



Sociodemographic Characteristics and Medical Conditions of Patients under Homecare Service

Muhammed Mustafa Uzan¹, Memet Taşkın Eğici², Dilek Toprak²

¹Family Medicine, Ulubey District State Hospital, Uşak, Turkey

²Clinic of Family Medicine, Şişli Hamidiye Etfal Training and Research Hospital, İstanbul, Turkey

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ABSTRACT

Objective: The aim of this study is to investigate the medical health status, sociodemographic features and non-health needs of patients receiving services from the home healthcare department.

Methods: A 27-question survey was applied to the patients and/or patient relatives who were receiving home health services. This is a descriptive, cross-sectional study. SPSS 22.0 was used for the analysis.

Results: 170 patients were included in the study. 38% of patients were between the ages of 75 and 84 years. The female population was greater. The most common diagnosis was hypertension. The most commonly received services were routine physical examination and laboratory examination (72%; n=121). More than 80% of patients stated that they had non-health problems. 90% (n=160) of patients were satisfied with the home healthcare service. 71% (n=121) of patients did not receive any support from people other than their family.

Conclusion: Patients have non-health problems such as transportation, housing and heating problems. To solve these problems, coordinating governmental and non-governmental services and expanding the scope of services to accommodate non-health social components may be beneficial.

Keywords: Home healthcare, non-health problems, satisfaction

INTRODUCTION

Home care services include all psychosocial, physiological, medical support, and social services provided to an individual and his or her family to support the elderly people, disabled patients, those with chronic disease, or those who are in recovery in their own environment. The goal is to enable them to maintain their social life and ease the family members' burden of caring for an individual (1).

In accordance with the regulations regarding the provision of home care services promulgated in the official gazette no. 29280 on February 27, 2015, it is necessary to conduct examinations, analyses, treatments, medical care, and rehabilitation of individuals in need at their homes and in their family environments. The aim is to provide social and psychological support services to individuals and family members together as a whole. It was targeted to compose the home care services to be provided by the Ministry and the subsidiaries, determine the rules and procedures regarding the provision of coordination among institutions and organizations for their administration, and apply these services as equal, accessible, of good quality, effective, and efficient in the whole country in accordance with social state understanding (2).

With the provision of this service, a health care team composed of experts from other fields, including physiotherapists, social service specialists, and dieticians, is required in addition to physicians and nurses (3). Furthermore, resources have to be efficiently deployed to achieve the goal. Access to the services must be easy and quick, and requirements should be evaluated together with social dimensions. In addition, services have to be provided by a health care team trained in geriatrics.

Therefore, studies on home care services that have been conducted or are to be conducted in our country are both guiding and milestones. In this study, we aimed to examine the medical status, sociodemographic characteristics, and other requirements of patients receiving home care services unrelated to health; to create awareness in line with the results obtained by the Ministry of Health, Ministry of Family and Social Policies, Ministry of Labor and Social Security, municipalities, other state institutions and organizations, civil society organizations, and special rehabilitation centers; and to provide reliable data for policy makers.

METHODS

A total of 170 patients who received home care services between September and October 2015 were included in the study. Ethics committee approval (no. 1067; dated 01.09.2015) was obtained



for our study. Our study is descriptive. Sociodemographic characteristics, such as age, sex, education level, and marital status, and data on patients' medical conditions and other requirements unrelated to health were obtained via a questionnaire consisting of 27 questions. Using this questionnaire, we obtained data on patients' chronic diseases, health services received related to diseases, expectations and requirements, social and physical conditions of the environment they lived in (such as heating, illumination, and sheltering), and their level of satisfaction with the services they received. Some of the questions were multiple choice, and some were open-ended questions. Therefore, we aimed to enable our patients to express themselves better by moving away from the classical patterns. Questions were asked after obtaining consent from the patients and their relatives.

Statistical Analysis

SPSS 22.0 for Windows (IBM Corp.; Armonk, NY, USA) software was used for the statistical analysis of survey data.

