and create rather than result from impaired social circumstances.

In this study we found an association between increasing age and length of stay, but even in the oldest age group—that is, 85 years and over—44 (72%) out of 61 patients were discharged at 28 days. Thus age alone does not make a major contribution to prolonged hospital stay, and even when 14 days is taken as the optimum length of stay in general medical wards only half of those aged 80 years and over are placed inappropriately. Nevertheless, the very old patients remaining in hospital occupy a disproportionate number of bed days.

In conclusion, the prolonged stay in hospital of elderly patients is related to medical rather than social factors. Furthermore, contact with members of a geriatric medical unit in such patients results in shorter lengths of hospital stay,⁵ lower mortality, fewer admissions to nursing homes, and an improvement in functional state after discharge from hospital.¹³ Improvements in community social services would have at best a marginal effect on the turnover of elderly patients in general medical wards. A better approach would be to strengthen geriatric services so that all elderly patients identified as likely to require the expertise of the geriatric medical unit may receive this soon after admission.

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Bed blocking in Bromley

JEREMY COID, PETER CROME

Abstract

A point prevalence survey of all acute beds in the Bromley district found that more than one in 10 patients were classified by their doctors as bed blockers (one in five in the medical wards). There were appreciable clinical and demographic differences distinguishing bed blockers from patients whose stay had been prolonged and who were judged as still requiring acute beds. Social and administrative problems also contributed to bed blocking so that further action by geriatricians, psycho-geriatricians, and social workers was required to reduce the numbers. A substantial proportion of bed blockers, however, were highly dependent and could be transferred only to long stay wards or nursing homes.

Bed blocking seems inevitable in wards that are attempting to cope with the steadily increasing proportion of elderly patients according to traditional models of acute care.

Introduction

It is important to know the extent of bed blocking and prolonged stay in acute medical and surgical wards. Not only do these factors prevent the use of a bed for its intended purpose but the presence of bed blockers and long stay patients can also have a detrimental effect

on staff morale. For example, nurses in one acute medical ward complained of having to be constantly vigilant to prevent ambulant demented patients from wandering and getting lost. On another ward so many patients were awaiting transfer to a long stay geriatric bed that the ward sister voiced her intention to resign. The management proposed that some patients be "referred" to beds in other departments, if necessary against the wishes of the consultant responsible. Indeed, this actually occurred when both acute and geriatric wards had to be closed as part of financial cuts. Most staff believed that these problems had not always existed and were getting worse. Anecdotal accounts from neighbouring districts suggested that the problems were no worse in Bromley than elsewhere.

The generally accepted definition of a bed blocker is someone who has been in hospital for more than four weeks and who in the opinion of the medical and nursing staff no longer requires the facilities provided there.¹ These patients need to be distinguished from long stay patients, who are thought still to need the facilities of an acute medical ward.

This investigation was initiated by one of us (JC) while on rotation as senior registrar in psychiatry to Bromley health district, the major impetus for the study being the demand by staff that "something must be done." The aims of the study were, firstly, to ascertain the extent of bed blocking in Bromley; secondly, to try and elucidate clinical differences between bed blockers and long stay patients; and, finally, to suggest ways to minimise this problem.

Methods

Background data were first obtained from the South East Thames Regional Health Authority on trends in occupancy of all acute beds in the four Bromley district hospitals with specialties of general medicine and chest diseases, general surgery including urology, and orthopaedics. Data were obtained for the nine years 1975-83 on patients' age and duration of stay in the form of (a) the annual number of discharges and deaths and (b) units of occupancy in bed days.

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A point prevalence survey of all patients occupying acute beds in the three specialties on 15 June 1983 was carried out. A questionnaire was completed for each patient who had occupied a bed for 31 days or more from interviews with medical staff (senior house officers or registrars), nursing staff in charge of the ward, and three social workers covering the four hospitals. Patients' case notes and social workers' files were also reviewed. Patients were divided into two groups: bed blockers were those who had occupied a bed for 31 days or more and who in the opinion of the junior medical staff no longer required the facilities of an acute ward; long stay patients were those who were thought still to require these facilities.

A follow up survey was carried out 18 months later to ascertain the number of patients who continued to occupy these beds.

Groups were compared using the χ^2 or Student's *t* test, and differences were considered to be significant if $p < 0.05$.

