where, in-depth interviews with older people and their families and focus groups with stakeholders were employed to identify factors influencing older people living in ILUs to enter the acute care system. The University of South Australia Human Research Ethics Committee approved the project, and appropriate written consent to participate and ethics clearance was provided by participating aged care organisations and other organisations from which staff were recruited for the project.

Sampling strategy

Participants were purposefully selected based on their ability to provide rich information for study in depth (Patton, 2002). As Patton (2002, p. 230) points out, 'studying information-rich cases yields in-sights and in-depth understanding rather than empirical generalizations'.

In-depth interviews

In-depth interviews were conducted with older people and their families to explore the factors influencing the decision of older people living in ILUs to enter the acute care system. Participants were drawn from three South Australian aged care organizations offering ILU accommodation. Older people were selected from both the metropolitan and non-metropolitan sites of these organizations in order to ensure that non-metropolitan issues were also considered. Older people, 65 years or over, living in an ILU, who had been involved in a decision to enter the acute care system (whether admitted or not) within the 90-day period preceding the interview were eligible to participate. The 90-day period was chosen, in line with the research of McAuley *et al.* (1997) and Cheek and Ballantyne (2001), to ensure that 'accurate retrospective descriptions of the decision-making involved were captured' (McAuley *et al.*, 1997, p. 239). Following participant consent, the interviews were audio-taped and later transcribed. In-depth semi-structured interviews were initially conducted with 25 older people living in ILUs. The sample size was guided by McAuley *et al.* (1997) and previous experience (Cheek & Ballantyne, 2001), thus it was anticipated that no new themes would emerge.

Older people interviewed were asked to nominate a family member involved in the decision-making process who could be approached for interview. If the older person was confused, then only an interview with the family member was conducted. Of the initial interview cohort of 25 older people, less than five named a family member who was available or whom they were willing to have the research team contact. Consequently, the researchers increased the interview cohort to 31 older people, which provided interviews with 10 family members. Respondents were encouraged to talk about and describe their personal experience of the decision-making involved when choosing to enter the acute system. A direction was given to the interview so that the content focused on the four crucial issues of the study outlined earlier.

Qualitative analysis of the interview data involved four phases (Cheek *et al.*, 2002) iteratively applied over the duration of the data collection and analysis phase of the research:

- the material collected was studied to give a sense of the whole;
- themes and categories were identified;
- recurrent patterns were identified;
- summative themes were identified.

Drawing on Miles and Huberman (1994) we noted patterns and regularities in the data and began to develop initial code and categories from the data from the start of data collection from which we developed our broad thematic areas as our research study progressed. To ensure consistency, at least two members of the research team independently reviewed each transcript (Becker & McCabe, 1994; Emerson, 1995). Reviews were exchanged and any disagreements were discussed and resolved by consensus (Rudman & Verdi, 1993; Van Til *et al.*, 2003). However we remained open to other ideas and possibilities as we added to our analyses from more interviews. Such an iterative approach where the working code and categories provide a framework for organising and rewriting data assist in the verification of data (Walker, 1999). We returned to the actual transcripts to test our ideas and emergent themes at all times, checking to make sure that 'a conclusion (read theme) is actually rooted in the data' (Walker, 1999, pp. 285–286).

The inductive analysis of the transcripts produced major categories of themes identifying factors/issues influencing older people's decisions to enter the acute care system from the perspectives of individual older people and family members.

Focus groups

To enable a comprehensive analysis of the factors/issues influencing older people living in ILUs to enter the acute care system, it was important to include the perspective of the service providers who come into contact with older people and their families in the acute care system. Focus groups were decided as the most effective means of achieving this purpose. Focus groups provide an efficient use of resources; they are relatively easy to undertake as results can often be obtained quickly and participants tend to express views that they might not express in other settings (Stewart & Shamdasani, 1990). In addition, a researcher can clarify issues and explore unanticipated but potentially fruitful discussions. Responses have high face validity due to the clarity of the context and the detailed nature of the discussion focusing on issues identified (Grbich, 1999).

