

## ORIGINAL ARTICLE

# “Making an effort for the very elderly”: The acceptability of a multidisciplinary intervention to retirement village residents

Isabelle Jung BSc<sup>1</sup> | Katherine Bloomfield MBChB<sup>1,2</sup>  | Joanna Hikaka PhD<sup>1</sup>  |  
Annie Tatton BA<sup>2</sup> | Michal Boyd ND<sup>1</sup>

<sup>1</sup>Faculty of Medicine and Health Sciences,  
University of Auckland, Auckland, New  
Zealand

<sup>2</sup>Waitematā District Health Board,  
Auckland, New Zealand

## Correspondence

Katherine Bloomfield, Waitematā Clinical  
Campus, North Shore Hospital, PO Box 93  
503, Takapuna, Auckland 0740, Aotearoa  
New Zealand.

Email: [katherine.bloomfield@waitematadhb.govt.nz](mailto:katherine.bloomfield@waitematadhb.govt.nz)

## Funding information

Maurice and Phyllis Paykel Trust, Grant/  
Award Number: N/A

## Abstract

The retirement village (RV) population is a growing one, with many residents having unmet healthcare needs. Despite this, there is a relative paucity of research in the RV community. We previously performed a randomised controlled trial (RCT) of a multidisciplinary (MD) nurse-led community intervention versus usual care within 33 RVs in Auckland, New Zealand. Participant acceptability is an important aspect in assessing intervention feasibility and effectiveness. The aim of this current qualitative study was to assess the acceptability of the intervention in participating residents. Data were collected using semi-structured interviews designed around the Theoretical Framework of Acceptability. Thematic analysis was undertaken using a general inductive approach. Of the 199 participants in the intervention arm of the original RCT, 27 were invited to take part in this qualitative study. Fifteen participants were recruited with a median age of 89 years, 10 were female and all were of European ethnicity. Participants were generally positive about the intervention and research processes. Three themes were identified: (1) participants' understanding of intervention aims and effectiveness; (2) the importance of older adult involvement and (3) level of comfort in the research process. Despite the MD intervention being deemed acceptable across several domains, results provided learning points for the future design of MD interventions in RV residents and older adults more generally. We recommend that future intervention studies incorporate co-design methodologies which may improve the likelihood of intervention success.

## KEYWORDS

community intervention, evaluating complex interventions, multidisciplinary teams, patient perspectives, qualitative analysis

## 1 | INTRODUCTION

Population ageing is a phenomenon occurring across the globe (Cornwall & Davey, 2004). In many countries, the concept of 'ageing in place' is favoured, where older adults requiring support remain in their own homes or supported accommodation for longer before entering long-term care (LTC) facilities (Davey, 2006). Thus, there is

a need for appropriate housing, healthcare and services to meet the needs of this group (Yeung et al., 2017).

Concurrent with the rise of the ageing population, the last 30 years have seen a boom in the Aotearoa New Zealand (NZ) Retirement Village (RV) sector, elsewhere known as continuing care retirement communities, where approximately 14% of the NZ over 75-year-old population live (Jones Lang LaSalle, 2021). RVs are

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2022 The Authors. *Health and Social Care in the Community* published by John Wiley & Sons Ltd.

unlike LTC facilities (known as rest homes and private hospitals in New Zealand, and internationally as nursing homes) that provide 24-h personal care and health supervision for the frailest older people who can no longer live independently. Instead, RVs provide private accommodation for independent older people in a communal setting and fill a gap in the housing market by offering services and support, while promoting independence, security and privacy (Yeung et al., 2017).

In response to the ageing population and the corresponding changing patterns of health needs, there has been increased interest in healthcare integration and multidisciplinary (MD) care approaches (Mitchell et al., 2008). These approaches aim to prevent, defer and reduce demands on the secondary and tertiary health sectors, while improving health by managing healthcare needs in a community setting (Mitchell et al., 2008). In MD care, the individual is typically assessed by several professionals who may have separate but inter-related roles and maintain their own disciplinary boundaries (Ellis & Sevdalis, 2019). Core principles of a MD meeting include involving the individual, the establishment of patient-centred goals, representation from key disciplines and the communication of suggested healthcare actions (Ellis & Sevdalis, 2019). The higher rates of multiple, chronic morbidities that occur in ageing populations mean that a team-based approach is often required for effective management (Ellis & Sevdalis, 2019).

To establish successful interventions that improve health, an understanding of needs and preferences is required and consideration of the individual experience should be prioritised in healthcare intervention development (Lee, 2017). Intervention effectiveness can be evaluated in a number of ways, with participant acceptability being one important outcome measure (Sekhon et al., 2017). Multiple components and concepts contribute to 'acceptability' and Sekhon et al. (2017) defined acceptability in the Theoretical Framework of Acceptability as a multi-faceted concept that determines the extent to which a healthcare intervention is appropriate to both individuals and providers, based on anticipated or experiential cognitive and emotional responses. The seven components of the framework are as follows: affective attitude (how an individual feels), burden (perceived effort required to participate), ethicality (extent to which the intervention fits with an individual's values), intervention coherence (extent to which the individual understands the intervention), opportunity costs (sacrifices/burden to participate), perceived effectiveness (the extent to which the participant perceives the intervention to succeed) and self-efficacy (the participant's confidence in participating in the intervention; Sekhon et al., 2017). These domains encompass prospective, concurrent and retrospective views of acceptability, acknowledging the changing perspectives of 'acceptability' that an individual may hold at different stages of the research process (Sekhon et al., 2017).

