Continuity of care for older people

Older people transferring from NHS hospitals to independent sector nursing homes need continuity of care. However, nurses in the NHS and independent sectors are often out of touch with each other. In the second of two articles on discharge and older people, the author discusses the need for education, assessment and effective communication to help nurses, wherever they work, to provide effective care for elderly people. The author describes an assessment scale for physical and mental abilities, developed to assist the transfer process. The first article was published in Nursing Standard (Nazarko 1998).

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A quarter of 85-year-old and half of 90-year-old people live in residential care (DoH 1997). Many older adults discharged from hospital are transferred to independent sector homes. People entering long-term care, and their relatives, often ask nurses what homes are like and what type of care they offer. Medical staff often rely on nurses to advise them when a patient can be discharged back to the nursing or residential home. Care managers often ask nurses about the level of care provided in local nursing homes. Yet many of today’s senior ward nurses qualified more than ten years ago (Seccombe and Smith 1996) before independent sector homes were commonplace. Many hospital nurses do not know the range and levels of residential care available (Nazarko 1991). Independent sector nurses trained in NHS hospitals may not appreciate the impact of the changes in the NHS. Nurses who want to provide high quality care must work together to break down the barriers that separate state and independent sector care.

RANGE OF RESIDENTIAL CARE
Residential care for older people ranges along a continuum: sheltered accommodation (Box 1) provides the lowest level of care; residential homes (Box 2) provide personal care for a more frail client group; and nursing homes (Box 3) provide a high level of nursing care for people who need rehabilitation, respite, continuing and palliative care.

Sheltered housing may be privately owned, or provided by local authorities or housing charities. It is defined and categorised under the Housing Act (1985). Residential homes are regulated under part one of the Registered Homes Act (1984), which distinguishes between ‘personal care’ – similar to that which a caring relative would provide – and ‘nursing care’. There are clear differences between residential homes and nursing homes.

Local authorities provide approximately 30 per cent of residential home places and independent sector homes 70 per cent. Local authority homes tend to be larger, averaging 30 beds, while independent sector homes have an average of 19 beds (DoH 1997).

Nursing home staff now care for a highly dependent client group with a wide range of nursing needs (Table 1) (Nazarko 1997). Residents’ abilities are often dependent on the quality of care in the nursing home. Homes offering rehabilitative care enable residents to function to capacity, and dependency is lower than in homes offering custodial care.

BRIDGING THE NHS-INDEPENDENT DIVIDE
NHS and nursing home staff work in different cultures and in stressful situations, which can cause poor communication and turn difficulties into crises. It is easy for attitudes to become polarised into ‘them and us’. Nurses have a responsibility to bridge the divide between the NHS and the independent sector and to provide care that appears to be seamless, no matter how many misunderstandings arise.

Education, assessment and effective communication can help nurses to provide effective care for older people wherever they work.

Education There is only one specialist diploma and degree course for nursing home nurses, run by South Bank University. Although 25 per cent of nurses now work outside the NHS (Seccombe and Smith 1996), student nurse placements in non-NHS settings are rare. The NHS cares for only 10 per cent of older adults requiring continuing care, but many students are not given the opportunity to learn about the range of continuing care. Nurse
Box 1. Sheltered housing categories (McCafferty 1994, MacKintosh et al 1990)

**CATEGORY 1**
- Purpose-built flats or bungalows designed for ‘active elderly’ people
- No special requirements
- Common rooms and shared facilities are rare

**CATEGORY 1:5**
- Similar to Category 1
- Alarm system
- Warden support
- Communal facilities are rare

**CATEGORY 2**
- Purpose-built flats or bungalows designed for less active people
- Usually linked by heated internal corridors
- Warden support (resident or non-resident)
- Alarm system
- A method of calling the warden
- One or more shared lounges, laundry and guest room must be provided

**CATEGORY 2:5**
- To provide an environment suitable for frail older people
- May employ care assistants to provide assistance with the activities of daily living
- Meals may be provided in a communal dining room
- May have a laundry service and communal facilities such as specialist bathrooms with hoists
- Commonly referred to as ‘very sheltered’ or ‘special sheltered’

Box 2. Residential care homes

**MANAGEMENT**
Do not have to employ an RN as a manager, who may be a senior care assistant. Most registration and inspection departments insist that the manager has six months’ experience as a deputy manager. NVQs or management qualifications are not required

**STAFF**
Typically, one member of staff for every ten residents on the early shift. At night, homes with fewer than 15 residents normally only have a care assistant sleeping on the premises in an on-call room. The care assistant will wake if a resident rings, attend to them and then go back to sleep

**ANCILLARY STAFF**
Usually employ a part-time cook. Care assistants usually have additional cleaning and laundry duties

**RESIDENT DEPENDENCY**
Residential homes vary enormously in their willingness and ability to care for frail, older adults. Many do not accept residents with continence problems or urinary catheters. Some reports (Dumfries and Galloway 1996, Pattie and Heaton 1990) suggest that many people living in residential homes require nursing

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Teachers can help to unite the profession by finding placements for student nurses in continuing care settings.