Drawing on the approach used by Beattie *et al.* (1996), seven focus groups were initially planned. However, information gained through the in-depth interviews with older people and their families highlighted a broader range of stakeholders who would have insights to add to the study. In total, 14 focus groups were conducted with combinations of interested stakeholders (older people, family members, GPs, ILU staff, community advisers, ambulance personnel and emergency department staff).

The focus groups explored the perspectives of participants about factors/issues influencing the decision of older people living in ILUs to enter the acute care system. The questioning framework was derived from the thematic analysis of the in-depth interviews, and developed into interview prompts to provide the facilitator with a broad outline of the topics to be discussed. Participants were given the opportunity to contribute any other information related to the study focus. Two members of the research team attended each focus group, one as facilitator and one as observer/recorder. Each focus group was audio-taped and the tape was transcribed and the observer's notes were collated. The transcript was then carefully analysed following the parameters outlined in the analysis of the in-depth interviews.

Findings

Analysis of interview and focus group data revealed eight major facets impacting on the decision of older people living in ILUs to enter the acute care system. These were: expectations of support in the ILU not being met; the presence/absence of safety nets; lack of after-hours support; the desire to remain independent; the general practitioner as pivotal; the influence of others; perceptions of the emergency department; and having access to information. Differences between metropolitan and non-metropolitan experiences, where they emerged, were highlighted. Each of these facets are outlined below.

Expectations of support in the ILU not met

Participants reported having expectations of living in ILUs as a way to maintain their independence, and access the support they needed more easily. Many participants considered ILUs to be a form of supported accommodation with 'care staff' available in time of need/emergency. Similarly Buys (2000) found that the availability of care and support was the most common reason cited by older people for moving to an ILU. When older people's expectations were not realized, in that ILUs did not provide this support, this often led to them accessing the acute care system to gain the support they had thought would be available in the ILU. Many participants reported frustration between the incongruence of the care that was available and what they expected the ILU should offer or was promised, especially after-hours.

However, ILU staff perceived that their presence on-site meant 'residents are… not as independent as… we feel they should be'. They felt pressure from residents and their families to make the decision for the older person to access acute care services even if it was outside of their expertise. Some acknowledged that changes in the way ILUs operated meant they did not 'have that… close contact anymore' with residents. Further, ILU staff perceived that residents often expected them to be able to treat the older person, and might delay calling an ambulance as a consequence.

Presence/absence of safety nets

'Safety nets' were perceived by many older people as a way of keeping out and staying out of the acute care system, and also to ensure that when needed, entering the acute care system could be done with minimal fuss or delay. The presence/absence of these safety nets influenced the decision-making of the older person as to whether or not to enter the acute care system. Safety nets identified are discussed below.

Private health insurance

Participants with private health insurance cited it as the most important contribution to their well-being/independence and would forego other material things in order to maintain the cover.

Veteran's health card

Some older people reported having a 'gold card' (repatriation health card) which ensured that they got the assistance they needed when they went into the acute care system – 'The Gold Card means I get 100% treatment'. This influenced perceptions of ready access to the acute care system, and prompted decisions to go in sooner rather than later.

Day surgery

Older people and health professionals perceived 'day surgery procedures', where a patient is admitted, treated and discharged on the same day, as a way of getting help quickly and assuring a return home. However, health professionals perceived that because some day surgery 'standard pre-op assessment falls short' of effectively assessing 'potential postdischarge needs', these procedures could inadvertently increase older people's entry to the acute care system.

Being prepared

Some older people kept their past health history on a book/sheet nearby – often on the fridge – as a way of ensuring they received appropriate attention quickly and possibly avoided acute care admission. However, the information recorded was often found to be out of date, particularly in relation to medications.

The support of a partner

Living with a partner often meant 'looking out for' each other in terms of health needs, which helped keep them out of the acute care system, or stay out longer after discharge. However, difficulties arose when one partner needed hospitalizations, which often revealed the failing ability to cope with the remaining partner, leading to hospitalization, respite care, support services/Community Aged Care Packages or residential care.

