

# 15 Residential and nursing homes

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*Demographics • Historical context • Characteristics of residents •  
Characteristics of homes • Conclusion*

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Residential and nursing homes represent a significant proportion of the resources spent on the care of older people. There have been major changes to these services in recent years, including a large increase in the size of the private sector. To some extent, people living in 'homes' are still set apart. They are the present day successors to the "frail shadows", described in the *The Last Refuge* (Townsend, 1962), who were forced to seek shelter in the workhouses of the 1950s.

## Demographics

The developed world is experiencing a rise in the proportion of the older population. This is particularly evident in those aged over 85, and has implications for residential and nursing homes. In 1994 almost half a million older people in England were living in residential homes, nursing homes or long-stay hospital beds (House of Commons Health Committee, 1995) (see Table 15.1). This represents 6% of the older population: a similar proportion of the older population lived in workhouses at the turn of the century (Pelling & Smith, 1991). The major change over the past 20 years has been a substantial rise in the number of private sector places. Over the same period there has been a smaller contraction of hospital and local authority care (Joseph Rowntree Foundation, 1996).

**Table 15.1** Long-term care places for elderly people, England (1000s) (adapted from House of Commons Health Committee, 1995)

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	General hospital	Psychiatric hospital	Local authority	Voluntary	Private	Total
1977	56	–	113	33	28	229
1980	55	–	114	35	36	240
1985	56	–	116	37	80	316
1990	49	24	105	35	145	448
1994	38	18	69	46	164	483

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## Historical context

The concept of 'old age' has changed in recent history. Victorian surveys refer to people aged 40 as 'old'. In the 1930s fewer than half of men aged over 65 were retired, compared to around 90% today (Victor, 1994). Old age has been refined so that 'young' old people (50s to mid-70s) are differentiated from the 'old' old (75+) (Laslett, 1989).

### Seventeenth century

In the 17th century, children were born at a later stage of the reproductive period, reflecting a tendency for marriages to be somewhat delayed. Additionally, women would continue to have children into their late 30s or early 40s (Stone, 1982). Consequently, there was a strong possibility of having at least one child at home when the parents or parent entered old age (Laslett, 1977). There is evidence that elaborate retirement contracts were made whereby retirees exchanged land and buildings for specific services and support. Living with children or grandchildren was not necessarily considered preferable to an independent household (intimacy at a distance) (Rosenmayr & Kockeis, 1963).

### Eighteenth and nineteenth centuries

The main focus of charitable spending on older people during the 18th and 19th centuries was building accommodation. Access to better quality accommodation, such as alms houses, was conditional on good behaviour, sponsorship and good health, shadows of which remain today. The Victorian workhouse was required to accept almost all comers, and has come to represent much of the negative side of institutional care in old age. The proportion of males aged 65 to 74 in poor law institutions rose from 3% in 1851 to 6% in 1901 (the peak of Victorian asylum provision). For females, the comparable figures are 2 and 3% (Pelling & Smith, 1991). Figures from a study in Bedford showed that one in six men and one in 13 women would spend at least one night in a workhouse (Thomson, 1983). One in 10 women would expect to end their lives there (Fennell *et al*, 1988). The stigma associated with the workhouse was powerful, and elements of this remain attached to present day residential care.

### 1940s

The establishment of the National Health Service led to the demarcation of 'hospitals' from local authority 'residential care' provision. Some former workhouses became hospitals for the long-term sick, and later become part of the geriatric medical services. The remainder fell to the responsibility of local authorities.

## **1950s**

In the 1950s public assistance institutions were spartan, offering dormitories and day rooms which separated the genders, even splitting married couples (Townsend, 1962). Few residents could identify personal possessions, and most spent their days bereft of comforts and satisfactory activities. As a consequence of Townsend's observations and recommendations, authorities spent generously to create a network of smaller homes, either by building new houses, or by refurbishing houses previously occupied by wealthy families. Many public assistance institutions were closed and demolished.