Our recent work on RVs demonstrates many RV residents have significant unmet health needs and a high prevalence of comorbidities, frailty and loneliness (Bloomfield, Wu, Tatton, et al., 2021; Boyd et al., 2021; Broad et al., 2020). Based on previous successful MD interventions reducing hospitalisations in LTC facilities (Connolly

### What is known about this topic?

- Retirement village (RV) residents have high health and well-being needs.
- Multidisciplinary interventions may overcome some barriers to communication and coordinated care of older adults.

### What this paper adds?

- A nurse-led multidisciplinary intervention in RV residents was deemed acceptable to participants.
- While the intervention was enjoyable and of low burden, participants did not perceive it to be directly beneficial.
- Ensuring participants fully understand the purpose of the intervention is an important aspect of research design.

et al., 2016; Connolly et al., 2018), we undertook a randomised controlled trial (RCT) of MD community-based intervention in a sample of RV residents (Bloomfield, Wu, Broad, et al., 2021). This RCT did not reduce time to acute hospitalisations, LTC entry or mortality. This current qualitative study aims to assess participant acceptability of the MD health intervention.

## 2 | METHODS

Our research group has undertaken a large multiphase study of the health, social and functional needs of RV residents, including a RCT of a community MD intervention versus usual care (2017–2019). Detailed methodology of the original RV study and RCT phase has been published elsewhere (Bloomfield, Wu, Broad, et al., 2021; Peri et al., 2020). In summary, 577 cognitively intact RV residents from 33 RVs in Auckland, NZ, consented to an assessment of health, functional and well-being needs. Following this assessment, 412 participants with higher healthcare needs were identified and randomised to usual care or MD intervention. The intervention included a further meeting with a research gerontology nurse specialist (GNS) who collated current healthcare issues and participant goals and contacted with research clinical pharmacist who performed medicines reconciliation. A geriatrician or nurse practitioner reviewed collated data and relevant secondary care notes. A meeting was held with the participant and the above research clinicians to discuss healthcare needs, and a series of individualised recommendations were generated. Although the participant's usual general practitioners (GP) were invited to attend, only 4.5% participated in the meetings. MD meetings either occurred in the participant's own home, or community/shared spaces in the relevant RV and lasted 45 min. RCT participants and GPs received a written summary of discussion points and recommendations based on the MD meeting.

## 2.1 | Ethics

The RV study is an on-going study with original ethical approval to 2022 (Ref 15/CEN/135) with participants taking part in on-going health and well-being assessments as the overall study continued. Consistent with NZ ethical guidelines, participants with significant cognitive issues were excluded. The current qualitative study described here aimed to assess participant acceptability of the MD intervention. While the original ethical approval encompassed the time period to 2022, we were aware that the specific questions and methodology that were needed for this sub-study were not specified in that original ethical application and approval. As per usual ethical procedure in NZ, an amendment to our original submission was sought, to re-interview a small number of participants in this manner, and was approved (Health and Disability Ethics Committee Ref 15/CEN/135/AM01). All subjects taking part in this qualitative study gave further written, informed consent for this aspect of the study. The University of Auckland Medical Programme Directorate gave additional approval for home interviews, and interviews were carried out in accordance with institutional in-home visit procedures.

## 2.2 | Participants

Participants who had taken part in the intervention arm of the RCT were eligible for inclusion. There were low numbers of non-European participants in the overall RCT (4 Māori, 6 Asian of 412 participants in the RCT phase, and from this 1 Māori, 4 Asian participants were randomised to intervention), therefore we wished to preferentially approach all five of these participants first, with additional participants approached from the remaining European participants. For convenience, European participants were selected by choosing the two median study ID numbers from the 10 closest RVs to the researchers' base. The research GNS (AT) reviewed hospital records to assess whether potential participants were still alive, still in the RV and still had the capacity to consent. The GNS contacted potential participants by phone or email to gauge interest. If they declined, or if there was no response or reply after three messages left after 1 week, the next eligible participant on the list from this RV was contacted. Upon confirmation of interest, another team member (IJ) phoned the participants to set a date, time and location to meet to gain written, informed consent and (if consent was granted) to interview. Participant support from family/friends/others was allowed. The original letter generated from MD meeting and sent to both RCT participant and GP were re-presented to study participants to aid as a prompt reminding them of the discussions that occurred during the intervention.

