Contemporary Themes

Blocked beds

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Summary

In a cross-sectional survey of 325 surgical and orthopaedic beds 43 (16%) of the 265 occupied beds were filled by patients who had no medical need to be in an acute ward. They had been in hospital for a median time of 40 weeks up to the survey date. Of the 43 patients, 11 were awaiting transfer to a geriatric ward; 13 to community residential care; and seven to their homes. There was no plan for discharge or transfer for the remaining 12 (28%). Those "at risk" of becoming long-stay patients for social reasons on these wards were women, over 75, living alone or with one relative, who had been admitted to hospital in emergency with a fractured femur, head injury, or other trauma. Action necessary to reduce the number of social long-stay patients includes (a) changing attitudes to the solving of social case problems; (b) revising procedures of assessment and planning of future care; (c) improving teamwork and record keeping within the hospital and the community services; (d) providing a better balance of acute, medium, and long-stay hospital beds; and (e) putting more resources into rehabilitation.

Introduction

The problem of patients on acute medical wards who do not need medical care came to attention in Newham District because of shortages of emergency admission beds and great financial pressure. Compared with other districts, we noted longer lengths of stay in some acute units and that there were more acute beds but fewer geriatric beds. There were many opinions, but little exact information, on why patients needing no more than social care stayed in hospital.

Methods

A cross-sectional survey of surgical and orthopaedic wards was carried out on a Monday morning in May 1976. All patients who had occupied a bed on these wards for 28 days or more up to that day were reviewed and, largely on the basis of nursing assessment, those regarded as not needing to be in an acute hospital bed were selected for study including personal and medical details; social and nursing assessment; residence before admission; plans for discharge; and precisely why they had not returned to their homes. This information was collected at interviews with nursing, social work, medical, and administrative staff and by inspecting medical and nursing records. Geriatric hospital and social services departments' waiting lists were examined, and the dates of key events were noted.

Results

In four hospitals 325 beds containing 265 patients (81% occupancy) were reviewed. Eighty patients had been in the acute wards for more than 28 days, and 43 patients did not need medical care and were therefore blocking 13% of the acute beds. The ages of these 43 patients ranged from 39 to 98, median 83 years. There was a ratio of four women to each man. The commonest diagnosis was fractured femur (17), followed by head injury (5), and amputation (3). The accident and emergency departments had admitted 35 patients. Thirty-one patients (67%) had previously lived alone and a further 11 (25%) with relatives, usually a younger relation who went out to work. In comparison only nine of 37 patients (24%) who *did* need to be in hospital had previously lived alone, and nine with relatives.

These 43 patients, who did not need hospital care, had none the less been inpatients for between five and 234 weeks, median 40 weeks. Seven patients had been in hospital for over two years. The longest-stay patients had been transferred into acute wards after the closure of two small, non-acute hospitals.

Disabilities included some limitation of mobility in 32 patients, varying degrees of incontinence in 25, and mental confusion or abnormalities of behaviour in 26.

Eleven patients were receiving no nursing care, 20 were in nursing care group 2 of the scale developed in Oxford by Barr,[1] and only three required nursing in bed. Fifteen patients were receiving no medical treatment, and none of the remaining 28 were having more than oral medication. No occupational therapy was available to these patients, and any physiotherapy tended to be intermittent.

When the future plans for the patients were studied it was found that 11 were awaiting transfer to a geriatric ward, 13 to some form of community residential care, and seven to go home. There were no plans for discharge for 12 patients (28%). The median interval between admission and appearance of a patient's name on a geriatric hospital or social services department waiting list was 27 weeks. Referral to a medical social worker appeared to have taken place, on average, 12 weeks after admission.

Discharge home was planned for only seven patients, although 18 patients were thought by nursing, medical, and social work staff to be physically and mentally capable of returning home, given ideal circumstances including family support. For nine of these patients progress was being held up by reluctance of the relatives either to have the patient in their own home or to help in care at the patient's home. The professional staff sympathised with this attitude in four of the nine cases—for example, where there had been many years of bad relations between patient and relatives—but the general feeling was that relatives were not accepting their proper responsibility for the remaining five, and medical social workers were continuing to work with these families.

Discussion

The proportion of patients in acute hospital wards but not needing medical care found in this small survey was slightly

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smaller than the 22% reported from Liverpool[2 3] but the effect on emergency resources and average lengths of stay of blocking 13% of acute beds is obvious. Financially the 43 patients were estimated as absorbing over 1% of the total district budget for 1975-6. From 1982 this district's acute hospital services will be provided from only two hospitals, one of which will be a "nucleus,"[4] and this will require a change to high intensity use of a smaller number of acute beds. Thus it is necessary to solve or minimise the blocked-bed problem. But how?