RESULTS

The mean age of the patients included in the study was 77.1 ± 15.6 years. Of the patients, 38% of were within the age range of 75–84 years (advanced age). Female patient population was higher (59%; $n=100$). On comparison based on marital status, education level, and income level, 59% ($n=100$) of them were single or widowed, 79% had low education level, and 56% had an income below 1,000 TL, respectively. It was determined that 49% had no previous profession (Table 1). The age of female patients was significantly higher ($p<0.05$).

Diagnosis of hypertension was available in 30% ($n=51$) of the patients included in the study. Moreover, the number of patients with previously diagnosed cerebrovascular diseases (28%; $n=47$), other cardiovascular diseases (21%; $n=35$), and Alzheimer's disease (17%; $n=29$) was significantly high.

When we considered the distribution of towns and districts the patients lived in, 66% of them lived in Şişli, and when sub-districts were considered, the least number of patients (1%; $n=1$) lived in the Kuştepe district.

Of patients receiving home care service, 41% ($n=70$) had been confined to bed or home for 2–4 years. The proportion of patients receiving home care service in the scope of home care service between 0 and 1 year was 56% ($n=95$), and the proportion that were hospitalized 1–5 times at any time of their lives was 51% ($n=94$).

When patients who were evaluated within the scope of home care service were asked whom they lived with, we found that 19% ($n=33$) were living with their spouses and children and 81% ($n=137$) with their relatives, caretakers, etc. The proportion of patients who stated that they would not live alone at home was 89%, and the proportion who had no children was 8%.

When we examined the problems of patients receiving service unrelated to health, transportation was the most remarkable with a rate of 21% ($n=36$). Another problem was heating with a rate of 17% ($n=29$). More than 80% of our patients stated that they had problems unrelated to health.

When patients were asked to put their current problems in order of importance, problems regarding their health came first (23%; $n=39$) and those regarding transportation (19%; $n=33$) came second.

When we considered physical conditions of the houses where the evaluated patients lived, 86% of the houses ($n=146$) used natural gas as the energy source and 71% of the houses ($n=120$) had no elevator. In terms of the number of rooms in the houses, 58% ($n=54$) were 2+1, and in terms of ownership, 51% ($n=93$) were owned by the patients.

The proportion of patients who had no one to support them, apart from the closest family members, and who lived with caretakers providing services was 71% ($n=121$).

No statistical significance was observed in terms of having or not having a problem unrelated to health according to income and marital status ($p>0.05$). However, as the income level decreased, the number of problems unrelated to health increased. As education level decreased, problems unrelated to health displayed a statistical significance ($p=0.001$).

When we considered the ability to live home alone according to age, sex, and marital status, no statistical significance ($p>0.05$) was observed. As education level decreased, the proportion of patients who stated that they could not live alone at home was statistically significant ($p=0.048$) (Table 2).

Table 1. Sociodemographic features of patients receiving home care service

		Min–Max	Median	M±SD/	n-%
		18-100	81	77.1±15.6	
Age	≤64			21	12%
	65–74			26	15%
	75–84			64	38%
	≥85			59	35%
Sex	Female			100	59%
	Male			70	41%
Marital status	Married			74	44%
	Single/Widow			96	56%
Educational level	Elementary education			135	79%
	High school			22	13%
	Higher education /University			13	8%
Income level	≤1,000 TL			95	56%
	1,001–1,500 TL			53	31%
	1,501–2,000 TL			14	8%
	>2,000 TL			8	5%

Min: minimum; Max: maximum; M: median; SD: standard deviation

No significant difference was observed with regard to the number of hospitalizations of patients according to their diagnoses ($p>0.05$). However, the number of hospitalizations in patients with chronic diseases and previous cerebrovascular events numerically increased.

While 90% of patients ($n=160$) receiving home care services were satisfied with the service they received, 10% ($n=10$) were not (Table 3); 72% of the patients ($n=123$) received home care services for the service of routine examination and analysis request (Table 3).

No significant relationship was observed between requesting routine examination and medical workup and age and diagnosis ($p>0.05$). Routine examination request in females displayed statistical significance ($p=0.049$) compared with males.