Information resources

Keeping informed regarding their health and using this information to guide their decision-making was an important safety net for many participants. Information resources ranged from the Internet, brochures/magazines in GP surgeries, talkback radio, books from the library or the pharmacy, and complementary health practitioners.

Personal alarms and monitoring systems

Personal alarms or monitoring systems provided some participants with a sense of personal security without compromising their independence, and were an important way of asserting their ability to look after themselves. Conversely, others perceived such systems as an indication that they were older and no longer independent. While the presence or absence of safety nets influenced the decision to enter the acute care system, other factors also impacted on the decision.

Lack of after-hours support

Access to after-hours support emerged as a significant facet influencing the decision of the older person to enter the acute

care system, either directly or indirectly. Participants identified that 'emergencies' seem to happen more often at night. Emergency department staff noted that older people lost confidence at night when the social support structures they relied upon were absent. As one older person put it, 'don't fall over at three o'clock in the morning'. As a result, calls to the ambulance service were often made at night, 'after twenty-three hundred (2300 hours)', when no other assistance was perceived to be available. Ambulance staff identified that this made their jobs particularly complex, specifically with regard to establishing whether the older person 'just want(s) to sit and talk to someone' or they are in fact 'feeling unwell'. The above is suggestive of a lack of adequate after-hours support resulting in acute care services being accessed inappropriately as a stop-gap measure when older people perceive no other support is available. However even if support was available, it did not mean older people in ILUs would use it. Some older people in the study, particularly older men, either declined help or only reluctantly considered accessing any available services.

The desire to remain independent

In line with Forbes and Hoffart (1998), remaining independent was identified as being of great importance to older people in this study. Older people wanted to be independent both in functional activities and their decision-making. The desire to remain independent underpinned many of the decisions made with respect to entry to the acute care system. Many older people reported that they made the decision to enter the acute care system themselves, in some cases without their family, which may in part be reflected by the fact that in our study so few older people identified a family member to be interviewed in relation to the decision to enter the acute care system. As one older person put it 'I make the decision and then tell them what I am doing… I have made my decisions all my life why would I change now?'

Paradoxically, the desire to remain independent could lead to greater dependency on the part of the older person. In seeking to maintain their independence, older people often masked their deteriorating health status from family members. Ambulance staff insights underline the complexity of the independence/dependence paradox. Often older people were reluctant to call an ambulance because of their perception that by calling an ambulance/entering the acute care system, they were jeopardizing their independence. Participants noted that 'choices made for those in independent living were in some way influenced by the fact that…each time you… requested an ambulance or had an event…that it was one further step out of independent living'. This

perception resulted in delays in seeking assistance often exacerbating unstable health conditions unnecessarily, resulting in forced admission to the acute care system. Despite the older person's desire to remain independent, powerful others were also identified as influencing the decision to enter the acute care system, for example general practitioners and family members.

The general practitioner as pivotal

The GP emerged as a key influence of the older person's decision about whether to enter the acute care system. Three aspects of the pivotal role of the GP emerged from the data. They are discussed below.

GP/older person relationship

The GPs are perceived by older people as a highly respected source of health information (McKenna *et al.*, 2003). Where a trusting relationship existed, older people were prepared to take advice from a GP, and many would not challenge their GP even if they were unhappy with the advice they received. Where such a trusting relationship did not exist or if the older person did not have a GP they knew well, older people often accessed the acute care system via an emergency department, perceiving emergency department staff as knowing what they were doing and able to be trusted.

Ease of access to the GP

Timely, and ease of access to a GP can facilitate early intervention and help the older person stay out of the acute care system, by discussing new health concerns, and possible services to access. Where ease of access to a GP was not available, some older people reported visiting the emergency department, perceiving it to be easier than waiting for an appointment with the local GP.

