CARE IN THE NURSING HOME SECTOR – CHALLENGES AND OPPORTUNITIES*

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At present in the UK, less then 5% of the older population live in institutions. However, around 500,000 people are in care homes of which 80% are dependent on state funding. During the 1970s and 80s there was a marked reduction in long-term care beds funded by the National Health Service (NHS). The provision of health care and social care in the nursing home sector was encouraged and expanded rapidly. This coincided with the demographic change in the population which is now showing an increasing number of people aged over 60, particularly in the over 85 age group, who typically make the greatest use of health and social work resources. This trend was reflected in the cost of long-term care, which in the UK in 1983 was £103 million but which increased ten fold in only six years to £1,000 million. Concerns were expressed that money was being used to fund 'care in homes' when many patients would prefer 'care at home'.

The NHS and Community Care Act (1990) arose out of many of these concerns: it emphasised the concept of 'needs assessment' and gave the lead responsibility for implementing this policy to the Local Authorities. Care managers were given a budget for purchasing care and ensuring its provision in an appropriate setting with the aim that vulnerable people should, wherever possible, be enabled to live in their own homes and communities.

Despite the large number of older people in care, 'Care Home Medicine' has a limited knowledge base, and we do not know why or whether many of these people actually require such care; the exact health care costs and the actual outcome of care are also not well documented. The scope of this symposium was to examine the main challenges facing nursing home care at the beginning of the twenty-first century.

NURSING HOMES

In Scotland since the first nursing home registration act was passed in 1938 the function of nursing homes has changed dramatically. The initial definition in the 1938 Act was of 'any premises used or intended to be used for the reception of and the providing of nursing for persons suffering from any sickness, injury, or infirmity, and includes maternity homes'. Currently nursing homes provide continuing care predominantly for older people. Initially, the regulation of nursing homes was the responsibility of the Local Authorities but, as part of the NHS reforms in 1972, this responsibility passed to Health Boards.

There are 517 homes in Scotland providing 23,611 beds mostly for the long-term care of older people (1998 figures). The majority are owned privately but increasing numbers are being run by national companies. The care cost in 1996/97 was £290 million amounting to 56% of Local Authority expenditure on older people.

PRE-ADMISSION ASSESSMENT

A major theme throughout the symposium was the importance of adequate and thorough multidisciplinary assessment of individuals to identify appropriately their needs for health and social care. Decisions regarding the admission of older people to care homes are complex and should involve the individual, their family and members of the multidisciplinary team involved in the assessment process.

It has long been recognised that many residents in nursing homes do not actually require such levels of care. The reasons for this are not always apparent but a number of common situations are recognised. Some residents may not have had appropriate assessment or rehabilitation prior to admission. Others may have made some functional improvement after admission and no longer require to be there. Other residents, who are self-funding, may have chosen to pay for nursing care because they felt their clinical state required this level of care.

The Scottish Office Guidance on NHS Responsibility for Continuing Health Care has laid down clear instructions on the need for collaborative assessment of persons being considered for such admission involving health and social work. The social worker has a key role in coordinating the assessment process for people requiring state funding. Adequate and accurate medical information is required on the relevant medical problems known to be present, then diagnosis and prognosis. Hospital-based specialists in geriatric medicine should also form part of the multidisciplinary team when patients are being transferred from hospital to nursing home care or NHS-funded continuing care. The general practitioner has a pivotal role in those patients being admitted directly to nursing home care from their own homes.

While all this works satisfactorily in most cases, a more specialised assessment has to be shown to curtail some admissions. Hutchinson, Tarrant and Severs[1] studied 34 older people who had been referred for nursing home care by their GP but whose social worker felt would benefit from further assessment. After a short inpatient assessment, 13 people could be discharged home with support and ten people were able to be transferred to residential care. Placement could not be accurately predicted from a patient's functional state, and the setting up of an 'assessment bed' as an initial entry point into the care system is one way of preventing inappropriate admissions to nursing homes.[1]

