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Case Report

Family and Friends as the Last Resort in Acute Hospital Care

Ludwig Mathias Kuntz*

Faculty of Management, Economics and Social Sciences, University of Cologne, Department of Business Administration and Healthcare Management, Albertus Magnus Place, 50923 Cologne, Germany

***Corresponding author:** Ludwig Mathias Kuntz, Faculty of Management, Economics and Social Sciences, University of Cologne, Department of Business Administration and Healthcare Management, Albertus Magnus Place, 50923 Cologne, Germany, https://orcid.org/0000-0002-4083-4574

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Abstract

Based on the description of a treatment period of an 88-year-old woman, it is made clear how important family and friends can be in acute health care. In particular, the description shows that the support of family members or friends cannot be compensated for by increasing hospital resources.

Keywords: Informal Caregiver; Family; Hospital; Workload; Management.

Introduction

During the COVID-19 pandemic, many hospitals exceeded their capacity to provide safe care, a scenario that recurs regularly, such as during winter pressures, leading to increased mortality. In response to these challenges, one strategy to enhance patient safety is the involvement of caring family and friends in hospital care. This approach not only augments the healthcare team‘s efforts but also provides emotional support to patients, potentially saving lives. We illustrate the impact of this approach with a detailed patient experiences, underscoring its potential benefits in enhancing hospital care during critical times.

Data

The complete outpatient and inpatient treatment course for this case were prepared based on the insurance treatment data. The insurance data were provided by the insurance company in the form of a paper document. Additionally, all doctor‘s letters regarding hospital stays were available. The period and intensity of home care were extracted from the existing contracts with nursing services. Furthermore, the family member who accompanied during the last hospital stay provided additional information regarding the treatment process. Data of the treatment process are illustrated in Figure 1.

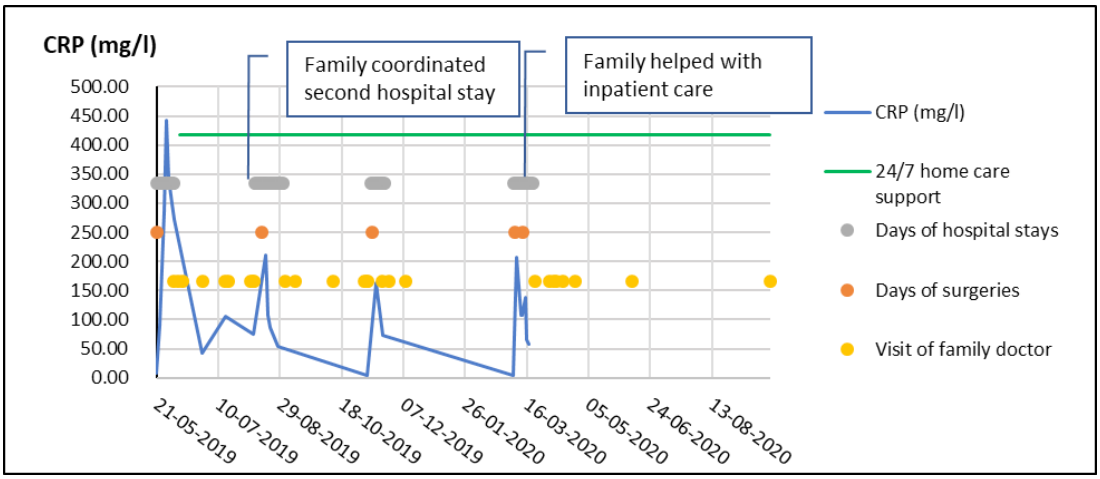

Figure 1: Illustration of treatment process of Mrs. K. CRP = C-reactive protein.

