Problems of care in a private nursing home

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Abstract

To assess problems of care in a private nursing home an observational study was carried out over two months, during which a research nurse worked as a member of the staff in a home caring for 25 patients aged 62-90. During the second month a consultant physician visited the home weekly to hold case conferences and assess each patient's functional ability and drug regimen. Various problems in medical, nursing, and bureaucratic matters were identified—for example, staff failed to understand the appropriate response to various medical symptoms; no clear policy existed for managing pressure sores; and one patient's anticoagulant state could not be assessed when industrial action meant that transport to take him to hospital was not available—and several changes in drug treatments were recommended.

The problems that were identified were mainly due to poor communication between the home and general practitioners and hospitals and to the lack of guidance policy on common issues that arise in long term care. Such a policy could be produced by health authority staff, general practitioners, and representatives of nursing homes.

Introduction

The private sector has an established role in providing long term care of the elderly. Though controversial, the white paper *Caring for People* confirms that in the future the independent sector will remain an important provider of care.[1] Traditionally, care provided by the NHS and social services entails an initial assessment of the patient and then continuing review. These often formalised bureaucratic procedures are a form of quality assurance and a measure of the deployment of services. We previously documented some of the consequences of not having a regulatory bureaucracy for private nursing homes.[2] In this study we observed the problems of care and management in a 25 bed nursing home over two months.

Methods

A research assistant who was a trained nurse (JP) worked as a member of the staff in a 25 bed nursing home with the agreement of the proprietor (the matron); the staff were aware of her role. An observation period of one month enabled her to integrate into the staff. During the second, consecutive month a consultant (CEB) visited the home weekly.

The consultant's first visit consisted of a case conference, and at the next visit he appraised each patient's functional ability. At the third visit drug schedules were discussed at length, and at the final visit a "debriefing" case conference was held. The consultant did not subvert the role of the patients' general practitioners but advised them of the results of review when appropriate.

Observations

The 25 residents of the nursing home ranged in age from 62 to 90 (mean 81). Their duration of stay varied from one to 31 months. In the initial four week period the observer developed a working relationship with the staff. It became clear that issues fell broadly into three categories, medical, nursing, and bureaucratic.

Medical matters—Ten of the residents had not been seen by their general practitioners for at least four months. Eight of these patients were totally dependent, and two deteriorated notably during the month of observation, though the lack of clear change meant that in some cases the staff did not contact the general practitioner and in other cases the general practitioners were reluctant to visit. The staff failed to understand the appropriate level of response to medical symptoms, which seemed to be due to inadequate information and inadequate communication between doctors and staff.

Nursing issues—Clear policies for managing common nursing problems were lacking. Nine of the patients had scores of less than 14 on the Norton risk scale for pressure sores (scores below 14 imply appreciable risk),[2] and four of these had scores of less than 10. The home did not have a clear policy for managing pressure sores, and in addition there was no clear policy for individual patients. Nine patients were incontinent, of whom seven were doubly incontinent. Four patients had been catheterised satisfactorily, but incontinence had not been evaluated systematically by even simple documentation of its pattern. At times a patient's privacy was compromised by inadequate use of screens. Staff, particularly care assistants, often lacked skill in lifting patients.

Bureaucratic matters—The difficulties of managing patients in a mixed health economy are illustrated by one particular patient, who was receiving anticoagulants and was due to attend a hospital clinic for assessment. Industrial action led to his transport to hospital being unavailable. The nursing home did not have suitable transport, and he was considered unfit to travel by taxi. His general practitioner was reluctant to undertake the venesection, and the practice nurse advised that it was beyond her jurisdiction and indemnity to visit a private nursing home. The matron and staff, though willing, did not have the approval of the health authority to undertake venesection. A further difficulty in managing the patients arose because of the wide range of dependency and care needs. For example, a severely confused and agitated patient with dementia was nursed in isolation to preserve the standards of care of other patients. One resident did not require nursing care, having originally been admitted to be with her husband, who had needed care and had later died; she insisted on staying in the home,

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paid for by income support as a person requiring full nursing care.

