MEDICAL PRACTICE

Hospital Topics

“Homeward bound”: a minimal care rehabilitation unit

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Abstract

A 20 bed minimal care rehabilitation unit was set up by Newham District Health Authority in a small hospital originally scheduled for closure when a new district general hospital was opened. During the first year 114 patients were admitted (throughput 5.7), with a median length of stay of 30 days; in the second year 173 patients were admitted (throughput 8.65) with a median length of stay of 28.5 days. The cost per inpatient day was less than that of an inpatient day at the district's long stay geriatric unit. Before the unit opened 24% of the acute beds had been occupied for more than six weeks, whereas two years later only 6% of the acute beds were occupied for such a period.

Introduction

During 1983 the hospital services in Newham were fundamentally changed when a new district general hospital was opened and four smaller hospitals subsequently closed, with the loss of 179 beds. Fears were expressed that if the pattern of bed blocking that already existed continued the service would grind to a halt. In 1979 a survey showed that 32% of the acute beds were occupied for more than four weeks and 5% for more than a year. In 1981, 24% of the beds were occupied for more than six weeks and 4% for more than a year. This pattern of bed blocking had probably come about because the medical staff at that time were not particularly concerned about rehabilitation, could not offer occupational therapy, and had little association with social workers. In addition, the district geriatric service had an adequate number of beds, but the throughput was so slow that the wait for transfer was very long.

A decision was made to use part of one of the hospitals that was

closing to provide 20 beds for minimal care rehabilitation—the Homeward Bound Unit. These beds were offered to the geriatricians, but they refused to service them so they were left as part of the acute complement and serviced by the department of community medicine and a local general practice, with the admitting consultant remaining in charge of the patient.

Homeward Bound Unit

The purpose of the unit is to provide an environment different to that of the acute ward, encouraging physical and social independence to achieve a speedier discharge. It has a staff of seven nurses and 5.5 whole time equivalent nursing assistants. A physiotherapist works 12 hours a week and there is a full time occupational therapy aide. The unit is funded for a whole time occupational therapist, but the post has been filled for less than half the time that the unit has been open. Speech therapy and chiropody are available.

Patients are admitted after referral by the consultant and social worker dealing with their case. This is because, though the medical condition of the patients is stable, there is a further factor preventing discharge: usually the patients cannot manage the basic activities of daily living—for instance, walking, dressing, and caring for themselves. Every patient referred is visited by the senior clinical medical officer or the ward sister to assess his or her suitability. Patients who are too ill or are already personally independent are not accepted.

We try to make the atmosphere of the unit as close to a home environment as we can. The patients have the right to get up, go to bed, be sociable, or be reclusive as they will, but they are expected to be as independent as possible. The staff, who are not in uniform, are there to encourage and help the patients to become independent. The main meal of the day is cooked and provided by the hospital service, but other meals are left for the patient to try to prepare, though very few can actually achieve this.

The patient's discharge is planned by the social worker, liaison nursing officer, occupational therapist, and staff of the unit. Most discharges occur after the patient's home has been visited. This is important, as Newham is a deprived borough; the elderly tend to live in Victorian terraced housing, which is often in a bad state of repair and has no hot water system and an outside lavatory.¹ Occasionally the housing is so bad that rehousing or admission to part III accommodation is the only alternative. Rai states that social factors by themselves play little part in prolonging hospital stay²; this is not so in Newham. Three patients had their houses condemned after they

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had been admitted to hospital. After discharge the patients are visited by the social worker to make sure all is well and that the patient is coping.

Patients and costs

The patients admitted during the first two years differed very little from the mix that would be expected in a geriatric rehabilitation unit. Although patients of any age could be accepted, most were aged 80-89 years, the range being 51-95 years (table I). Their physical capabilities ranged from relatively competent to very disabled, the severest of which was an 80 year old woman with hemiplegia and a recent amputation above the knee on the "good" side; she was discharged to part III accommodation.

TABLE I—Age of patients in Homeward Bound Unit

Age (years):	50-59	60-69	70-79	80-89	90-99	Total
First year	2	20	35	46	11	114
Second year	3	22	59	71	18	173

The cost per inpatient day was considerably less than that of the acute unit and that of a long stay bed in a geriatric ward. The cost of an inpatient day in the unit was £29·20, in the long stay geriatric ward £34·92, and in the two district general hospitals £55·96 and £70·14 (administration, training, cleaning, portering, and estate management were not included).

Results

The number of patients discharged from the unit was 114 in the first year and 173 in the second. The median length of stay in the acute unit before transfer to the Homeward Bound Unit was 30 (range 5-455) days. Five of the first patients admitted to the unit had been in an acute bed for 120 to 455 days. Table II compares the number of days spent in an acute bed with those spent in a bed in the Homeward Bound Unit by these five patients.