Case Description

In 2019, the patient, Mrs. K, an 88 year old widow living in a rural area in Germany in 2019, lived in her own apartment connected to her eldest daughter's house, one of three children. Mrs. K did not have to take any medication, but had recently shown symptoms of mild dementia. When Mrs. K fell during a walk in the park, an ambulance was called and she was taken to one of two hospitals in the vicinity (<30 km) for treatment. Mrs. K had no preference for a particular hospital. The hospital she was taken to was a small hospital with under 200 beds. Mrs. K was admitted on May 21st. On May 22nd, a dual-head prosthesis was directly implanted in her hip joint. Due to persistently high levels of C-reactive protein (CRP; normal < 5 mg/l) and no clear treatment strategy at the hospital ("We can't do anything more"), Mrs. K was discharged on June 4th with a CRP level of 272, at the request of her relatives. Starting from June 9th, a care person was present in her household 24 hours a day, solely taking care of Mrs. K. Various aids (care bed, wheelchair, walker, bath lift, toilet chair, etc.) were quickly organized. This was made possible by the son's efforts in organizing it and the available financial resources. Mrs. K was under continuous observation by her family doctor, who made eight home visits over four weeks. By August 8th, Mrs K's condition had deteriorated significantly, and she could only walk with extreme pain using a walker. The daughter who lived with her drove her to the hospital where she was originally treated. A CT scan was performed on Mrs. K, only after great insistence from the daughter. The hospital stated that "nothing more could be done here" for Mrs. K. She was then driven back home with a copy of the CT scan. After contact between the son and the orthopedic department of a nearby university hospital (with all departments available and around 1,500 beds), it was agreed that Mrs. K could continue treatment there. At that time, Mrs. K's CRP level was 74.1 (August 7th). On August 9th (Friday), Mrs. K was admitted to the university hospital. Based on the CT scan, a Psoas abscess with a suspected hip prosthesis infection was diagnosed. Even though the situation was considered acute, the son, in consultation with the responsible surgeon, agreed that Mrs. K should not undergo immediate surgery because the "optimal" team for the planned operation was not available on the weekend. On August 14th, Mrs. K had her hip prosthesis removed and a spacer implanted. The goal of the treatment was to implant a new hip prosthesis after the inflammation subsided. There was also the option, given Mrs. K's advanced age, to leave the spacer as a final treatment solution, despite the permanent mobility restrictions it would cause. Mrs. K was discharged home on August 31st. Her CRP level had already dropped to 54.1 four days before discharge. Until November 8th, six examinations were carried out by her family doctor, and one outpatient follow-up examination took place at the university hospital (October 18th). Mrs. K was admitted to the university hospital on the 11th of November for further treatment (CRP 4.0 on the 8th of November). On the 13th of January, the spacer was explanted, and a hip prosthesis was reimplanted. Mrs. K was discharged home on the 22nd of November. Two days before discharge, the CRP level was 73.5. A postoperative loosening of the acetabular cup was documented in the discharge letter.

A further stay at the university hospital was planned after two follow-up examinations on November 28th, 2019, and January 7th, 2020. On March 5th, with a CRP level of 3.8, Mrs. K was admitted to the hospital. On March 6th, the existing hip prosthesis was removed, and a prosthesis with an individual pelvic replacement was implanted. While in the hospital, Mrs. K had daily visits from one of her children. Unfortunately, Mrs. K could not be discharged routinely as a hematoma developed. On March 13th, she underwent further surgery for wound revision and hematoma removal. Although Mrs. K survived this operation and intensive care, her condition on the regular ward was extremely weak and she was disoriented. Due to the critical situation, the son decided to be admitted as a companion. From March 14th, he shared a two-bed room with Mrs. K. The situation worsened when an x-ray revealed fluid in her lungs. With the son's presence, not

only was a familiar environment created for Mrs. K, but the son also supported her and carried out care tasks in consultation with the medical team. These tasks included five breathing exercises, four to six bedpan uses with a caregiver, three to five mobilizations and feeding sessions, 10-20 bed position changes, foot creaming twice, and a morning report on the day's progress to the medical team. Mrs. K was discharged on March 23rd, 2020, and left the hospital. All the attending professional groups (doctors, nurses, and cleaning staff) were applauding in the hallway of the ward. There were still 11 general practitioner examinations to follow until July 27th, 2021. Mrs. K is still living in her apartment today (May 5th 2024) and is only taking a Vitamin D supplement, not requiring any other medication besides the bathtub lift.

Discussion

Mrs K is covered by the statutory health insurance and has private supplementary insurance for hospitalisation, which covers treatment by a specific consultant and accommodation in a double room. Mrs K had access to medical services and experienced no significant waiting times. While most medical services are funded by the statutory health insurance scheme, the supplementary insurance ensures that significant personal financial resources are not required. However, the rapid implementation of round-the-clock home care did require personal financial resources (around €10,000). Overall, Mrs K's financial resources played a minor role and the health system worked well in terms of timely access.

However, family involvement was crucial in two situations:

First, the process was poorly integrated across hospitals. This was particularly noticeable at discharge after the first operation with high inflammation levels. Family members organised diagnostic information and managed the transfer to the second hospital, which would probably have failed without their help. Here, standards of best practice care transitions integrating informal caregivers were not met [1].

Second, the family ensured the provision of necessary tasks for Mrs K when no realistic staffing plan could do so. Before Mrs K and her son left the hospital on March 23th, the ward manager acknowledged the family's critical role, stating: 'Without you, she would have died. We couldn't have done it without you!" This case highlights that in extreme situations, hospital systems can reach the limits of available resources, resulting in a high risk of mortality [2,3]. Therefore, family members should actively support the system, especially during acute care episodes.

Conclusion

There are acute treatment situations that can only achieve a better outcome through the involvement of familiar acquaintances. Family and friends should be aware that they, alongside doctors and nurses, can also bear responsibility for the outcome. Doctors and nurses should recognize and enable this.

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