Nursing homes: a suitable alternative to hospital care for older people in the UK?

ADRIAN TURRELL

Trent Institute for Health Services Research, Core Unit, Regent Court, 30 Regent Street, Sheffield S1 4DA, UK
Fax: (+44) 114 2724095. Email: a.turrell@shef.ac.uk

Abstract

Over the past two decades nursing homes have become the major supplier of long-stay care for frail older people in the UK. Demographic projections indicate that the volume of nursing home places will continue to increase to keep pace with demand and that the population of homes will become steadily more dependent. Little systematic research exists to indicate how nursing home care compares with hospital care; the evidence that does exist tends to be restricted to local studies and thus is not generalizable. Local studies indicate that in both care settings there are shortfalls in terms of meeting basic quality of care standards. Despite this, there is obvious potential for nursing homes to act as an alternative to hospitalization, provided that there is suitable access for residents to specialist care and, for example, appropriate administration of medicines. Proposed changes in government policy will introduce more uniform standards in nursing homes and associated inspection structures and procedures. However, further research is needed to ascertain the clinical and consumer value of different interventions in nursing homes, and the cost-benefit of enhancing provision available in terms of preventing or forestalling demand on hospitals or reducing hospital length of stay. In the light of the commitment to develop evidence based practice, it is important that such research is urgently advanced to eliminate poor practice. In our rights conscious society, future generations of older people are unlikely to be as tolerant of substandard care.

Introduction

Over the past two decades, UK nursing homes have become the largest provider of long-stay health care for frail older people. In 1995 they provided care for an estimated 158,000 residents, compared to 34,000 in long-stay NHS beds [1]. Despite this shift to non-NHS care, the over 65’s (constituting 16% of England’s population), account for 37% of general and acute ordinary admissions and 63% of general and acute bed days [2], 47% of health expenditure [3, 4] and 48% of social services expenditure [5].

Resident dependency in nursing homes has increased over time [6], particularly since the introduction of the 1990 NHS and Community Care Act [7, 8]. This has put increasing pressure on nursing homes [9], possibly exacerbated by earlier discharge [10], although the evidence is equivocal [11–13]. The recent Royal Commission on Long Term Care estimated that the demand for care home beds would double by 2050 [1]. The nursing home sector can thus anticipate accommodating larger numbers of increasingly frail older people.

UK nursing homes operate outside the NHS, predominantly as profit-making institutions. Nursing homes have not been subject to the kind of systematic research or audit that routinely pre-occupies the secondary care sector of the NHS: something recognized for well over a decade [14], and more recently by the Royal Commission [15].

This review of the UK evidence on nursing homes explores whether nursing homes provide a suitable alternative to hospital care for older people given the aim of the Department of Health to secure comprehensive, high quality of care for all those who need it, regardless of where they live [16].

Hospitals and nursing homes: two sides of the same coin?

Patient flows between nursing homes and hospitals reflect a range of factors that are affected by the quality,
configuration and organization of health care provided in these two care settings [2, 17]. For example:

- two-thirds of general medicine and geriatric patients admitted are over 65 [18], thus admissions from hospitals to homes are likely to continue to be important [2];
- average length of stay for older hospital inpatients is falling [2, 19], fuelling the prospect of problematic early discharge [20] to nursing homes [21];
- the spectre of ‘bed-blocking’ by older people in hospital is partly related to slow access to nursing homes [22–24] and inappropriate hospital use by older nursing home residents [25, 26];
- the efficacy of emergency hospitalization for older people is questionable [27–29], feeding the undesirable seasonal phenomena of ‘winter pressures’ (which poor nursing home care can exacerbate [30]), which in turn can prompt premature discharge and subsequent poor recovery [31]. The government objective to reduce emergency hospitalizations of the over 75s [2], [16] emphasises the need to address this problem;
- hospital care for older people in general has been criticised [32–35] with its potential to exacerbate stress, anxiety and illness [36–39]. Nursing homes could prevent hospitalization [26, 40];
- unplanned hospital readmission rates for older patients [41, 42] can be reduced by providing effective care and treatment in nursing homes;
- comprehensive assessment before nursing home admission [28, 38, 43, 44], involving GPs [45] can forestall or avoid subsequent hospital admission.

Arguably, there is much that nursing homes could do to prevent or forestall hospitalization and reduce length of hospital stays [2].

A changing policy context

The location and configuration of UK nursing homes since the 1980’s has been unplanned and hence uncoordinated [46]. As a result, wide variations in the availability of nursing home beds per capita prevail across the UK [47], failing to reflect demographic need or complement local primary and secondary care NHS services [22, 48]. Nevertheless, a wide ranging policy initiatives are now being applied to the older population in general and the long-stay population in particular:

- the advent of the National Care Standards Commission in April 2002 with responsibilities to provide new independent inspection arrangements for care homes [49–52];
- the establishment of national and local Long Term Care Charters [53, 54];
- the development of national standards for older people in acute hospitals [33, 55] and residential care and nursing homes [56–58];
- the drive to increase participation of older people in policy development [59, 60].

