Contemporary Themes

Half-way house in geriatric practice

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Geriatric units are multiplying as the elderly population increases. The way a particular unit should run depends mainly on the attitude of the consultant and partly on the resources available. Generally speaking most units cater for assessment, rehabilitation, and continuing care, while others concern themselves mainly with continuing care and rehabilitation. It is debatable which practice is desirable and the more successful so far as the consumers are concerned. Either way a time is reached when the patient is fit to leave hospital but not to return home—particularly if he lives alone. In the half-way house an attempt is made to create a hotel atmosphere. The idea is not new but one we believe might be developed more widely. The patient's day assumes a more normal pattern than is practicable within the hurly-burly of an acute ward. Help is available, but not so readily as in hospital. Such accommodation is a logical step in progressive patient care. It has a wider application than a self-care unit. It provides convalescence for those who have been acutely ill. Furthermore, it is not essential or practicable for many patients who are able to leave hospital to become completely independent. Plans for further management may be assessed; relatives and neighbours who had felt unable to contribute often revise their decision when they see how well the patient is coping.

The patients also are encouraged by their progress and at the same time become aware of their limitations. They see what it is like to live in a community and more readily accept life in an old people's home. The social services have time to make their plans, for the patient's condition does not deteriorate but rather improves during the inevitable waiting period. When patients wait for welfare accommodation in hospital it is all too easy for them to become dependent on the nursing staff. The longer they remain in one environment the more reluctant they are to change it. If they fail at the half-way house, it is clear that they will not be suitable for welfare accommodation. Readmission to hospital is much less traumatic for all concerned from the half-way house than from a county home.

The home

Our half-way house is run by a religious order with nursing and teaching experience. Lay staff are also employed. The total staff consists of one State-registered nurse (the matron); three State-enrolled nurses; five auxiliaries (two full-time, three part-time); nine attendants (six full-time, three part-time); and six

dining-room servers (five full-time, one part-time). One or two of the attendants are on night duty. The building is an old girls' school and originally comprised a large dining hall, a day room/lounge, single and double bedrooms, cubicled dormitories of up to seven beds, and bathroom and lavatory facilities.

Extensive improvements were carried out at our request, but at the religious order's expense. Access roads were widened and special doors at the entrance were inserted for ambulances. A lift was installed from the ground floor to all bedroom floors. Odd steps were replaced by ramps, and in many cases the floors were raised so as to avoid steps. A separate TV/smoking lounge was created on the ground floor and a small lounge upstairs. Additional roomy cloakrooms were constructed within easy reach of the day rooms. The kitchen and laundry were modernised and all the requisite fire precautions installed. The speed with which these alterations were carried out was a revelation to anyone who has had to deal with the National Health Service machinery.

ADMITTANCE CRITERIA

Five criteria were agreed for admission. The patients must be continent (or reasonably so); able to dress themselves (or with a little help); able to wash themselves (or with a little help); able to do a few steps; and not be severely mentally confused. Only elderly patients are accepted. The half-way house differs from an ordinary convalescent home in this respect and in the degree of medical supervision.

MEDICAL CARE

A local general practitioner is responsible for the day-to-day care, and this is financed by the religious order. He is also employed on a sessional basis in the geriatric unit, so he is familiar with the patients and our methods. The two consultants in geriatric medicine and the senior registrar take it in turn to do a weekly ward round with the general practitioner. Facilities exist for carrying out a few essential haematological, biochemical, and radiological investigations.

Arrangements with the local authority

Over the years the numbers have increased and the home now takes 60. There is a nucleus of permanent residents (at present 20), who cover their own expenses. The rest of the beds are available on a contractual arrangement, previously with the regional hospital board and now with the area health authority. The hospital patients are sent for two weeks, and if by then there is a medical reason which prevents their returning home they may stay for a further two weeks or in exceptional cases a little longer. The authority pays only for individual patients. The

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numbers at any one time varied from 15 to 25 during the past year.

Before reorganisation the local authority had a contractual arrangement whereby patients from the community could be admitted for convalescence or to enable a caring relative to go on holiday. They also covered expenses when hospital patients remained for social reasons. The home is hoping to make a similar arrangement with the department of social services shortly. As well as applying to become permanent residents, elderly people in the community may book in at their own expense for short periods if they wish. Patients from hospital are not confined to admissions from the geriatric wards alone but come from all branches of medicine and from the whole of North Wales.

The total elderly population catered for by the North Clwyd Geriatric Unit is about 30 000 out of a total population of 160 000. During the summer these numbers are considerably increased by holidaymakers. The unit's turnover for the last three years is shown in table I.