The expectation of the time was that the population, previously subjected to the rigours of workhouse life, would enjoy the advantages of better appointed residential homes. Townsend's hope was that this would improve the general health and well-being of those in residential care, and there would be a shift in their behavioural and dependency problems toward better integrated behaviour and independence in self-care. Unfortunately, this did not happen. Instead, much of the pathological behaviour seen in the workhouse was (almost certainly) derived from underlying mental and physical morbidity compounded by, rather than caused by, the institutions' environment. This morbidity was simply transferred and redistributed within the residential home network (Wilkin *et al.*, 1983).

In addition, pressures mounted for the admission of more older people to this form of care. Pressure came from the community, where more people were surviving and being cared for into later life, and from the hospital services which were keen to use their beds for the active assessment, treatment and rehabilitation of patients. Furthermore, hospitals were embarrassed by the poor quality of life they were able to provide for long-term residents in their institutionalised and inappropriately sited wards.

## **1960s**

In the 1960s, older people in care, in most parts of England and Wales, were housed in 'Part III' homes run by local authorities (Audit Commission, 1986; House of Commons Social Security Committee, 1991). There was only a modest contribution from privately run residential or nursing homes, usually accepting people who could pay for their own care, and from charities interested in this work. The pattern of care in Scotland and Northern Ireland was, and has remained, different. The balance of provision in Scotland between Part III homes and the hospital service depends upon a greater level of hospital care than was available in England and Wales. In Northern Ireland, the health and social services are integrated, and this has facilitated the best use of resources with a minimum of friction.

Local authorities wanted to improve the quality of care in their homes, but were keen to offer a 'capacity that was appropriate to demand or need', because they were responsible for a rationed service. It was accepted that a level of 25 beds per thousand people aged over 65 years was desirable. A few determined authorities were able to achieve this. Many could afford only half of this level, and pressures within their communities became intense. Interestingly, the disability profile in well and poorly provided local authorities was similar (McLauchlan & Wilkin, 1982). This suggests that even at this level of provision, there was little room for less disabled residents.

### *Specialisation*

Within the network of homes, the advantages of specialisation was canvassed and explored (Meacher, 1972; Wilkin *et al*, 1983, 1985). Powerful arguments were rehearsed for specialised homes for the elderly mentally ill. These were not universally well received, but in some authorities where close links were forged with psychiatric services for the elderly (notably Newcastle upon Tyne where Gary Blessed and Klaus Bergmann were influential) the system worked very well. Despite claims, and some evidence, for the advantages of mixed 'all comers' homes, the move toward specialised provision gained ground. It is now confirmed, in separate registration arrangements for nursing homes and residential care homes (both of which are for the elderly or the elderly, mentally infirm). This is a pattern seen in the USA, Australia and Europe (Jolley & Arie, 1992).

### *Alternatives*

Townsend's vision of alternative arrangements to cater for older people who require help, supervision and a guarantee of safety from intruders, is being explored in a range of 'sheltered' schemes in this country and in other parts of the world. Whole townships for retired people have been established in the USA, while complexes offering facilities including independent living in bungalows or flats, residential 'hotel' accommodation, and full nursing care have been developed in Europe and parts of the UK. Such initiatives have received the encouragement of governments in some countries (e.g. Denmark) but have usually depended upon voluntary or private sector enthusiasm and sponsorship in the UK. Some local authorities are convinced of their advantages (Wright *et al*, 1981; Bond *et al*, 1989; Copeland *et al*, 1990; Oldman, 1990; Pattie & Moxon, 1991).

### **1980s**

The stranglehold of rationing in the residential care sector, which had restricted Part III development, was released in the 1980s. New legislation

allowed the Department of Social Security to make special payments to applicants who required more care and attention than could be provided for them at home because of their age-related frailty or disability (House of Commons Social Security Committee, 1991). These payments (unlike NHS provisions and social service activities) were not subject to rationing by fixed budgets, but were a claimant's right if they fulfilled the necessary criteria. In practice, the criterion was simply that the individual felt they could not cope in their own home.

