

# Elderly peoples' experiences of discharge from hospital

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**SUMMARY.** In a study of patients' perceptions of the transition from hospital to the community, 115 elderly people registered with a central London group practice were interviewed shortly after they arrived home. Many patients received little notice of discharge, a third being told on the day they left the hospital. A third felt they had been discharged too soon and those living alone were significantly less likely to return to a heated home containing basic items of food. Seventy-seven patients, including 80% of those living alone were visited by family, friends or professionals within three days of coming home. Eighty-six per cent of non-professional visitors were women. Several of the elderly couples appeared to be under considerable stress and not all individuals were receiving the help they considered most appropriate to their needs.

Many of the problems identified were due to poor communication between practice, hospital and patients. We suggest several measures aimed at improving the quality of that communication, so as to ensure that available resources can be mobilized to support this vulnerable group of people.

## Introduction

**SURVEYS** of elderly patients' views conducted in the last 15 years by voluntary sector organizations and community health councils have shown that discharge from hospital is often poorly planned.<sup>1-6</sup> Some of the needs of elderly people coming home from hospital,<sup>1-5</sup> and the ways in which after-care services could be improved have been identified.<sup>5,6</sup> Two current trends may be affecting the needs of elderly people after discharge: the increasing population of elderly people many of whom live alone<sup>7</sup> and the cuts in public services associated with the shift of social policy away from state provided care and towards increasing reliance on family and friends.

This paper examines the process of discharge from hospital from the perspective of elderly patients from one general practice. It also looks at the amount of support provided by professionals, family, friends and neighbours during the three days after discharge, and in particular whether the support was adequate and appropriate.

## Method

The study took place in an inner London general practice with approximately 13 500 patients, served by seven partners and two trainees along with attached health visitors, district nurses and health advisers for the elderly. Patients are mainly admitted to three local teaching hospitals. In November and December 1985, following discussions with community and hospital staff and with patients, a structured questionnaire was developed and tested in 25 pilot interviews. In the main study the modified questionnaire was used to collect data about home circumstances,

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length of hospital stay, discharge arrangements, mobility and self-care ability on returning home and level of support by community services, family and friends.

The survey aimed to identify all the patients aged 60 years or over registered with the practice within four weeks of their discharge from 'acute' hospital wards to their own homes, after a hospital stay of more than 24 hours regardless of whether admission was 'sudden' (by urgent referral from the general practitioner, via a 999 call or through an accident and emergency department) or 'planned' (from a waiting list). Those discharged to part 3 accommodation or from psychiatric wards were excluded. An earlier survey had already established that hospital discharge letters did not arrive soon enough to be a reliable method of identifying all subjects leaving hospital.<sup>8</sup> The general practitioners and community nurses in this study were therefore asked to complete a daily record of the names of patients admitted, discharged or about to be discharged from hospital. In addition, the researcher telephoned hospital records departments twice weekly to inquire whether inpatients registered with the practice had been discharged. This information was supplemented by details from the hospital discharge reports that had been received.

Of the 138 patients discharged who could be contacted, nine were excluded from the study because the general practitioners or health advisers for the elderly felt that they were too ill or 'confused', and 14 (eight men and six women) refused an interview; 115 patients were interviewed between September 1986 and April 1987. The median interval between discharge and interview was 13.5 days, and 61% of the sample were interviewed between seven and 21 days after discharge; the variations in timing resulted from delays in learning about discharge. There was little difference in interview timing (on average one day) between those who lived alone or with others, and between men and women. Sixty-six per cent of the 115 had been discharged from University College Hospital.

## Results

Table 1 shows the age, sex and living situation of the 115 people interviewed. Fifty-nine per cent of those living with others lived with a spouse of roughly similar age. There were significantly more women than men living alone.

**Table 1.** Sex, age and living situation of the 115 elderly patients.

	Number (%) of patients		
	Living alone	Living with others	All
<i>Women</i>			
Under 75 yrs	18	13	31
Over 75 yrs	23	11	34
All women	41 (63)***	24 (37)	65 (100)
<i>Men</i>			
Under 75 yrs	5	19	24
Over 75 yrs	8	18	26
All men	13 (26)	37 (74)	50 (100)
All	54 (47)	61 (53)	115 (100)

\*\*\* $\chi^2 = 15.7$ , 1 df,  $P < 0.001$  versus men living alone.

