Private nursing homes: contribution to long stay care of the elderly in the Brighton Health District

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Abstract

Two surveys of private nursing homes, designated geriatric wards, and a sample of social service part III homes were carried out in the Brighton Health District using questionnaires supplemented (in the second survey) by some interviews. The dependency of old people in the private nursing homes was more like that of long stay hospital patients rather than that of residents in social services homes. In the private nursing homes, however, a smaller proportion of patients were in the medium to heavy nursing category (178 (31%) compared with 158 (63%) in the hospital long stay wards) and a larger proportion in the heavy nursing category (170 (30%) compared with 44 (17%) in the long stay wards). Of the patients in private nursing homes, 401 (82%) were local residents, 488 (86%) were long stay, and 459 (88%) were women; their mean age was 88 years. Two thirds of the patients were over 80. There were no significant differences between the private nursing homes and the wards in nursing workloads or staffing, except for a slightly higher provision of state registered nurses in the private sector. In the private nursing homes 348 (63%) of the patients had fees paid by private funds, 26 (5%) were in contract beds paid for by the National Health Service, and 176 (32%) were subsidised by the Department of Health and Social Security.

Private nursing homes make a substantial contribution to the care of the elderly in the Brighton Health District, and the health authority should develop a more active partnership with this sector.

Introduction

A remarkable lack of detail is available about patients in private nursing homes, though a substantial proportion are supported by the state. Wade *et al* studied different care provision for the elderly on a national basis using a stratified sampling technique including eight private nursing homes.¹ While their report is an important contribution, it is still necessary to examine private nursing homes in the context of a local district, where this may have considerable bearing on the facilities provided by the National Health Service. The aims of this study were to examine the contribution made by private nursing homes to the care of the elderly in the Brighton Health District; to compare characteristics of patients in these establishments with those of patients in geriatric wards and clients in part III accommodation (social services homes); to compare the staffing and style of care in the three types of institutional settings; and in the light of the findings to review the policy and planning issues relating to private nursing homes.

Current provision

The Brighton Health Authority is responsible for 68 600 people aged 65 and over, who constitute 22.9% of the total population; 33 000 are 75 and over. By 2001 there will be 12 900 people aged 85 and over compared with

7200 at present. There are 345 designated geriatric beds, giving 5.01 beds per 1000 population aged 65 and over, compared with a recent recommendation of 7.807/1000.² Social services provide 967 places in part III residential homes, giving 14.09 places per 1000 elderly. In 1982 private nursing homes registered to take elderly people had 676 places available, giving 10.10 private beds per 1000 population aged 65 and over in Brighton compared with 5.48/1000 in the South East Thames region and 3.27/1000 nationally.³ Figure 1 shows the changes in provision since 1982.

FIG 1—Distribution of various types of institutional accommodation for the elderly in Brighton Health District in 1982 and 1984. (Figures obtained from institutions.)

*Number of places.

†Number of establishments/wards.

Methods

The study was carried out in two stages: basic details about the residents (dependency and nursing in private nursing homes) in 1982 and further details about facilities and environment in 1984. Lists of private nursing homes registered in the district were obtained and those classified as "medical and geriatric" and "elderly infirm" approached by telephone and invited to take part (homes for psychogeriatric patients were excluded). A sample of the 23 social services homes in the district was taken (10 homes) and a list of all wards (13) designated as having geriatric beds obtained and the persons in charge telephoned and invited to take part. Two specially designed questionnaires were then sent, supplemented with some interviews in the second survey. The questionnaire used to collect the basic census type information in 1982 was based on that devised by Purkiss.⁴

Results

In the first survey (1982) a 100% response rate was obtained across all three sectors, from 37 nursing homes covering 565 people, 13 geriatric wards covering 317 people, and 10 social services homes covering 376 people. In the second survey (1984-5) a 90% response rate was obtained from private nursing homes (n=35) covering 676 people and a 100% response rate from the 11 geriatric wards covering 260 people and the nine social services homes covering 345. Four private nursing homes did not return the questionnaire and three homes gave details on facilities but not individual patients' details. Results presented relate to replies received.

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SIZE AND BEDS AVAILABLE

In 1982 there were 676 beds available in the private nursing homes, which had increased to 812 by 1984. In 1984 there were four private nursing homes with fewer than 10 places and 15 with 11-19, 17 with 20-37, and three with more than 40. The size of the geriatric wards ranged from 19 to 34 beds, nine wards having 24 or more, altogether providing 317 beds. The social services homes had between 23 and 60 places each, five of the 10 homes having 50 places or more. In all they provided 376 places.