By moving into care, older people gave up their independence and the pleasures of a home life they had created over a lifetime, and took on a life shared with other older people, under the supervision of staff. However, they and their families were released from the worry of making ends meet financially, and from the vagaries of coping in a world which is sometimes hostile and dangerous to older people, and makes many other demands upon their families. Payments were 'means tested' so that people who had capital resources above £6000, or a substantial pension, would have to pay for their care. For a large section of less well off pensioners these new arrangements opened a door from a world of poverty and hazard into one of security and comfort.

There was a massive increase in the independent sector residential and nursing home availability throughout the country, on a scale not imaginable within the planned budgetary expenditure of the NHS or social services. The capacity of this component of the overall care system expanded dramatically. Flexibility of access and the range of style and quality of care also increased. Indeed, new requirements setting standards for the quality of accommodation and staffing led to an improvement in the facilities. At the same time, the direct provision of services by local authorities came under close scrutiny and intense budgetary pressure, as did the provision for long-stay patients within the NHS.

Many local authorities reduced their own provision of residential care to a minimum, or even ceased provision (Age Concern, 1991; Association of Directors of Social Services, 1994). Health authorities were encouraged to see nursing homes as direct alternatives to long-stay hospitals, within the geriatric and mental health responsibilities. Much of the NHS accommodation was poorly sited, poorly appointed, difficult to staff adequately and received minimal input from specialist consultants (Benbow & Jolley, 1992; Benbow *et al*, 1994). The prospect of moving care from dormitories in distant mental hospitals to well-sited, well-furnished and well-staffed nursing homes, where they would be under the medical care of general practitioners, and be sponsored by the Department of Social Security (or their own capital and pension) was very attractive. Results of the residential boom are summarised in Box 15.1.

**Box 15.1 Results of the residential boom**

As the number of places in residential and nursing homes increased exponentially, the overall cost rose in a similar fashion, and far outweighed the apparent advantages to local authority and NHS budgets (Audit Commission, 1986; House of Commons Social Security Committee, 1991)

There was a 'perverse incentive' for older people to give up their independence and to go into care. This was counter to the philosophy of community care. Pressure came from family members keen to be assured of safety, and professionals keen to empty NHS beds as soon as possible so that they could be used for others in more urgent need of therapy

Older people with modest capital and pension resources found that their assets were taken from them to pay for care, which a few years previously would have been provided free by the NHS. Surviving spouses might be required to live in penury, and offspring find themselves denied an expected inheritance

As the cost of good quality care rose, the payment of benefits did not, putting pressure on families (where they existed) to find 'top-up' payments, or requiring older people to move to bottom-of-the-market homes

Continuity of medical care, particularly the contribution of geriatricians or psychogeriatricians to the multi-disciplinary team, was compromised

Training and the maintenance of skills of the medical, nursing and rehabilitative professions suffered

The optimal use of resources in the community such as care at home, day care, respite and long-term care, became impossible because of the fragmentation of responsibilities and competing roles of those involved in making clinical decisions

**1990s*****Local authorities***

The National Health Service and Community Care Act (1994) addressed some of these issues. Following Sir Roy Griffiths' recommendations the open budget of the Department of Social Security was closed, ring-fenced and given over, with all responsibilities for purchasing care, to local authorities who had certain requirements (Box 15.2) (Griffiths, 1988; Department of Health, 1989).

This 'capped' expenditure terminated the exponential rise in cost to the public purse. It put services under pressure, but ensured that

**Box 15.2 Local authority requirements**

Identify people in need of care  
Carry out appropriate assessments  
Purchase care designed to meet their needs, taking into account  
the resources available  
Review need, and how far current services were meeting that  
need, at regular intervals  
Spend a fixed proportion of the budget on the independent  
sector

older people were properly assessed before major decisions were made about their care. The number of people going into care dropped and the number of viable residential and nursing homes reduced accordingly.