Seventy-two per cent of the sample had done manual or semi-skilled work and none had been in professional occupations. Ninety per cent of the women had worked outside the home. Sixty-eight per cent of the sample were living in council rented homes, 12% in private rented, 4% in sheltered housing and 13% in owner occupied accommodation (3% lived in other types of accommodation such as community housing projects). Eighty-two per cent had a telephone. Seventy-one per cent of patients had central heating: the rest heated some rooms only with gas or electric fires. Twenty-two per cent felt that their housing was definitely not suited to their needs and nearly half of the entire sample (43%) reported problems such as repairs needed, dampness, poor access, noise or inadequate heating.

**Hospital admission and discharge**

The median length of stay in hospital was 10.5 days for those living alone and 9.0 days for those living with others. There was also little difference between those who lived alone and those who lived with others in the ratio of planned to sudden admissions, their reported notice of discharge or the day of the week they were sent home. However, more of those living alone felt, with hindsight, that they had not been ready to go home at the time they were discharged (Table 2).

There was little difference between those aged under and over 75 years and between men and women with regard to these factors, although the mean length of stay for men was shorter (12.2 days) than for women (15.3 days).

Patients reported that they were given little notice of discharge (Table 2) and there was little difference between University College Hospital and the other hospitals. The median length of stay of those who received more than a day's notice of discharge was 9.5 days compared with 8.5 days for those who were told on the same day or the day before.

**Table 2.** Patients' experiences and views of hospital admission and discharge.

	Percentage of patients	
	Living alone (n = 54)	Living with others (n = 61)
Admission was sudden	70	67
Notice of discharge was:		
Same day	33	33
1-2 days	46	38
>2 days	21	29
Stay in hospital was 'too short'	28	33
Had not been ready to go home	45	30

n = total number of patients.

Thirty of the 36 patients who felt that their stay in hospital was too short had definite ideas about why they felt this: 17 said they had not felt well enough to go home and had received insufficient treatment, five were frightened of being at home alone and not coping, and eight explained that there was a shortage of hospital beds and that their bed was wanted for someone else.

Sixty-seven patients (58%) reported that their ability to cope at home had not been assessed before discharge. Seven patients said that a member of staff had visited their home before discharge. The rest had been given a brief verbal assessment, including in 11 cases an assessment of their mobility.

**Arriving and managing at home**

The circumstances to which patients returned were significantly influenced by whether they lived alone or with others. Those living alone were less likely than others to return to a heated home (22/54 compared with 55/61;  $\chi^2 = 29.4$ , 1 df,  $P < 0.001$ ) or to find basic food items at home such as bread, milk, sugar and tea (37/54 compared with 57/61;  $\chi^2 = 10.3$ , 1 df,  $P < 0.01$ ). Notice of discharge did not seem to influence these aspects.

We concentrated on looking at community support in the first three days, as only one interview was carried out before the end of the third day. Table 3 shows several of the characteristics of the patients and their visitors. Thirty eight (33%) of the 115 patients were not visited by family, friends or professionals within three days of discharge: 20% of the 54 patients living alone, and 44% of the 61 living with others were not visited.

Fourteen of the 77 patients who were visited felt that they had needed more help than had been given in the three days after discharge. Two thirds of all the men depended on their wives to look after them. Eighty-six per cent of non-professional visitors were women, and 28% were friends and neighbours rather than family. Sixteen patients reported that services usually received had not been resumed in the three days following discharge but that family, friends or neighbours had been able to cover the gaps.

Sixteen of the 38 people who were not visited (42%) felt they had needed more help than had been provided. This group included 11 living with others, who identified stress placed on wives or lack of support from husbands and sons as important reasons why more help was needed. Eleven of this group did not feel they needed more help but nevertheless experienced difficulties, six because of undue strain on an elderly spouse, and five who lived alone had difficulty in coping unaided.