Results

TRENDS IN BED OCCUPANCY AND TURNOVER

There was a 10% fall in discharges and deaths of all patients aged under 65 and a 10% rise in those aged 65 and over during the nine years (figure). When these figures were analysed by specialty the increase in turnover for those 65 and over was found to have occurred entirely within the general medical wards. Over the same period the proportion of patients aged 65 and over who stayed for 31 days or more fell initially and then remained steady at a mean of 17%, compared with only 3% of patients under 65 whose stay was prolonged. By 1983 patients of 65 and over accounted for 66 390 (72%) bed days in general medicine, 28 766 (53%) in general surgery, and 21 424 (58%) in orthopaedics. Each of these three specialties had seen a 10% rise in patients aged 65 and over from 1975 to 1983.

Annual discharges and deaths by age.

POINT PREVALENCE SURVEY

On the day of the study 503 patients (222 men, 281 women) occupied 565 available acute beds. Of these patients, 145 (29%) had been in hospital for 31 days or more but only 27 (5%) had stayed for six months or more. Table I shows that although 14% of all patients were bed blockers, the proportion in different specialties varied from 22% in medical wards to only 2% in surgical wards. This difference was highly significant ($\chi^2 = 36.8$, $p < 0.0001$). Table II shows that 63% of all acute beds were occupied by those aged 65 and over.

TABLE I—Patients classified according to duration of stay and specialty (figures are numbers (%) of patients)

	Specialty			Total
	Medicine	Surgery	Orthopaedics	
Stay ≥ 31 days:				
Bed blockers	56 (22)	3 (2)	9 (9)	68 (14)
Long stay	34 (14)	16 (10)	27 (28)	77 (15)
Stay < 31 days	159 (64)	140 (88)	59 (62)	358 (71)
Total	249 (50)	159 (32)	95 (19)	503 (100)

TABLE II—Patients classified by status and age (figures are numbers (%) of patients)

Age (years)	Bed blockers	Long stay	Others	Total
0-14		3 (4)	1 (0.3)	4 (1)
15-24		3 (4)	23 (6)	26 (5)
25-34	2 (3)	1 (1)	8 (2)	11 (2)
35-44	1 (1)	2 (3)	21 (6)	24 (5)
45-54	4 (6)	13 (17)	27 (8)	44 (9)
55-64	6 (9)	22 (29)	47 (13)	75 (15)
65-74	33 (49)	23 (30)	59 (16)	115 (23)
75-84	18 (26)	9 (12)	118 (33)	145 (29)
85+	4 (6)	1 (1)	54 (15)	59 (12)
Total	68 (14)	77 (15)	358 (71)	503 (100)

The largest number of patients was in the age group 75-84. Bed blockers were found in all age groups from 25-34 upwards, the greatest proportion being in the age group 65-74.

Investigation of the home circumstances of the bed blockers and long stay patients showed that 62 (43%) lived alone, 72 (50%) lived with relatives, and 11 (8%) had been admitted from residential and nursing homes. These proportions were identical for both groups of patients.

Table III shows the primary diagnosis on admission. Many patients had several diagnoses, and a secondary diagnosis was recorded when the medical staff considered that it made an important contribution to prolonging the stay. The most common diagnosis was cerebrovascular disease, which occurred in 27% of all patients. All had suffered a stroke except for one patient, who had had a subarachnoid haemorrhage. Most patients with fractures were 65 or over, but this category had a wide age range and included the four youngest patients, who were nursed in the same ward as the adults. All patients with a secondary diagnosis of fracture had either a malignancy or a more serious primary condition. The most common secondary condition contributing to prolonged stay was senile dementia.

TABLE III—Diagnostic categories (figures are numbers (%) of patients)

Disease category	Primary diagnosis	Secondary diagnosis
Cerebrovascular	39 (27)	
Fracture	34 (23)	8 (12)
Cardiac	11 (8)	6 (9)
Digestive system	8 (6)	2 (3)
Central nervous system	8 (6)	5 (8)
Skin	8 (6)	5 (8)
Neoplasm	8 (6)	6 (9)
Respiratory	7 (6)	6 (9)
Dementia	5 (3)	15 (23)
Musculoskeletal	4 (3)	6 (9)
Social admission	4 (3)	
Genitourinary	3 (2)	
Endocrine and metabolic	3 (2)	5 (8)
Blood	2 (1)	1 (2)
Infection	1 (1)	1 (2)

COMPARISON OF BED BLOCKERS AND LONG STAY PATIENTS

Three quarters of bed blockers were aged 65-84 (mean 79.8 years). This contrasted with the long stay patients, whose mean age was 68.3 years ($t = 4.28$, $p < 0.0001$). Three quarters of the bed blockers (51/68) were women, compared with 65% of the long stay patients (50/77) and 51% of the patients who had been in acute wards for under 31 days (183/358).