*Health authorities*

The responsibilities of health authorities in 'purchasing' long-stay care were re-examined, and it was confirmed that they have an absolute responsibility to ensure that patients, severely damaged by multiple, complex or unstable pathologies, are cared for within the NHS (Neill & Williams, 1992; Laing, 1993; Health Service Commission, 1994; Department of Health, 1995a, 1996; House of Commons Health Committee, 1995, 1996; Wistow, 1995; Joseph Rowntree Foundation, 1996). This means some health authorities have to reinvest in facilities. All authorities have been required to produce criteria for the use of their long-stay facilities (in liaison with social services departments) and put a procedure and appeal system in place.

**The future**

It is unlikely that the balance of beds will return to the pre-free market era of five continuing care beds per 1000 people aged over 65 in geriatric medicine, and two and a half beds per 1000 people aged over 65 in old age psychiatry.

The significance of NHS beds is wider than their capacity to care for individual patients. They emphasise the contribution of specialist health teams in offering advice, training and liaison to other caring teams; and facilitate the cohesive nursing of multi-disciplinary, multi-agency, multi-modal services for populations. Provision of a few beds may reduce the need for many people to enter long-term care in other ways.

## Characteristics of residents

### Age

The age profile of residents has shifted, almost exclusively, to the very old. Very few people now enter care in advance of the 80–85 year age band, and average ages continue to rise (Department of Health, 1994*b*, 1995) (Table 15.2). Younger residents are more likely to be suffering from severe disability arising from medical, or more often, mental illness.

### Gender

In residential care women outnumber men in a ratio of roughly three to one. This reflects the phenomenon of women surviving beyond their husbands.

### Marital state

Remaining married is a strong protector against entry to residential care. Only in long-stay hospital or, to a lesser extent nursing homes, are married people seen in any numbers, and then only among the more severely disabled. Married couples are traditionally determined to see each other through 'till death us do part', and they still do, though this phenomenon was threatened by the excess access to care available between 1985 and 1993.

### Behavioural characteristics

Many residents are frail and unable to care for themselves. Townsend not only noted this but described a simple rating scale to quantify and compare the abilities of individuals and home populations (Townsend, 1962). Other scales have been developed and acquired popularity in general usage. The Crichton Royal Behavioural Rating Scale was constructed by Sam Robinson during his work with elderly mentally ill patients (Box 15.3). Wilkin added memory and bathing to reflect the most pertinent characteristics of people in care (Wilkin & Thompson, 1989).

**Table 15.2** Age distribution in residential care homes for the elderly (%)

	1989	1995
<65	2	2
65–74	10	9
75–84	40	35
85+	47	55

**Box 15.3 Important characteristics of people in care**

Memory  
Bathing  
Mobility  
Orientation  
Communication  
Cooperation  
Restlessness  
Dressing  
Feeding  
Continence

The use of such measures confirms that while residential care populations are, on average, more behaviourally dependent than older people living in private households, many very disabled or disordered older people still live in their own homes or with their families. The role of hospitals in caring for the very disabled has always been numerically small. The spectrum of disability and disorder is more severe in nursing homes than in residential homes. Long-stay hospital patients are even more damaged. There is a strongly held belief that the level of disability among residents has been increasing, progressively. However, follow-up studies using comparable scales, and a review of Townsend's findings, suggest that the changes over the past 40 years have not been that substantial (Wilkin *et al*, 1978; Davies & Knapp, 1981; Capewell *et al*, 1986; Hodkinson *et al*, 1988).

**Physical health**

More than half of admissions to residential and nursing homes occur after a period of care in hospital. The degenerative disorders (strokes, ischaemic heart disease, Parkinson's disease and arthritis) are common and often present in combination. Impairment of hearing and vision compound communication difficulties. The 'geriatric giants' of immobility, falls and incontinence, are often evident and respond to positive approaches. Decubitus ulcers are common and demand watchfulness and preventative work. Diabetes and other endocrine disorders often require daily supplements (Brocklehurst *et al*, 1978; Challis & Bartlett, 1987; Gosney *et al*, 1990; Peet *et al*, 1994). Residents maintain health but the incidence of intercurrent illness and decompensation of previously quiescent pathologies is higher among people of equivalent age at home (Nolan & O'Malley, 1989; Central Health Monitoring Unit, 1992; McGrath & Jackson, 1996).