DISTRICT OF RESIDENCE

One hundred and one (18%) of the patients in private nursing homes in 1982 were admitted from addresses beyond the Brighton Health District compared with 11 (3%) in social services homes and 13 (4%) in geriatric wards.

FIG 2—Percentage age distribution of subjects being cared for in three types of institutions in Brighton Health District in 1982.

ADDRESS ON ADMISSION

Of patients in private nursing homes in 1984, 215 (36%) had been admitted from their own home. A similar proportion (206; 34%) had been admitted directly from hospital (26 were in contract beds). Fifty nine (10%) had been transferred from another nursing home, 77 (13%) from rest homes, 25 (4%) from a relative's home, 11 (2%) from other or unspecified places, five (1%) from sheltered housing, and only two (0.3%) had been admitted from social services homes.

The most common routes of admission to a social services home were from the person's own private address (n=180; 53%), a hospital bed (70; 20%), and another social services home (39; 11%—owing to the recent permanent closure of a home and refurbishment of another); 31 clients (9%) were admitted from a relative's home, 12 (3%) from sheltered housing, six (2%) from rest homes, and for three (1%) the route was not known.

On the geriatric wards the most common route of admission was from another ward in the hospital (133 patients; 51%). The second most common route was from the patient's own home (86; 33%), followed by admission from social services homes (18; 7%). Only three patients (1%) had been admitted directly from private nursing homes to the geriatric wards. Ten (4%) were admitted from a relative's home, seven (3%) from a rest home, and three (1%) from sheltered housing.

AGE OF RESIDENTS

Figure 2 shows the age distribution of the patients and residents in the three types of institution. Over two thirds (385; 68%) of patients in the private nursing homes were over 80, as were 234 (62%) in the social services homes and 160 (64%) in long stay wards. Mean ages were 87.8 years in the private nursing homes, 86.5 years in the social services homes, and 89.8 years in the geriatric wards (mean age in rehabilitation wards 87.5 years, long stay wards 90.9 years).

SEX, NUMBER, AND MARITAL STATE OF RESIDENTS

Table I shows the number and sex distribution of residents in 1982. Women in care were represented in a ratio of about 4:1 in the private nursing homes, 3:1 in social services homes, and 3:1 in geriatric wards; when geriatric wards were separated into long stay and rehabilitation wards the preponderance of women in care was most pronounced in the long stay wards (6:1) and numbers were almost equal on the rehabilitation wards. Marital state was significantly different in the three sectors of care, with a very low proportion (14; 3.7%) of married people in the social services homes.

TABLE I—Number and sex distribution of residents in three sectors in 1982

	Private nursing homes	Social services homes	Geriatric wards		
			Long stay	Rehabilitation	Total
No (%) of men	106 (18.8)	91 (24.2)	37 (14.8)	33 (49.3)	71 (22.4)
No (%) of women	459 (81.2)	285 (75.8)	213 (85.2)	34 (50.7)	246 (77.6)
Total	565	376	250	67	317

LENGTH OF STAY

A greater proportion of patients in the long stay geriatric wards (143; 57%) had been there for less than a year in 1982 compared with patients in private nursing homes (189; 34%) and residents in social services homes (118; 31%). Most patients in all sectors (1543; 98%) had been in care for five years or less. Nine patients (2%) in private nursing homes, three (1.2%) in long stay wards, and 15 (3.9%) in social services homes had been in care for more than 10 years.

DEPENDENCY

Dependency of the old people in 1982 was measured using a simple index developed by Purkiss.⁴ As expected, low dependency (those who needed no help with "toilet") occurred more frequently in social services homes (193 patients; 51%) and in rehabilitation wards (35; 52%); the figure for private nursing homes was 127 patients (23%) and for long stay geriatric wards 20 (8%) (table II). The two high dependency categories (3 and 4) accounted for

TABLE II—Dependency categories of patients in private nursing homes and geriatric wards, 1982. Figures are numbers (percentages) of patients

	Dependency category*				Total
	1	2	3	4	
Nursing homes	127 (22.5)	89 (15.8)	178 (31.6)	170 (30.1)	564
Long stay wards	20 (8.0)	28 (11.2)	158 (63.2)	44 (17.6)	250
Rehabilitation wards	35 (52.0)	13 (19.4)	6 (9.0)	13 (19.4)	67
Totals	182	130	342	227	881

*Category 1=least dependent.
 $\chi^2=129.25$; df=6; $p<0.0005$.