There was no significant relationship ($p>0.05$) in terms of underpad use report according to age, sex, and diagnosis. However, as the age increased, the use of underpads increased.

No significant relationship ($p>0.05$) was observed in terms of receiving medication report service according to age, sex, and diagnosis. As age increased, receiving medication report service also increased.

Catheter change service was provided mostly to patients aged 65–84 years, and this service was provided more to male patients than to female patients ($p=0.021$).

There was no significant relationship between receiving and not receiving the service of dressing and/or wound care according to age, sex, and the stage of disease ($p>0.05$).

DISCUSSION

A higher population of females in the age group ≥ 65 years indicates that disability is more common in females in this age group

than that in males (4). According to the research results conducted by Jakopzone et al. (5, 6), when only the population ≥ 65 years was taken into consideration, the proportion of elderly population receiving home care services in Canada by the year 1998 was 17.0%; it was 16.0% in the United States, 11.7% in Australia, 11.2% in Sweden, 9.6% in Germany, 6.1% in France, and 5.0% in Japan. In our study, most of 170 patients included within the scope of health care service were over 65 years. The age factor had similar characteristics in the conducted studies. As age increases, the rates of being confined to bed and chronic diseases rise, and this indicates that this age group requires more service.

Women constitute 67% of the people receiving home care services in the USA, and 57.0% of those who require long-term care are ≥ 65 years old. More than 80% of them receive home care service (6, 7). Yörük reported that 68.7% of patients who receive home care service were women (6, 8). In our study, there were more female patients than male patients. A higher frequency of chronic diseases, higher morbidity rate, and higher life expectancy in females explain this phenomenon.

In the study conducted by Çatak et al. (9), the education level of 97.2% of the patients was elementary school and literacy. This rate was 95.2% in the study by Enginyurt et al. (10). In our study, most patients (79%) were elementary school graduates or only literate and illiterate group. Considering that the patients with high education level would have a high income and receive service from the private sector, low education level of our patients was to be expected.

When the diagnoses of patients for whom home care services were provided in the US were considered, the most important reasons were cardiovascular problems, and neoplasias were in the first place in patients receiving hospice care defined as palliative care service. When the diagnoses of patients receiving home care services in the study by Genç et al. (12) are considered, the most frequent diagnosis was hypertension with the rate of 25%. In a study conducted in a primary health care center in Ankara, it was seen that the stroke rate was higher in people aged 80 years

Table 2. The ability to live alone according to sociodemographic features

		At home alone				p
		Can live		Cannot live		
		n	%	n	%	
Age	≤64	3	14.3%	18	85.7%	0.776
	65–74	4	15.4%	22	84.6%	
	75–84	7	10.9%	57	89.1%	
	≥85	5	8.5%	54	91.5%	
Sex	Female	11	11.0%	89	89.0%	0.930
	Male	8	11.4%	62	88.6%	
Marital status	Married	7	9.5%	67	90.5%	0.533
	Single/Widow	12	12.5%	84	87.5%	
Educational level	Elementary education	11	8.1%	124	91.9%	0.048
	High school	5	22.7%	17	77.3%	
	University	3	23.1%	10	76.9%	

Table 3. The satisfaction level of patients receiving home care health service and the kind of services they receive

		n	%
Satisfaction with home care health service	Not satisfied at all	9	5%
	Unsatisfied	9	5%
	Somewhat satisfied	66	39%
	Satisfied	32	19%
	Very satisfied	54	32%
Distribution of basic services taken as home care	Routine examination and analysis request	123	72%
	Report of the drugs used	31	18%
	Change of catheter	20	12%
	Use of disposable underpads	19	11%
	Dressing or wound care	16	9%

and older (13). In our study, the most frequently seen disease was hypertension, at the rate of 30%. When we grouped the chronic diseases, previous cerebrovascular event came in second at the rate of 28%. The diseases of the patients within the scope of home care services, which required home care service, were various, and accordingly, we are of the opinion that the dependence level increased.