## **Mental health**

### *Dementia*

The strongest determinant of need for residential care is dementia. The Newcastle community follow-up studies of the 1960s demonstrated that few people survived alone with dementia for more than a few months, and most moved into residential care (Kay *et al*, 1970). Mental hospital provision, although important for the few who were disturbed, was numerically dwarfed. This remains the case. At least half of people in care are suffering from dementia (Kay *et al*, 1962; Jolley, 1981; Harrison *et al*, 1990).

### *Depression*

Depression is more common among residents than the general population, although the aetiology, characteristics and need for treatment require careful consideration (Mann *et al*, 1984; Ames, 1990; Stout *et al*, 1993). Some depressed residents have personality factors related to the difficulties encountered in late life, others have the features of 'biological' depression and benefit from antidepressants. It is important to avoid permanent placement in residential care when an individual might be better served by treatment of their depression and support in their own home. Similarly, caution is required in making the best provision for dysphoric individuals, who may find life within a home even less to their liking.

### *Long-standing mental illness*

People with long histories of mental illness or those with learning disabilities are commonly placed in care with older people. Many towns found it possible to relocate the 'less damaged chronic psychotics' from the back wards of the local mental hospital into more-or-less specialised homes during the golden era of the 1960s and 1970s. Subsequent placements of similar people may continue this pattern of specialist homes, or take advantage of vacancies in any home willing and able to accept them. In similar fashion, individuals with lifelong learning disability may

#### **Box 15.4 Characteristics of residents**

Age: old and getting older  
 Gender: female, three to one  
 Marital status: usually widowed or single  
 Poor physical health  
 Disabled  
 Mental illness: over half have dementia

be placed in homes when their support system (often aged parents or older siblings) begins to falter. A feature of the chronic mentally disabled is their relative youth (60–70 years on admission) within a pool of much older people. This occurs because hostels for the younger mentally ill frequently require residents to move on when they reach retirement age, and they may be loathe to accept new admissions of older clients even when they are in their 50s (Jones, 1985; Jolley & Jolley, 1991*a,b*; Jolley & Lennon, 1991; Faulkner *et al*, 1992; Davidge *et al*, 1994).

## Characteristics of homes

### **Ownership**

Most residential homes (59%) are within the private sector and may be run as a family business or, more often, belong to a chain of homes under the umbrella of a large organisation (Faulkner *et al*, 1992; Department of Health, 1994, 1995; Joseph Rowntree Foundation, 1996). Charities have maintained a small contribution to the range (16%), often taking the lead in innovations of style and quality. Local authority stock has dwindled, sometimes by making over properties to local charitable trusts or by selling to the private sector. Nursing homes are very largely a private sector venture, many being run by one of a number of large national and international companies.

### **Distribution**

Coastal resorts and other retirement areas have traditionally offered more homes than working towns and this pattern continues (Warnes, 1982; Davies & Challis, 1986; Larder *et al*, 1986; Fennell *et al*, 1988). In addition, homes cluster where there are suitable properties for conversion or cheap land available for new buildings. This means that the stock of homes, nationally and locally, does not relate to the need for such accommodation. People may be reluctant to move across town for their care. If they do, they may feel out of place as accents and topics of conversation are unfamiliar. These considerations are even more pertinent when moving to a new town to be near a relative or to take advantage of an available place in a favourite holiday resort.

### **Size**

Although homes are regarded as 'homely' compared to the institutional alternatives, there is a wide range of size, from three beds to more than 100. The economics of a small home leave little room for profit, and only dedicated family businesses can operate in this way. Even then, most require 20 or more beds to be viable within the funding allowed to

residents sponsored by the local authority (Jolley, 1992, 1994, *a,b,c*). Larger organisations may favour a complex of wings, with 20 to 24 beds in clusters of five or six, on one site (a total of around 140 beds). This allows for economies of scale in central facilities such as catering and laundry, flexibility in staffing, and for developing special environments within wings. This may include a special unit for the more behaviourally disturbed.