There were significant differences in problems of ward management between the bed blockers and long stay patients (table IV). Long stay patients were more likely to be bedbound because they were either seriously ill or suffering from fractures requiring traction. Bed blockers tended to be

TABLE IV—Problems of ward management (figures are numbers (%) of patients)

	Bed blockers (n=68)	Long stay patients (n=77)	Significance
Bedbound	5 (7)	20 (26)	$p = 0.006$
Non-ambulant	45 (66)	27 (35)	$p = 0.001$
Unable to dress	41 (60)	27 (35)	$p = 0.004$
Unable to feed	9 (13)	11 (14)	NS
Incontinent of urine	38 (56)	20 (26)	$p = 0.005$
Incontinent of faeces	27 (40)	15 (19)	$p = 0.012$
Demented	27 (40)	5 (6)	

left with residual handicaps that were a considerable burden on nursing staff. They were more likely to be unable to walk without support and dress themselves unaided, and they were often incontinent.

A review of all cases with the ward staff showed a further 12 patients with a diagnosis of dementia that had not been entered in the case notes; interestingly, more were designated bed blockers than long stay patients. Twelve (8%) patients were under psychiatric care for conditions other than dementia, mainly effective disorders; they comprised eight bed blockers and four long stay patients, and their conditions were not contributing to the duration of their stay. Overall, 52 (76%) bed blockers had been reviewed by hospital social workers, but a second opinion had been obtained from a geriatrician in only 33 (49%) cases and from a psychiatrist in 12 (18%).

In the long stay group clinical problems prevented discharge or transfer of patients at the time of the study. These problems included continuing severe illness or fracture in 41 (53%) patients, prolonged rehabilitation in 24 (31%), and complications or secondary conditions in 10 (13%). Discharge of bed blockers was prevented by a combination of clinical, social, and administrative factors. Clinical problems included dementia in 20 (29%) patients, strokes with no further improvement or multiple handicaps, or both, in 18 (26%), and the failure of other conditions to improve in 12 (18%). In 18 (26%), however, there was no clinical reason preventing discharge. In 33 (49%) a major social problem prevented transfer: relatives of 11 (16%) patients refused to have them at home; seven (10%) patients had no relatives and the necessary support within the community was not available to them; four (6%) would have support from official agencies but it was taking a long time to arrange; three (4%) were waiting for their homes to be sold to pay for private care; three (4%) refused to be discharged or to cooperate in further arrangements; and five (7%) had miscellaneous other reasons for not being discharged.

Data on home ownership were available for 64 bed blockers, showing that 28 (44%) owned their own home; for 10 (15%) of these this was wholly or partly the reason for their prolonged stay as relatives had refused to support them on discharge yet had also refused to cooperate in selling their home. Only nine (13%) patients were not being delayed by administrative problems. Twenty two (32%) awaited transfer to a long stay geriatric bed and six (9%) to a psychogeriatric bed in a mental hospital in the catchment area, five (7%) awaited discharge to part 3 accommodation, and 14 (21%) awaited discharge to other forms of hostel or nursing home, many in the private sector. For 12 (18%) bed blockers, however, no plans for transfer or discharge had been formulated.

FOLLOW UP SURVEY

Only two of the original 145 patients continued to occupy the same acute beds at follow up 18 months later. As the number of acute beds in the district had been reduced by 93, however, urgent attention had been paid to the problem and a major reorganisation undertaken. Two further bed blockers continued to occupy the same beds in a ward that had had its designation changed from acute medicine to geriatric medicine.

Discussion

Bed blocking in Bromley was found to be a problem in acute medical and, to a lesser extent, orthopaedic wards. There were appreciable differences between specialties, and these probably explain the varied findings of other investigators. Thus the proportion of bed blockers was as high as 23% in Leicestershire,² 22% in Liverpool,³ and 16% in east London⁴ but only 4.8% in a second Liverpool survey.¹ Prospective studies have found a much lower proportion; Seymour and Pringle reported that only 0.24% of patients admitted to surgical wards in Dundee became bed blockers.⁵

The characteristics of the patients were similar to those in previous studies, but when comparisons were made with a group of patients whose stay was judged to be necessarily prolonged striking differences were found. Long stay patients tended to be more seriously ill, with some receiving terminal care, or else they had healing fractures. In general they either deteriorated progressively or continued to respond to rehabilitation. A further subgroup was similar to the patients of Seymour and Pringle, having developed complications requiring a new course of treatment. In contrast, the condition of bed blockers tended to be static, and they were left with severe residual handicaps so that few could be transferred to the community unless they had relatives willing to devote a considerable amount of time and energy to their care.

