

Contemporary Themes

Geriatric patients in an acute medical ward

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Summary

During a nine-month study 160 out of 482 bed-weeks in an acute medical ward were accounted for by 11 patients who no longer needed to be there. This was unsatisfactory both for the 11 patients concerned and for those patients requiring admission for whom the beds were blocked.

Introduction

This study was initiated because it is proving increasingly difficult to admit acutely ill medical patients to the wards. There seems to be a serious shortage of beds. In several instances patients who would have benefited from the specialised resources of a large teaching hospital could not be admitted from the outpatient department, surgical wards, or other hospitals without unacceptable delays.

Method

Over nine months a weekly study was made of all patients under the care of one consultant team. The patients concerned were in the female medical ward of a large teaching hospital.

One day each week the complete medical team met to review treatment. They were asked to state whether medical investigations or treatment were still in progress or whether completed for each patient. Patients who remained in the ward after medical care had been completed were noted and their records studied in detail.

Results

On average 33% of beds under one consultant's care were occupied by patients no longer in need of acute medical care. Of the total 482 bed-weeks studied 160 bed-weeks were accounted for by 11 patients. Medical care had been completed for these patients and they were all awaiting alternative accommodation.

These patients had an average age of 79.3 years (range 62-89 years). Before admission eight patients had been living alone. Two had been living in residential homes for the aged, and in neither case was it felt that the patient could return: one had quarrelled with the staff there and the other had become demented. Another patient had been nursing her 90-year-old invalid husband, who died shortly after she was admitted. These 11 patients spent an average of 1.4 weeks (range 0-5 weeks) in the ward for medical reasons compared with an

average of 14.5 weeks (range 1-32 weeks) waiting for after care accommodation. Three patients were admitted not for medical reasons but because the appropriate units (in two cases geriatric, the other psychogeriatric) were unable to accommodate them. Three patients were admitted because of cerebrovascular disease, two after digoxin toxicity, one after a myocardial infarction, one after confusion and amnesia, and one after grand mal seizures.

During the period seven of these patients were waiting for alternative accommodation a variety of incidents additional to their admitting complaint occurred. Two patients developed respiratory infections and one a urinary tract infection, one became doubly incontinent, two fell out of bed, while another fell in the ward, breaking her leg.

Three of the patients suffering from confusion and dementia frightened other patients in the ward by roaming at night, being noisy, and trying to climb into other patients' beds. Two patients were accepted by a convalescence home for two weeks but returned to the ward as soon as the allotted period was over. In another case the relatives took the patient to Lourdes but returned her to the hospital a week later. These bed-weeks were not included in the total.

Of the 11 patients four were eventually discharged to geriatric units, three to psychogeriatric units, and one to a convalescence home before going to her own home, and one patient died. Two patients were still awaiting discharge at the end of the study—one to a psychogeriatric unit and the other to a geriatric unit.

Discussion

These patients were occupying beds urgently needed to relieve beds in the acute medical receiving area. They no longer required the facilities of a large teaching hospital nor were they always suitable for teaching purposes. Clearly an acute medical ward is not a comfortable or suitable place for long-term stay. This is not a new problem; eight years ago a study in the acute medical wards of Aberdeen hospitals showed that one-third of the beds were used by long-stay patients.¹

One bed-week in this teaching hospital costs £178.60; in a local geriatric hospital it costs £49.01. Consequently the 160 bed-weeks accounted for by these 11 patients cost £28 576.00, whereas they would have cost only £7 841.60 in the geriatric hospital. Thus a £20 734.40 would have been saved if these patients could have been accommodated in geriatric hospitals as soon as they were ready for discharge from the acute medical ward.