The median length of stay in the unit was 30 (3-195) days in the first year and 28·5 (3-240) days in the second (table III). The unit discharged 238 patients to their own homes (78%) and 33 to part III accommodation or a private rest home (11%). Five died (2%) and 31 were readmitted to the acute hospital either because a fresh illness occurred or their original illness worsened (10%). Thus the problem of long stay patients did not occur. Of the discharges home in the first year, only two were readmitted to the acute hospital within two months after discharge. Of the patients discharged home, 86% were in the unit for less than six weeks, but 76% of patients discharged to part III accommodation waited more than six weeks.

Discussion

The homeward bound unit was established to free blocked beds, and it has been successful at this. The bed state is reviewed every six weeks, and the highest number of patients occupying an acute bed

TABLE II—Duration of stay (days) in acute hospital bed and Homeward Bound Unit bed of five patients

Case no	Acute hospital	Homeward Bound Unit
1	455	76
2	344	33
3	190	43
4	180	90
5	120	21

TABLE III—Duration of stay (days) of patients in the Homeward Bound Unit*

Days:	0-14	15-28	29-42	43-56	57-70	71-84	85-98	99-112	113-127	128-240
First year	16	36	29	5	12	6	5	2	0	3
Second year	38	59	51	13	13	3	6	0	4	6

*Includes 20 patients remaining in unit at the end of the second year.

in 1985 for more than six weeks was 27 out of 446 (6%). The community social and nursing services in the district are excellent so a straightforward discharge home was not delayed. The main delay occurred when patients needed rehousing or could safely be discharged only to part III accommodation. Of the 29 patients discharged to part III accommodation, nine needed custodial care because of dementia, three were confined to a wheelchair, three were terrified of living alone after being mugged in their own homes, and two had had their homes vandalised. The remaining patients suffered from a combination of physical disability and poor housing.

Much of the success of the unit was due to the personality of the sister in charge. Despite having no geriatric or rehabilitation experience she was able to shed the nursing role and make sure that the patients' full potential was realised. Andrews and Brocklehurst suggested that nurses could take more responsibility for actual rehabilitation.³ The nursing staff of this unit have taken this on with enthusiasm and consequent success.

One disadvantage of the unit might be that it has no resident medical staff, though in the three years that it has been open only once has a real emergency occurred (an acute asthma attack), and this patient was reached within 10 minutes by the doctor on call. Another disadvantage is that the availability of the unit may have lessened the drive towards rehabilitation on the acute wards.

To evaluate the effectiveness of the unit is difficult because a ruthless consultant can discharge a patient whatever the social consequences, thus improving his throughput, especially if "bounce" readmission is forgotten about. The consultants in the district prefer not to do this and have welcomed the alternative provided by the unit. Even if the unit were no more successful at rehabilitating the patient more rapidly than the acute ward much money is saved by transfer to a less expensive bed.

References

1 Office of Population Censuses and Surveys. Census 1981. County Report: Greater London Part 1. Table 41.
2 Rai GS, Murphy P, Pluck RA. Who should provide hospital care of elderly people? *Lancet* 1985;i:683-5.
3 Andrews K, Brocklehurst JC. Provision of remedial therapists in geriatric medicine. *Br Med J* 1984;289:661.

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A family has become distressed because a daughter, and to a lesser extent the rest of the family, have become loaded with static electricity. Touching each other causes blue sparks and is painful, but kissing is worst of all. They have a wool rather than a nylon carpet so I have advised them to stop wearing synthetic fibre clothes and rubber soled slippers. What further advice can I offer, and why should this have developed so severely in the past few weeks?

The problem of static electricity is quite common. It is generated as a result of the friction between surfaces—for example, in combing hair surface electrons are picked up by the comb giving it a net negative charge and leaving the hair positively charged. Static is dissipated more easily where the relative humidity is high since a thin film of water is a good conductor. We usually come across the problem of static in two circumstances: firstly, walking across surfaces—for instance, a nylon carpet—and, secondly, movement of the body against clothes. Although synthetic surfaces are more usually associated with static, it may occur with natural products. It is interesting that one or two anecdotal cases seem to suggest that women may be more severely affected and that symptoms may be worse at the time of the menstrual period. The first mechanism for removing static is to use natural products where possible, and it would be useful to ensure that the family are really following this advice. An additional and most effective measure would include raising the relative humidity—this may be achieved in the usual way or by using antistatic sprays (the latter, however, must be repeated weekly). Should this not resolve the problem there are various—rather cumbersome—ways to conduct the static away from the body more effectively. Why this problem should have developed so severely in the past few weeks is not immediately apparent, but it would be worth exploring the possibility of a recent change in relative humidity either in the domestic or working environment.—DAVID BAXTER, specialist in community medicine, Manchester.