What remains to be seen is whether these initiatives can deliver improvements in health care for the long-stay elderly population in nursing homes.

Nursing homes and long-stay hospital care: no comparisons?

Few direct comparisons of nursing home care and hospital care in the UK have been published. Perhaps the best known are studies of experimental NHS nursing homes. Other studies comparing nursing homes with care in hospitals have tended to focus on reporting differences in dependency levels [61–70], although some have been more general [71–75]. The evidence from studies of NHS nursing homes indicated that there was little to choose between these two care settings [76]. However, two differences were noted: the more rapid deterioration in mental and physical functioning [77] and a greater risk of accidents [78] for nursing home residents. These differences were attributed to the greater freedom (and hence superior quality of life) of nursing home residents compared to their hospital peers [79–81].

Hospitals and nursing homes: physical environments compared

The trials of NHS nursing homes indicated that they offered a better physical environment compared to geriatric wards, and could cater more easily for individual lifestyle choices—an argument supported elsewhere [71, 76]. Whether this is typical of nursing homes today is questionable: resident’s perspectives on this issue may differ markedly [82] and homes and hospital wards vary up and down the country [43, 72, 74]. Although the Royal Commission commented that standards of buildings and amenities within care homes were improving [83], they are still thought to fall below proposed national standards [58] to be enforced by the proposed National Care Standards Commission.

A recent report critiqued many aspects of acute hospital treatment of older patients, prompting the Secretary of State for Health to establish a National Service Framework for Older People [55] and the Dignity on the Ward campaign [84]. Similar scope to improve the quality of nursing home accommodation has been identified [71, 85, 86], although greater criticisms sometimes applied to the hospital ward environment which were viewed as less personal, private and homely environments [43, 71, 73, 87].
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Nursing homes: markers of good quality care and support

In this context the UK nursing home literature is reviewed against five markers of nursing home care, chosen because some evidence of practice exists in these areas. These markers are:

- prescribing practice;
- access to medical care;
- access to nursing care;
- access to rehabilitation therapists and facilities; and
- patient documentation and assessment.

Prescribing practice

Multiple drug use is common amongst older people with the risk of hazardous consequences if not carefully monitored [88]. Comorbidity in older nursing home residents manifests itself in the high levels of medication per capita [73, 89, 90]. Drug therapies in nursing homes are not subject to adequate scrutiny: with wide variations in prescribing practice, overuse of psychotropic drugs and infrequent medication review [86, 91–98]. Poor drug management by GPs in relation to older patients carries a higher risk of hospital admission [99, 100]. Although medication should be reviewed as part of the annual over 75’s health check [101], these may be undertaken by nurses, not GPs [88].

However, recent reports on prescribing practice in general [102], and GP prescribing support initiatives in particular [103], may help improve medication management and monitoring in nursing homes.

Current nursing home inspections have to be undertaken at least twice per annum. Inspections should include an audit of drug records; the inspection team can be advised by pharmacists. However, recommendations for change based on prescribing anomalies are not enforceable.

Existing home inspection mechanisms have been described as ‘incomplete and patchy’ having developed in a ‘piece-meal fashion’, resulting in new proposed standards in areas such as the administration of medicines in homes [58]. These and all other proposed standards were out for consultation until March 2001 in anticipation of the establishment of the National Care Standards Commission in April 2002. Given the pockets of evidence indicating poor prescribing practice in nursing homes [104–106], there seems no defence for failing to adopt these new standards.

Access to medical care

Frail older patients, especially with comorbidity, need regular medical supervision. Medical assessment on admission, and systematic monitoring thereafter are an essential prerequisite of appropriate treatment and rehabilitation. Whilst consultant physicians, geriatricians and psychogeriatricians are responsible for medical care of their older patients in hospitals, GPs bear this responsibility in nursing homes.

Older residents of nursing homes suffer from a range of conditions that commonly occur and can be poorly managed (for example: diabetes mellitus, incontinence and confusion [48, 98, 107–114]. It is the manifestation of such conditions in frail older people that demand the particular expertise of specialists if they are to be managed effectively [115]. However, such specialist expertise is not routinely available to nursing homes [86, 116], even though one study revealed that the presence of specialist advice or equipment could have prevented over 60% of hospitalizations [26].

A GP’s input to nursing homes may be contracted through a variety of arrangements, but delivering care to nursing home patients under the terms of their General Medical Services (GMS) contract is proving onerous and has elicited calls for nursing home residents to be excluded from the GMS contract [117, 118]. Evidence that GPs are struggling to institute regular medical review of nursing home patients clearly exists [85, 89–91, 95, 96, 119, 120] and may be compounded by whether residents keep their GP following transfer to homes [43, 87, 95, 121]. The requirement, under their GMS contract, to make home visits can determine whether GPs agree to keep their patients when they move into a home, bearing in mind the extra workload involved [90, 97, 122, 123].

Access to nursing care

All registered nurses, whether in hospitals or homes must demonstrate that they are updating their clinical practice through training. In hospitals, nurse training and ward skill-mix are monitored. Even so, hospitals still fail to deliver quality nursing care [32, 33].