The lack of available geriatric beds is mostly due to staffing difficulties. There was an average shortfall of nursing and paramedical staff in the geriatric services of 25-30% during 1974. As a result at least a quarter of the 500 geriatric and psychogeriatric beds in this district were closed. The shortage of geriatric beds was aggravated by the lack of local authority accommodation. In 1970 Sumner and Smith² pointed out the lack of provision for the elderly outside hospital in Scotland. At the end of 1974 (six months into the study period) there were 56 patients in geriatric hospital beds in the district who had been accepted as suitable for transfer to local authority accommodation,³ but this was not available. In March 1974 the cost per bed-week in local authority accommodation was approximately £23—half that of a geriatric hospital bed and one-eighth that

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of an acute medical bed. Thus there is a chain reaction: acute medical receiving beds are blocked because the acute medical beds to which patients should be transferred are blocked by patients who should be in geriatric beds; but these are blocked because there are too few local authority beds to receive patients discharged from geriatric wards.

The acute medical ward is unable to offer its highly specialised and expensive resources to the appropriate patients because a third of its beds are occupied by patients no longer in need of medical care. As Rosenfeld *et al* have said, this type of hospital will only operate to "the best advantage of the sick, the payment agency and the community at large if both admission and length of stay are based on the patients' needs for service which cannot be rendered as well in other types of institutions, out patient clinics, general practitioner's surgery, or at home."⁴

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Clinical Studies

Ambulatory electrocardiographic records in patients with transient cerebral attacks or palpitation

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Summary

Continuous electrocardiographic (ECG) records were made over 24 hours in 130 ambulant outpatients complaining of syncope, dizzy turns, or palpitation. In all these patients resting ECGs had failed to show significant dysrhythmias. Exercise testing was performed on 64 patients and also failed to reveal any dysrhythmias. Analysis of the tape recordings, however, showed appreciable dysrhythmias in 74% of the group. In most cases the dysrhythmias were complex mixtures of rapid supraventricular and ventricular rhythms. Bouts of ventricular tachycardia were seen in seven patients, all of whom were women. Episodic complete heart block was seen in only two patients, but prolonged ventricular gaps (greater than 1.5 s), not associated with ectopic beats, were found in 26. No episodes of ventricular fibrillation were recorded.

We conclude that many patients with vague symptoms suggestive of transient cerebral ischaemia or irregular heart action have significant and often dangerous dysrhythmias which can be diagnosed only by long-term recording of the ECG under fully ambulant conditions.

Introduction

Episodes of transient cerebral ischaemia presenting with ill-

defined symptoms such as "dizzy turns" are a common reason for hospital outpatient referral. Many of these patients have no obvious abnormal physical signs and are often labelled as suffering from cerebral arteriosclerosis. Similarly, many patients are referred with "palpitations" and are thought to be neurotic when examination shows no abnormality. Transient cardiac dysrhythmias could account for the symptoms in both groups. McAllen and Marshall¹ studied several patients with transient ischaemic attacks who were found to have episodes of complete heart block which accounted for their symptoms. Other workers²⁻⁴ have shown that accurate heart rhythm analysis requires continuous recordings over long periods in ambulant conditions. We have used the method of long-term electrocardiographic (ECG) recording to study a group of patients presenting with ill-defined symptoms of cerebral ischaemia or palpitation to determine the frequency and nature of cardiac dysrhythmias which might have contributed to their symptoms.

Patients and methods

We studied 130 patients who were referred to a general medical outpatient clinic. All were complaining of one or more of the following symptoms: palpitation, dizzy attacks, faints, or blackouts (syncope). A full examination was performed in the clinic with an x-ray film of the chest and a 12-lead ECG. The ECG included 30-40 beats and a 10-beat record of lead 2. Sixty-four of these patients were exercised for five minutes on a bicycle ergometer with continuous ECG monitoring. The 12-lead ECG was repeated at the end of this test and again five minutes later. These procedures failed to show any serious dysrhythmias and a 24-hour recording was performed on an outpatient basis.

RECORDING TECHNIQUE

The Medilog cassette recorder was used with a single channel for ECG.⁵ The electrodes were applied in the V1 and V5 positions to give an ECG configuration similar to V5. The tape recorder was light,

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