Students can learn a great deal about nursing skills and management in a nurse-led unit. Without the help of nurse teachers the NHS, independent divide may be perpetuated for another generation of nurses.

**Post-registration education** PREP gives NHS and independent sector nurses the opportunity to improve their clinical, managerial and communication skills. Nurses could fulfil part of their PREP obligations by:

- Spending a day working in a hospital ward or nursing home
- Spending a day updating clinical skills relevant to day-to-day practice. Nursing home staff might wish to spend a day on the orthopaedic or neurology ward as most nursing home residents are admitted after fracture or as a result of neurological disease (Nazarko 1997)
- Spending a day in a centre – NHS or independent – where staff are acknowledged to have specialist expertise in an area relevant to day-to-day work.

**PRE-ADMISSION ASSESSMENT**
Before a person is admitted to a nursing home a senior member of the nursing home staff normally visits for a pre-admission assessment. The assessor asks questions about the person who needs continuing care. These include:

- Admission:
  - Why is continuing care required (for example, because of the illness or death of a carer)?
  - What relatives and friends are close by?
  - How does the person feel about being admitted to a nursing home?
  - Does the person want to bring any furniture?
  - Does the person have a pet that they would like to bring with them?
- Nursing care:
  - Does the person have any wounds?
  - If so, where, and how serious?
  - How are they dressed?
  - Is the wound improving?
  - Does the person have any nutritional problems or special dietary requirements?
  - Can the person swallow?
  - Has the person had any infections – including methicillin-resistant Staphylococcus aureus (MRSA) – recently?
  - If so, have they been treated?
  - Is the person currently having any physiotherapy or occupational therapy?

Some NHS trusts are reluctant to divulge details of MRSA infection to ‘outsiders’ including nursing home staff as they consider such information ‘commercially sensitive’. Nursing home staff must know about infection control risks and act to prevent cross infection.
CARE OF OLDER PEOPLE

Box 3. Nursing care homes

MANAGEMENT
Usually managed by RNs, but they do not have to be. The manager’s role is a demanding one, but no specialist qualifications in gerontology or management are currently required.

STAFFING
Must have at least one RN on duty at all times. Typically, a ratio of 30 per cent RNs to 70 per cent care assistants. Homes usually provide one member of staff for every five residents on the early shift.

ANCILLARY STAFF
Usually larger than residential homes. They employ a full range of ancillary staff including a chef, domestic, laundry and secretarial staff.

RESIDENT DEPENDENCY
Half of all nursing home residents are receiving palliative care and have a life expectancy of less than a year (Reardon 1996). Increasingly, nursing home staff care for people with similar levels of dependency to those nursed in hospital.

Table 1. Profile of nursing home residents

<table>
<thead>
<tr>
<th>Cognitive impairment:</th>
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<tbody>
<tr>
<td>Lucid</td>
<td>33 per cent</td>
</tr>
<tr>
<td>Mildly cognitively impaired</td>
<td>33 per cent</td>
</tr>
<tr>
<td>Severely cognitively impaired</td>
<td>34 per cent</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Resident dependency:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>17 per cent</td>
</tr>
<tr>
<td>Medium</td>
<td>22 per cent</td>
</tr>
<tr>
<td>High</td>
<td>23 per cent</td>
</tr>
<tr>
<td>Extremely high</td>
<td>40 per cent</td>
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<table>
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<tr>
<th>Nursing needs include:</th>
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<tbody>
<tr>
<td>Monitoring unstable insulin dependent diabetes</td>
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<tr>
<td>Gastrostomy feeding</td>
<td></td>
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<tr>
<td>Peritoneal dialysis</td>
<td></td>
</tr>
<tr>
<td>Suprapubic catheters</td>
<td></td>
</tr>
<tr>
<td>More complex and extensive wounds</td>
<td></td>
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<tr>
<td>Increased use of syringe drivers</td>
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</tbody>
</table>