TABLE I—Turnover of patients in the geriatric unit

Year	Average daily available beds	Average daily occupied beds		Discharges or deaths	Average duration of stay (days)	Waiting list
		No	%			
1973	193.4	181.4	94	1355	48.9	—
1974	210.6	196.8	93	1541	48.0	5
1975	215	203	90	1674	44.3	44

The unit's arrangement with the half-way house has been operating for 10 years, and the number of patients sent from the unit has risen from 83 in 1966 to 328 in 1975. The numbers for the last three years are shown in table II. Of the 29 readmitted to hospital in 1975, 13 were to the geriatric unit, three to the orthopaedic unit for fractures after falls, one to the psychiatric

TABLE II—Dispersal of hospital patients sent to half-way house

Year	No of patients sent from hospital	Discharged to own home	Readmitted to hospital	Discharged to welfare home	Private care including permanent care at convent	Sudden death
1973	244	187	10	30	15	2
1974	276	218	16	26	12	4
1975	328	250	29	29	18	2

unit, and the rest for surgical emergencies or planned readmission for further surgery.

Advantages of a half-way house

It is obvious from table I that this geriatric unit has been functioning with substantially less than the recommended ratio of geriatric beds of 10 per 1000 old people, and this is largely made possible by the existence of this half-way house. In these times of financial stringency we need to get the best value from our limited resources. Half-way houses have a therapeutic benefit and also sound economic advantages. On average a fortnight's stay in our half-way house costs the area health authority £35, while a hospital bed costs £296.24.

It is hoped that such non-profit-making institutions, if they can be persuaded, could and would support the establishment of many more half-way houses. The elderly in our population are steadily increasing. Hospital beds are very expensive and should be used only for those who really require a full hospital service.

We are grateful for help from the Sisters of Charity of Our Lady of Mercy, the matron and staff, Dr John Curley, Mrs Myra Thomas, Mrs B Lloyd, and also Dr David T Jones.

What limitations, if any, should be placed on women scuba divers? Should they dive while menstruating? What depth can they dive to? Should they dive while pregnant? How soon after delivery?

It is not necessary to limit the activities of non-pregnant women divers, nor, with modern sanitary techniques, is it necessary to restrict diving while menstruating. While the fetus, being extremely vascular and devoid of air spaces, is unlikely to be harmed by decompression sickness—which results from the direct effects of pressure (barotrauma) or by nitrogen narcosis—theoretically it might be adversely affected by the abnormally high oxygen partial pressure produced by breathing compressed air at depth. For this reason pregnant women are commonly advised, purely empirically, not to dive deeper than 2.1 m and to avoid dives needing decompression. A further problem late in pregnancy is the purely physical one of getting suit and weight-belt to fit and of getting in and out of boats while encumbered with an abdominal mass. It is safe to resume diving four to six weeks after delivery.

A teenage girl is going to Guyana for four weeks in July. What preventive treatment for malaria should she be given?

Guyana, which has recently experienced a resurgence of malaria, is in South America, an area where falciparum malaria is often resistant to chloroquine. The most effective chemosuppressant for chloroquine-resistant falciparum malaria is the synergistic combination of pyrimethamine 25 mg with sulfadoxine 500 mg (Fansidar). This is an effective chemosuppressant when administered once a month^{1,2} (a three-tablet dose in adults) or one or two tablets may be taken every two weeks³ or one tablet a week.⁴ Unfortunately Fansidar is not

marketed in the UK, but it is obtainable in most tropical countries. Alternatively, in Guyana, malarial chemosuppression with weekly chloroquine (300-mg dose in adults) would probably be somewhat less effective. Antimalarial chemosuppression should be continued for eight weeks after leaving endemic areas.

¹ O'Holohan, D R, and Hugoe-Matthews, J, *Southeast Asian Journal of Tropical Medicine and Public Health*, 1971, 2, 164.

² Lewis, A N, and Ponnampalam, J T, *Annals of Tropical Medicine and Parasitology*, 1975, 69, 1.

³ Pearlman, E J, *et al*, unpublished information.

⁴ Lucas, A O, *et al*, *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1969, 63, 216.

How long before a holiday should travellers be given a booster poliomyelitis injection?

The rationale for recommending a "booster" dose before travelling abroad is to make good any possible failure of primary immunisation. The oral vaccine contains three polio virus types, and each dose enables one type to infect the gastrointestinal tract. Three doses are given so that each virus type can infect in turn. Once a single "take" of a virus type has occurred, immunity against that type persists for a very long period, probably for life, and there is no need to boost immunity with subsequent doses. Occasionally, however, one of the primary doses may fail to infect for reasons which are not certain, but may include competition by wild enterovirus strains or reduced activity of the vaccine virus through inappropriate storage and transport. The timing of subsequent doses, given to cover the possibility of previous failures, is therefore not critical. For travellers the dose can be given well in advance, at any time up to one month before departure, so that any missing immunity against one of the virus types is given time to develop.