Table 4 shows that 41 patients (36%) received professional visitors in the first three days, and the proportion had risen to at least 56% by the end of the first week after discharge. All professionals except general practitioners more often visited patients living alone. Eleven of the 41 visited in the first three days

**Table 3.** Characteristics of patients not visited or visited in the three days after discharge from hospital.

	Number of patients				All (n = 115)
	Not visited (n = 38)	Visited by family/ friends/neighbours only (n = 36)	Visited by professionals only (n = 10)	Visited by family/friends/ neighbours and professionals (n = 31)	
Women	18	20	8	19	65
Men	20	16	2	12	50
Living alone	11	19	4	20	54
Aged >75 yrs	23	13	8	16	60
Felt they needed more help:					
In first 3 days	16	3	3	8	30
In general	10	6	4	11	31

n = total number of patients.

said that they would have liked more help than they received during this time; three of these had no non-professional visitors. The other eight patients who had both professional and non-professional visitors felt that they would have liked more company and needed more help with tasks such as cooking meals and washing. Five of these were living alone and four had more than one professional visitor.

Sixty-seven patients were visited by non-professionals in the first three days. In 30 cases, visitors came to keep them company, not to perform practical tasks. The rest helped with shopping (29), cooking (16) and housework (nine). Friends and neighbours tended to help with shopping and provided company, while female family members helped with cooking and cleaning and sons helped with shopping. Again, despite having had visitors, patients were concerned about the strain on an elderly spouse.

As expected, there was a general decrease in mobility and ability to self care after hospitalization (Table 5). At the time of the interview 38% of the sample reported that they were unable to manage most self care tasks except going to the toilet and dressing. This applied to 43% of those living with others and 31% of those living alone and to twice as many men (52%) as women (26%). Fortunately all six who were bedfast were living with others, five being men discharged to the care of elderly wives.

## Discussion

This study was conducted in a practice well endowed with attached community staff and with close links to several nearby hospitals. Our findings may therefore give a more optimistic view of the process of discharge and professional support than would

be obtained from a more typical inner city practice. In addition, elderly people tend to express more satisfaction than younger people, and have more modest expectations of health services.<sup>9,10</sup> It is therefore notable that a third of our sample were dissatisfied with the notice of discharge they were given. Certainly a third were actually informed only on the day they went home. A third were also dissatisfied with the length of stay in hospital, and almost half of those living alone felt, in retrospect, that they had not been ready to go home. Patients who lived alone were more likely to return to an uncomfortable environment, unheated and lacking basic food items, and were less likely to have someone waiting at home.

Reduced mobility and capacity for self care after discharge from hospital may be transient or may be a sign of the progression of a chronic disease. It contributes to a sense of vulnerability or being unable to cope. Therefore, for many elderly people additional help is especially necessary at this time. It is important that those who need support are identified and receive help appropriate to their needs. Several people felt the help they had received did not match the needs they felt to be most important, often company or domestic support.

The recent Griffith's report<sup>11</sup> emphasized that most care for the elderly will be provided by family, friends, neighbours and local people. While such carers may not be able to provide expert nursing or medical and physiotherapy help, they give considerable support through providing company and doing household tasks. However, it may not be reasonable to assume that they will always be available. Our study confirms that family care is usually provided by women and there are several indications that fewer women may be available in the future to fulfil this role.<sup>12,13</sup> These include a reduction in the ratio of women aged 50–59 years to people over 75 years and an increase in the number of married women who are economically active and expected to work until retirement.<sup>12</sup> Increasing divorce rates are leading to complicated family patterns, often combining new and old ties, and may negatively affect feelings of family responsibility.<sup>13</sup> One result of all these factors may be to share caring for the elderly more evenly between the sexes. Carers are increasingly elderly themselves<sup>14</sup> and many of our patients expressed anxieties about the possible burden on their carers. For example, one patient was very concerned that his wife was finding it increasingly difficult to lift him and another was worried that his incontinence caused his wife so much work.