A basic need seems to be to change attitudes. The long delays in organising effective action and the fact that no plans for discharge or transfer had been made for 28% of the patients showed the low priority given to solving these largely social problems. For the medical staff this is understandable as their attention was necessarily focused on the patient's medical needs. Social workers, however, are expert in this field but the impression was gained in this survey that they tended to be undervalued, even by themselves, and their activities were regarded by some hospital staff as peripheral—only in one hospital were they allowed to write in the ward notes. The second major requirement—revising procedures of assessment and planning of future care—arises from the fact that medical decisions are made within a defined organisational structure whereas social action, such as arranging a complex discharge from hospital, demands collaboration, based upon good communications, between widely separated people not related by a hierachy.[5 6] Examples of weaknesses in team work were that information on a patient could be found in various places within the hospital so that no one knew the total picture, a patient's name could be added to long-stay hospital waiting lists without the relevant consultant visiting the acute ward or advising the staff there, or the primary care team did not appear to play any part in planning future care.

A reasonable conclusion is that the planning and providing for the patient who has completed medical treatment, which absorbs such a large proportion of NHS resources, must be given serious consideration from the first day of admission, especially of a socially high-risk patient—that is, the elderly person living alone.

This would demand changes in existing procedures, including the noting of a careful social history and the first discussion with the relatives on admission, followed within a day or two by an interview with a social worker leading to home assessment and exchange of information with the domiciliary teams, so that the patient's place in the community does not "disappear" during the stay in hospital.

Rehabilitation advice to ward staff from geriatrician or consultant in rheumatism and rehabilitation, or both, would clearly be of great value. Shared care or combined ward rounds might be advantageous.

These changes would mean that a plan for the patient's future care, based upon comprehensive assessment of the patient's likely needs, could be prepared and discussed with the patient and relatives at the same time as, and not after, the completion of medical treatment.

This district is doubtless not atypical in that reallocation of resources including the redesignation of beds from the short to the long- or medium-stay wards seems necessary and desirable in theory but almost impossible in practice. This study confirms that such a change is essential if hospital services are to match up to the reality of population needs. Of the allegedly acute surgical and orthopaedic patients studied here, 16% basically needed the rehabilitative skills of the geriatrician. It is all too easy to see the blocked-bed problem as a misuse of expensive hospital technology, whereas it is even more a disservice to patients who are misplaced and lacking the attention they need.

Local authority social services departments have been criticised for not taking patients away from acute hospital beds,[7] but in this study only one-third of the patients who did not need to be in hospital were waiting to go into residential community homes. Local authorities do not appear to be any more able than health authorities to command the money to build more residential places at present, and thus the problem of housing the elderly patient seems to come to (*a*) discharging home every one who can be cared for at home, and (*b*) making the best use of existing resources for the remainder. This means giving the social needs of elderly patients as much care and attention as is given to their medical problems.

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What is the incidence of retinitis pigmentosa in the population? Are both men and women affected or are women carriers? A patient of mine is affected and is now blind. What is the chance of the children of his two daughters being affected and at what age can the disease be diagnosed before the onset of eye symptoms?

The incidence of retinitis pigmentosa in England is not known. It has been stated that it occurs in some five persons per 1000 of the world population,[1] although other authors have suggested figures that are probably more realistic—1 : 7000 in Switzerland[2] and 1 : 4500 in Israel.[3] Both men and women are affected, the male to female ratio being about 6 : 4; and the disease may be transmitted as an autosomal dominant, an autosomal recessive, or an X-linked trait.[1] In the family in question it is not possible, without further information about the father and his family history and without examining his daughters, to state whether the grandchildren are at risk of being affected. If the father has the autosomal dominant form of the disease, and his daughters are unaffected, the chances of the grandchildren being affected are small. If the father has the autosomal recessive form and his daughters have not married a relative, the chances of the grandchildren being affected are very small. If the father has X-linked retinitis pigmentosa his daughters will be carriers and will have a 50% chance of producing affected sons. The carrier state can, however, be diagnosed in almost every instance[4] and this possibility can therefore be ascertained. The disease can be diagnosed in children before the onset of symptoms by electroretinography or electro-oculography. Electroretinography can be performed on small children under a general anaesthetic, but this is seldom justifiable in the absence of symptoms. Most children will co-operate sufficiently by the time they are 7 or 8 years old for electro-oculography to be performed; if the result of this is normal they are unlikely to develop retinitis pigmentosa.

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