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Contemporary Themes

Changes in behavioural characteristics of elderly populations of local authority homes and long-stay hospital wards, 1976-7

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Summary and conclusions

Behavioural characteristics of the elderly populations of seven local authority residential homes and three long-stay hospital wards were assessed in 1976 and 1977 with the Crichton Royal behavioural rating scale. In 1977 the levels of behavioural problems had increased in the residential homes, but declined in the hospital wards. Differences between the homes had decreased as the overall level of problems increased.

The findings suggested that the additional burden of caring for increasing numbers of severely disabled elderly people was affecting the balance of institutional care, and a radical reappraisal of present patterns of care may be necessary to meet their future needs.

Introduction

The number of old people in England and Wales is expected to increase by about one million between 1971 and 1991, but the biggest increase will be among those aged 75 and over,[1] many of whom cannot care for themselves because of mental and physical illnesses. Most will be cared for at home,[2] but the concentration of severely disabled people in institutions is already posing problems of both policy and practice. At a time of economic constraint, and when expansion of institutional facilities is also unfashionable, existing establishments are coming under increasing pressure as the demand for care rises.

Studies that have described the characteristics of the elderly populations of hospitals, local authority homes, and other institutions[3–5] have shown that allocation to different forms of care varies with locality and is influenced by the services available and the way these respond to the demands made on them. Thus many people find their way into conditions not ideally suited to their needs,[6–8] and present patterns of care are rarely those described in "official guidelines."[9 10] Changes in the demand for institutional care and the facilities available should be monitored regularly and there is a continuing need for up-to-date surveys on current conditions.[11]

We describe changes in the behavioural characteristics of the elderly populations of local authority homes and long-stay hospital wards in south Manchester during one year.

Services

Social service provision to the resident elderly population of Manchester (roughly 90 000 of retirement age) is among the best in Britain. Domiciliary services are well developed, and include 700 home helps, who visit almost 10 000 households, and a system of neighbourhood wardens and neighbourhood visitors in contact with over 5000 households. Almost 900 000 meals-on-wheels are delivered every year, and in addition 40 luncheon clubs are well attended. There are five day centres, and most residential homes accept up to four day attenders. Residential care is provided in purpose-built or converted homes, with an average capacity of 40 residents and a total of 25 places for every 1000 aged 65 or more. There are six administrative areas in the City of Manchester, and each area provides a team of social workers and assistants and has various facilities, such as residential homes, for caring for elderly clients.

Hospital facilities for the elderly are less ample. The geriatric services continue to carry the burden of providing for those who live in the commuter suburbs outside Manchester itself. Thus, although there is an academic department of geriatric medicine at Withington hospital and a total of four geriatric firms working from the hospitals of south Manchester, the ratio of beds available is roughly 0·7 per 1000 elderly, with 40 day places in a catchment population of 54 000 elderly. Psychiatric beds for demented people are in the ratio 1·5 for every 1000 elderly, with no designated day care at all. The level of provision of facilities did not change during the study.

Methods

The Crichton Royal behavioural rating scale (CRBRS)[12] was used to assess behavioural characteristics in residents in seven local autho-

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rity homes for the elderly and in patients in two long-stay geriatric wards and one long-stay psychogeriatric ward in 1976 and 1977.

The residential homes represent the provision available for one social services area, the two geriatric wards the designated long-stay complement of one geriatric firm, and the psychogeriatric ward the designated long-stay accommodation of the psychogeriatric service for the same area. Each resident or patient was assessed on eight items (mobility, orientation, communication, co-operation, restlessness, dressing, feeding, and continence) by a research worker helped by the officer in charge or ward sister. An estimate of the overall level of behavioural problems in each case was obtained by summing the scores on these eight items. "Total behaviour ratings" obtained in this way ranged between 0 (no problems) and 31 (severe problems), high scores indicating poor intellectual performance and physical dependence.[12] In a study of patients in long-stay wards and residents in local authority homes, all of whom scored 17 or more on the CRBRS, 93% scored less than half marks on an information and memory test, and in 88% the diagnosis was senile dementia or cerebrovascular disease.[13]