Failure of rehabilitation was a great problem in patients with stroke, whereas a secondary diagnosis of dementia usually meant that the primary illness had been treated successfully and the dementia then unmasked. Most of the patients with dementia awaited transfer to a long stay geriatric ward as medical staff had given up attempting to obtain a bed in a psychogeriatric ward because of the long waiting list.

In defining bed blockers as we have done we recognise that many of them might still have benefited from assessment and treatment by geriatric or psychogeriatric specialists. Many more might have benefited had they either been admitted directly to a specialist unit or been referred earlier after their admission to hospital. The survey showed, however, that many patients were not referred even after they had been classified by their doctor as bed blockers. It is hard to believe that non-referral was due to a lack of knowledge of the geriatric services in Bromley; a more likely explanation is a low expectation that action would be taken—that is, that the patient would be transferred from the acute ward to a geriatric or psychogeriatric ward. "There is no point in referring these patients; nothing happens anyway," was an attitude frequently encountered.

Though it was not possible to obtain figures from all local geriatric units, the records from Orpington, where one of us works, show that 21 of 170 admissions during the three months May to July 1983 were in fact transfers from other wards. Early transfer of patients from acute to geriatric wards does not merely transfer the problem of bed blocking from one service to another. An appropriate number of beds for this is of course necessary; McAlpine quoted a figure of 15 beds/1000 patients aged 65 and over, which is vastly in excess of the number pertaining in the south east London⁶ (the appendix shows one figure in Bromley). The problem arises when, as is often the case in Bromley, patients are referred late—when they have developed pressure sores and contractures—or the management in the acute wards is considered by the geriatrician to be inappropriate—for instance, when bed rest is recommended for elderly patients with fractures. The longer the delay in referral the more likely it is that the family will be unwilling to resume their important role of supporting their elderly relatives at home, and there is often disbelief that patients designated as needing long stay geriatric care by specialists in acute care can actually respond to treatment in the geriatric department. A geriatrician refusing to transfer such patients or placing them on a waiting list that is so long that in reality they will not be transferred will incur the wrath of his colleagues while at the same time denying the patients a chance of recovery. A geriatrician who does transfer such late referrals immediately may consider that all he is doing is colluding with less than optimal practice.

The problems of and attitudes to geriatric medicine described here are not unique to Bromley. Solutions to these difficulties have been implemented elsewhere, the two most popular being an admission policy related to age, whereby all patients over a certain age are admitted directly to the care of the geriatric service, and an integrated approach, whereby beds in geriatric and general medical wards are pooled. As there were twice as many bed blockers aged under 75 as aged 75 and over in Bromley it would be necessary to set the cut off age quite low if a service related to age were to pick up all potential bed blockers.

Both of the above approaches were suggested by geriatricians in Bromley in 1983 as a method of tackling the problem of bed blocking but were rejected by the medical staff in the acute hospitals. Did the consultants fear further loss of beds, difficulties in recruiting junior medical staff, and closer scrutiny of their clinical practices or did they believe that doctors working in geriatric medicine were in some ways inferior? The reasons for rejection were never stated openly, so comments must be somewhat speculative. The team approach of geriatric medicine does impose some obligations on the medical staff. The staff must discuss their care of patients with colleagues who are not medically qualified and must expect their actions to be questioned. They must be willing to speak to relatives rather than leave it to junior medical staff. Rotation and cross cover at night between geriatric and general medicine works well in many hospitals but has never been used in Bromley. Perhaps the reductions in junior staff proposed by our region together with

the necessity of arranging one in three rotas, which has not yet occurred in geriatric medicine in Bromley, will promote this integration of juniors.

It is quite impossible for a geriatric department to fulfil its traditional role of providing long term care and at the same time provide emergency treatment for all elderly people with acute illness if its allocation of beds is progressively reduced. The conditions in Orpington are no different from those in other districts that suffered under the provisions of the Resources Allocation Working Party. In 1981 there were 492 admissions to 217 available geriatric beds. In 1985 the number of admissions had risen to 1044 despite the reduction of 73 beds. The throughput thus increased from 2.3 to 7.3. The number of beds in private nursing homes in the district has increased, and it is both local and national policy that these, rather than the hospital geriatric service, should provide long term care when this cannot be provided at home. Supplementary pension is available for those whose own resources fail to cover the costs. Most geriatricians have reservations about this policy, but it is the reality we have to face in a district that will shortly lose another 90 acute beds.

