Can home placement after hospital be justified?  

Although functional outcomes are not usually the focus of care in hospital, they may be critical determinants of functional decline beyond that attributable to the acute illness itself. They proposed a model, which they call ‘dysfunctional syndrome’, that results from the interaction of clinical features and elements of hospitalisation contributed to the process of functional decline and institutionalisation (Covinsky et al 2000). Palmer et al (2003) speculated that potentially modifiable elements of hospital care could affect outcomes, particularly for social care staff being concentrated on the issues of cost containment. This situation has been polarised between opposition to one another; one is concerned with rapid throughput, the other with client choice and social care staff being concentrated on the issues of cost containment. With NHS and social services priorities in surrounding reimbursement. Once professionals still, by law, undertake a nursing needs assessment where there was no standardised approach to this process, and that, because they knew little about it, most rehabilitation activities seemed to be withdrawn and the priority shifts to achieving a speedy discharge. Further, having ‘sown a seed’ that long-term care is the only option, it is very difficult subsequently for social care staff to explore alternatives. When entitlement to social care is means-tested. Even if conceived negatively ‘anywhere but here’ – which patients, families and friends are often offered the opportunity to achieve their full rehabilitation potential before long-term care settings, and patients overall were significantly less likely to be discharged to a long-term care facility. Receiving care using the latter approach were discharged directly from hospital to nursing home (‘home’ rather than the usual target of ‘discharge to care home’). Broad-based, co-ordinated, low-tech care over a longer period would therefore appear to be out of proportion to stretched resources. But despite widespread guidance emphasising the importance of older people being offered adequate care, the decision to opt for care-home placement was often made by professionals, with hospital nurses indicating that specific aspects of hospital care may contribute to adverse outcomes among older people. The experience of hospitalisation for a patient with an acute illness may result in ‘depersonalisation’ and negative expectations. Covinsky et al (2003) reported that fewer patients admitted for short hospitalisation (less than 7 days) were found to have depressive symptoms on admission are more likely to become dependent in activities of daily living during and after hospitalisation (Figure 1). They contrast this with the benefits of an environment that employs an inter-disciplinary approach to the team targeted a positive outcome (returning home) rather than the usual target of ‘discharge to care home’ – being discharged from the hospital to home (Figure 2). The team also created a ‘functional trajectory’ (Figure 3 overleaf) for the patient’s status at discharge, showing that there was no standardised approach to this transition and home-care requirements. In focusing on any client potentially requiring long-term nursing care, the importance of older people being offered adequate care decisions are made and the occurrence of iatrogenic illness (Palmer 1995) is fundamental in services for older people and its systematic and sensitive assessment is fundamental in services for older people and its systematic and sensitive assessment is fundamental in services for older people and its systematic and sensitive assessment is fundamental in services for older people.
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care homes, they could not offer much sup-
port. They also felt that it was not part of
their job to know such things as other staff
(ie social workers) were in charge of the
process. Whitehead et al (2001) reported
that 10 per cent of people referred for
assessment of need for placement recovered
sufficiently to return home and, even more
worryingly, Victor et al (2001) found that 15
per cent of people admitted to long-term
care recovered sufficiently to return home,
but were unable to do so having given up
their own home. Could such circumstances
be created by a ‘mindset’ that older people
require permanent care, or a lack of recog-
nition that, in fact, older people can be
extremely resilient and go to considerable
lengths to preserve their independence.

Ensuring appropriate recommendations
are made relies on knowledge of the avail-
able care options and the accuracy of nurs-
ing needs assessment (Lloyd 2001).

Research has shown, however, that nurses
do not have adequate knowledge about the
different care options available and are
potentially making inappropriate decisions
(Reed and Morgan 1999). The assessment
process includes a combination of objective
‘factual’ detail and subjective opinions of
need.

The real world of patient care comprises
‘messy and indeterminate situations’ where
best outcomes may be very much a matter
of opinion (Greenwood 1993) and the
knowledge, professional judgement and
the attitudes and values of the assessor
have a profound influence on assessment
(Hughes 1995, cited Worth 2001). Bau-
mann and Deber (1989, cited Bryans and
McIntosh 1996) define decision-making as
‘situations in which a choice is made among
a number of possible alternatives, often
involving trade-off among the values given
to different outcomes’. Problem recognition
is intimately related to professional percep-
tions of healthcare need (Liss 1993, cited
Bryans and McIntosh 1996) and failure to
recognise a potential decision-making task
may limit subsequent interventions.

The potential influence of ‘real world’
constraints, such as the demand for a serv-
ice, the availability of local healthcare
resources or limited time and resources,
impact on decisions. Harbison (1991) offers
a model of ‘decision analysis’ where the
problem is constructed showing the avail-
able options and the consequences of fol-
lowing each, with outcomes being given a
score related to benefit for the patient.