Results

DISTRIBUTION

Much of the burden of increased mental and physical impairment among old people in long-term institutional care in south Manchester was absorbed in the social services residential homes (table I). The number of relatively able residents (score 0-8) decreased, while the number of moderately and severely impaired increased in 1977: 19 more scored 9-16 and 14 more scored 17-31 (increases of 44% and 58% respectively). At the same time, the long-stay hospital wards contained fewer severely impaired patients in 1977 than in 1976, giving some bed space to less severely impaired people (table I). Eighteen fewer patients (37%) scored between 17 and 31 in 1977 while 10 more (110%) scored 8 or less.

TABLE I—*Changes in distribution of behavioural problems in elderly patients in residential homes and long-stay geriatric wards as assessed by scores on Crichton Behavioural Rating Scale (CRBRS), 1976-7. Figures are numbers of patients*

CRBRS score:	0	1-4	5-8	9-16	17-31	Total
			Residential homes			
1976	49	69	51	43	24	236
1977	43	59	31	62	38	233
			Long-stay wards			
1976	3	2	4	25	49	83
1977	6	8	5	23	31	73

LEVEL OF BEHAVIOURAL PROBLEMS: RESIDENTIAL HOMES

Although there was an overall increase in the level of behavioural problems in the residential homes between 1976 and 1977, this was not evenly distributed among the different homes (table II). In 1976 the mean scores of residents in the seven homes varied considerably. The overall increase in the level of impairment between 1976 and 1977 was accompanied by less variation between homes. The characteristics of the two homes carrying most disability in 1976 remained essentially unchanged, but the others were all managing more disabled residents. Thus, while the mean CRBRS score for the homes rose from 6·46 to 8·48, its standard deviation fell from 2·59 in 1976 to 1·58 in 1977. In five of the six homes where the level of problems had increased, behaviour related to mental disturbance (orientation, communication, co-operation, restlessness) accounted for a greater proportion of the increase then that related to physical dependence (mobility, dressing, feeding, continence). This pattern was most noticeable in the converted homes that lacked some of the facilities of the purpose-built homes, and accordingly tended to accommodate fewer residents with physical impairment and more ambulant confused people.

TABLE II—*Mean CRBRS scores for seven residential homes, 1976-7*

Residential homes:	1	2	3	4	5	6	7	Overall mean	Standard deviation
1976	10·9	9·1	6·0	5.8	5.4	4.1	4.0	6·46	2·59
1977	9·4	10·6	8·7	8·0	9·1	8·2	5·5	8·48	1·58

Discussion

Statements of policy suggest that services are provided according to the needs of clients and their relatives.[9] In practice, however, levels of provision are usually predetermined and the criteria for usage determined by the day-to-day interaction between this provision and changing levels of need. The number of severely impaired old people using services is increasing as the number of very old people in the population rises. Our findings suggest that the additional burden of caring for these people is changing the balance of care within the institutional system. While hospital wards were providing long-stay care to fewer patients with moderate and severe impairment, the number of similarly impaired residents in local authority residential homes increased sharply. These people were almost invariably severely mentally impaired and highly dependent on staff for basic physical care.

Hospital services seem to be responding to increasing pressure on limited resources by making their facilities for assessment and rehabilitation of the reversible components of disability available to more people. Thus, there was an increased "throughput" in the geriatric and psychogeriatric wards compared with previous years. Hospital inpatient statistics suggest that this reflected national trends in the care of the elderly in hospital.[14] This can be achieved only by reducing their alternative role of providing care for people incapacitated by severe and irreversible disorders, which is increasingly being thrust upon residential homes provided by the local authority. So far, these residents have been absorbed without the homes becoming anything like long-stay hospital wards, and in none of the homes reviewed in 1977 was the overall level of behavioural problems any greater than that in the home with most problems in 1976.