## 2.3 | Data collection

One-off, semi-structured interviews were conducted by one team member (IJ) using a semi-structured question guide for the interviews. The interviewer was not part of the original study team and

had never met any of the participants prior to consenting them. The question guide (Figure 1) was developed using the Theoretical Framework of Acceptability (Sekhon et al., 2017). The question guide was piloted with other team members and members of the public prior to use. All interviews were carried out at the participant's location of choosing, audio recorded and transcribed verbatim. Participants were informed that the interviews would take approximately 1–1.5 h. Transcripts were returned to the participants by post and participants were given the option to review their own transcripts but not to provide feedback on findings of the current study. A pragmatic approach to sample size was utilised, aiming pre-data collection for at least 15 participants, rather than employing a 'data saturation' approach to sample size collection with data saturation being a contested approach in qualitative research (Braun & Clarke, 2021).

## 2.4 | Data analysis

A general inductive approach was used to analyse the data (Thomas, 2006) with multiple steps by the research team to ensure rigour. All authors read through to familiarise themselves with the data individually and then met as a group to discuss transcripts. Individuals then coded the data and IJ collated codes under the seven different domains of the Theoretical Framework of Acceptability (Sekhon et al., 2017). Researchers reviewed the codes to generate initial themes and the initial themes were then reviewed against the evidence (quotes) and research question to ensure the themes were both supported by the evidence and answered the research question. This review led to minor adjustments to themes. Quotes were included verbatim with parentheses '[]' used when words were inserted to clarify the context.

## 2.5 | Positionality

The authors acknowledge the active role that researchers play in thematic development and how research is influenced by researcher experience and as such, thematic development was supported by researcher experience and the multiple lenses through which the research team see the world (Braun & Clarke, 2019). IJ is a medical student at The University of Auckland who joined the team as part of a summer research scholarship and has prior experience in qualitative interviewing. The rest of the research team (JH, KB, MB and AT) have experience as clinicians and researchers with expertise in clinical assessment, geriatric medicine and nursing, qualitative and quantitative research, health equity and Māori health.

## 3 | RESULTS

A total of 27 RV residents were approached with 5 declining to participate and 4 participants not responding. Reasons for declining

**Affective Attitude: How an individual feels about the intervention**

- Did you enjoy participating in the meeting? \*
- Did the meeting go how you expected it to? \*
- What were your thoughts after the meeting? \*
- If you had not wanted to be a part of the meeting, how do you think you would have been able to communicate that to the researchers (prompt: would you have felt comfortable to do that, or to withdraw?)
- Was the meeting too long/too short/just right?
- How many meetings of this type would have been useful for you? How frequently would you like these?
- How did you feel about the number of people at this meeting?
- Was there anybody there that didn't need to be there from your point of view?
- Was there anybody that you would have liked to have been there that wasn't? Prompt: GP/whānau, if necessary.
- How did this meeting differ to other health meetings or visits you have had in the past?
- In what ways was it useful for you to discuss your health in this way? Prompt to explain further if necessary.
- What was most helpful about that meeting?
- What was least helpful about that meeting?
- How do you think the meeting would have been different if your GP was part of it as well?
- What would you like to see changed about this meeting or research?
- In what ways do you think your health or wellbeing changed because of this intervention?
- If your neighbour came to you and said they had been invited to participate in a study like this, what would your advice to them be, or what experiences would you share with them?
- Based on your experiences in this project, what would your advice be to any researchers wanting to do a similar research project in the future?

**Burden: The perceived amount of effort that is required to participate in the intervention**

- What difficulties did you have or what was hard about being involved in the intervention or research? \*
- Where did you have this meeting?

Ethicality: The extent to which the intervention has good fit with an individual's value system

- Did you feel comfortable participating in the meeting?
- Did you feel comfortable meeting (in your home/in the meeting room?)
- Did you get the opportunity to discuss all the things that were important to you?

**Intervention Coherence: The extent to which the participant understands the intervention and how it works**

- What did you think the purpose of the meeting was?
- Why did you choose to participate?
- Had you participated in a similar sort of meeting before? \*

**Opportunity Costs: The extent to which benefits, profits or values must be given up to engage in the intervention**

- Was there anything you feel you sacrificed in order to participate in the meeting, for example, had to postpone plans with family? \*

**Perceived Effectiveness: The extent to which the intervention is perceived as likely to achieve its purpose**

- Do you think the meeting achieved its purposes? \*
- Based on this summary, are you aware if your GP:
  - Changed any medications that you are aware of?
  - Referred you to any other doctors/community workers eg, physiotherapist?
  - Arranged any investigations, things like blood tests, or x-rays?
  - Do you remember receiving a letter from the research team summarising your health needs and recommendations? If so, what do you recall about this information?
  - Was it accurate?
  - In what ways was it useful to have a written summary?
  - Were any of the recommendations surprising to you? (prompt: What were these and what surprised you about them?)
  - What did you do with this information? (Prompt is needed: Did you take it to your GP to discuss any relevant points? If so, did your GP discuss these with you further?)
  - What discussions did you and your GP have about the research or the letter?
  - Did having a written summary make help you to discuss specific health issues with your GP?

