DOMICILIARY CARE

Home visiting by a geriatric department

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SUMMARY. The practice of home visiting by the geriatrician in an inner city area is described. Visiting was of two kinds: domiciliary consultations made at the request of the general practitioner, and visits made with the consent of the general practitioner to see whether hospital admission was essential. Since 1962, 4,000 visits have been made, and in a sample of 100 visits made in 1977, 45 were domiciliary consultations and 55 followed requests for admission. Fifty-six patients were admitted at once and five following a subsequent outpatient appointment. The patients were referred by 51 general practitioners. At none of the consultations was the geriatrician accompanied by the general practitioner. Referral information given by the general practitioners was analysed. Information about acute physical disease and social conditions was commonly given but reference to psychological state, chronic disabilities, and drug therapy was much less common. Drugs were mentioned in only 27 referrals. More complete referrals would have been valuable to the geriatrician and to the general practitioner in deciding their courses of action. More accompanied visits and reference to a check-list consisting of acute physical disease, psychological state, social conditions, chronic disabilities, and drug therapy is suggested to improve communication and the quality of referrals.

Introduction

HOME visiting is an established practice of many geriatric departments. The Report of the Hospital Advisory Service (1976) described districts where few or no visits were made and others with 2,000 visits each year. These variations reflect local circumstances such as the development of the hospital service, extent of the area, density of population and social class, housing and, no doubt, local prejudices and customs. The practice of home visiting by geriatricians excites differing opinions. Some general practitioners feel that domiciliary visits are a cause of considerable conflict, while others welcome them as part of a good geriatric service. There are few reports of home visiting by geriatricians though the subject is mentioned in every account of the organization of geriatric services.

Home visiting is commonly of two kinds. First, there are domiciliary consultations carried out by consultant geriatricians to advise general practitioners about the care of patients. These are made at the request of the general practitioner and a fee is paid to the geriatrician. Secondly, there are home visits made with the practitioner's knowledge and consent to see if hospital admission is essential; no fee is paid. In some districts the geriatrician is accompanied by a social worker and in others a social worker visits alone, so that practice varies considerably.

Home visiting has the following advantages:

To the geriatrician

1. Most appropriate treatment is decided at the start, saving time in hospital and making efficient discharge easier.
2. Priority of admission is decided.
3. Appropriate choice of facilities is made; these often vary widely in different sections of a geriatric service.
4. Education of the geriatrician himself in the needs of the district and closer association with general practitioners.

To the general practitioner

1. Advice and help with patients who are presenting special problems.
2. Sharing of responsibility, particularly if there is delay in admission.
3. Closer association with the geriatric service.

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To the patient

1. Familiarity with the doctor who will look after the patient in hospital and some fears of hospital allayed.

2. Opportunity for discussion before the start of treatment.

For all parties, therefore, there are advantages which are likely to result in better care of the patient. However, home visiting is very time consuming and duplication of effort may result.

Tower Hamlets

In the past two decades, many changes have taken place in East London, the most immediately obvious being the vast amount of rebuilding. In the 1960s the borough of Tower Hamlets was known as a problem housing area and now, in 1979, is an inner city area in decline, receiving special assistance under the Docklands Scheme (Department of the Environment, 1977). The characteristics of primary care in Tower Hamlets are similar to those of other inner city areas, with a higher proportion of older doctors and of those qualified overseas than is found in the country generally (DHSS, 1978). The district is 'restricted'. There are 92 principals of whom 42 have practices with less than 2,000 patients and seven with more than 3,500.

Aim

Since 1962, 4,000 visits have been carried out in East London, for the most part in Tower Hamlets and by one observer (C.P.S.). As a result of this, and the fact that the character of Tower Hamlets is changing, we felt it worthwhile to review our long-established practice of home visiting.

Method

In 1977 the geriatric service dealt with 882 admissions, of which 579 were from home or welfare homes. We decided to examine in detail the first 100 of 216 home visits made that year, which represents a characteristic sample of the whole series of 4,000 visits.

