THE EFFECT OF A CONSULTANT AS "GATEKEEPER" ON ACUTE GERIATRIC ADMISSIONS

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Introduction
Emergency admissions to district general hospitals are rising. A retrospective study suggested that about 10% of medical and geriatric admissions to hospital might be suitable for alternatives (Coast J et al BMJ 1996;312:162-6). When a senior doctor assessed potential medical admissions, admissions reduced by 15% (Wanklyn P et al JR Coll Phys 1997;31:173-6). We looked at the effect of consultants taking all calls for admission, to a needs-related geriatric unit.

Method
For one calendar month (October 1997) the four consultant geriatricians took all calls 24 hours a day from general practitioners (GPs) and the A & E Department for potential acute admissions. We have a needs related admission policy based on departmental guidelines. All GPs in the area and the A & E Consultant were informed of this study at the beginning of September 1997.

Results
315 calls were received (113 male x age 81, 202 female x age 84), 180 from GPs (57%), 135 from A & E (43%). 293 calls (93%) were between 8 am and midnight. 13 patients from each group were given an alternative to admission: 9 out patients, 4 domiciliary visits, and 5 referred to Social Services. 2 admitted to community hospital, 3 back to rest or nursing home, 1 each advice to GP, referred to district nurse or day hospital attendance. These 26 patients were followed up for 28 days from the date of the call. 2 patients were subsequently admitted within 28 days.

Conclusion
Consultants taking calls for potential admission to a needs-related geriatric unit can reduce admissions by about 8% with an acceptable re-admission rate. This has both clinical relevance (patients not admitted have a more appropriate alternative) and economic importance (inpatient episodes are expensive, alternatives are much cheaper).

GENERAL PRACTITIONERS' VIEWS OF DOMICILIARY VISITS (DVs) IN GERIATRIC MEDICINE

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Introduction
The number of DVs performed by geriatricians has declined steadily as units have provided easier access for emergency admissions. However, in our District, DVs remain widely used despite an easy integrated admission process. We therefore decided to examine GPs' DV requesting practice.

EVALUATION OF GERIATRICIAN INPUT TO GENERAL SURGICAL PATIENTS - A CONTROLLED STUDY USING ROUTINE DATA

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Introduction
In November 1996 a consultant geriatrician started visiting the 3 general surgical wards in a DGH on weekdays to assist with the medical management of elderly patients and their discharge planning. Daycase wards were not visited. Data from the patient administration system (PAS) were used to obtain a rapid evaluation of the initiative.

Methodology
The target group (E2) was all general surgical patients aged 65 years and over admitted between 1/12/96 and 31/10/97. The concurrent control group (Y2) was patients aged 18 to 64 years and the historical controls (E1 & Y1) were admitted between 1/12/95 and 31/10/96. Data were extracted from PAS, lengths of stay (LOS) were calculated

Results
Group E1: n=1915, LOS=9.4 days, E2: n=1951, LOS=8.1 days, difference=1.3 days, 95% CI 0.6 to 1.9 days. Group Y1: n=2069, mean LOS=6.0 days, Y2: n=2213, LOS=4.7 days, difference=1.2 days, 95% CI 0.7 to 1.8 days. These differences were maintained after adjusting for sex, elective/emergency admissions and further disaggregation of age using analysis of variance.
Conclusion
The target group showed an important reduction in LOS which was similar to the younger controls. This may be because the intervention was directed at the ward level so any training benefit to staff would automatically apply to the younger group. The absence of unbiased controls makes it difficult to attribute the benefit to the geriatrician. Nonetheless, the intervention was associated with a worthwhile benefit and the speed with which this was shown encourage support for continuing geriatrician input to surgical patients.

BENEFITS OF ORGANISED CARE FOR PATIENTS WITH LOWER LIMB AMPUTATIONS

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A unique tripartite collaboration between vascular surgery, prosthetic rehabilitation, and geriatric medicine has produced a coordinated service for lower limb amputees based on a 15 bed inpatient Dysvascular Limb Unit (D.L.U.) in a community hospital. This critical mass has allowed, multi-specialty care, regular liaison, counselling, a dedicated wound care service, specialised therapists and equipment and a patients group to be established. A study of the first 82 admissions showed them to be younger than those in generic beds, median age 71.7 years (40-96). The inpatient mortality was 8% (7) with 3% (2) of survivors transferred to other hospitals and 5% (4) discharged to institutional care. The remaining 92% (69) returning to a private domicile. Inpatient stay was between 1 and 177 days with a median of 51.5 days. The unit selectively attracts complex cases as extra-contractual referrals and does not see fitter patients who go home directly from the surgical wards. Despite this adverse casemix, D.L.U. patients unit receive their prostheses earlier, 58 days post amputation compared to 70 days for those attending the Regional Rehabilitation Centre (R.R.C) and 82 days for those seen by R.R.C outreach teams in other hospitals (p<0.001). Outcome is superior for the D.L.U. sample with 87% walking with their prosthesis (with or without other mobility aid) at six weeks compared with 61% of the subjects seen by outreach teams and 63% seen at the R.R.C. P<0.05 Post amputation stay on the surgical wards has dropped from a mean of 29 days in 1994 to 21 days for those discharged directly home and 11 days for those going to the D.L.U.

ACUTE ADMISSIONS FROM NURSING HOMES; HOSPITAL UTILIZATION AND OUTCOME

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Introduction
While some referrals from nursing homes have been considered inappropriate, the process and outcome of admission is unclear. We examined acute admissions from nursing homes in 3 health districts to assess hospital utilisation and determine patient outcome.

Methodology
Prospective study of consecutive admissions from nursing homes to acute medical units of 3 hospitals (3 months). Acute and chronic diagnoses, investigations and clinical interventions noted. Outcome measures; mortality, length of stay and change in Barthel index.

Results
128 consecutive patients were identified (age 65-97). 31 acute diagnoses were made, the most frequent being pneumonia (36%), delirium (24%) and urinary tract infection (17%). 80% of patients received one or more first line investigations, 20% underwent further second line investigations. 85% were managed by one or more simple interventions; change in oral medication, intravenous, or oxygen therapy. 15% required additional intervention. Inpatient mortality was 31%. Mean length of stay was 12.1 days (range 1-81) and total bed occupancy 1550 days. There was no significant improvement in Barthel Index between admission and discharge (p>0.05).

Conclusions
The majority of patients did not have acute medical diagnoses on admission. Most patients required limited medical intervention, appropriate nursing care and access to basic investigations. A minority of patients required a more complex process of care which was not associated with functional improvement.

READMISSIONS IN THE ELDERLY: A PROSPECTIVE COHORT STUDY

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Introduction
Previous studies of readmissions have been limited by the selective admissions process of the hospital or specialty studied and have targeted single diagnostic groups. We sought to determine the characteristics of elderly readmissions, at risk groups and contributory factors using a detailed multidisciplinary assessment.

Methodology
Prospective (4 month) cohort study of consecutive readmissions (12 weeks index admission) to a single District General Hospital