Improving the emergency medical treatment of older nursing-home residents

ADRIAN R. TURRELL, C. MARK CASTLEDEN
University of Sheffield, Trent Institute for Health Services Research, Regent Court, 30 Regent Street, Sheffield S1 4DA, UK

Address correspondence to: A. R. Turrell, 11 George Avenue, Beeston, Nottingham NG9 1HD, UK. Fax: (+44) 114 222 4095. E-mail: adrian.turrell@nottingham.ac.uk

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Introduction

Improving the care of older residents in nursing homes during a medical crisis is an important challenge. Although the respective priorities, accountabilities and responsibilities of homes, hospitals and primary health care services differ, developing a defined and co-ordinated approach is highly desirable [1, 2]. For example, a recent Audit Commission report stated that hospitals were dependent on nursing homes to provide places for frail older people who no longer required acute care [3] and were ‘blocking’ beds [4, 5]. Similarly, older people in nursing homes are vulnerable if, for example, support from general practice is inadequate [6, 7].

Some emergency admissions from nursing homes could be prevented if some ill residents were treated in the homes themselves. This would require better preventative, rehabilitative, diagnostic and interventional facilities [8–24] in nursing homes, as well as support from primary and community care services [25–28] (perhaps equivalent to that offered by hospital-at-home schemes). Such support would enable some older residents to stay in their homes and minimize risks associated with hospital transfer. Indeed, experience from North America suggests that some frail older patients do less well if sent to hospital than if given treatment in nursing homes [12, 14, 16, 29–31].

For older residents with acute medical needs, increased co-operation between public and private sectors would result in more effective use of professional skills and time. Such co-operation would result in more efficient use of hospital facilities, more humane treatment and perhaps better health outcomes and could be enhanced through initiatives such as:

1. Better transfer of documentation between institutions and professionals—especially on admission, transfer or discharge [29 32–35];
2. Better inter-disciplinary support of frail older people to prevent illness and unnecessary hospitalization [36, 37]—given its potential risks, adverse outcomes [5, 16, 22, 30–32, 38–45] and the uncertain effectiveness of emergency treatment [28];
3. Improved recuperation facilities after illness;
4. Systematic visiting by general practitioners (GPs) to nursing homes;
5. Better access to trained practitioners with expertise in old-age medicine [8].

The aim of this review is to examine UK research and explore alternatives to current arrangements for monitoring, assessing, diagnosing and treating older nursing-home residents during acute crises. We reviewed the UK literature through keyword and author searches of Medline and BIDS from 1982 to 1997. Our UK literature search is supported by selective reference to other research findings, particularly from North America.

The hospital perspective: accident and emergency and acute inpatient services

Many nursing-home residents in the UK are admitted directly from hospital to long-stay homes [34, 46–50]. However, hospitals often lose contact with these
patients until they next attend the accident and emergency department or are readmitted—which happens to older people more than other adults [27, 28, 35, 51–53]. When older people re-enter hospital, accurate diagnosis is aided by information from the previous hospital attendance; assuming that accurate and comprehensive clinical information is exchanged [32, 35, 54].

The complexity of illness in old age necessitates access to specialist expertise traditionally provided by geriatricians and psychogeriatricians. This is particularly important in acute crises when speedy and accurate diagnosis can help avoid unnecessary health decline [55]. However, GPs and junior doctors in medical or accident and emergency units may have little such experience or expertise [35, 55–59], which contributes to poor assessment and decision-making [32, 60] and to sub-optimal care [17–19, 21, 22, 58, 61–65]. Furthermore, this British skill deficit may not improve given the threats to the identity of geriatric medicine [66], with the shift towards short-term acute intervention [67], the loss of long-stay National Health Service beds [68, 69], reduced lengths of stay [36, 60] and ever-earlier discharge.