An experienced secretary recorded all requests for a domiciliary visit or admission, in shorthand. She sought further information if it appeared necessary but a structured questionnaire was not used and no specific enquiries were made about drugs. Most requests were telephoned by the general practitioner himself but sometimes by the receptionist and, on the hospital side, some calls were answered by the consultant. Each was analysed for information that the geriatrician would be most likely to seek. This was considered under the following headings: acute physical disease, psychological state, social conditions, chronic disabilities, and drug therapy. Additional information was sometimes available in "a letter at the house", and this was included in the analysis.

Table 1. Outcome of visiting. Failures to comply with advice in parentheses (100 referrals).

Admission	58 (2)
Outpatient appointment	25 (1)
Occupational/physiotherapy	2
Day hospital	5 (1)
Advice only	9
Died	1

Table 2. General practitioners' referrals. Information included and omitted (100 referrals).

	Acute physical	Psycho-logical	Social	Chronic disabilities	Drug therapy
Included	86	27	88	35	27
Omitted	14	73	12	65	73

Results

Ninety-seven patients (26 men, 71 women) were visited, of which 20 were aged 63 to 74 years, 52 aged 75 to 84 years, and 25 aged over 85 years. Ninety-four patients were visited once and three twice; 77 visits were made by one observer (C.P.S.) and the remainder by registrars; 55 visits were made in response to requests for admission; 45 were domiciliary consultations. The patients were referred by 51 general practitioners, none of whom accompanied the geriatrician on his visit.

Sixteen visits were made on the day of referral; 43 on the first day after referral; 13 on the second and 28 three or more days after referral; 11 were Friday referrals and the visits were made after the intervening weekend.

The outcome of visiting is shown in Table 1. There were a total of 61 admissions, 56 patients being admitted directly from home and five after subsequent reference to the outpatient department; 38 admissions followed requests for admission (55) and 23 followed domiciliary consultations (45). Four patients did not comply with instructions.

In a very large number of referrals allusion was made to acute physical disease and social state, but there was no mention of psychological state, chronic disabilities or drug therapy in almost as many (Table 2). In some referrals there was nothing of importance to say under a particular heading but in others there were important omissions. Drug therapy was omitted 73 times. While some drugs were ordinary laxatives and analgesics, no indication was given that two patients were receiving thyroxine regularly.

Table 3 shows the general practitioner's referral in relation to the geriatrician's findings and the agreement and disparity between the two. The geriatrician had the advantage of spending some time at the home and his conclusion was often reached following further investigation and hospital admission. Agreement was recorded if both general practitioner and geriatrician considered a

Table 3. Agreement and disparity between general practitioner's referral and geriatrician's findings (100 referrals).

	Agreement	Disparity A	Disparity B	Total disparity
Acute physical	77	12	11	23
Psychological	83	13	4	17
Social	85	12	3	15
Chronic disabilities	82	17	1	18

feature was present or if neither considered there was anything worthy of mention. Column A shows disparity when the geriatrician considered a significant finding was present which was omitted by the general practitioner and Column B shows disparity when the general practitioner and geriatrician recorded findings but differed over what these were, explaining them in an entirely different way.

Table 3 shows agreement under each heading in about four fifths of all referrals and disparity in about one fifth. Disparity under the heading of acute physical disease included differences of a purely clinical nature; for example, one patient with an unsuspected fracture of the femoral neck and two with unsuspected retention of urine and overflow incontinence, while some patients described simply as unable to walk were found to have had recent cerebrovascular accidents or, when described as deteriorating, bronchopneumonia or congestive cardiac failure. A patient referred because of falls had an inoperable carcinoma of the rectum with profuse rectal bleeding (diagnosed six months previously at another hospital), which the general practitioner did not mention. Another patient was referred as having a carcinoma of the oesophagus, but the hospital concerned had failed to inform the general practitioner that this diagnosis had subsequently been amended to pharyngeal pouch.

Disparity over abnormal mental states was usually due to omission of any reference by the general practitioner to states such as confusion or dementia (17 referrals). The social background, of great interest to the geriatrician, was omitted in 12 patients and there was a tendency to emphasize past illness in patients who might instead have been referred primarily for social reasons. Thus, one patient was described as suffering from hypertension and recurrent heart failure when the real problem appeared to be that the family wished the patient to go to a welfare home. Quite often chronic disabilities were omitted: severe deafness, blindness, and rheumatoid arthritis were omitted ten, three, and four times respectively.

