Needs of elderly people in residential homes: comparison of records held by carers and general practitioners

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SUMMARY. Fifty patients from one practice who were resident in private nursing homes or residential local authority homes for the elderly (part 3) have been studied. The main carers in the residential homes completed a questionnaire on the care requirements, medical problems and unmet needs of each patient. This information was compared with that available to the general practitioners from the patients' medical notes so that areas of poor communication between the doctor and the main carer could be identified.

The 11 male patients had a mean age of 82 years and the 39 female patients a mean age of 83 years. Many of the patients had complicated medical problems and were highly dependent on nursing care. Carers were unaware of 34 medical problems among the patients and general practitioners were unaware of care needs in eight patients. Improved communication between general practitioners and the carers in residential homes may benefit patients but proper regard must be given to the privacy and confidentiality of medical information in this setting.

Introduction

THE number of old people in society is increasing.[1] In the National Health Service the number of available beds has fallen,[2] while the provision of private nursing home beds has increased.[3] Most old people retain their independence but up to 4% of those aged over 65 years are in some form of residential care outside hospital.[4]

Many studies have looked at aspects of medical care in private nursing homes[5-10] and care requirements have been described in terms of client 'dependency'[5] and facilities available within the nursing home.[11] There may be considerable unmet need in some establishments that could benefit from additional medical input,[12] especially as the medical problems of many of the residents are similar to those of long-stay patients in hospital.[5] General practitioners visit their patients in private nursing homes and part 3 social services homes regularly or on demand. Often many different doctors are responsible for patients in one establishment and care may also be influenced by the policy or personality of the matron or sister at the home. In this situation, adequate communication between the general practitioner and the main carer within the residential home is especially important.

The aims of this study were to document the medical and nursing needs of a group of patients from one practice who were in residential care, in order to compare the information available to the general practitioner and the main carer and so identify any areas of unmet need in this population.

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Method

The study practice with three full time and two part time general practitioners has 8800 patients within a well defined area on the outskirts of Nottingham; 8.8% are over the age 65 years and 5.2% over 75 years. There were 50 patients in residential care at the time of the study which took place during a two week period in September 1988. All these patients were over 65 years old. Thirty five patients were resident in four different private nursing homes and 15 were resident in two local authority social services (part 3) homes. The patients were identified by checking all the local homes and cross checking with the practice age–sex register.

A questionnaire was completed by the 'main carer' in the residential home for each patient. The main carer was defined as the matron or sister in the private nursing homes and the senior worker who had overall responsibility for the patients in their care in the part 3 homes. The questionnaire looked at the carers' perception of the medical diagnoses and problems of each patient; the drug therapy being given to each patient; the nursing and general care needs of the patients that were provided by the homes themselves and other specific areas of care which included the availability of physiotherapy, chiropody and district nurse input. There was also an open section where the carers could report problems that needed extra input from the general practitioner, unmet needs of the patients and problems they themselves faced in dealing with medical aspects of the patient's care.

The general practice notes of each patient were reviewed to provide information on medical problems and diagnoses, drug therapy and any other care needs that were recorded.

These two sources of information were compared to identify differences between the general practitioners and the main carers in their perception of the needs of each patient.

Results

There were 11 male patients (mean age 82 years, range 65–94 years) and 39 female patients (mean age 83 years, range 72–97 years) in the study group; all 50 had a questionnaire completed by their main carer in the residential home.

The main carers reported a total of 118 problems with a mean of 2.9 medical problems per patient for the male patients (range 1–6) and 2.3 problems for the female patients (range 0–6) (Table 1). Eleven patients were described by their main carer as being confused and these patients were grouped with those patients described as having dementia.

All drugs prescribed by the general practitioners were accurately documented by the main carers (Table 2). Six patients were receiving no medication and the remaining 44 patients were receiving a mean of 2.8 drugs each (range 0–9).

The nursing needs of the patients are shown in Table 3. Although most patients were able to feed themselves, many had difficulties with other activities of daily living; 34 patients (68%) could not go to the toilet independently and 35 (70%) had mobility problems even on the level. Urinary incontinence was always present in 11 patients (four men and seven women) of whom 10 required long-term catheterization. Occasional urinary incontinence was present in a further 10 patients. Faecal incon-

Table 1. Medical problems reported by the main carers.

Type of problem	No. (%) of patients with each problem		
	Men (*n* = 11)	Women (*n* = 39)	Total (*n* = 50)
Mental			
Dementia	4	21	25 (*50*)
Depression	3	3	6 (*12*)
Anxiety	1	2	3 (*6*)
Mental retardation	2	0	2 (*4*)
Nervous system			
Hemiparesis	3	12	15 (*30*)
Parkinsonism	1	3	4 (*8*)
Blindness	2	2	4 (*8*)
Deafness	1	2	3 (*6*)
Epilepsy	1	1	2 (*4*)
Musculoskeletal			
Arthritis and effect of past trauma/fractures	3	10	13 (*26*)
Cardiovascular			
Hypertension, angina and/or heart failure	2	9	11 (*22*)
Gastrointestinal			
(including constipation)	2	6	8 (*16*)
Respiratory			
(mainly obstructive airways disease)	2	3	5 (*10*)
Other			
Diabetes mellitus	0	2	2 (*4*)
Other endocrine or poorly defined problems	2	9	11 (*22*)

n = total number of patients.

Table 2. Drug therapy reported by the main carers.

