
Inappropriate acute admissions from nursing homes

SIR—Further to our letter of 1997 [1], we established an outreach team, composed of a consultant geriatrician and a nurse experienced in the care of elderly people, to try and reduce inappropriate admissions from nursing homes to our acute medical beds. We assessed potential admissions in the nursing homes and managed acute problems there if appropriate, paying full consideration to views of the family and admitting the patient to hospital if necessary.

We now report a pilot study in which the services of the team were offered to eight nursing homes (those with most acute admissions in the original audit). Before starting, we discussed the project with all general practitioners involved in care of residents in those homes, health authority representatives, members of the Nursing Home Association and all matrons.

Referrals were to be made by either the matron or the general practitioner (with the general practitioner informed about any referrals made by the matron). We then applied the appropriateness evaluation protocol [2] to patients managed by the outreach team and to patients admitted from the pilot homes and from homes outside the scheme. The results are shown in Table 1.

Of those patients managed by the outreach team, a few were admitted briefly to hospital for investigation or stabilization. Of those admitted to hospital from the pilot homes, early discharge was possible with the aid of co-ordination and support from the team in some cases. The consultant, who carried an electrocardiograph machine and peak flow meter, used the laboratory for simple investigations and carried medications including anti-anaphylaxis drugs, intravenous diuretics, intramuscular and oral antibiotics. The use of subcutaneous fluids (supplied by the hospital) and once-daily intramuscular antibiotics was the main change in management.

After the consultant made the diagnosis and began treatment, he contacted the general practitioner and the care plan was discussed. The first dosage of medication was supplied by the outreach team after which the general practitioner took over prescribing. A discharge letter was sent to the general practitioner after the end of the team's involvement with the patient.

The homes involved in the scheme have been supportive, some using it as a ‘selling point’ to potential customers. Some nursing-skill deficiencies were identified (for example pressure area care, subcutaneous fluid use and percutaneous endoscopic gastrostomy feeding). These were addressed during patient care but a formal programme of training is

Table 1. Effect of outreach team visits to nursing homes included in pilot scheme, December 1997–March 1998

<table>
<thead>
<tr>
<th>Home</th>
<th>No. of homes</th>
<th>Total</th>
<th>Fulfilling protocol*</th>
<th>Top three diagnoses</th>
<th>Medial length of contact/stay (days)</th>
<th>Median no. of visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot Outreach</td>
<td>8</td>
<td>31</td>
<td>28</td>
<td>Pneumonia (13)</td>
<td>6 (5 in nursing home, 1 in hospital)</td>
<td>7</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Pressure sore (5)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>DVT (3)</td>
<td></td>
<td></td>
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<tr>
<td>Hospital admission</td>
<td>8</td>
<td>23</td>
<td>23</td>
<td>Fit/collapse (5)</td>
<td>6 (5 in nursing home, 3 in hospital)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Bradycardia (3)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Chest infection (3)</td>
<td></td>
<td></td>
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<tr>
<td>Other Hospital admission</td>
<td>24</td>
<td>54</td>
<td>48</td>
<td>Fits/falls/collapse (16)</td>
<td>8 (in hospital)</td>
<td>5</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Chest infection (10)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>COPD/CCF (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>108</td>
<td>99</td>
<td>-</td>
<td>20</td>
<td>-</td>
</tr>
</tbody>
</table>

DVT, deep vein thrombosis; COPD, chronic obstructive pulmonary disease; CCF, congestive cardiac failure.

*Fulfilling appropriateness evaluation protocol.
needed to improve standards and increase the success of the outreach scheme. The scheme seems to be a success, saving about 190 bed days in 4 months and allowing patients to be managed in the most appropriate setting. For some of those admitted, the scheme has allowed faster discharge. Identification of training needs will help improve formal training and skills of nursing home staff. We intend to expand the scheme to all nursing homes in the area.

**Letters to the Editor**

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**Community hospitals...and district general hospitals**

SIR—I read with interest the paper by Cook and Porter on the effect community hospitals had on admissions to a district general hospital [1]. The authors concluded that community hospitals have only a small effect on the use of district general hospital beds. This contrasts with our study [2], in which we found that when a traditional long-stay hospital was transformed into a community hospital and general practitioners were allowed to admit patients directly (following specific consultant-led guidelines) then the local district general hospital bed use declined.

Given the wide variation in community hospitals as described in the accompanying Editorial [3], I am concerned that we draw too firm a conclusion from the hospitals in Oxford as the use of these hospitals may be influenced by local consultant and general practitioner practice.

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**SIR—**The drive to reduce costs has led to a political imperative to transfer the treatment of some elderly patients from district general hospitals into community hospital or intermediate-care facilities. It has been repeatedly stated, to the extent that it is assumed to be true, that care in community hospitals is cheaper than that in major hospitals [1]. The evidence does not support this.

Unless the patient is mobile and simply waiting for a residential home, the same nurse/patient ratio is required for the more acutely ill patient as for a dependent longer-stay patient needing rehabilitation. The same levels of physiotherapy, occupational therapy and speech therapy are required. Heating, lighting and cleaning costs are the same. There are economies in scale for catering, which is cheaper in the larger district general hospital.

General practitioner time is more expensive than senior house officer time. The same amount of specialist expertise is required whether a ward is in a district general hospital or in a community hospital. The difference in published expense is because a National Health Service costing convention allocates a proportion of the expenses of the ‘super’ specialties and the large administration overheads to each district general hospital ward.

If a ward were to be detached from the district general hospital corridor, no savings in these overheads would be made and the remaining beds would become more expensive. The only savings which can be made are if there is neglect in the community with reduced levels of nursing and therapy staff. Outcome is improved by a dedicated inter-disciplinary team. The recruitment problems in many areas mean that the full inter-disciplinary approach may be denied to patients in some community hospitals.

A balance is required between ease of access for visitors and the ease of access by the patient to specialist and diagnostic facilities in the district general hospital.

I submit that the cost of a ward is the same whether it is attached to a corridor of a district general hospital or stands alone and is labelled a community hospital. Community hospitals have little effect on hospital medical bed use and, by increasing the overall bed use [2], result in additional expense.

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