Discussion

Although we have given an account of home visiting by the geriatric service in an inner city area, some features have a general application. The largest number of referrals by any single doctor was four. Thus, to the individual practitioners, the home visit, and indeed the geriatric admission, is a comparatively unusual event. As described, are such home visits as valuable to all parties as they should be? Only 38 of 55 patients referred for admission were admitted. To the geriatrician even a small number of unnecesssary hospital admissions is important while home visiting is itself an appreciable commitment. He must decide the need for admission or the desirability of a visit on the information with which he is supplied. In the whole series of 4,000 home visits it was virtually unknown for the home visit to show that there was no problem to investigate, but sometimes the problem was different from that suggested by the practitioner or could be dealt with in ways other than admission, for instance an outpatient appointment or help from social services. Thus, general practitioners were very good indeed at discerning where the geriatrician could help. However, a more systematic and complete reference would assist not only the geriatrician in making the best use of time and resources but also the general practitioner in looking at the patient in the most practical way and considering treatment or community services not previously thought of. Only 17 patients in the sample were being visited by the district nurse.

Under the heading of acute disease (Tables 2 and 3) disparity between the information supplied by the general practitioner and the geriatrician's findings is, of course, likely to underlie the very reason why the practitioner has sought help. It may also be due to the situation altering between the general practitioner's and the geriatrician's visits. The percentage (73 per cent) of referrals without any information about drug therapy is very high but is in accord with other reports (Alarcon and Hodson, 1964). It is understandable that practitioners may not wish to trust drug names and dosages to a secretary but in such cases the information should be left at the house or the patient asked to produce the drugs for inspection.

Under the headings of psychological state, social conditions, and chronic disabilities (Tables 2 and 3) omissions by the general practitioner are the usual reason for disparity. In the longer term, training in geriatrics, as suggested in the joint report by the British Geriatric Society and the Royal College of General Practitioners (1978), should promote greater interest in the care of the elderly and improve referrals. However, indifferent referrals are often due simply to failure in communication and could easily be improved. The accompanied domiciliary consultation would overcome the necessity for detailed referrals but is often difficult to arrange at a mutually convenient time and is time consuming for the practitioner, who may find the geriatrician's painstaking collection of facts a lengthy procedure. A doctor-to-doctor telephone conversation might be thought most satisfactory and some patients

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Enquiries should be addressed to:

The Accommodation Secretary,
Royal College of General Practitioners,
14 Princes Gate, Hyde Park,
London SW7 1PU.
Tel: 01-581 3232.

Whenever possible bookings should be made well in advance and in writing. Telephone bookings can be accepted only between 9.30 hours and 17.30 hours on Mondays to Fridays. Outside these hours, an Autophone service is available.

should certainly be discussed by direct contact. However, for all referrals to be made at times mutually convenient to geriatrician and general practitioner would be difficult and delay would result. Much more important is the doctor-to-doctor conversation when admission has been requested and refused. Then the geriatrician can explain the reason for adopting a different course and the decision is taken only when mutually agreed upon. A letter is usually too slow. Least satisfactory is a secretary-to-secretary conversation which often does little more than indicate the need for admission or consultation. This leaves as the most practical solution the telephoned referral, where the experienced secretary takes the information from the general practitioner himself and its quality depends upon the information which the general practitioner volunteers. To improve communication at the time of referral general practitioners in Tower Hamlets are now being encouraged to supply information under five headings:

1. Acute illness.
2. Psychological state.
3. Social conditions.
4. Chronic disorders.
5. Drugs.

The use of this check-list must be two-sided, with the general practitioner anxious to give and the secretary anxious to seek information. We are also encouraging more accompanied domiciliary consultations.

Conclusion

Had this report been written from the point of view of the general practitioner and not the hospital service then, without doubt, other ideas and criticisms would have been voiced. However, we hope that these two measures, which are of mutual interest, will ensure that general practitioners and geriatricians work more closely together.

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