INNOVATIONS IN CLINICAL PRACTICE

An inpatient bed for acute nursing home admissions

STUART G. HUTCHINSON, J. TARRANT, MARTIN P. SEVERS

Portsmouth Healthcare NHS Trust, Portsmouth and South East Hampshire Health Authority, Queen Alexandra Hospital, Cosham, Portsmouth PO6 3LY, UK
1School of Postgraduate Medicine, University of Portsmouth, St Michael’s Building, White Swan Road, Portsmouth PO1 2DT, UK

Address correspondence to: S. Hutchinson: Fax (+ 44) 1705 200381

Abstract

Background: some older patients are admitted directly to nursing homes without a comprehensive assessment.
Objective: to determine whether a hospital assessment bed might provide better assessment, treatment and a more appropriate placement for selected older people.
Setting: a single bed in an elderly care unit of a district general hospital.
Subjects: older people who general practitioners thought needed nursing home care but whose social workers felt might benefit from inpatient assessment.
Main outcome measures: type of treatment needed (acute care, rehabilitation, palliation, long-term care) and placement (home, nursing home, residential home or hospital).
Results: of 34 patients assessed, 22 (65%) needed further clinical assessment or care and 26 (75%) left hospital for places other than nursing homes.
Conclusions: inpatient assessment is a successful way of assessing the needs of some older people who would otherwise have been admitted directly from their homes to nursing homes.

Keywords: acute nursing home admissions, assessment

Introduction

As a result of the Community Care Act (1990), in 1993 social services became the lead agency for care in the community, in particular for placement in residential and nursing homes. This had previously been the responsibility of The Department of Social Security. During the first 3 months of the Act’s operation in Portsmouth (April-June 1993), three times as many patients were being referred to nursing homes directly from home as from hospitals. In addition, social services were concerned that nursing home beds were being used inappropriately. We therefore operated a nursing home assessment project to see if any of the patients currently being sent to nursing homes directly from home would benefit from specialist inpatient assessment. There have been studies of outpatient assessments of potential residents for residential homes [1, 2] and informal assessments on admission to a nursing home [3]. We are, however, unaware of any studies of inpatient assessments of potential nursing home residents from their own homes.

Method

Patients were admitted through their general practitioner (GP) on the recommendation of a social worker. Admissions were limited to those whom the GP thought needed nursing home placement, but whom the social worker felt needed further assessment. All local GPs were sent explanatory letters at the start of the project and subsequent reminders. Patients with disturbed behaviour who were mobile were excluded. A bed was designated for care management on an acute ward, with another two beds on a continuing care ward for those awaiting placement.

Once admitted, the patient was assessed within 48 h by a senior registrar or consultant. Diagnoses were
Table 2. Placement at discharge and subsequent placement at the follow-up

<table>
<thead>
<tr>
<th>Placement</th>
<th>No. of patients Discharge</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Private residential home</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Local authority long-stay home</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Nursing home</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Palliation/long-stay/inpatient</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Dead</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

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Results

Between March 1994 and December 1994, 34 patients were admitted to the care assessment bed, of which one was inappropriate (Barthel score 20, awaiting rest home). There was one readmission. This represents about 10% of the total admissions to nursing homes during this period.

Twenty-eight of the patients were women and six were men. The mean age was 85 years (range 74–94, SD 4.8) and the mean length of stay was 17.2 days (range 3–36 days, SD 8.4). The mean number of diagnoses was 5.1 (range 2–9). Mean Barthel score was 8.7 (range 0–20, SD 4.7) on admission and 11.2 (range 0–18, SD 4.6) on discharge. Mean mental test score was 6.3 on both admission or discharge. Social dependency score increased from a mean of 4.0 on admission to 4.9 on discharge. Results of initial assessment of need are shown in Table 1. Results of placement and summary of follow-up data are shown in Table 2.

At the time of follow-up, of the 13 people who had been returned to their homes, nine remained there, two of whom required an increase in care over their level of support on discharge, in four there had been no change and three had had their home support decreased. Three patients died and one was in a psychiatric ward. Of the five patients discharged to local authority (part I) accommodation; two remained, two had returned home and one had been readmitted to the care assessment bed. Of the five patients discharged to private residential rest homes, one remained, one had been transferred to a nursing home and three had died. Of the eight patients who were admitted to nursing homes, five remained, one had returned home and two had died. These findings are summarized in Figure 1.