202 patients (80%) in long stay wards and 348 (62%) in private nursing homes. One hundred and seventy (30%) of the high dependency group in private nursing homes, however, were totally dependent (category 4) as compared with 44 (18%) in long stay wards, and the smallest proportion of highly dependent patients (16; 4%) was noted in the social services homes. This group included those who were bedfast, chairfast, and required complete help with toilet and feeding. Patients in this category were spread evenly throughout the social services homes, showing that each of these homes could cope with a few totally dependent residents.

Incontinence—In hospitals in 1984, 191 (73%) of all patients and 159 (86%) of those in long stay wards were rated as incontinent of urine (sometimes or always or had a catheter) and 160 (62%) as faecally incontinent (sometimes, always, or had a colostomy). In the private nursing homes the proportions were 345 (59%) and 279 (47%) respectively, and in the social services homes 141 (41%) and 86 (25%). The numbers with indwelling catheters were 73 (13%) in the private nursing homes, seven (2%) in the social services homes,

and 37 (17%) in the long stay wards. In hospital three long stay patients (2%) had a colostomy, as did two patients (0.5%) in social services homes and nine (2%) in private nursing homes.

Confusion—The number of confused (sometimes or always) patients in social services homes (140; 41%) was substantial but was greater in the private nursing homes (334; 56%). A minority of matrons of private nursing homes stated that they found it difficult to cope with wandering or confused patients, and four homes stated that they would not accept such patients. In all the wards 151 patients (58%) were rated as sometimes or always confused, with a difference between rehabilitation wards (20 patients; 27%) and long stay wards (131; 71%).

PRIMARY CARE AND MEDICATION

Contrary to what was expected, only 65 patients (11%) in the private nursing homes in 1984 had a private general practitioner. For 390 patients (72%) in private nursing homes their present general practitioner was the one they had had before admission. In the social services homes 225 residents (65%) had their original general practitioner.

Data on medication were available for 557 patients (88%) in private nursing homes, 331 residents (96%) of social services homes, and 221 (85%) ward patients. Only a small proportion of patients were not receiving any medication. Psychotropic drugs, analgesics, diuretics, and laxatives were the most common drugs being used (table III).

TABLE III—Estimated numbers and percentages of patients receiving certain categories of medication

Medication	Private nursing homes (n=557)	Social services homes (n=331)	Geriatric wards (n=221)
No drugs	68 (12)	74 (22)	22 (10)
Psychotropic drugs:			
Minor tranquillisers—for example, diazepam	66 (12)	13 (4)	26 (12)
Major tranquillisers—for example, chlorpromazine	76 (14)	51 (15)	41 (19)
Hypnotics—for example, nitrazepam	180 (32)	91 (27)	46 (21)
Antidepressants; tricyclics—for example, amitriptyline	41 (7)	18 (5)	14 (6)
Monoamine oxidase inhibitors—for example, phenelzine	4 (0.7)	2 (0.6)	11 (5)
Other antidepressants—for example, lithium, trazodone	9 (2)	9 (3)	16 (7)
Analgesics:			
Paracetamol/dextropropoxyphene	129 (23)	45 (14)	56 (25)
Codeine/morphine	18 (3)	14 (4)	15 (7)
Antiarthritic—for example, ibuprofen	39 (7)	22 (7)	18 (8)
Other specified categories:			
Antiparkinsonian drugs (excluding Kemadrin)	38 (7)	23 (7)	24 (11)
Insulin and other hypoglycaemic drugs	21 (4)	21 (6)	11 (5)
Cardiac regulators	108 (19)	38 (11)	32 (15)
Diuretics	205 (37)	97 (29)	37 (17)
Hypotensives	30 (5)	20 (6)	7 (3)
Laxatives	139 (25)	28 (9)	65 (29)
Other unspecified drugs:			
All other	137 (25)	96 (29)	78 (35)
Anticonvulsants	15 (3)	18 (5)	24 (11)
Hormones	41 (7)	15 (5)	14 (6)
Antibiotics	22 (4)	12 (4)	5 (2)

NURSING, STAFFING, AND WORKLOADS

Nursing time in the 11 largest private nursing homes (20-37 residents) in 1982 was compared with that in the nine exclusively long stay wards (with 19-35 patients). In the long stay wards a total of 26.25 whole time equivalent state registered nurses were looking after 211 patients (145 dependency category 3, 35 dependency category 4). In the private nursing homes a total of 54.85 whole time equivalent state registered nurses were looking after 283 patients (75 category 3, 101 category 4). The ratios of whole time equivalent state registered nurses to patients (including those in categories 3 and 4) were therefore 19.4:100 in the private nursing homes and 12.4:100 in the long stay wards.