Attendances at accident and emergency units by older people are increasing, especially among the over-80s (56], as is the proportion being admitted to hospital [55]. The care required by these patients can be considerable, and may be less effective in accident and emergency departments which can be busy, noisy, visually disturbing, frightening, impersonal and clinical rather than homely: the antithesis of what older people need when ill and factors in aggravating or creating disorientation [13, 52, 70–72].

The prognosis for some older people after hospitalization, particularly emergency admission, is poor [12, 14, 16, 17, 20, 22, 24, 25, 27, 30, 32, 41, 57, 73, 74], given the attendant risk of further complications [12, 18, 30, 38, 40, 42, 44]. Hence, the need to review how best to manage acutely ill nursing-home residents [75] (especially those over 85). One UK study indicated that demand on acute medical wards by older people from nursing homes increased by 400% over 4 years (numbers of nursing-home beds increased by only 68% during this period). Of these admissions, 91% were emergencies and, of all admissions from nursing homes, 61% were deemed ‘inappropriate’ [60] and preventable if basic facilities or advice had been available in or to the homes [8, 12, 16, 21, 60, 75].

Specialist advice available to accident and emergency departments, GPs and nursing-home staff might prevent unnecessary admission and effect better health outcomes [76], particularly for those older people with complex medical histories or presentations. Making accident and emergency departments and acute medical wards less disturbing to older patients would also help those transferred to hospital [73]. The need to improve documentation on the health needs of older residents, and the transfer of such information when residents move between care settings, seems indisputable. Documentation should perhaps incorporate the wishes of older people and their carers about treatment options, should health crises arise. A recent USA study indicates that if residents are given the choice of acute treatment in their nursing home, rather than being sent to hospital, many would prefer to stay put [77]. In the UK the unavailability of hospital-type care in nursing homes denies residents this choice.

**The primary care perspective**

Inadequate patient data [33, 34] and lack of geriatric expertise and training [33, 59] will prevent some GPs from effectively treating acute illness or preventing and treating chronic disorders in nursing homes. Poor continuity of care to older residents by some GPs can exacerbate this problem [34, 47, 59, 78].

Since the early 1980s GPs have progressively inherited medical responsibility for the frail older population in the wake of the nursing-home expansion and the corresponding reduction in National Health Service long-stay beds. Given the heavy demand on general practice from older nursing-home residents [79] and the indications that many GPs feel under-trained to cope with these demands [59], it is not surprising that some GPs feel overwhelmed by their responsibilities to these patients [6, 34, 77, 80].

Consequences of this transfer of responsibilities to GPs, which has occurred without their prior agreement and without a proportionate increase in investment in GP training or staffing levels, include: irregular GP visiting to some homes [7, 34, 47, 78, 79], inadequate review of residents’ medication by some GPs [6, 7, 33, 34, 78] and some nursing homes failing to gain adequate input from other health workers [34, 49, 59, 78, 81]. Problems such as these are likely to be compounded by the current recruitment crisis in general practice [80].

The ageing population, increasing public expectations, specialist clinics and time spent on administration (which could increase under current National Health Service reforms) may have contributed to the reduction in time available for patient care and visits to nursing homes. One possible way forward is through shared care, as occurs with psychiatric and diabetic patients, and in midwifery and palliative care. For example, geriatric nurse practitioners could provide ‘intermediate’ care, linking primary and secondary care, and shared protocols could then be developed and applied [82].

Training to the standard of the Diploma in Geriatric Medicine would help equip willing GPs to give better clinical support to homes. Properly remunerated [79] adequate GP time to carry out reviews, monitor chronic illnesses and visit those recently discharged...
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### Key points
- Hospital emergency treatment is not always suited to older nursing-home residents.
- Pressures on secondary and primary care services will increase given the ageing population in nursing homes.
- Limited research in this field suggests that the effectiveness of current emergency treatment in homes and hospitals is poorly evaluated.
- Emergency care of older residents would improve by introducing evidence-based treatment.
- Improving emergency treatment facilities, access to geriatric advice and communication between care providers are areas that merit further research.

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