Knowledge/understanding of the GP about available services

Our study reported that some GPs in the metropolitan area did not adequately understand, or were unaware of, the full range of services available to older people. This is in line with Cawthra's (1999, p. 100) contention that GP's 'are often poorly informed about the full range of health and community services in their area'. In contrast, GPs working in non-metropolitan areas often provided services to local hospitals, and therefore had a better understanding of the full range of support resources available, and how to access them effectively. As a consequence, these non-metropolitan GPs were perceived by some participants to be in a position to provide better continuity of care, thereby helping the older person stay out of the acute care system.

The influence of others

In addition to the GP, others identified as directly influencing the older person's decision to enter the acute care system included families, peers, ILU staff and ambulance staff.

Families

Older people's families often played a key part in their decision to enter the acute care system. When family relationships were characterized by trust and open communication, issues could be discussed before they became concerns, and admission to the acute care system was often pre-empted by collaborative problem solving. However, some family carers, exhausted by the ongoing and increasing care needs of the older person, resented the situation, and looked for alternatives – the acute care system being one. Thus when some families reached a crisis point, they took an older relative to the emergency department.

Peers

Community advisers observed that older people with supportive networks were less likely to go into acute care. Informal support provided by neighbours was an integral part of a 'neighbourhood watch' mechanism in ILUs for 'keeping an eye on one another': peers effectively monitored each other. Many older people also used their peers as resources: they learnt from the mistakes, successes and consequences of the choices of others.

ILU staff and ambulance staff

Although older people in the study spoke of the importance of being independent, many relinquished control to ambulance officers about decisions pertaining to entry to the acute care system. Ambulance officers often influenced the older person or actually made the decision for the older person to enter the acute care system. Conversely they also contributed to keeping older people out of the acute care system, by providing advice or support that enabled the older person to continue living in their ILU.

At times ILU staff also influenced the decision to enter the acute care system. When ILU staff had the respect and trust of older people, they knew the older person would listen to their opinions. Some ILU staff called in the GP before ringing for an ambulance; some made the decision about whether an ambulance was necessary themselves.

Perceptions of the emergency department

Another important facet in the decision-making surrounding an older person's entry into the acute system was the perceptions they held about the emergency department. This pertained to both perceptions about what the emergency department is for, and perceptions about how the older person would be treated once in the emergency department.

What is the emergency department for?

Participants in the study noted a perception held by many older people, including those living in ILUs, of the emergency department as a convenient and time efficient 'one-stop shop' for getting a second opinion and having tests done, or as an after-hours health service. Such perceptions made it more likely that older people would choose to enter this part of the acute system.

Health professionals in the study reported an increase during long weekends and holiday periods of 'granny dumping' (Hurst, 1992) – elderly relatives were dropped off at hospital emergency departments as the family left to go on holidays. Health professionals suggested that older people being 'dumped' was symptomatic of lack of respite for families/carers, and/or inadequate knowledge of services/ options available.

How the older person would be treated once in the emergency department

Older people are often viewed as making inappropriate use of the acute care system (Whitehead *et al.*, 2001; Howe, 2002), and are perceived as 'not critical'. Older people in the study reported waiting for hours, left on a barouche, without a call bell, and having to rely on others to access toilets or refreshments. Such negative experiences meant an older person would reconsider and delay presenting to the emergency department.

Health professionals suggested that delays, both with respect to the older person deciding to enter the emergency department and once they are in there, can result in deteriorating health, and contribute to premature acute care admission. Furthermore, older people were sometimes sent home from the emergency department in the early hours of the morning in a taxi. Some older people preferred to wait in the emergency department overnight so that they could use their 'bus pass/concession card' to return to the ILU: 'And so mine (bus) doesn't start till nine o'clock so I like, like to stop there till nine o'clock' in order to get the cheaper pension rate'.

Having access to information

Access to information was an underlying theme across the facets discussed above. However two aspects of the influence of having access to information on the decision-making of

older people emerged as significant in their own right. They were having information about what help and support is available and getting information to the right people.