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NURSING INVOLVEMENT

Individuals who need continuing care have inter-related health and social needs although the distinction between the two can be very difficult. Nurses argue that their duties encompass both medical and social aspects of care and, if these become increasingly polarised, the totality of their care may become fragmented. Patients who may have been previously assessed as requiring nursing care may now be regarded as requiring social care and they are thus potentially deprived of specialist nursing support. The Royal College of Nursing is developing a 'nursing assessment tool' to enable the assessment of an older person's health status through a comprehensive range of categories. The potential uses for such an assessment tool include identifying the need for registered nurse involvement, developing a patient-specific care plan, and determining appropriate staff skill-mix according to the individual needs of each resident. This tool focuses on the contribution of the registered nurse to continuing care and has the potential to make a significant impact on the fuller development of the nurse's role. The tool consists of five stages and, once the operator becomes familiar with it, can be completed in about thirty minutes.

ON-GOING ASSESSMENT

The need for on-going medical review and functional assessment was emphasised. Geriatric medicine developed as a specialty from the pioneering work of Marjory Warren who identified the 'unmet needs' of residents in continuing care hospital wards. In recent years, however, an increasing involvement in acute services and the transfer of patients from NHS continuing care wards to nursing homes has meant geriatricians have devoted less time to the needs of continuing care patients.

MODELS OF MEDICAL CARE IN NURSING HOMES

A number of different models for improving medical care in nursing homes have been proposed. The symposium attendees were appraised of the pilot scheme based at Falkirk Royal Infirmary, a District General Hospital serving an area with 900 beds in nursing homes. An increasing number of nursing home residents with increasing dependency and clinical needs were making increasing demands upon both primary and secondary healthcare sectors. Locally agreed criteria for entry to nursing home have been agreed and all applicants are screened by a multidisciplinary panel including a consultant physician, experienced nurse and social work manager. The establishment of a joint health and social work inspection and registration team has minimised the differences in standards of care across the nursing home sector. An initial, retrospective audit of acute hospital admissions from nursing homes showed that seven out of nineteen admissions were inappropriate with five of these patients dying within 48 hours. Thirty-two per cent of the admissions were only for nursing care. Essential information on medication and pre-morbid functional level was frequently absent. As a result, guidelines were agreed to establish an admission policy and ensure equal access of nursing home residents to specialist services. An outreach team consisting of a consultant, physiotherapist, occupational therapist, liaison nurse, pharmacist and a dietitian was established to enable rapid, specialist assessment in the nursing home. Communication with general practitioners was improved and decisions on appropriateness of intervention were discussed prior to any crisis. A repeat audit suggests there have been far fewer inappropriate admissions.

Further improvements in the medical services provided to nursing homes were achieved by using funds released from the closure of NHS long-term care beds to invest in additional equipment, a continence service, an infection control nurse specialist, and a tissue viability nurse.

This model seems to work well for the Falkirk area, and the key points seem to be clear guidelines, good communications and rapidly available support from secondary care for primary care. Different models are being considered in other areas of the UK.

PRACTICAL DILEMMAS

Part of the symposium involved participation of the audience using a 'digivote' system to examine their approach to a number of common clinical scenarios based on real cases. These concerned issues of when to investigate, when to refer or admit, and how to manage the difficult patient who is aggressive or who will not eat and drink?

As expected, a wide diversity of opinion was expressed by the audience comprising of 50% nurses, 30% doctors and 20% other professions allied to medicine, including social workers. This was particularly the case when dealing with ethical dilemmas in the frail, confused, older person. The importance of good communication between all members of staff, relatives and the patient was highlighted. When nursing home residents become unwell, there is often the opportunity to avoid hospital admission. For example, with patients with pneumonia, evidence exists that treatment within the nursing home rather than hospital may have an outcome similar to a hospital admission.[2]

The need for easy access to a specialist opinion was emphasised. Many nursing homes are capable of administering intravenous or subcutaneous fluids. For example, 54% of nurses working in the nursing home sector stated their home could safely do so, yet only 12% had actually done so.

