Letters to the Editor

Comment on ‘Care home medicine in the UK—in from the cold’

Sir—We read with interest the commentary by Donald et al. [1] describing current and emerging models of medical care provision to homes in the UK.

As the authors state, the medical care of elderly residents in nursing homes is invariably provided by general practitioners (GP).

However, with the introduction of the General Medical Services contract in 2004, many GPs no longer provide out-of-hours care but contract this from other agencies. This may result in a ‘deputising’ GP assessing a resident with complex problems about which he or she knows little or nothing.

In 2005, we surveyed the six nursing homes in what was then one of five Primary Care Trusts (PCTs) in Leeds (population ~150,000) to determine how medical care was provided to residents in- and out-of-hours and what information was available to doctors assessing patients.

A questionnaire was sent to all 91 GPs in the South Leeds PCT and the matrons of all six homes had a structured interview.

A total of 69 GPs (76%) responded; 66 looked after residents during the day, but only 12 out-of-hours. Out-of-hours cover was provided by GP deputising services to all six homes which had between 30 and 120 residents, and 1 and 11 general practices responsible for their residents’ care. Daytime cover varied enormously depending on which GP a resident was registered with. At best, one practice provided a session every fortnight with a 6- to 8-week routine review of residents on its list. Specific sessions or routine reviews were not provided for other residents who would only be seen if problems arose.

Five matrons felt that care during the day would be improved by fixed GP sessions and regular reviews of all residents. All matrons felt that out-of-hours care could be improved.

During the day, GPs obtained information about residents from GP medical records but these were unavailable out-of-hours, when they were reliant on information from nursing staff.

GP’s felt that the information available during the day was adequate, but the vast majority felt that out-of-hours it was inadequate. Five matrons felt that the lack of information available to GP’s out-of-hours was a significant factor in hospital admission.

The move to community-based services [2] has resulted in more frail elderly people being cared for in the community and their care is largely falling on GPs. We must recognise that out-of-hours, this is often provided by a ‘deputising’ GP and strive to ensure that nursing homes have adequate information available within the home to provide the best possible care for this vulnerable group of people and prevent unnecessary admission to hospital. Initiatives which provide dedicated primary care sessions to routinely review patients, and the involvement of community matrons and community geriatricians as described by Donald et al. should be welcomed.

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The geriatric day hospital: past, present and future

Sir—the editorial by Young and Forster is timely, and made refreshing reading [1]. The future of the geriatric day hospital remains insecure but only if it sticks to its traditional role. Over past decades, the elderly population has changed and so have the demands on geriatric services. The multidisciplinary model of care is now being applied to many areas which were traditionally managed in outpatient clinics.

Geriatric day hospital is ideally placed to provide an environment suitable for frail patients irrespective of pathology. Availability of physiotherapist, speech therapist, dietician, pharmacist and occupational therapist under one roof makes the day hospital model ideal to deliver a seamless service. Fenced parking, dedicated transport, toilet facilities suitable for disabled patients, in-house phlebotomy, kitchen facility and most importantly nursing staff capable of meeting
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the specialist needs of frail patients gives geriatric day hospital a distinct edge over any other outpatient service.

Our experience of establishing a heart failure service for elderly patients based in the day hospital is an example of an innovative use of this resource. Elderly patient with possible heart failure were referred to the outpatient clinic but the patients had to make three to four hospital visits prior to confirmation of diagnosis and it took at least 6 weeks. Walking through long hospital corridors and visiting different departments was beyond the capability of many frail patients. However, concentrating services in the day hospital with in-house facility for echocardiography, respiratory function test, phlebotomy and close working relation with the X-ray department led to the diagnosis being confirmed and treatment commenced or changed on the very first visit. The day hospital environment and availability of multidisciplinary rehabilitation complemented this service as many frail patients with heart failure had unmet rehabilitation needs.

The future of geriatric day hospital is bright provided its role changes with the changing needs of the elderly population. It should maintain its traditional role but should offer new flexible services for frail elderly patients; the possibilities are endless. As the working of the geriatric day hospital is changing, it may be prudent to rename this facility. Elderly Medical Assessment Unit will be more realistic and will help to change its image.

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The effect of bedrails on falls and injury

SIR—Healey et al. [1] are to be congratulated for their review of the use of bedrails. I agree with their balanced conclu-...