### **Specialised environments**

The stratification of provision into residential homes, nursing homes and community hospitals is established. Within this framework, registration for work with the elderly, the mentally ill or the elderly mentally ill has been discussed earlier. There is a healthy move toward dual accreditation, allowing for a range of care within one home. This may be achieved by designated special wings or annexes, or on a named resident basis, allowing for a mixed environment. This reduces pressures for people to move on when their condition changes, and facilitates life together for husband and wife, who are differentially disabled. There is a modest market for homes dedicated to the care of people with requirements associated with background rather than current morbidity. Catholics, Methodists, Muslims, Jews, Asians, Afro-Caribbeans, ex-Service men and women, and even the medical profession may choose to travel, to pass time in the company of kindred spirits.

### **Staffing**

Staffing levels are determined by registering authorities who also specify and inspect the availability of qualified nursing staff. Most hands-on care comes from unqualified carer staff, who are responsible to managers or qualified nurses. Even the qualified staff may have spent their training days in acute wards, or operating theatres, which hardly give them experience appropriate to their chosen careers.

Good nursing homes may include occupational therapy and physiotherapy skills within their staff, but few have speech therapy, psychology, dietetics or other remedial therapies. The characteristics of care staff differ between homes, and reflect the local economy as well as the aspirations, reputation and personal style of the home manager. Many staff have no formal educational, let alone health care or social care qualifications. In the best environments carers are drawn from local, mature women, who take up the work when their children become more independent. They enjoy the friendships and personal rewards of the work and gel into a stable team (Avebury, 1984; Phillips, 1988; Wagner, 1988; Chapman *et al*, 1994; Murphy *et al*, 1994; Relatives Association, 1994).

Less healthy scenarios (reported in the USA and London) see hard-pressed poor women striving to make ends meet by holding down more

than one job at a time in an attempt to support themselves and their children. Their tolerance and devotion at work is limited, and they may drift from place to place, providing a pair of hands but never developing personal pride in the tasks, nor the shared confidence of team working to a common purpose. The need for generous and sensitive attention to the training and support of staff cannot be overestimated.

### **Other roles**

Although the main role of a home is likely to be the safe keeping of people approaching their last months of life, other activities should be undertaken.

### *Assessment*

Admission often occurs after a period of illness so that each new resident requires careful assessment and help in the tasks of regaining stability, confidence and skills. After a period of care, convalescence and rehabilitation they may become able to return home or move to a less supportive environment.

### *Respite*

People who are vulnerable at home and only coping because of sustained care from others, may benefit from day care or periods of respite admission. Some homes offer both these options, others limit themselves to planned respite admissions.

### *Outreach*

A number of agencies are now able to offer a full range of support, including outreach, to clients at home. This facilitates flexible arrangements, making optimal use of strengths, and covering for weaknesses when they threaten to show through. In other situations these differing aspects of care require coordination across a number of agencies.

### **Life within homes**

The quality and style of life available to residents are also functions of a number of other elements (Social Services Inspectorate, 1990, 1993; Research Unit of the Royal College of Physicians, 1992; Royal College of Physicians and British Geriatric Society, 1992):

- (a) Design is important, in the personal space available to individuals, most of whom will prefer single rooms, and in shared or public rooms and facilities, such as bathrooms and toilets. Furnishings,

wall coverings, floor surfaces, lighting as well as storage and personal possessions are all potent determinants of comfort, confidence and interest (Harding & Jolley, 1994).

- (b) The programme of events gives shape, purpose and meaning to each day. These derive, in large part, from the personalities and behavioural abilities of the residents, both individually and in sum. For most, hours are spent in company with other residents. Staff interventions may be few, though they dictate the pace and structure of each day and may helpfully orchestrate the contributions of others.
- (c) Frequent contact with children, friends and other relatives confirm for the individual that they are still part of that world which was theirs for so many years. They also serve to inform others in this inner world of styles and expectations, linked to a long-crafted reputation. Regular visits from other agencies including churches, schools, educational teams and volunteer visitors all add something to the fabric and richness of life, and are invaluable.