The issue of patient restraint was highlighted as a major concern. No 'legal' definition of restraint exists; it can be described as the use of physical, chemical, psychological, social or legal intervention to control a person's physical activity or speech, by reducing their capacity to undertake certain behaviours and, ultimately, curtail their freedom. In broad terms, it means preventing someone doing something they wish to do. Commonly used methods of restraint amongst older people include cot sides, harnesses, sedatives, placing furniture in locations so as to impede movement, using nightwear during the day, and using tip-back and tray-fronted chairs. Restraint can only be justified if it is used to protect the patient's interests. Unfortunately, there is often no record in the patient's notes as to the reasons why the patient was restrained.[3]

Restraint is most commonly used to control restless or agitated behavior but may be used for other reasons, including the punishment of residents and for the convenience of the staff. When managing aggressive patients, the emphasis should be on assessment and defusing the situation rather than restraint. There was agreement that this is an area where all staff require further education and training.

MAINTAINING STANDARDS OF CARE

The registration of nursing homes is designed to protect vulnerable residents from poor standards. There are four components to the process of regulation: standard setting, registration, inspection and sanctions (when encroachments of regulations are proven).

Legislation enables regulation of nursing homes by providing the power to set minimum standards that must be achieved. These rules are not static and can be changed in response to social change, different expectations and new knowledge. The principle behind such standard settings is to promote a quality of life and quality of care, thereby acknowledging the rights of residents as individuals.

However, the areas in which legislation empowers standards to be set are restricted to 'fitness' of the registered person, 'fitness' of the person in charge, staffing, the building, equipment, furniture, documentation, food and safety. Little reference is made to standards of care or outcome of care.

Inspection is performed twice a year at any reasonable time but can also be performed at non-standard times should that be deemed necessary. If poor standards are discovered then the only sanctions available are refusal to register and cancellation of registration. Since these are all or nothing sanctions the need for more enforceable intermediate sanctions was emphasised.

FUTURE DEVELOPMENTS

The recent Scottish Office White Paper, *Aiming for Excellence - Modernising Social Work Services in Scotland*, sets out a number of likely developments. These include the creation of a Scottish Commission for the Regulation of Care, a national statutory body independent of both Health Boards and Local Authorities which will have responsibility for regulating all social work services, including both residential and nursing homes. In relation to standards, the White Paper proposed a National Care Standards Committee, whose task is to develop through consultation a series of national standards for the services regulated by the commission. It seems likely that changes in legislation will follow this. Although the concept of Clinical Governance was introduced to ensure the NHS had appropriate mechanisms for monitoring and continuously improving the quality of care and clinical performance, it is desirable that nursing homes should have similar mechanisms in place. This may include use of clinical guidelines, clinical audit, achievement of national care standards, benchmarking and peer review. The Clinical Standards Board for Scotland was established in April 1999 to create a national system of quality assurance and to accredit clinical services. It focuses mainly on condition-related services following the patient's journey of care and therefore complements Clinical Governance. The aims of the Clinical Standards Board are to provide public reassurance, to support healthcare professionals, and to improve standards; it is already developing a template for standard setting, external peer review and public involvement.

The creation of a Scottish Parliament resulted in politicians having a greater interest in developing health and social services in Scotland. The commitment to a primary care-centered NHS with increased involvement of the public and the need for increased accountability will inevitably lead to changes in service delivery. A number of models for closer cooperation between primary and secondary care have been proposed, including an 'Integrated Framework of Care'.[4] This is based on having an individual care-plan for each resident using a multidisciplinary approach to create a Minimum Data Set (MDS). In addition, it is essential that specific and specialist health needs are identified using a variety of disease-specific and problem-specific resident assessment protocols. The MDS data can be monitored for each resident to measure outcome, quality assurance and regulation, while 'pooled MDS' data can be utilised for epidemiological information. A similar arrangement works successfully in some states in the US. Resource Utilisation Groups (RUGS), generated from the MDS, can be used to identify care costs and use of other resources. In this network of care, education and training are crucial in providing better standards of care for older people.