Having information about what help and support is available
In their study, Roe *et al.* (2001) reported that older people were unsure how to access support. Similarly, in this study most older people and their family members reported being unsure about the support services available to older people living in ILUs; very few participants knew of the full range of Commonwealth initiatives, or the establishment of Commonwealth Carelink Centres (information centres for older people, people with disabilities, and those who provide care and services). The *Enhanced Primary Care Medicare Item – Health Assessments* for people aged 75 and over was mentioned by GPs and staff in the hospital-avoidance programme as an opportunity to comprehensively assess an older person's health status, thus facilitating early intervention and referral. However, many older people had either not experienced such an assessment or did not mention it as a resource for maintaining their health and well-being.

Getting information to the right people

Participants reported not always telling family members and ILU staff about health issues believing that hospitalization or frequent ambulance use potentially led to respite and/or residential aged care placement. For different reasons, nor did others who may have relevant information, pass that information on to family members, GPs or ILU staff. For example, information regarding the older person's living circumstances and ability to cope held by ambulance officers was often not passed on unless the older person was actually taken to hospital. As a consequence, increased care needs were sometimes not recognized and/or addressed as they arose, potentially resulting in acute care admission, which might otherwise have been avoided. The difficulty of transfer of information between hospital and community staff is well documented in other studies (Closs, 1997; Worth *et al.*, 2000).

Hospital staff often discharged the older person from the acute system presuming support staff would be available for the older person once they arrived back at the ILU. Further, when the older person left the acute system family members/ILU staff, were not always advised of the older person's return to the ILU, resulting in inadequate support.

Getting information to the right people was confounded to some extent by provisions in The Privacy Act for securing individual privacy, and the restrictions regarding information that can be shared, and who can have access to information about another person.

Summation

Although this study focused on older people living in ILUs, the issues raised here have implications for older people living in the community both within Australia and internationally. The vulnerability of older people in acute care settings is well recognized (Nolan, 2001) and as older people form an increasing proportion of acute care system users (Kihlgren *et al.*, 2003), this suggests that 'keeping older people out' of acute care should be a part of all policy discussions in this area. Whilst the focus of this study was on 'keeping older people out' of the acute care system, it must be recognized that in some instances entering the acute care system is the best option for the older person.

Similar to McMurray (1999) our findings identify that a range of facets impact on older people and the way that they interface with the acute care system. A central, consistent and important finding was that many participants perceived ILUs to be a form of supported accommodation. Like Buys (2000, p. 150) in her study of residents expectations of care and support in retirement villages/ILUs the present study also found that 'there seems to be a substantial gap between residents' perception of care and support availability and reality of the provision of services by village (read ILU for the purposes of our study) management'. This raises the question of the adequacy of information supplied to residents at the time of entry into the ILU and ongoing supply of information once they have moved into an ILU. Are residents being told what they can and cannot expect ILUs to provide? And if residents are being informed, why do residents continue to hold such expectations of ILUs? Such questions may be extrapolated to other forms of accommodation in which older people find themselves, not just ILUs.

The findings also highlight the need to raise awareness among service providers, in particular emergency department staff, about the facets contributing to older people 'inappropriately' using the acute care system, such that unfounded negative stereotypes about older people do not lead to poor treatment of older people in the acute care system. For example inadequate after-hours support and a lack of respite services for families were both cited as factors contributing to the presentation of older people to the acute care system. Of course a broader question is raised as to what exactly an inappropriate or conversely appropriate presentation is. Are such understandings founded in premises about the acute acre system as episodic and curative focused? As Cheek (2004, p. 59) argues this necessitates 'a move beyond focusing on changes to the physical layout, or improving particular aspects of the care given, to focus instead on the often invisible and assumed understandings constructing what care

provision for older people in acute care locations is understood to be… Until such a shift occurs it is entirely possible that older people will never fit into the position constructed for them by understandings of the acute care place and will always remain problematic in it'.

The key point in all of this is not whether the acute system is 'good' or 'bad'/appropriate or inappropriate for older people. Rather it is that in a context of primary health care, the optimal use and management of finite resources generates a push for integrated and streamlined service provision, and an exploration of the options for the most effective management of the care needs of older people. The acute care system is one part of such service provision.

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