**Self-efficacy: The participant's confidence that they can perform the behavior(s) required to participate in the intervention**

- Did you have enough information and time to plan for the meeting? (Prompt: what information could have been provided to help you plan better?) and do you think you had enough support during and after the meeting?
- Did you feel confident in your abilities to participate in the meeting? \*
- Was there adequate support and communication prior, during and after the meeting? \*

FIGURE 1 Interview question guide

were as follows: ill health ( $n = 3$ ), wanting someone with more life experience to interview them ( $n = 1$ ) and not wanting to provide more study input ( $n = 1$ ). One participant dropped out on the morning of their scheduled interview after the requirement to self-isolate due to potential Covid-19 exposure. Two participants who were happy to

participate were unable to be interviewed due to time constraints. The remaining 15 participants consented and were interviewed from December 2020 to January 2021. Once consented, no participants dropped out or withdrew consent. The median age of participants was 89 years, 10 were female and all participants were European.

Three participants were considered moderate–severely frail, nine mildly frail and three not frail as per previous frailty measurements (Bloomfield, Wu, Tatton, et al., 2021). There was a mean of 985 days from the original MD meeting in RCT to the study interview date (range 690–1314 days). All interviews took place in the participant's own home and had a median duration of 43:51 min (range = 26.45–90.24 min) with no support people present.

Three themes were identified: (1) participants' understanding of intervention aims and effectiveness, (2) the importance of older adult involvement and (3) level of comfort in the research process.

### 3.1 | I did not know the purpose, but was appreciative—participants' understanding of intervention aims and effectiveness

This theme focused on intervention coherence, with participants expressing their perceptions of the aims of the intervention, and the effectiveness of the intervention, exploring their perception of benefit, if any, that the MD intervention had to them as an individual.

Participants held different perceptions of the purpose of the MD meeting compared to the actual intervention objectives. While the aims of the meeting were to improve health outcomes for residents, participants thought that the purpose of the meeting was the collection of general information about RV residents.

I thought they were doing a study on retirement villages, not so much me as a person but how people feel about being in a retirement village. (Female, 90y)

One participant stated that although she initially thought the purpose of the intervention was to collect information on residents, upon receiving the GP letter in the immediate time period after the intervention, she realised the meeting's true intent. This highlights the importance of the GP letter as a tool to aid participants' understanding of the MD meetings. Due to the lack of clarity as to the purpose of the intervention, some participants expressed feelings of ambivalence towards the meeting.

Despite the intent of researchers to improve individual health via the intervention, most participants felt that involvement did not lead to personal benefit to their health and well-being.

No, I wouldn't say that my health and wellbeing had changed. I think this is really a social study in the true sense; it's more information for the receivers of it than for the feedback. (Female, 93y)

Even though participants reported limited-to-no individual benefits, participants expressed positive thoughts about the study, with all participants reporting that they themselves would participate again and would encourage others to participate in similar meetings in the future.

Well I didn't quite know what the purposes were. But when it was over I was quite appreciative of it so it was very good, yep. (Female, 79y)

I'd say do it! I can't see how it cannot be beneficial to you. You're always going to come out knowing more than you did before, provided you got your ears open. If you've got an open mind, you'll benefit for it but if you've got a closed mind, it's a waste of your time. No, I'd recommend anyone to do it. (Male, 68y)

This showed that in this case, an accurate understanding of research intent and a perceived personal benefit were not required to facilitate participation in the research.

The lack of perceived personal benefit was further emphasised by the majority of participant responses that stated they would not want further MD meetings, or that if they did, and that it should occur no more frequently than annually.

I don't think I needed any more than the one [meeting] really because there was various people coming from various angles and I was very happy with what they all had to offer. (Female, 79y)

Despite this general consensus that a one-off meeting was satisfactory, some participants expressed disappointment in the lack of immediate feedback from the MD meeting. Not receiving follow-up to the meeting made the participants feel disregarded and as if their contribution to the research had been overlooked.

Although participants stated they did not think there were any benefits when asked generally, when prompted about specific aspects of the intervention, there was a perception of benefit. For example, participants expressed they were able to gain a better understanding of their medication regimens. The facilitation of medication adjustments seemed to be the majority of reported changes to health and healthcare after the MD meetings.

I think it was useful in terms of my medications. I don't think I would've done that otherwise. The GP was glad that I had discussed the situation with [the research GNS]. (Female, 89y)

The written summary was one aspect of the MD meeting that participants seemed to appreciate. Many participants thought it as useful for them to have, and that it enabled prompting discussions with their GPs at a later date.

### 3.2 | Swept under the mat—the importance of older adult involvement and inclusion in research

This theme presents how participants were happy to participate in the MD intervention based on altruism –they were helping others

and contributing to research on older adults in general. Several participants expressed that as 'able citizens', they considered participation in research as their 'social duty' to help those who may not be able to contribute or advocate for themselves. Many participants stated they saw no personal benefit from the MD meeting, but instead felt fulfilled by the feeling that they were contributing to research and society in general, and that was important for older adult inclusion.

I'd be very happy to [be involved in this type of research again]. I believe that people who can verbalise have a certain social duty to do things. (Female, 93y)

...I appreciate the fact that you people are trying to help and if I can assist, that makes me feel good. (Female, 78y)

Participants also expressed a feeling of gratitude that older adults were being prioritised in research efforts. They felt grateful that their perspectives were recognised and work was being done to improve the health of RV residents.

