Poster and platform presentations

providing an acute age related emergency admissions service > 70 years). Assessments: single observer interviews and assessments of patients and principal carers within 7 days of admission.

Results
1,278 admissions studied; 225 (20%) readmissions recruited. 51% of readmissions were within 28 days of recent discharge. 55% of patients had no planned medical follow up or arrangements to be seen within 6 weeks of discharge. Most prevalent diagnostic groups were CHF and Acute Pulmonary Disorders. Only 31% of patients were reviewed by their GP between discharge and readmission. 71% of patients with CHF did not receive ace inhibitor therapy in hospital or community prior to readmission. Changes in drug therapy to improve symptomatic control of CHF or COPD were not initiated by patient of practitioner prior to readmission.

Conclusion
Readmissions are a consequence of fragmented care across the hospital/community interface with poor patient compliance and a dependency upon in-patient care by patient and practitioner.

Effect of Audit on Geriatric Day Hospital Activity over Three Years
M J O'Donnell
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Introduction
I have audited Clifton day hospital where GPs have admitting rights and manage their own patients alongside those referred by consultant geriatricians (CG).

Methods
Audit of patients attending during the first week of March for the years 1995-1997 inclusive using RCP/BGS tool for Day Hospital. Data analysed with non-parametric tests [significance p<0.05].

Results
All patients attend twice weekly. Median [range] duration of treatment for all patients fell between 1995 and 1997 from 17[1-85] weeks to 6[1-26], p<0.001. There was no difference between GP and CG patients. Numbers of patients referred for rehabilitation were 46, 45 and 9 in 1995, '96 and '97 respectively; the number referred for assessment was 5 in 1996 and 38 in 1997. The number whose current attendance was for rehabilitation rose from 25 in 1995 to 38 in 1997. In 1995 only 10 patients had a multidisciplinary care plan [MCP] and few had standardised assessments [Barthel-BAD, depression score-GDS, mental test-AMT] and in 1997 48 had MCP, BAD, CDS, & AMT, p<0.01. Those with admission BAD score of 20 fell from 27 in 1995 to 8 in 1997. Significant numbers are depressed on GDS. GPs rarely participate in MCP for their patients.

Conclusions
Between 1995-1997 there was: a reduction in overall treatment duration, an increased use of planned care, an increase in the number of disabled patients referred for treatment, and an increase in numbers attending for rehabilitation. Audit has facilitated a change of activity in the day hospital from day care to rehabilitation.

A Better Way to Measure Disability in Older People
I Chadwick, I Philp, G Armstrong, G Coyle, ABC Machado
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Introduction
Current measures of disability such as the Barthel index are on an ordinal scale thus giving equal weight to each activity. We aimed to develop a weighted scoring system with the properties of a ratio scale for use with the Barthel index, and also as an extended instrument for assessing activities of daily living and instrumental activities of daily living (ADL/IADL).

Methods
Opinion on the relative importance of differing aspects of disability was sought from four groups: experts in health care for older people (n=15), disabled older people (n=17), their carers (n=22), and fit older people (n=22). Magnitude estimation was used to calculate a set of weighted scores for the relative importance of dependency in 18 ADL/IADL activities.

Results
There was good agreement in the rank order of weighted scores amongst the 4 groups (W=0.88,χ²=147.6,p<0.001), although experts gave greater weight to dependency in ADL relative to IADL.

Some example summary scores for dependency in the extended set of ADL/IADL measures are shown below.

<table>
<thead>
<tr>
<th>Item</th>
<th>Experts</th>
<th>Disabled elders</th>
<th>Carers</th>
<th>Fit elders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median (Range for 4 groups)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent accidents of the bowel</td>
<td>796</td>
<td>(652 - 1612)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to feed</td>
<td>710</td>
<td>(611 - 1233)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to walk without help</td>
<td>629</td>
<td>(618 - 724)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to climb stairs</td>
<td>403</td>
<td>(267 - 494)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to prepare meals</td>
<td>296</td>
<td>(369 - 510)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to use telephone</td>
<td>296</td>
<td>(262 - 384)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Conclusions
Our set of weights have properties of a ratio scale and are an advance on previous scoring systems for disability in older people.

Outcome and Dependency of Patients Admitted to Geriatric Continuing Care Compared to Nursing Home
A K. McKenzie, J M A Burns
Department of Medicine for the Elderly, Glasgow Royal Infirmary

Introduction
A review of the dependency and survival of patients transferred to continuing care since the introduction of the Community Care Act