Nursing homes must provide on-site trained nursing care 24-hours a day. However, the number of trained nurses employed in homes is agreed with the registering authority when the home is first registered and empty, based on the number of beds. If average resident dependency increases over time, the need for more trained staff grows too, but it is difficult to enforce changes in levels of trained nursing staff because:

i) the original registration is based on an agreed (lower) staffing level;

ii) a twice annual inspection only provides two potentially unrepresentative snapshots of resident dependency, and

iii) there are no nationally agreed measures of resident dependency to rely upon.

Nursing home nurse staffing and training levels may be equivalent to, if not better than those in geriatric
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hospitals [73]. But most evidence indicates that there are a range of concerns in respect of the level of training and skilled nursing care in homes [21, 58, 71, 74, 95, 104, 119, 120, 124–128].

Hospitals use the skills of specialist nurse practitioners, clinical nurse specialists, link nurses and practice development nurses to inform nursing practice. Nursing homes can, in theory, gain access to such nursing expertise if it is locally available. But there is no statutory duty on them to do so and no evidence that homes systematically obtain such support [21, 86, 107, 121]. The government’s reluctance to adopt the Royal Commissions’ recommendation to fund nursing care provided in nursing homes, in spite of recent legal judgements [129, 130], indicates that any development in this field may continue to rely on private finance in a sector where profit margins are already being squeezed.

Access to rehabilitation therapists and equipment

Rehabilitation services in hospitals may or may not be better than in nursing homes: studies making comparisons are rare [73, 74]. However, if access to specialist nurses is relatively rare in nursing homes, the same is true of rehabilitation therapists and mobility aids/equipment [43, 71, 73, 89, 121, 131–133]; an area where resident entitlement to support both is confused and confusing [43, 134]. Limited availability of local rehabilitation resources may explain the poor support to nursing homes, rather than nursing home policies or funding [131, 133]. Either way, the effect may be to increase the risk of hospitalization [132].

Patient documentation and assessment

Good quality assessment and documentation of nursing home patients is an essential prerequisite to ensuring that care is delivered efficiently and effectively. The public sector may not set an example for nursing homes to follow, given accounts of poor or inconsistent assessment and documentation on hospital admission or discharge [45, 85, 86, 89, 135] and in relation to continuing care placement [21, 86, 89, 136–141]. Assessment in nursing homes by GPs [88, 91] or by other staff can also be deficient [86]. Nursing documentation in the form of care plans must be systematically kept in nursing homes (as in hospitals), but whilst hospital nursing documentation is subject to routine audit, nursing home documentation is reviewed twice per year.

Developing a research agenda

The debate about the potential of UK nursing homes to develop services to older residents is seriously hampered by a lack of evidence. Given the important relationship between nursing homes and hospitals, improving nursing home care may offset demands made on hospital and/or GPs. Many research issues are worthy of pursuit:

- the impact of nursing home interventions in relation to hospitalization, GPs, quality of life and health outcomes;
- the impact on care costs and quality by improving access to specialist practitioners;
- the impact of protocols on standards in homes;
- an analysis of nursing home data collected by the National Care Standards Commission.

Conclusion

Nothing referred to here can prove that health care support to older residents in UK nursing homes is endemically substandard, compared to the care that would be provided if these residents were in hospital. Excellence does exist in UK nursing homes. However it is unclear how commonplace it is. This is unacceptable in an evidence-based health service and merits urgent remedy.

Government initiatives in the field of long-term care suggest that a crossroads is about to be reached in terms of policy that will determine in which direction practice is encouraged to go. It is tempting to argue that to take nursing homes in any clear national direction would be substantial progress. Key stakeholders in the process are geriatricians [142] and over-burdened GPs. Key issues include how to involve these clinicians appropriately in nursing homes, improving facilities and training in homes, gaining access to more community-based specialists. Looked at broadly, such investment may be cost-effective—if inappropriate hospitalization is to be avoided.

Future rights-conscious consumers of long-term care are unlikely to be as tolerant of the gaps in our knowledge, the inconsistencies in practice, and the cost-shunting between care sectors that now prevails in a disjointed long-term care system. The opportunity to address these issues should be grasped now, or the disparity between standards set in other areas of health care and in long-term care will be rightly exposed by future generations expecting excellent care in all nursing homes.

Key points

- Frail older people will place increasing demands on nursing homes.
- High quality nursing home can prevent or forestall hospitalization and reduce length of stay.
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- Government policy on long-term care is at a crossroads with new national standards and inspection mechanisms due to be implemented in 2002.
- Standards of care in nursing homes vary widely and residents needs should be addressed by ensuring, for example, that required levels of specialist clinical support are accessible.
- There is no conclusive evidence to indicate whether or not nursing homes do or can provide a suitable alternative to hospital care.
- Further research is needed to evaluate the impact of nursing home interventions in terms of quality of life, health outcomes and cost-effectiveness.

References

1. HMSO. With Respect to Old Age: Long Term Care—Rights and Responsibilities. A Report by The Royal Commission on Long Term Care. Cm 4192-I. London: HMSO, 1999. (See Research Volume I, Chapter 1, Table 2.10).
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