In the study conducted by Yiğit et al. (14), 70% of patients stated that they were satisfied with home care services. In this study, the proportion of patients who were partially satisfied and satisfied was 90%. We suggest that attentive and kind behaviors of the home care unit staff toward patients, going to treatment on the planned date, and informing the patient about the treatment date are important for patient satisfaction.

In the study conducted by Subaşı and Öztekin (6), oral treatment was applied at the rate of 81.4%, wound care at 22.1%, physical treatment at 8.1%, intravenous fluid treatment at 4.7%, catheter application at 4.7%, and oxygen therapy at 2.3%. In the study conducted by Genç and Alptekin (12), 98% of the patients requested examination and analysis. The most requested basic service by patients in our study (72%) was routine examination and analysis. We consider that the opportunity of receiving such a service at home without going to the hospital plays an important role in the preference of patients, particularly for women.

In the literature, there are studies not displaying similarity with our results but supporting them. In the study presented by Çölgeçen at the 1st Home Care Congress in 1998, 35.9% of the elderly people could not do shopping, 44% could not make food, 20.3% could not participate in housework, 25.4% could not do washing, 25.4% could not take their medications on time and at accurate doses, and 12.4% could not do calculations (15). In the study published by Enginyurt et al. (10), 91.2% of patients receiving home care service could not do cleaning themselves, 96.0% could not do washing, and 96.0% could not cook. When we look at the answers given in our study, 21% of the patients mostly had problems with transportation. Other problems were purchasing power, insufficient social communication, heating problems, and conditions related to the physical conditions of the house. What is meant by transportation here is reaching the hospital and home or transportation problems to meet the requirements from out of the house. We think that these problems are caused by unplanned urbanization, high number of buildings, narrow roads and streets, and old buildings, and there are no elevators in most of the buildings in towns such as Şişli and Beyoğlu. While 14% of the patients were using electric and heating stoves as the heating sources, the proportion of patients seeing heating as a problem was 19%. Here, the remarkable point was that heating with natural gas was a problem due to reasons such as cost and heating efficiency.

In the study conducted by Akdemir et al. (16), when problems determined in the patients could be solved or not at the end of the follow-up, psychosocial problems (50%), lack of sleep (50%), exercise (9.1%), infection (14.3%), contracture–deformity–atrophy (20%), and scarcity of environmental stimulant (25%) could not be solved. When we asked patients which of the problems they wanted to solve first, health problems came first (23%). These

were needs such as wheel chair, walker, air bed, normal bed, and hiring a caretaker. As is seen, patients receiving home care services have a wide variety of problems, and problems unrelated to health are remarkable.

In the study conducted by Ayrancı et al. (17), 23% of patients did not communicate with others except their relatives and 13% stated that they did not get in touch with anybody, even during religious festivals. Seventy-one percent of our patients did not receive any social support, and 89% stated that they could not stay alone. As can be understood, although the numbers differ, patients receiving home care services have problems of loneliness and communication, and they become dependent on individuals who continuously care for them. We observed that the ability to live alone at home does not have a significant relationship with age, sex, or marital status. A high level of education of those who state that they can live alone at home can indicate that they can better face problems, and the problem of dependency is smaller.

CONCLUSION

Extending geriatric approach to the primary health care centers would be helpful with regard to access of elderly people to these institutions. Moreover, the access of the elderly to this service should be organized well. Offering home care services by state is an important development. However, the scope of service lacking other social components or staying at the level of just medical services does not solve the problems that are unrelated to health. Patients receiving home care services should be supported medically as well as in terms of other social requirements. The support of psychologists or social service specialists also has to be provided as solution to patients' psychosocial problems and for giving support. Transportation, heating, and sheltering problems of patients should be additionally evaluated by teams providing home care services, and in case of need, support should be taken from state institutions and organizations, municipalities, and social institutions and organizations.

Ethics Committee Approval: Ethics committee approval was received for this study from the ethics committee of Şişli Hamidiye Etfal Training and Research Hospital.

Informed Consent: Written informed consent was obtained from patients and patients' parents who participated in this study.

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