WITH RESPECT TO OLD AGE: ROYAL COMMISSION ON THE FUNDING OF LONG-TERM CARE[5]

Professor R.W. Stout, Professor of Geriatric Medicine at Queen's University, Belfast and a member of the Royal Commission on Long-Term Care for the Elderly, gave the Sir Stanley Davidson Lecture on 'Nursing home care in the new millennium'.[6]

The Royal Commission was established in response to the widely held sense of injustice regarding the present situation in terms of funding long-term care. The Beveridge Report in 1942 and the creation of the NHS had led the public to expect free care 'from cradle to grave'. The public had not appreciated the difference between health care, which was free at the point of delivery, and social care, which had never been free. The community care reforms had appeared to change the boundary between health and social care, thus leading to this sense of betrayal.

The main term of reference was to examine all the short- and long-term options for providing a sustainable system of funding long-term care for older people, both in their own home and in other settings. It had to report within 12 months and recommend how and in what circumstances the cost of care should be optional between public and individual funds.

Before the Commission started work, the set of values was agreed upon. Older people are a valuable part of society and should not be regarded as a burden on society. Old age will come to an increasing number of people and should be seen as natural part of life. Older people have much to contribute to society and should be supported in their attempt to fulfill their lives.

The Commission attempted to predict the demand for long-term care in the future. Information on the period 1931-1991 suggests that the largest increase in the number of older people has already occurred, and that the predicted increase over the next few decades should be manageable. No information exists on likely changes in health expectancy, but the Commission assumed that the onset of disability and dependency would probably be delayed. It was assumed that the pattern of informal care provided by relatives and friends would not change significantly.

It proved extremely difficult to establish the exact cost of long-term care. The estimated expenditure for long-term care in the UK in 1995 was £11.1 billion, with £7.1 billion (64%) coming from the public sector and £4.0 billion (36%) from private funding. By 2051 it is estimated

that costs will have risen to £45.3 billion which represents an increase in Gross Domestic Product (GDP) from 1.6% to 1.9%. Of course the report did emphasise that predictions for beyond 2021 were unreliable. This was described as a 'funnel of doubt' with the degree of uncertainty increasing with time. In recognition of this, the Royal Commission proposed that a 'National Care Commission' was established to monitor trends, review the market for care and represent the interests of consumers.

The need for more effective joint working and sharing of responsibility between health, social services and housing authorities was emphasised. The report also stressed there should be greater emphasis on prevention and the promotion of health and independence, including rehabilitation. Perhaps the most radical of all the recommendations by the Royal Commission concerns the financing of care. Care was divided into three elements: personal care, living costs and accommodation cost. At present personal care costs about £8.2 billion or 1.2% of GDP. It is estimated this will increase over the next 50 years to approximately. 1.4% of GDP. The Commission felt that personal care should be free and that this would be affordable. Individuals should, however, continue to pay for their living costs and accommodation if they are found capable to do so on being means-tested.

The recommendation is that funding of long-term care should be financed from current taxation, and in that way the cost is spread and everybody is contributing. It should be progressive and commensurate with what is earned individually and should be flexible. If needs change, the money can be switched between the budgets.

The Royal Commission made a series of recommendations which were generally well received. The report was published 1 March 1999, but apart from the statement that it will study the report there has been no official response from the government. The problems identified by the Royal Commission still exist and further action is required.

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REFERENCES

1 Hutchinson SG, Tarrant J, Severs MP. An inpatient bed for nursing home admissions. *Age and Ageing* 1998; 27:95-8.

2 Fried TR, Gillick MR, Lipsitz LA. Short-term functional outcomes of long-term care residents with pneumonia treated with and without hospital transfer. *J Am Geriatr Soc* 1997; 45: 302-6.

3 Royal College of Nursing. Restraint Revisited: Rights, Risks and Responsibility Guidelines for Nurses working with Older People. London: RCN; 1999.

4 Bowman C. Clinical Geratology – Evidence-based Multidisciplinary Integrated Geriatric Care. *Rev in Clin Ger* 1998; 8:275-7.

5 Royal Commission on the Funding of Long-Term Care. *With Respect to Old Age: Long-Term Care – Rights and Responsibilities*. London: Stationery Office; 1999.

6 Stout RW. Nursing home care in the new millenium - the Royal Commission on long-term care. *Proc R Coll Physicians Edinb* 2000; 32:145-7.