Box 4. An example of effective communication

Staff on Mayberry, a female orthopaedic ward, routinely removed clips or sutures prior to discharging patients to local nursing homes. When Janet, manager of a local nursing home, arrived to assess a potential resident she had coffee with Helen, the ward manager. Over coffee Helen asked why, when pressure on beds was so great, nursing home staff could not remove sutures or clips. Janet explained that the difficulty was not removing clips or sutures but obtaining suture and clip removers. Janet agreed to accept residents with clips or sutures and Helen agreed to provide clip or suture removers. The orthopaedic unit discharges 95 patients to nursing homes every year and potentially saved two inpatient days per patient simply by improving communication.

Most nursing homes can accommodate small pets. It is more difficult to accommodate dogs, especially in urban homes with small gardens, because they need regular exercise.

Often nursing staff do not have this information and find it difficult to get it from the relevant professionals. Interprofessional record keeping enables professionals to offer consistent care and avoid the situation in which a physiotherapist is walking a person with a frame and nurses are hoisting the same person from bed to chair.

Pre-admission assessment visits give nurses the opportunity to get to know each other and to develop an understanding of each other’s role. Nurses can also liaise to organise a convenient day and time of discharge. Independent sector nurses can explain the level of care they are able to offer and any difficulties they face (Box 4).

Discharge documentation Pre-admission assessment tells nursing home staff about the nursing needs of potential residents, but good communication and discharge documentation are essential because an older patient’s needs can change so rapidly. Delays in discharge can render a pre-admission assessment worthless, but pressures to discharge the patient and nursing home staff shortages can make it difficult to reassess quickly. In such cases, high quality discharge documentation is invaluable.

Good communication helps nursing home staff get the information they need to offer continuity of care. A small project group of hospital, community and nursing home nurses and care managers considered the details that should be included in nursing discharge letters (Box 5).

Nursing home to hospital transfers Nursing homes often transfer residents to hospital for emergency treatment. The most common reasons for hospital transfers are when fracture is suspected after a fall, and when gastrointestinal bleeding is suspected. As two thirds of nursing home residents cannot give a reliable history or details of their ability to carry out the activities of daily living, nursing home staff must ensure that transfer documentation is of the highest possible quality. The Nursing Assessment Scale (NASAR) assesses physical and mental abilities. It was developed from a small survey of ward managers and a large survey of nursing homes (Box 6) (Nazarko 1997).

CONCLUSION
The number of older adults who are transferred between the NHS and the independent sector is set to grow because of demographic changes and advances in medical and nursing care. Nurses can ensure that patients receive continuity of care. What matters to patients is not where they are nursed but how they are nursed. Working together, nurses can...
Box 5. Information discharge letters should include

- Changes in condition since the pre-admission assessment
- Recent infection and antibiotic therapy
- Changes in wound care
- Specialist nursing input
- Changes in functional ability since assessment
- When the person left the ward
- When the person last ate
- When the person last had his or her bowels opened
- Current nursing care

Box 6. Nursing Assessment Scale Aged Residents (NASAR)

**KEY TO SCORING**

<table>
<thead>
<tr>
<th>SCORE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>0</td>
<td>Help required</td>
</tr>
<tr>
<td>1</td>
<td>Completely independent, none</td>
</tr>
<tr>
<td>2</td>
<td>Independently with aid very rarely</td>
</tr>
<tr>
<td>3</td>
<td>Supervision, prompting, minor assistance 25 per cent</td>
</tr>
<tr>
<td>4</td>
<td>Major assistance 50 per cent</td>
</tr>
<tr>
<td>5</td>
<td>Totally dependent, completely unable, 100 per cent dependent on staff</td>
</tr>
</tbody>
</table>

**ABILITIES AND NEEDS (SCORED)**

- Mobility
- Transferring
- Grooming
- Bathing/showering
- Dressing upper body
- Dressing lower body
- Bladder control
- Bowel control
- Communication – comprehension
- Communication – expression
- Eating
- Social recreational needs
- Spiritual needs
- Pain
- Braden score (for assessing pressure sore risk)
- Wounds
- Special nursing needs?
- State reason
- Mental abilities
- Motivation
- Anxiety
- Confusion
- Hostility
- Wandering
- Disorientation

**CLASSIFICATION**

- 10-20 low
- 21-39 medium
- 40-54 high
- 55+ = extremely high

**TOTAL SCORE:**

**ACKNOWLEDGEMENTS**

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**REFERENCES**

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