Well I was happy that they were making an effort for the very elderly. The very elderly are sort of swept under the mat. (Female, 89y)

And so yes they were very interested in that because you see when people [residents] come here, a lot of them feel forgotten about. Oh you're in a village, you're ok. And we're not always ok. (Female, 91y)

Participants felt that their participation in the research would improve teamwork and integration between health professionals, which in turn would improve healthcare services provided to older adults.

Oh yes. I think the more professionals are able to communicate with each other and express their experiences it must be helpful... (Male, 95y)

### 3.3 | A 'first class' atmosphere—level of comfort in the research process

This theme highlights the high level of participant comfort and satisfaction with the MD intervention. There was an overwhelmingly positive response surrounding the atmosphere of the meetings. Participants felt the researchers were friendly, supportive, non-judgemental and that they were made to feel comfortable and at ease.

Yes, I found it very interesting. The way it was handled was well done. Low key but kept on track um I didn't find it intrusive or anything. No, it was relaxed, it was fine...the whole atmosphere, and the questions involved and so on, were first class. (Male, 98y)

I was a little bit nervous if you like with so many people but that [nervousness] was quickly gone because I was made to feel very at ease. (Female, 79y)

Participants enjoyed simply being able to talk and interact with health professionals in a more informal manner, with less time pressure, than what they typically experience in a health-related meeting. Participants felt that the MD meetings had several differences from a GP visit, for example, they felt like the MD meeting took a more holistic approach to their health and that there was an abundance of time to discuss matters important to them (rather than a quick 15-min appointment that only addresses the specific issue at hand). One participant expressed that the open, friendly and casual nature of the MD meetings facilitated discussion about issues that had never been previously disclosed. For this participant, the meeting catalysed further discussion and led to the treatment of long-standing health issues with specialist health professionals.

Yes I did enjoy it. I remember coming out and coming back home and I was going to say I felt light, I just sort of felt as if I was skipping home because I'd told these people things I'd never told anyone and it was a sense of relief. A huge sense of relief. (Female, 79y)

With my GP, I go there for a reason. I go there for checkups but generally I drive the discussion I suppose because I've got a problem. This was more lightly structured and just information gathering and passing on some information back to me. So, it was yeah quite a different sort of format but very friendly. (Male, 68y)

All participants stated they preferred meeting at their own homes and that they felt the duration of the meeting was appropriate.

...I think I'd prefer it at home because sometimes you'd go out and sometimes give the impression of unnecessary formality. In your own home, I would feel there would be no chance of that happening. No I felt very happy with that. (Male, 98 y)

They also felt there was adequate time and information to prepare for the meeting, with most stating that they either did not feel the need to prepare anything.

I did not really think about [preparing for the meeting] too much you know; I went there with an open mind and I was happy with what I got so yeah. (Female, 79y)

It was interesting to note that most participants did not feel the need to have any support people or family members present at the meeting. This signified a certain level of comfort and self-confidence felt by participants in the lead-up to, and during, the meeting.

No hahaha, I would have preferred that they weren't there. (Female, 79y)

No, not for me. But I can understand for other people who might like family there. (Female, 80y)

Participants seemed to think having their GP present was not relevant to the meeting. Some participants expressed that they would have actually felt *uncomfortable* with their GP present and were concerned about how that may impact their patient–doctor relationship.

I think I would've been a little bit on edge wondering how that was going to affect my relationship with my GP in the future. So no I felt good that there wasn't anybody like that there. (Female, 79y)

[The GP] may have asked some questions, I don't know. I really couldn't say. I don't know that there would be any benefit since they got this [letter]. You know that's a lot less time for them, if they've got questions, you can go and ask so I don't really see any benefit of them being there. Some people may have wanted them there for a support mechanism. (Male, 68y)

When asked if they would have felt comfortable withdrawing from the meeting or from the research process as a whole, the majority of participants said yes. This demonstrates that participants felt in control and comfortable not only in the MD meeting itself but in all stages of the research process.

Well there are ways tactfully to withdraw like saying you have a phone call and only have so much time. To let people down gently but I didn't have any need for that. (Female, 89y)

Oh yes. I'm probably fairly up front haha. Again, of course, not everybody is. But if there had been a real problem I couldn't see my way through, I would've simply said go away hahah. (Female, 78y)

Some participants felt like they were not in a knowledgeable enough position to be able to provide constructive feedback about the intervention's effectiveness or research processes.

No, no I couldn't. No I don't think I would be intelligent enough to judge. I don't pretend to be clever. (Male, 95y)

... I'm not a researcher but it seemed to follow a good pattern yeah, [I'm] not qualified to judge really. (Female, 80y)

Many participants identified themselves as healthy, confident and able-bodied individuals, with the acknowledgment that those

with more complex health needs may feel less positive about the MD meetings. Participants expressed a high level of confidence and self-efficacy in their ability to participate in the meetings and express their perspectives.