Although this method has been criticised as
unsuitable for process-orientated nursing, it
is suggested that using the approach with-
out the scoring element, yet still focusing on

Figure 2 Prevention of the dysfunctional syndrome

Figure 1 Conceptual model of the dysfunctional syndrome

- Functional older person
  - Acute illness
  - Possible impairment
  - Hostile environment
  - Depersonalisation
  - Reduced mobility
  - Starvation
  - Medicines
  - Procedures

- Dysfunctional older person
  - Functional older person
  - Acute illness
  - Possible impairment
  - Hospitalisation
  - Acute Care for Elders Unit
  - Patient-centred care programme
  - Prepared environment
  - Interdisciplinary collaborative care
  - Multidimensional assessment
  - Non-pharmacological interventions
  - Medication review
  - Home planning/informal network
  - Transitional care

- Improved mood
- Positive expectations
- Reduced impairment
- Decreased iatrogenic factors

- Depressed mood
- Negative expectations
Discharge planning has become increasingly important in acute settings, but the speed required by short lengths of stay can be problematic. Wells et al. (2002) cite many studies showing that discharge-planning practices raised pragmatic issues with regard to efficiency, and are ethically questionable in that they can inhibit involvement in the decision-making process. The moral or ethical principles at stake, then, are informed decision-making and patient autonomy. Wells et al. (2002) suggest that the purposes or ends to be achieved, and the motives of participants, should be open for discussion. They promote a reflective process with the application of ‘discursive rules’:

1. Commitment to truth or accuracy
2. Sincerity
3. Taking conflicting values into account
4. Comprehensiveness of information leading to decisions.

In a review of assessments for placement in Cheshire, Wright et al. (2001) described a sense of assessments being carried out to confirm a decision for placement, rather than to inform the decision-making process, and the concerns of professionals were generally the most prominent. Assessments tended to describe a person’s level of functioning at the time of assessment but did not explore future potential. They particularly emphasised the need for assistance without detailing what the person could do, and identified risk factors but with no apparent risk assessment or exploration of a risk-management strategy.

The Department of Health (DoH 2001b) gives guidance on assessment for funded nursing care, and provides a structure for nurses to look at each person’s potential first and to ensure that they receive the support needed to reach their potential. Only once this has been tried should assessments go on to make recommendations about long-term care. The guidance thus acknowledges both that inappropriate referrals are made to care homes, and that an important factor affecting accuracy of the assessment is its timing. Assessments performed before a client has had an opportunity to recuperate or rehabilitate from an illness or disability will not always take into account the potential the person has to improve (Clisset 2001).

The association between physical and psychological dependency and destination on discharge is complex. Functional decline during and after hospitalisation is associated with an increased risk of falls, re-admission and care-home placement (Sager and Rudberg 1998, cited Palmer et al. 2003). Functional status is often measured in terms of activities of daily living (ADL), including the basic activities of bathing, dressing, transferring from bed to chair, toileting and continence, and eating. More complex activities are described as instrumental activities of daily living (IADL), such as maintaining independence in handling finances, taking medication, using public transport, shopping, performing household tasks, cooking and using the telephone (Waters 1994). Leidy (1994) suggested a useful framework for understanding the complexity of functional performance and described four dimensions: capacity, performance, reserve and capacity utilisation. Functional capacity is the individual's level of functioning, not necessarily their potential. Functional performance is the task performance level that an individual can achieve within the context of the environment. Reserve is an individual's capacity that is not currently being used. Capacity utilisation is the extent to which an individual uses their capacity.
The ability to avoid institutionalisation depends on the development of functional skills, and potentially prolonging the person's comfort and providing encouragement may all help adults to set appropriate goals that have meaning to them. Healthcare providers can influence and alter their full functional capacity. There are many ways in which motivation can be strengthened that can result in functional limitations (Cress 1995, Fried and Guralnik 1997, cited Resnick 1999).

Strengthening individual motivation may be an important component in helping older adults use their functional status. Performance is what the individual actually does and reserve is the difference between these two – that is, dormant abilities that can be used if needed. The reserve needed to help older adults live satisfactorily outside institutional care and prolong their maximum potential to perform activities of daily living, and includes underlying physical and cognitive data (age and marital status), social circumstances (living arrangements and social support), and the opportunity to achieve maximum potential, rather than merely describing or stating maximum potential.

The reserve needed to help older adults live satisfactorily outside institutional care and prolong their maximum potential to perform activities of daily living, and includes underlying physical and cognitive data (age and marital status), social circumstances (living arrangements and social support), and the opportunity to achieve maximum potential, rather than merely describing or stating maximum potential, is needed.


Department of Health (2001b) National and international studies within the literature are needed.

Inappropriate placements and complex activity, which should be practised in an informed way, and in partnership with older people, are unable to match services to needs. Even the most robust person-centred assessment and outcome interaction on rehabilitation hospitalwards for elderly people in England and Wales: a national audit.