Consequences of case review

Before the first visit by the consultant the home's records were updated. It was clear that the trained staff knew their patients in far more detail than was apparent from the documentation. Important but simple issues of medical management were identified in five cases.

- A patient with chronic lung disease had been receiving bronchodilator drugs nebulised with pure oxygen (which typically took 30 minutes). Drowsiness after treatment was corrected by using a mechanical nebuliser, which was bought by the home.
- A patient with Paget's disease had been treated for at least 10 months with biphosphonates without medical review. The general practitioner was advised.
- A patient with cerebrovascular disease and impaired awareness had been prescribed phenytoin two years previously after a single "turn." This treatment was stopped, and his awareness and cognition greatly improved.
- A patient with Parkinson's disease who was not taking any drugs was chairbound. The general practitioner was advised to refer the patient to the hospital for assessment in the day unit.
- A patient with diarrhoea of unknown cause had been prescribed diphenoxylate empirically and had become increasingly confused. Stopping this treatment resulted in some improvement in mental state.

It was noted that 10 patients had been prescribed diuretics, though none had had their electrolyte concentrations measured. Two patients had been receiving chloramphenicol eye drops for a long time for reasons that were unclear. Two of the patients admitted to the home from the visiting consultant's beds were discussed extensively; this led in at least one case to a more conservative approach to management with appropriate terminal care.

Discussion

The home that we studied had a good reputation among patients and their families, which was reflected in its high occupancy, despite the town having a surplus of beds in nursing homes,[3] and its waiting list. Similarly, general practitioners and hospital staff had a favourable view of the home's standard of care. The observer and visiting consultant considered that the greatest constraint on improving standards of care was the (sometimes total) lack of guidance and information received by the senior staff of the home. An acceptable form of documentation of shared care between the general practitioner, home, and, if appropriate, hospital is urgently required. Only then can nursing homes, such as the one studied, formulate a plan of care tailored to each patient.

Many issues seemed to be amenable to a guidance policy; for example, is the use of egg white in the management of bedsores—a practice being applied in the home—to be encouraged or discouraged? The management of incontinence and the administration of bronchodilator drugs were two other examples that would lend themselves to a guidance policy. Such advice could be produced by health authority staff, general practitioners, and representatives of nursing homes and made available in the form of a handbook. This approach would form a basis not only for practice but also for audit. The argument that this would interfere with clinical freedom should be tempered by the precedents of antibiotic policies set by hospitals and the management of medical emergencies according to district guidelines—for example, on the use of thrombolytic treatment.

In most bureaucratic matters the lack of a clear contract for care between the patient (or his or her representative) and the home may well be remedied by the strategies outlined in *Caring for People*,[1] whereby responsibilities will become better defined. The trained staff in the home, though clearly experienced and able, were, however, isolated professionally, a feature common in many private nursing homes. A visit that we made to a home run by a charitable body emphasised this issue, as officers of the charity and voluntary standing committees provided a supportive bureaucracy to the home but could not produce professional guidance.

The lack of training of care assistants is of concern. Lifting heavy dependent patients requires training not only to ensure comfort and safety for the patient but also to safeguard the health of employees. The planned development of training and standards for health care assistants is urgently needed.[4]

This observational study of a single, well regarded nursing home showed deficiencies in the provision of care for highly dependent, vulnerable patients. At the simplest level it identified problems of medical management for five of the 25 patients. In the catchment area of the local hospital some 300 patients may be in a similar condition of medical deprivation.

The model of the Hospital Advisory Service, itself born of the scandal of Ely Hospital in the 1960s,[5] could be expanded further. It has been estimated that, of the visits made by the service, 60% are to hospitals, 20% to local authority residential homes, 10% to day care centres, and 10% to "a mixture of private homes, sheltered housing, rehabilitation centres, and so on."[6] The health district in which our home is situated, though an extreme example, has 65 hospital beds of the kind with which the advisory service is concerned but over 1000 nursing home beds and 2000 private residential beds.[7]

Quality assurance in long term care is difficult to define succinctly. We suggest that a reporting system, giving advice and setting a guidance policy, might help to establish reasonable standards and expectations for homes, patients, and staff.

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