The survey disclosed two factors that have prevented the optimal use of nursing homes—namely, home ownership and the attitudes of social workers. Home ownership has not been examined before, and its contribution to bed blocking may be a distinctive phenomenon in an area with one of the highest concentrations of affluent suburban housing in England. Although home ownership was preventing transfer in several cases, social workers firmly stated that they did not see it as their job to pressurise relatives and patients into selling homes. A few relatives deliberately prolonged the patient's stay in hospital, and some had moved into patients' homes in their absence. In one case a relative visiting from Europe had returned there after ownership had been transferred legally to her name.

Social workers' practice with regard to transfer to nursing homes varies among local authorities. Some social workers are willing to assist patients and their relatives while others give no help whatsoever even when the patient and relatives want it. In Bromley social workers can officially give only factual information, but it is not uncommon to find that their reports recommend long term geriatric care as the only solution, and we are aware of families who have been told that they should ignore the doctors' pleas to resettle their relatives in a private home. To overcome what is seen as antagonism by the social workers to the health authority's policy of reducing the number of long stay patients and discharging as many people as possible to the community it has been proposed that a placement officer be appointed whose job would be to act as an agent between the homes and the patient. There is a danger, however, that such a move might antagonise social workers further, and that patients might be inappropriately placed in homes because they will bypass the geriatric team.

I noted from a recent television programme that the chances of becoming a centenarian were far greater for married than for single men but even greater for single than for married women. From this I conclude that the expectation of life for single and for married men and for single and for married women are strikingly different. Is this so?

What the programme showed was that among centenarians the proportion of single to married men was much less than that of single to married women. Your conclusion does not necessarily follow from this evidence alone, although there are in fact differences in this direction. The main reason for relatively few bachelor centenarians to the number of spinsters is that during the century of their lives higher male mortality, in general and from the wars, resulted in a paucity of men, so there remained fewer bachelors. It has been observed, however, that single people have higher death rates than married, the difference for men being somewhat greater than for women. These differences of mortality between people in different marital states are mainly the result of selection—that is, unhealthy people are less likely to marry. This selection was probably more extreme among men. In addition to health selection, other factors are entailed but probably they have less impact on the figures—for example, child bearing itself has some risks for various diseases.

In December 1985 a decision was made to introduce an admission policy related to age (75 and over); this started in January this year. The move was proposed by the general physicians, indicating that they had changed their minds about allowing geriatricians to manage elderly people with acute illnesses. At the same time, however, the hospitals' medical advisory committee voted overwhelmingly for a plan that would place all geriatric patients in two hospitals, leaving the acute wards in two others. This plan, which was produced in response to the need to make further cuts in beds, was approved by the health authority but rejected by the region. A start to solving the problem of bed blocking has thus been made in Bromley. This new admission policy should reduce the duration of stay of patients over 75; but there is still some way to go before the problem is eliminated completely.

We thank Dr Klaus Bergman, who supervised the study; Bina Chitkara, who performed the statistical analysis; the information department of Bromley District Health Authority; and the medical and nursing staff for their kind help and participation.

Appendix

Provision of Services for the elderly in Bromley 1983

Total population	299 000
Over 65	46 500
Over 75	19 200
Average geriatric beds available	334 (6.9/1000 patients over 65)
Psychogeriatric assessment beds	14
Nursing home places	171
Residential accommodation:	
Local authority	500
Private/voluntary	718
Beds for younger patients with chronic illness	13 (all contractual beds)
Consultant geriatricians	2
Consultant psychogeriatricians	0
Consultants responsible for younger chronic sick	0

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Although there is also some protection for others, notably for cancer of the breasts and of the ovary, there is also some evidence that men are in general more protected by marriage than are women.—A ADELSTEIN, epidemiologist, London.

Commentary: mortality by sex, age and marital status. In: *Registrar Generals statistics review of England and Wales 1967*. Part 3. London: HMSO, 131-63.

What treatment is advised for "housemaids' knee" in a man in his 70s?

Treatment of "housemaids' knee" is conservative or operative. The patient should be advised not to kneel and if this is unavoidable to use kneeling pads. If the swelling is large the fluid within it may be aspirated and perhaps a sclerosing agent or hydrocortisone injected. If the swelling recurs frequently and is a nuisance the bursa itself may be excised surgically. If infection within the bursa occurs incision and drainage are required. Recurrences of this problem should be treated by surgical excision. In a man of 70 the more conservative approach is indicated unless there has been a considerable problem.—C D R LIGHTOWLER, consultant orthopaedic surgeon, London.