Thus there remains a range of able and disabled people within individual homes, with many of the residents remaining quite able. But the variation between individual homes has been lost, since all provide for similar proportions of disabled residents. The variation that remains allows some homes (usually those with specific facilities such as lifts) to cater for more physically dependent residents, while others cope with more who are mentally disordered. The increased dependency of people in the homes has not been matched by corresponding improvements in staffing levels, training programmes, physical facilities, etc, and a point may have been reached where, as more time is directed to severely impaired clients, less staff time is available for caring for the needs of other residents, whose demands may consequently escalate.

If the changes observed between 1976 and 1977 continue, the many advantages that residential homes offer at present as alternatives to long-stay hospital wards would almost certainly be compromised. An assessment of the consequences of these changes for disabled residents, less disabled residents, relatives, care staff, and for the use of expensive hospital facilities is essential. The advantages of caring for people in non-hospital settings can be maintained only if there is an improvement in the numbers and training of staff, but specialist advice and support is also increasingly needed. This will probably not be provided while suitable medical, nursing, physiotherapy, and occupational therapy skills continue to be concentrated in hospitals. A radical reappraisal of present patterns of institutional care may be needed to meet the demands created by the

expanding population of disabled old people whose needs for care cannot be met in the community.

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Clinical Topics

Physician's use of laparoscopy

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Summary and conclusions

The role of laparoscopy in medical practice was assessed by studying 238 consecutive laparoscopies performed under local anaesthesia by physicians in a single teaching hospital. Indications for laparoscopy were assessment of possible and known hepatic disease, possible disseminated abdominal malignancy, abdominal mass, and conditions such as ascites and splenomegaly. A definitive diagnosis was reached in 223 cases (76·5%). No organic disease was detected in 41 patients, though findings were false-negative in two of them (0·8%). The procedure failed in 15 (6·3%), mostly because adhesions from previous surgery hindered adequate visualisation. Six patients (2·5%) had complications, one of whom subsequently died.

If patients are appropriately selected laparoscopy is relatively free of postoperative complications, and is an effective diagnostic procedure in abdominal malignancy and decompensated liver disease. Cost-effectiveness is an additional advantage.

Introduction

Laparoscopy has been widely practised in Europe for many years and is well established in gynaecological practice in the United Kingdom. The application of laparoscopy to general surgical problems has been repeatedly advocated in recent years.[1-5] Performed under local anaesthesia and mild sedation, and using modern operating laparoscopes that permit tissue diagnosis under direct vision, the procedure is highly acceptable to patients and cost-effective. Despite the potential advantages, laparoscopy is rarely used in medical practice in the United Kingdom.

Information on the role of laparoscopy in medical practice is sparse,[6-8] and is often based on relatively small series. There has recently been a plea for the role of laparoscopy in medicine to be re-evaluated.[9] We tried to assess this role by examining data from 238 consecutive laparoscopies performed in a gastrointestinal unit of a teaching hospital.

Patients and methods

Laparoscopies were performed in 238 consecutive patients (mean age 58 years, range 11-81). Most were from a single clinical department of general medicine which has a major interest in gastroenterology, but some were specifically referred for laparoscopy from other departments.

All laparoscopies were performed under local anaesthesia and diazepam sedation in an ordinary endoscopy room equipped with an electrically tilting table and scrub-up facilities. The pneumoperitoneum was introduced via a Verris needle with an automatic insufflation apparatus.[10] Whenever possible, a midline supra- or infra-umbilical site was chosen for introducing the trocar. Stortz operating laparoscopes (sterilised by ethylene oxide and electrically warmed) were used throughout, using single-puncture technique only. All biopsies were performed through the operating channel of the instruments. The procedure was performed by one of 12 different people, many of whom were inexperienced laparoscopists under instruction, but always under the supervision of one of the authors.

Table I shows the indications for laparoscopy in the 238 cases. These were usually to assess probable or known hepatic disease, abdominal malignancy, or abdominal mass. Other indications included investigation of ascites and splenomegaly.

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