I didn't feel a problem if I wanted to ask a question. That's partly the person I am haha. And people who perhaps aren't confident enough for want of better words probably wouldn't have agreed to partaking, I would think. (Female, 78y)

## 4 | DISCUSSION

The MD intervention in the RCT of our RV study did not influence studied healthcare outcomes (acute hospitalisations, LTC entry or death; Bloomfield, Wu, Broad, et al., 2021). We wished to explore participant acceptability of this intervention as one method of understanding the reasons for these negative results and to inform future research. Our findings revealed several themes and showed that the intervention was acceptable across a number of the Theoretical Framework of Acceptability domains including affective attitude, low burden, opportunity costs and self-efficacy. For other researchers designing similar studies, it is worth noting that the location, duration and lack of primary care presence were not deemed negative factors by participants in this intervention. A written summary of the MD meeting recommendations and the relaxed nature of the intervention were positive aspects.

For the first domain of 'affective attitude', participants generally considered the MD meetings as a positive, friendly and casual experience. However, despite the generally positive feedback, the majority of participants perceived a lack of personal benefit and had a limited understanding of the intervention objectives. This lack of understanding of the purpose of the intervention has similarly been described in other studies of proactive comprehensive interventions (Darby et al., 2017; Rietkerk et al., 2019).

There was an overwhelmingly positive consensus that the research was well organised and posed a limited 'burden' on the participants. Similarly, participants felt there were no considerable 'opportunity costs', and considered the intervention to be a valuable and worthy experience. This high level of comfort and enjoyment suggests that the 'ethicality' of the MD meetings was a good fit with the value systems and beliefs of the participants. However, it is important to note that because our participants were ethnically homogenous, this intervention may not have been an ethical fit with participants of other cultures, particularly since all potential ethnically diverse participants declined to participate. A concept like 'acceptability' is subjective and can greatly differ between individuals and groups. Therefore, when considering health interventions aimed at large population groups, care should be made to ensure cultural and ethical safety.

The perceived effectiveness of the intervention explores the extent to which participants felt the intervention was beneficial. It was

difficult to fully examine the perceived effectiveness of the intervention as participants were unclear about the intention of the research, reflecting low intervention coherence. Going along with the participants' perceived intervention purpose—to generate further information about retirement village residents generally and to do so in a way in which they felt comfortable—the intervention was successful. An important finding from this study was that an accurate understanding of research intent and a perceived personal benefit was not required to facilitate participation. The fact that participants saw no need for their GP to be present in the meeting further emphasises how they viewed the MD meeting as a separate entity to their own health-related needs when in reality the intervention was designed to improve individual clinical outcomes. In contrast, study investigators query whether one of the reasons the RCT study did not show improvement in health outcomes was related to GPs not being integrated into the MD intervention (Bloomfield, Wu, Broad, et al., 2021). Participant views from our current study suggest greater researcher reflection, and imagination may be required when integrating primary care into interventions in a manner that satisfies participants and also increases study fidelity.

Participants expressed high levels of confidence and agency within the research process. Many participants identified themselves as healthy, confident and able-bodied individuals and acknowledged that those with more complex health needs may feel less positive about the MD meetings. This is despite the majority of participants living with some degree of frailty. Prior research demonstrates those living with frailty see themselves as resilient, independent and not frail (Pan et al., 2019), which may also be an influencing factor here. It is important to acknowledge that the perspectives of participants in the current study may not be representative of those more vulnerable.

These results share similarities with other research in this area. Corry et al. (2021) assessed the acceptability of a pilot study of nurse-led MD anticipatory care planning embedded within primary care where specialist nurses conducted several home visits over a 10-week period. Similar to our study, home visits were well received, with participants feeling at ease and relaxed in their own environments and appreciated the person-centred communication and emotional support. As in our study, medication reviews were appreciated. However, some participants did not immediately see how the intervention was relevant to their health and well-being in the here and now, with the authors commenting that participants were potentially reluctant to identify with frailty, showing some similarity with our participant responses. In contrast, Corry et al's participants identified GP involvement as integral to their intervention. Similarly, in a study by Izumi et al. (2018) of a nurse-led community palliative care intervention in older adults with chronic conditions, several participants thought the intervention was providing more than they needed. Again, in Izumi et al's study, participants reported receiving information about medications, rapport and flexibility as being successful aspects of the intervention.

Our group's earlier work in RVs demonstrates that the RV resident population in NZ has little ethnic diversity (under 4% of

residents were of Māori, Pacific Asian or other ethnicities; Broad et al., 2020; Joseph et al., 2021). For this study, we were unable to recruit a small number of non-European original RCT participants. This in itself is an interesting observation and raises the concern that the original study may not have been acceptable to non-European people. Our original intervention study methodology was designed several years ago (Peri et al., 2020), and although it involved pilot work within RV communities and buy-in from the RV industry and RV resident association, was not co-designed with RV residents/participants. A co-design methodology including appropriate representation of participants from relevant ethnic and socioeconomic groups, and incorporation of culturally appropriate research methods, would potentially mediate this issue in future study design (Hudson et al., 2010). Co-design achieves 'better patient experiences' by involving participants and health professionals in the design of healthcare services, exploring and capturing these experiences, then reflecting on and working together to improve them (Boyd et al., 2012). Co-design can be a powerful tool in the creation of effective, acceptable and efficient health interventions, especially in the domain of aged care. This is because while older individuals are often high users of health services, they may receive inadequate and/or harmful care, commonly due to a lack of communication with health professionals and the failure of care coordination (Giguere et al., 2018). Older adult's engagement with their healthcare has been shown to be directly associated with an improvement in care quality and a reduction in costs (Giguere et al., 2018).