Nursing workloads were calculated using the ratio 2:3:4:7 devised by Norwich and Senior,^{5,6} relating to dependency levels 1, 2, 3, and 4. A comparison of total nursing workload, individual staff workload, and ratio of staff to residents showed no significant difference in the long stay wards and the 11 largest nursing homes. The only significant difference found was in the slightly higher provision of state registered nurses in the private sector.

Respondents were asked if any of their nurses had received training in

geriatric nursing; 27(77%) replied. In 16 (59%) of the private nursing homes it was stated that some nurses had received training in geriatrics.

Agency staff were used by eight (89%) of the social services homes, nine (82%) of the geriatric wards, and 23 (74%) of the private nursing homes (no reply from one).

PARAMEDICAL SERVICES

Table IV shows the proportions of patients in 1984 receiving paramedical services. No distinction was made on the questionnaire between diversional therapy and more formal occupational therapy. The long stay wards varied widely in the pattern of services available to their patients. Four (36%) stated that there was never any physiotherapy carried out in the wards and three others that it was available only when requested. In many respects the paramedical services in the long stay wards were similar in quantity to those in the private nursing homes.

Chiropody services used by the private nursing homes were almost exclusively provided privately, 263 (93%) of the patients (where information was available) receiving the service privately and 21 (7%) receiving it on the NHS (table V).

TABLE IV—Details of paramedical services received by patients in the three sectors. Figures are numbers (percentages) of patients

	Private nursing homes (n=604)	Social services homes (n=340)	Long stay wards (n=185)	Rehabilitation wards (n=75)
Occupational therapy	42 (7)	27 (8)	131 (71)	66 (88)
Physiotherapy	66 (11)	2 (0.6)	30 (16)	66 (88)
Chiropody	344 (57)	258 (76)	155 (84)	37 (49)

TABLE V—Analysis of whether services received by patients in private nursing homes were inclusive in total nursing home fee or not. Figures are numbers (percentages) of establishments

	No	Included in fee	Not included in fee	Not provided
Occupational therapy	33	8 (24)	16 (48)	9 (27)
Physiotherapy	34	3 (9)	22 (65)	9 (26)
Chiropody	35	4 (11)	26 (74)	5 (14)

PHYSICAL ENVIRONMENT

In 1984 the social services homes provided the most privacy in terms of the proportion of single rooms available (236 (78%) of total rooms); private nursing homes provided 344 single rooms (67% of the total) and the geriatric wards only seven side rooms (one single room and six double rooms) for 250 long stay patients.

Social services homes included the highest proportion (8; 89%) with a day room available. All had dining rooms and most had more than one day room. About half of the private nursing homes had a day room and nine (81%) of the geriatric wards had a day room. Provision of a separate dining room and day room is recommended for private nursing homes, but is not obligatory; only 10 (29%) had a separate dining room.

FINANCE

Information on the exact fee paid in 1984 by each resident was available from 23 homes covering 401 patients. Information on Department of Health and Social Security subsidies was available from 31 homes (some aggregated data). Fees ranged from £110 to £350 a week (late 1984, early 1985). Seventy eight patients (19%) were paying more than £200 a week. The range of fees bore no particular relation to the size of the home. The DHSS standard payment at the time of the survey was £164 and the most common fee paid (for shared or single rooms) was between £160 and £179 a week. Ten homes had no patients receiving a DHSS subsidy, 12 homes had more than half receiving it, and three of these homes had more than three quarters of their residents receiving this subsidy. In general at the time of the survey attendance allowance was used to top up the fees, and in 23 homes for which

information was available 254 patients (68%) were receiving this. In three homes all residents were receiving the attendance allowance and in 10 homes 90% were receiving it. One patient was funded by Private Patients' Plan and eight by the British United Provident Association. For 31 private nursing homes 348 (63%) of the weekly fees were paid by private funds, 26 (5%) were for contract beds and paid by the NHS, and 176 (32%) were paid by the DHSS.