### **Physical health care (Box 15.6)**

The cocoon of care in homes can distance them from medical, nursing and other therapeutic professionals, who should be involved in checking the progress of chronic illnesses, treating relapses and maintaining residents in the best possible health. Perversely, the danger may be greater in nursing homes because they are looked on as providing comprehensive care for health needs, as well as a safe roof and hotel accommodation. Residents may become invisible, and health care professionals convinced that they have no more to offer (Health Advisory Service, 1993).

### *General practitioners*

Residents are under the care of a GP, who may or may not know them. Many homes rely on a nearby practice to accept new residents onto their

#### **Box 15.5 Characteristics of homes**

Ownership: now largely private  
 Distribution: coastal, or where large cheap buildings are found  
 Size: often large, over 100 beds  
 Staffing: mostly unqualified  
 Design: important for individual rooms, and shared areas  
 Events and activities: dictate the pace of life  
 Contacts with outside agencies: add to the fabric of life

list. The practice may be paid an honorarium to provide additional services, such as advice or training to staff, but it is not allowable within NHS contracting to employ them on a sessional basis to provide clinical sessions within the home. That means that many older people with multiple disabilities and pathologies are not reviewed regularly. Homes that encourage residents to be registered with one practice, risk the probability that their new doctors will not know them, may not receive good information about them, and may never establish a warm relationship. Homes that encourage retention of long-established GPs run the dangers of multiple medical input to one establishment, and delay or reluctance in visiting.

### *Specialists*

Contact with physicians or surgeons may be made, or maintained, through out-patient appointments or domiciliary visits, although follow-up by routine visits to the home by geriatricians or their equivalent is rare, as is the use of day hospital. When patients are very ill, they may be admitted to hospital. There is a suspicion that admission is sometimes less readily offered to residents of homes than to people living independently and suffering from similar pathology.

### *Prescribing*

One of the deficiencies of medical and nursing supervision which has attracted concern is the prescribing, delivery and monitoring of medication (Nolan & O'Malley, 1989; McGrath & Jackson, 1996). The modal intake of medicines per resident, in one study of homes, was five different compounds daily. Some residents were receiving up to 14 different medicines. Some medications have persisted from previous regimes and never been reviewed. Potential adverse effects by interaction abound.

### *Other services*

District nursing responsibilities spread to residential but not nursing homes, but in the competition for scarce resources, residents may lose out in the allocation of nursing time and the provision of facilities such as incontinence classes and other aids. Occupational therapy, physiotherapy and other remedial skills are often very limited. People who are housed safely, and in reasonable comfort, still require informed and sustained rehabilitative programmes.

Death and the management of dying are important features of home life and should be approached actively for the benefit of staff and relatives, as well as residents. These frail friendships are repeatedly broken by final partings, and it is important to be sure that everyone is confident and

competent in managing this most significant of transitions (Bender *et al*, 1990; Black & Jolley, 1990, 1991).

### **Mental health care (Box 15.8)**

The residential care population is a concentrate of mental morbidity, dementia, mood disorders, chronic psychosis and a fertile, stressful environment for the emergence of new difficulties of adjustment reactions. Nevertheless, it is common for the mental health of residents to receive little attention beyond that of an interested and informed home manager and the individual concerns of families (Royal College of Physicians & Royal College of Psychiatrists, 1989). It is terribly easy for morbidity to be hidden, or to be seen but not appreciated for what it is, with limitations being attributed to age, deterioration and the approach of an inevitable demise.

The scale of the challenge is daunting (1400 people in over 60 homes in a town, such as Wolverhampton, with an elderly population of 40 000) but there is no doubt that specialist psychiatric services for older people should address the situation actively. The potential for improving the quality of life for individuals and groups of older people is considerable, as is the prospect for increasing the job satisfaction of staff in the homes, and the potential for obtaining optimal use of services of all kinds.