## What can be done?

It became evident early on in the study that practice staff had incomplete and rather haphazard information about admissions and discharges. Hospitals often do not notify a practice when a patient is admitted and pressure may need to be exerted on the relevant unit manager to ensure that a reliable system of notification is established. In the meantime primary care teams could adopt the sampling methods described in this study to identify patients in hospital and could also encourage people, particularly the elderly, to inform a member of the team if they are to be admitted. This request could be included in literature given to patients when they register with a practice. Community staff could then inform ward sisters about a patient's home circumstances and the names of staff to contact before the patient is discharged. A key worker, probably the health adviser for the elderly in this district, would be able to arrange for someone to check that the patient returned to a hospitable environment with appropriate social support. Hospital staff could also make sure that the patient took home a card with the telephone numbers of relevant community services. They should also send

Table 4. Visits from health and social service workers.

	Number of patients visited in first three days after discharge			Number of patients visited in first week after discharge <sup>a</sup> (n = 64)
	Living alone (n = 24)	Living with others (n = 17)	Total (n = 41)	
General practitioner	3	6	9	20
Health advisor for the elderly	12	8	20	32
District nurse	12	4	16	22
Meals on wheels	14	3	17	20
Home help	17	6	23	34

<sup>a</sup>20 patients were interviewed before the seventh day.

Table 5. Patients' ability to manage specific tasks in daily living, before and after going to hospital.

	Percentage of patients who could not manage task (n = 114)	
	Before hospital <sup>a</sup>	After hospital
Shopping	41	63
Preparing and cooking a meal	32	46
Washing clothes	42	59
Housework	45	53
Bathing	44	44
Dressing	13	13
Getting to the toilet	8	10
None of these (bedfast)	4	5

n = total number of patients (one missing observation).

<sup>a</sup>Usual daily living in the two months before admission.

a letter to the general practitioner promptly at the time of discharge as well as giving a copy to the patient when it is likely that other community staff will be involved in their care. Primary care staff could develop a policy of visiting elderly patients in the first few days, especially those living alone, unless, as in the case of one Islington hospital, they are visited before and after discharge by voluntary workers.

Elderly couples may be under considerable stress even though they may not admit it. We consider that a plan of support after discharge tailor-made for individuals is best achieved through negotiation between the patient, informal carers, where they exist, and professionals, rather than relying on a one-sided assessment of the patient's requirements by the general practitioner or community nurse.

The apparent trend towards discharge at an earlier and more vulnerable point in the process of recovery will increase stresses on patients, their families, community health workers and ultimately hospitals if, for example, hurried and inadequately planned discharges are a factor leading to increased re-admissions. In our district a reduction in the number of acute hospital beds led to patient 'throughput' (patients treated per bed per annum) increasing by 27% between 1983 and 1986, by shortening stays and the period between vacating and occupying beds (Bloomsbury Health Authority. *Meeting the challenge*. 1987. Unpublished). Pressure to further increase 'throughput' means that hospital stays will continue to decrease, leading to a lengthier period of recovery at home; there are also local plans for extending the scope of day surgery. It is vital that measures are taken to improve communication between practices and hospitals and between family and professionals so that the optimum use of resources is made to support elderly people recently discharged from hospital.

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## RESEARCH FUNDING

### Scientific Foundation Board

Applications are now being received for grants for research in or relating to general medical practice, for consideration at the May 1989 meeting of the Scientific Foundation Board. In addition to its general fund the Board also administers some specific funds including the Windebank Fund for specific research into diabetes.

The Scientific Foundation Board's definition of research is catholic and includes educational research, observational as well as experimental studies, and accepts the methodologies of social science as valid. It is not in a position to fund educational activities.

If the study involves any intervention or raises issues of confidentiality it is wise to obtain advance approval from an appropriate research ethics committee otherwise a decision to award a grant may be conditional upon such approval.

Studies which do not, in the opinion of the Board, offer a reasonable chance of answering the question posed will be rejected. It may sometimes be useful to seek expert advice on protocol design before submitting an application.

Care should be taken to ensure that costs are accurately forecast and that matters such as inflation and salary increases are included.

The annual sum of money available is not large by absolute standards and grant applications for sums in excess of £15 000 for any one year are unlikely to be considered.

Application forms are obtainable from the Secretary of the Board at: The Clinical and Research Division, 14 Princes Gate, London SW7 1PU. *The closing date for receipt of completed applications is 12 March 1989; any forms received after that date will, unfortunately, be ineligible for consideration.*