In the social services homes the statutory minimum fee paid by a resident was £28.65 a week (early January 1985), usually paid out of the pension. For residents with more than £1200 capital 25p a week for every complete £50 over the £1200 limit was contributed; the proportion of residents contributing in this way ranged from 53% to 83% within each home, and in only three of the homes were fewer than 70% of residents contributing.

Discussion and recommendations

The results of this study have for the first time enabled the characteristics of elderly people in private nursing homes and the facilities provided in the Brighton Health District to be clarified and compared with those in hospitals and social services homes.

The main limitation of this study is that the exact contribution by the private sector in providing institutional care for the elderly has not been fully established, as the private and voluntary residential homes registered with the social services and private and statutory sheltered housing were not included. Rest homes now offer over twice the number of places that social services provide (fig 1), and the number of private sheltered housing planning applications is roughly five times that of local authority applications.

THEORETICAL REQUIREMENT FOR GERIATRIC BEDS IN DISTRICT

In 1982, 170 people in the highest dependency category (bedfast or chairfast, needing complete help with "toilet" and feeding) were receiving care in private nursing homes, and 16 in this category were in social services homes. When these were added to the available designated geriatric beds in this district the "equivalent" number was still about 100 short of the need assessed by the DHSS (according to normative planning) in this district.

Alternative styles of care should be explored, such as having more nursing input into social services homes with the possibility of joint control of a certain number of places in these homes. Godber has argued for closer collaboration between part III and long stay hospital sectors with a radical shift in the way the clientele are split.⁷ He points out that if social service departments had access to some of the funds currently soaked up by the private sector they could enlarge the scope of the social services homes towards the nursing home model.

It is imperative for district health authority officers to take a keen interest in developing and fostering cooperation with the private sector in order to achieve the mutual goal of good patient care and to obtain early warning about closures.^{4,8}

A nursing home representative should be invited to take part in planning the district's services for elderly people, and there should be regular meetings between staff of the health authority and the heads of the homes. Access to NHS services should be clear and proprietors should be informed of those services they can reasonably expect. Many owners would welcome cooperation with the NHS in order to provide remedial facilities.

The possibility of extending the facility of NHS in service training departments to untrained staff in the nursing home sector—for example, in teaching basic nursing skills—has been suggested by Young⁹ and Day and Larder.¹⁰ This would help to increase the cooperation between the private sector and the NHS and raise the standard of training in the private sector. The possibility of a clinical nurse manager or education staff from the school of nursing arranging teaching in private nursing homes by invitation should be investigated, and also informal visits to geriatric wards by private nursing home owners might be arranged.

Discharge of hospital patients to private nursing homes is a setting where improvement of present arrangements might be achieved by requiring that before discharge hospital staff, com-

munity liaison staff, a clinical nurse manager with responsibility for inspecting private nursing homes, and other relevant people meet along the lines of a case conference, such as is normal practice before admission to a social services home. A hospital discharge form for use in those cases where the elderly person is being discharged to a private nursing home has been devised. The matrons of the accepting homes are being encouraged to come to the ward to discuss the future care of the patient with ward staff.

Effective arrangements for exchange of information should be made, such as an administrator from the community unit sending DHSS hazard notices and other relevant health circulars routinely to private nursing homes. Other material such as articles on care of the elderly and notices of seminars, lectures, and so on should also be sent to homes. Extra lines of communication might encourage a continuing and constructive dialogue with home owners and a move away from the more traditional role of registration and inspection only.

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A complete report of the study was accepted by the Faculty of Community Medicine for the part II membership.

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In our practice we have recently seen a few patients with mild, self limiting, upper respiratory tract infections associated with pronounced hypertrophy of the papillae of the tongue giving a strawberry tongue appearance that is less aggressive and localised than that associated with a streptococcal infection. What is this syndrome?

A "strawberry tongue" is not seen only in scarlet fever. Any condition affecting the mucus membrane of the tongue resulting in peeling of surface layers can give this appearance including, for example, measles, toxic shock, and Kawasaki disease. Several respiratory viruses and enteroviruses, which produce upper respiratory tract symptoms, are protean in their manifestations and could have been responsible for the syndrome described. Modern virological techniques are allowing the re-evaluation of many "classic" signs and symptoms, and culture. Immunofluorescence and serological techniques are increasingly available to general practitioners. If an unusual outbreak can be ascribed to a particular organism it should be reported to PHLS Communicable Disease Surveillance Centre (England, Wales, and Northern Ireland) or Communicable Diseases (Scotland) Unit.—ERIC WALKER, lecturer in infectious diseases, Glasgow.