Discussion

The project has shown that for a sub-group of people who would have been admitted to nursing homes, a period of assessment as an inpatient can make a difference to placement. Of those admitted, 65% (22/34) needed some further form of input or assessment. Because of the number of diagnoses and the complexity of medical and nursing care needed, a hospital setting was an appropriate environment in which to assess them. Many of the patients were thought to have no acute medical problems by their GPs, who would normally have asked for direct placement in a nursing home. This shows that medical assessment at home
was not adequate for at least 10% of the elderly people who would have been admitted to nursing homes, and this reinforces the need for inpatient assessment by specialists in elderly care. Such assessments resulted in a difference in placement, 75% (26/34) of the patients admitted being sent out from hospital to places other than nursing homes, where they no longer needed 24 h nursing care. More people were returned home than could be predicted from their functional status. The expected discharge destination by Barthel score was: 0–4, hospital long-term care (local criteria for long-term care); 5–10, nursing home placement; 11–15, private rest home/local authority home placement; 17–20, return to own home.

We did not investigate the specific reasons why more people went home than had been predicted on the basis of their Barthel score. The most important finding of this study is that people were able to return home. This project might result in financial savings for social services, as keeping people in their own homes can be cheaper than placement in residential care, and placement in residential care is cheaper than nursing home placement.

The average Social Dependency Score showed a fall between admission and discharge. This is because the patients were assessed on their level of support before admission. This level of support was clearly not adequate as these subjects failed to cope. If all patients had been admitted to a nursing home as planned, then the Social Dependency score would have fallen to 6 (the score for nursing home placement). The observed figure of 4.9 therefore represents an improvement on what would otherwise have happened.

There is considerable variation in the functional and mental status of patients who were considered to require the level of care provided in nursing homes. This suggests that criteria for placement are complex and that using a disability scale (e.g. the Barthel score), will not accurately predict all placements. Other studies have shown a wide range of disability in residents of both residential and nursing homes [7, 8] and evidence of misplacement if functional status alone is measured [9, 10]. Our findings concur with other studies which have looked at discharges from hospital [11] which have used other measures of disability (such as the CAPE).

We did not investigate the reason for admission to nursing homes, but from those who had acute medical needs and those who subsequently returned home, it is assumed that in many cases a medical crisis had arisen and the reason leading to admission was a reversible medical condition. We did not investigate the specific reasons for GPs' decisions to refer the 34 study patients to nursing homes. Perhaps patients were being placed in nursing homes when elderly care beds were unavailable. However, general medical beds are always available if the GP wants an acute admission for medical reasons. As GPs had been placing patients in nursing homes despite the availability of hospital beds, it seems unlikely that the group studied represents those who would have come into an acute medical bed had the assessment bed not been available.

Many patients in this study had complex medical and nursing needs. Good liaison is necessary between professionals caring for them in hospital and those caring for them at home. Such co-ordination also needs to be continued on discharge, most particularly between nurses, as many of the continuing needs of the patients are nursing needs.

This is not the only model for assessing people before they are placed in a nursing home, nor is it necessarily the best for all people contemplating such
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placement, but it is one approach for those whose social workers and GPs are unsure about potential for functional improvement.

Key points

- Selected older people thought by their general practitioners to require nursing home care were assessed in a designated elderly care hospital bed.
- Two-thirds of these patients required other forms of treatment or assessment.
- Three-quarters left the hospital for places other than nursing homes, some returning to their own homes.
- Placement could not be accurately predicted solely from a patient’s functional state.
- An assessment bed is one way of preventing inappropriate admissions to nursing homes.

References


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Appendix

Residential Homes are governed by part I of the Registered Homes Act (1984). The level of personal care is similar to that which would be given by a caring relative. The residents are entitled to receive care from the Community Nursing Team where necessary.

Part III homes are run by local authorities and are not registered under the Registered Homes Act. The level of care is similar to that provided by Residential Homes.

Nursing Homes are governed by part II of the Registered Homes Act. They are registered with the local authority. They must have a trained nurse with appropriate qualifications on duty throughout the 24 h period.