With appropriate staffing and a determined strategy it is possible to forge effective links with all the significant homes in a locality. In the pattern which concentrated 'elderly mentally ill' patients in particular homes, this was facilitated, at least for the residents of those homes. There was, however, always the risk that only the most troublesome were recognised by such arrangements, and the mild mannered, depressed or muddled majority who might benefit from attention never receive it. It may be feasible to include routine visits to homes in the work specification of community psychiatric nurses.

#### **Box 15.6 Physical health care**

Homes may easily become cocooned from health services  
 Residents tend not to be reviewed regularly by their GP  
 'New' GPs may have little information and poor rapport with residents  
 Maintaining 'old' GPs leads to multiple medical input  
 Polypharmacy is the rule, and five medications is most common  
 Hospital specialists rarely follow-up and may be reluctant to admit residents to hospital  
 There is often limited input from occupational therapists or physiotherapists

Another approach, which has advantages, is to add this responsibility to qualified staff based in long-stay or continuing care community hospitals which are an intrinsic part of NHS provision (Wilkin *et al*, 1982; Jolley, 1994a). This emphasises the role of such units as part of a spectrum of care, which can help other agencies involved in similar work, by offering expertise through liaison, training and exchange of good practices, rather than simply taking away the most difficult minority. It is important, however, to develop the expectation that the help available to the care homes will come from a full range of skilled professions (including consultant psychiatrists, clinical psychologists, psychiatric nurses, occupational therapists and others), and not just from one over-stretched community psychiatric nurse. With this multi-disciplinary approach, residents will have the benefit of a full competent assessment (Box 15.7)

Although homes are sometimes seen as 'the last refuge', they have tremendous therapeutic potential and, used properly, can achieve this very well for people vulnerable to mental disorders. People who have begun to fret and become frail because of progressive dementia can find reassurance and companionship, eat more, put on weight and contribute with encouragement to a communal life. Individuals who are prone to relapsing depression, despite strong support and the best of physical and psychological therapies, may find their present strengths become sufficient when the worries of organising every day food, warmth and structure are taken on by a home.

People with schizophrenia or paraphrenia can find a niche within the tolerant, confident, supported life of a home which sees itself as part of a wider spectrum of 'psychogeriatric' care. This means that florid symptomatology and the behavioural disorders that go with it can be

**Box 15.7 Mental health assessments in residential or nursing homes**

Full referral including background information  
Gather further information from notes, staff and GP  
Take a full history, mental state and physical examination  
Speak to a relative or friend of the patient  
Admission to day hospital or in-patient care may be necessary for further investigations  
Management of troublesome behaviours are outlined in Chapter 6  
Behavioural programmes can be effective  
Other professionals may become involved, such as community psychiatric nurses, psychologists or social workers  
Inform staff fully of assessment and interventions  
Follow-up

**Box 15.8 Mental health care**

Mental health problems are often not detected  
 Psychiatric services have a key role to play  
 Effective links should be forged, e.g. regular community  
 psychiatric nurse visits  
 Psychotropics may be poorly or overprescribed  
 Antidepressants may be underprescribed

minimised, reducing in turn the stresses and demands on the system of care (Jolley, 1994b).

There is particular interest in the use of psychotropic medicines. These may be poorly prescribed and under reviewed. Neuroleptics are sometimes prescribed with the intention of sedating patients. Their anticholinergic side-effects may worsen Alzheimer's disease. Antidepressants are often under prescribed. Residents may not be assessed because staff or doctors consider their depression to be understandable. Alternatively, residents may be overlooked as they cause no immediate concern.

## Conclusion

Residential and nursing homes have an important role to play in the care and support of the most needy sections of society, including the old and the mentally ill. Recent history has shown that changes in Government policy can have a profound effect on these institutions. Resources should be focused on improving the health and quality of life of residents. This may allow residential and nursing homes to finally emerge from the shadow of the workhouse.

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