Several limitations have already been discussed above. Additionally, a mean of approximately 2.5 years had passed between the original intervention and the current study interview, which has likely affected participant recollection.

Through the dissection of participant experiences, the importance of assessing the acceptability via a multi-dimensional and holistic framework became apparent. This highlights the need for co-design and integration of older adult perspectives for the success of future interventions, particularly in populations like older adults, whose voices may more commonly be ignored (Ibrahim & Davis, 2013). The use of this multi-dimensional framework has revealed the presence of previously undetected benefits to the MD meetings in terms of positive contribution to participants' well-being and quality of life and illustrates that clinically based outcomes may not be the only way to measure the success of a health intervention. The information gained from this qualitative study is valuable to future researchers and health providers developing MD interventions for community or RV-dwelling older adults. Our research group has learned both from the original RCT process and from the voices of our participants in the current study and we strongly encourage future researchers to consider co-design methodologies.

#### AUTHOR CONTRIBUTIONS

All authors meet the criteria for authorship stated in the Uniform Requirements for Manuscripts Submitted to Biomedical Journals.



## ACKNOWLEDGEMENTS

Thank you to our study participants and the Maurice and Phyllis Paykel Trust/the University of Auckland summer scholarship programme for funding. Open access publishing facilitated by The University of Auckland, as part of the Wiley - The University of Auckland agreement via the Council of Australian University Librarians.

## CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

## ORCID

Katherine Bloomfield  <https://orcid.org/0000-0001-6679-1763>

Joanna Hikaka  <https://orcid.org/0000-0001-6792-6607>

## REFERENCES

- Bloomfield, K., Wu, Z., Broad, J. B., Tatton, A., Calvert, C., Hikaka, J., Boyd, M., Peri, K., Bramley, D., Higgins, A. M., & Connolly, M. J. (2021). Learning from a multidisciplinary randomized controlled intervention in retirement village residents. *Journal of the American Geriatrics Society*, 70, 743–753. <https://doi.org/10.1111/jgs.17533>
- Bloomfield, K., Wu, Z., Tatton, A., Calvert, C., Peel, N., Hubbard, R., Jamieson, R., Hikaka, J., Boyd, M., Bramley, D., & Connolly, M. J. (2021). An interRAI derived frailty index is associated with prior hospitalisations in older adults residing in retirement villages. *Australasian Journal on Ageing*, 40(1), 66–87.
- Boyd, H., McKernon, S., Mullin, B., & Old, A. (2012). Improving health-care through the use of co-design. *New Zealand Medical Journal*, 125(1357), 76–87.
- Boyd, M., Calvert, C., Tatton, A., Wu, Z., Bloomfield, K., Broad, J. B., Hikaka, J., Higgins, A. M., & Connolly, M. J. (2021). Lonely in a crowd: Loneliness in New Zealand retirement village residents. *International Psychogeriatrics*, 33(5), 481–493.
- Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589–597.
- Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, 13, 201–216.
- Broad, J. B., Wu, Z., Bloomfield, K., Hikaka, J., Bramley, D., Boyd, M., Tatton, A., Calvert, C., Peri, K., Higgins, A. M., & Connolly, M. J. (2020). Health profile of residents of retirement villages in Auckland, New Zealand: Findings from a cross-sectional survey with health assessment. *BMJ Open*, 10(9), e035876.
- Connolly, M. J., Broad, J. B., Bish, T., Zhang, X., Bramley, D., Kerse, N., Bloomfield, K., & Boyd, M. (2018). Reducing emergency presentations from long-term care: A before and after study of a multidisciplinary team intervention. *Maturitas*, 117, 45–50.
- Connolly, M. J., Broad, J. B., Boyd, M., Zhang, T. X., Kerse, N., Foster, S., Lumley, T., & Whitehead, N. (2016). The 'Big Five': Hypothesis generation: A multidisciplinary intervention package reduces disease-specific hospitalisations from long-term care: A post hoc analysis of the ARCHUS cluster-randomised controlled trial. *Age and Ageing*, 4, 415–420.
- Cornwall, J., & Davey, J. A. (2004). *Impact of population ageing in New Zealand on the demand for health and disability support services, and workforce implications*. Ministry of Health. Retrieved February, 2021, from <https://www.health.govt.nz/publication/impact-population-ageing-new-zealand-demand-health-and-disability-support-services-and-workforce>
- Corry, D. A. S., Doherty, J., Carter, G., Doyle, F., Fahey, T., O'Halloran, P., McGlade, K., Wallace, E., & Brazil, K. (2021). Acceptability of a nurse-led, person-centred, anticipatory care planning intervention for older people at risk of functional decline: A qualitative study. *PLoS One*, 16(5), e0251978.
- Darby, J., Williamson, T., Logan, P., & Gladman, J. (2017). Comprehensive geriatric assessment on an acute medical unit: A qualitative study of older people's and informal carer's perspectives of the care and treatment received. *Clinical Rehabilitation*, 31(1), 126–134.
- Davey, J. (2006). "Ageing in place": The views of older homeowners about housing maintenance, renovation and adaptation. New Zealand Centre for Social Research and Evaluation, Ministry of Social Development. Retrieved February, 2021, from <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/ageing-in-place/index.html>
- Ellis, G., & Sevdalis, N. (2019). Understanding and improving multidisciplinary team working in geriatric medicine. *Age and Ageing*, 48(4), 498–505.
- Giguere, A. M. C., Farmanova, E., Holroyd-Leduc, J. M., Straus, S. E., Urquhart, R., Carnovale, V., Breton, E., Guo, S., Maharaj, N., Durand, P. J., Legare, F., Turgeon, A. F., & Aubin, M. (2018). Key stakeholder's views on the quality of care and services available to frail seniors in Canada. *BMC Geriatrics*, 18(1), 290.
- Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te ara tika. Guidelines for Māori research ethics. A framework for researchers and ethics committee members*. Health Research Council of New Zealand Publication. Retrieved February, 2021, from [https://www.hrc.govt.nz/sites/default/files/2019-06/Resource%20Library%20PDF%20-%20Te%20Ara%20Tika%20Guidelines%20for%20Maori%20Research%20Ethics\\_0.pdf](https://www.hrc.govt.nz/sites/default/files/2019-06/Resource%20Library%20PDF%20-%20Te%20Ara%20Tika%20Guidelines%20for%20Maori%20Research%20Ethics_0.pdf)
- Ibrahim, J. E., & Davis, M. C. (2013). Impediments to applying the 'dignity of risk' principle in residential aged care services. *Australasian Journal on Ageing*, 32(3), 188–193. <https://doi.org/10.1111/ajag.12014>
- Izumi, S. S., Basin, B., Presley, M., McCalmont, J., Furuno, J. P., Noble, B., Baggs, J. G., & Curtis, J. R. (2018). Feasibility and acceptability of nurse-led primary palliative care for older adults with chronic conditions. *Journal of Palliative Medicine*, 21(8), 1114–1121.
- Jones Lang LaSalle. (2021). NZ retirement villages and aged care. Whitepaper. New Zealand Retirement Village Database (NZRVD) and Aged Care Database (NZACD). Retrieved October, 2021, from <https://www.jll.nz/en/trends-and-insights/research/retirement-villages-market-review-2021>
- Joseph, C. M., Hikaka, J., Bloomfield, K., Broad, J., Wu, Z., Boyd, M., Peri, K., Calvert, C., Tatton, A., Higgins, A. M., & Bramley, D. (2021). Research in the retirement village community – The problems of recruiting a representative cohort of residents in Auckland, New Zealand. *Australasian Journal on Ageing*, 40(2), 177–183.
- Lee, D. (2017). A model for designing healthcare service based on the patient experience. *International Journal of Healthcare Management*, 12(3), 1–9.
- Mitchell, G. K., Tieman, J. J., & Shelby-James, T. M. (2008). Multidisciplinary care planning and teamwork in primary care. *Medical Journal of Australia*, 188(S8), S61–S64.
- Pan, E., Bloomfield, K., & Boyd, M. (2019). Resilience not frailty: A qualitative study of the perceptions of older adults towards 'frailty'. *International Journal of Older People Nursing*, 14(4), e12261.
- Peri, K., Broad, J., Hikaka, J., Boyd, M., Bloomfield, K., Wu, Z., Calvert, C., Tatton, A., Higgins, A. M., Bramley, D., & Connolly, M. (2020). Study protocol: Older people in retirement villages. A survey and randomised trial of a multi-disciplinary intervention designed to avoid adverse outcomes. *BMC Geriatrics*, 20(1), 247. <https://doi.org/10.1186/s12877-020-01640-6>

- Rietkerk, W., Smit, M. F., Wynia, K., Slaets, J. P. J., Zuidema, S. U., & Gerritsen, D. L. (2019). Explaining experiences of community-dwelling older adults with a pro-active comprehensive geriatric assessment program – A thorough evaluation by interviews. *BMC Geriatrics*, *19*, 12.
- Sekhon, M., Cartwright, M., & Francis, J. J. (2017). Acceptability of health-care interventions: An overview of reviews and development of a theoretical framework. *BMC Health Services Research*, *17*(1), 1–13.
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, *27*(2), 237–246.
- Yeung, P., Good, G., O'Donoghue, K., Spence, S., & Ros, B. (2017). What matters most to people in retirement villages and their transition

to residential aged care. *Aotearoa New Zealand Social Work*, *29*(4), 84–96.

**How to cite this article:** Jung, I., Bloomfield, K., Hikaka, J., Tatton, A., & Boyd, M. (2022). "Making an effort for the very elderly": The acceptability of a multidisciplinary intervention to retirement village residents. *Health & Social Care in the Community*, *30*, e5356–e5365. <https://doi.org/10.1111/hsc.13957>