

## EDITORIALS

# Do we still need care homes?

Specialist geriatric medicine in the UK grew from long-stay hospital wards, but nowadays expends considerable effort in trying to avoid institutional placement. And not unreasonably. Most older people would rather stay at home, and health services should aim to maximise function, and avoid unnecessary disability. But is this the whole story?

A paper by Bowman *et al.* in this issue reports a census of residents in BUPA's residential and nursing homes [1]. The population was very elderly (69% over 80, and 26% over 90). They describe high prevalences of mobility disability (82% nursing, 60% residential residents requiring help), incontinence (80% nursing, 50% residential) and mental health problems (80% nursing, 70% residential). 27% overall were confused and immobile and incontinent. Various forms of 'brain failure', particularly dementia and stroke, were identified as leading reasons for admission.

In the 1970s and 1980s various studies described disability and dependency in long-term care facilities (e.g. [2, 3]). A major focus was prediction of the type of care required, attempting to draw disability thresholds for local authority or private residential homes, nursing homes or long-stay hospital beds. Considerable overlap was evident. One popular explanation was inadequate assessment and consequent widespread misplacement. But the reality was more complicated. Residents who deteriorated in low-dependency settings were often allowed 'security of tenure'. Particular mixes of physical, mental and sensory impairments were not always well described on single dependency measures (for example, dementia or blindness were often associated with relatively good basic activities of daily living scores). What characterised a particular setting was more the mix of residents than the absolute level of dependency.

Following the expansion in provision of private nursing and residential care, the decline in long-stay hospital care, and renewed emphasis on domiciliary support in the 1980s, age-specific institutionalisation rates remained remarkably constant, despite a rapidly ageing population [4, 5]. At the same time systematic study of disability and dependency in care homes largely dried up, not least because access to scattered private establishments was difficult to obtain.

Recently a few studies have revisited the issue of dependency in institutional care [6–8]. For example, Netten *et al.* reported a cohort of 2,544 new, state-funded, admissions to care homes. Of these, 60–70% had dementia (including 35% with behavioural disturbance), 50–75% were incontinent and 40–80% required help with mobility. Although half the residential placements were 'low dependency' on the Barthel Index, 37% of these had dementia, and they concluded that the great majority of placements were appropriate. Mortality at 30 months was 60–80% [6]. Mortality patterns suggested that prognostic factors (conditions expected to

deteriorate) explained some apparent discrepancies in disability levels. The recent studies generally support the contention that the disability of residents in homes has increased (probably substantially) over the years.

Bowman *et al.*'s study is notable for its size (15,000 residents in 244 homes), and completeness of the data (97%). The inclusion of self-funded residents makes the denominator population more typical than previous studies which only included state-funded residents [6, 8]. Information bias is possible if homes wished to impress on their head office how hard they were working, and ascertainment of main diagnoses was via non-health professionals in residential settings, but the data collection form was simple, and disability prevalences were similar to other recent reports.

Seventy-three per cent of residents were state funded, about in line with national figures. Although the majority were nursing placements, the 4,000 residential home residents make this a substantial sub-study in its own right. The study was cross-sectional, so describing the work of care homes at any one point in time, but not the experience of a cohort of new entrants. Differential survival, changes in health, and the effect of the home environment could all cause these to be different, but the figures were similar to those from studies of consecutive admissions [6–8].

Is this an exercise in self-justification by a large care-home provider? Or do they have a point? Avoiding unnecessary disability through appropriate rehabilitation should remain a priority. But rehabilitation cannot restore irrevocably damaged people or indefinitely defer the impact of progressive disease. Many remain too disabled to live independently even after rehabilitation. In theory, it should be possible to manage anyone at home with sufficient will and resources. Unfortunately, in some cases there is not the will. The truth that most people want to remain at home is sometimes assumed to mean that all older people want to remain at home, which is not the case. In other cases there are not the resources, be that a cohabiting spouse, or intensive home care. Caring for someone alone at home with dementia and poor safety awareness, and unpredictable need for assistance, remains difficult or impossible. Support at home requiring more than about 4 h of care a day is more expensive than care-home placement. Support at night is very hard to come by.

The goal of rehabilitation is often stated to be the 'maximising of functional abilities'. In an era of patient choice and increased respect for autonomy, maybe this can be restated as 'increasing the number of choices available to patients and families'. In many cases this will mean avoiding unnecessary and unwanted care-home placement. In practice, not every placement is avoidable.

Some people cannot get home, some have little inclination to do so. Institutional care will continue to be an inevitable

and important part of the spectrum of continuing care. Bowman *et al.* point out that care-home commissioning, provision and regulation currently reflect a social (rather than medical) model of care. They question the distinction between residential and nursing categories, as others have done [8]. They suggest that greater attention to clinical needs may enhance 'social' functioning, as well as limiting avoidable acute events and hospitalisations. They also lament the absence of healthcare expertise in UK regulatory bodies, and suggest that systematic ongoing monitoring of health status is required to track care needs and monitor outcomes. All are sensible points.

Rather than considering care homes a backwater for unwanted and uninteresting citizens, a more compassionate approach would recognise their necessity, and develop positive policies for meeting the health and social care needs of residents, including adequate provision for medical care, rehabilitation and occupation. High quality nursing home care is possible [9, 10], although there is pitifully little research evidence to guide us. A renewed drive to develop more positive philosophies of care is overdue.

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## Inappropriate prescribing in older people

Inappropriate prescribing, medication errors and drug-related morbidity have become the focus of international interest in recent years. Publication of *Organisation with a Memory* [1] in the UK, and *To Err is Human* [2] in the USA has highlighted the incidence of injury caused by medication, and the cost to healthcare systems. In response to this interest, groups such as the National Patient Safety Agency, Agency for Healthcare Research and Quality and the Australian Council for Safety and Quality in Healthcare have focused on tackling errors in healthcare, including medication errors.

In the UK, the government has made a commitment to reduce serious errors in prescribed drugs by 40% by 2005 [3]. One element of this is the publication of a report by the Chief Pharmaceutical Officer [4], which highlights some of the most serious types of medication errors, and proposes systems of working that can be implemented by individual organisations to help prevent future occurrences.

International work on medication-related admissions has shown that a median of 7% of hospital admissions are medication-related, and that around two-thirds of these admissions are potentially preventable [5]. Older people are known to be at higher risk of drug-related morbidity, with as much as a four-fold increase in the likelihood of older people being hospitalised with an adverse drug event [6]. Older people in care homes, known to take more medications than older people in the wider community [7], are particularly at risk.

The National Service Framework (NSF) for older people recognises the special medication needs of older people and the need for regular review of medications (6-monthly in patients taking four or more medications) to help avoid inappropriate prescribing and drug-related morbidity [8, 9]. However, only 30% of nursing home residents in a study in Leeds had had a medication review in the previous 12 months [7].