Drug category	No. (%) of patients receiving drug		
	Men (*n* = 11)	Women (*n* = 39)	Total (*n* = 50)
Cardiovascular (antihypertensives, antiangina, cardiac glycosides)	7	17	24 (*48*)
Gastrointestinal (H_2 blockers, laxatives and antacids)	5	18	23 (*46*)
Central nervous system (analgesics, antiparkinsonian)	5	17	22 (*44*)
Mental (antidepressants, antipsychotics, anxiolytics and hypnotics)	3	18	21 (*42*)
Musculoskeletal (nonsteroidal antiinflammatories, muscle relaxants)	3	10	13 (*26*)
Skin	1	11	12 (*24*)
Respiratory (bronchodilators)	0	2	2 (*4*)
Other (vitamins, drugs for endocrine disorders)	0	7	7 (*14*)

n = total number of patients; only 44 were receiving drugs.

Table 3. Nursing needs of the patients reported by the main carers.

Task		Number of patients able to carry out task		
		Yes	With some assistance	No
Wash	Men	4	1	6
	Women	8	3	28
Dress	Men	2	2	7
	Women	7	3	29
Feed	Men	7	2	2
	Women	30	3	6
Go to the toilet	Men	5	2	4
	Women	11	1	27
Climb stairs	Men	0	2	9
	Women	4	1	34
Move from room to room on the level	Men	3	4	4
	Women	12	1	26

tinence was always present in one man and four women and sometimes present in a further four men and five women. Incontinence of some sort was a nursing problem in 21 (42%) of the patients.

Skin sores were being treated in eight out of the 50 patients and all but two had their dressings changed daily. Four of the eight patients were catheterized; all but two were in private nursing homes. Only one patient received physiotherapy from a hospital outpatient department but the carers felt that it would benefit a further three men and four women if it were more widely available. Chiropody was provided for 31 patients by a qualified chiropodist. This service was provided privately in all cases in private nursing homes and in half of the cases in the part 3 homes. District nurses visited one patient in a part 3 home to change dressings.

Table 4 shows information in the general practice notes which was not known to the main carers. Thirty four separate problems were not known to the main carers. There were several important omissions from the carers' results such as allergy history, peptic ulcer history and renal impairment. Seven patients were receiving treatment for depression and two were known to have had depression within the last two years. However, this diagnosis was unknown to the carers in three cases.

When asked for details of patients' unmet needs only carers in part 3 homes responded. The unmet needs included help for suspected depression (one patient), treatment for arthritis (one), help with deteriorating mobility (one), blood pressure monitoring (one), a wheelchair (one) and treatment for aggression (two).

Problems known to the carers but not to the general practitioners included deafness (two patients), blindness (two), presumed haemorrhoids (one), skin sores (one), presumed dementia (one) and disabling dysphagia (one). In each case it was assumed by the main carer that the diagnosis was established and known to the patient's general practitioner.

Discussion

This study investigates the care needs of elderly people in residential homes and describes the differences in knowledge between the patients' general practitioner and their main carer in the home. Patients' characteristics in terms of age, care needs and medical problems were similar to those found in other studies,[5,11,13] with many patients having major nursing problems such as incontinence and skin sores. The patients' drug therapy was also similar to that reported in comparable populations.[5,8] The nine patients (18%) with active or recent depressive illness compares with 33% in a case finding study in a similar population[9] and 15–23% in a community study of the elderly.[14]

Table 4. Medical problems unknown to the main carer.

Type of problem	Number of patients
Cardiovascular	
Previous heart failure	7
Hypertension — receiving treatment	6
Gastrointestinal	
History of peptic ulcer	3
Previous iron deficiency anaemia	1
'Idiopathic' diarrhoea	1
Central nervous system	
Parkinsonism	2
Focal epilepsy	1
Glaucoma	2
Mental	
Depression	3
Musculoskeletal	
Gout	1
Arthritis	3
Secondaries in spine (recent hospital discharge)	1
Other	
Renal impairment	1
Allergy to cotrimoxazole	1
Low calcium post parathyroidectomy	1
Total	34

Depression may therefore be underdiagnosed in this group of patients.

The general care needs of this group of patients are, as expected, higher than those of the elderly who live in the community[15-17] whose carers are usually family members, friends and neighbours.[18,19] The care staff in private nursing homes include many trained nurses but in part 3 homes a significant care burden is managed by non-nursing staff. More qualified nurses may be needed in part 3 homes if recent screening recommendations are to be met.[20] The perceived need for additional physiotherapy in the residential homes was not formally assessed by a physiotherapist but the option of such an assessment would help the carers in providing what they see as good overall care.

The comparison between the information about each patient that is available to the general practitioner and to the main carer suggests that improvements in communication need to be made. A lack of full and accurate information can hinder the care of the patient and also decisions made in interviews with relatives. Many of the patients came from hospital geriatric or psychogeriatric wards where the nursing staff knew most of the important medical and social information about their patients. However, this information was not necessarily transferred with the patients when they moved to the residential home and the situation could be made worse if patients had also changed their general practitioner. In contrast, patients transferred from the community often had comprehensive social work reports compiled with the help of their carer in the community.

How much the main carer in the residential home needs to know about each patient will vary. For patients who are mentally alert and communicative the carer may only need information about active medical problems and drug therapy but for the patient with more marked intellectual impairment or complicated medical problems more information will be needed. The main carers need adequate information so that they can coordinate the different agencies involved in the care of patients but it is also important to respect patients' privacy and the confidentiality of their medical records. The elderly in residential care have often exchanged a private and autonomous position in the community for an environment where even with the best interests of the patient at heart, such autonomy may be restricted.[21] Achieving a balance between information given to the carers and other agencies and privacy and autonomy for the patient usually rests with the general practitioner. Each patient should be managed with this in mind.

Lay carers of demented patients in the community benefit from sharing information with the primary care team[18] and the main carers in a residential home may be similarly supported by improved communication with the general practitioner. The maintenance of standards of care in this group of patients may depend on it.[22]

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