Factors leading to older people in care homes being admitted to hospital as emergencies

by

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THESIS

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Statement of Originality

This thesis and the work to which it refers are the results of my own efforts. Any ideas, data, images or text resulting from the work of others (whether published or unpublished) are fully identified as such within the work and attributed to their originator in the bibliography or in footnotes. This thesis has not been submitted in whole or in part for any other academic degree or professional qualification.

Signed

Mary Taylor Clay

Date 23.12.08

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ABSTRACT

To meet a government target (DH 2005a), NHS Primary Care Trusts are required to reduce hospital usage and care home residents have been identified as a group whose admissions may be avoidable. Yet little is known about hospital admissions from care homes as few UK studies have been published. This mixed method study identified factors that led residents to be admitted to hospital as emergencies and unlike previous studies included the perspectives of residents. As the outcome of the research is to inform a local resident-centred hospital admission avoidance strategy their views are important.

The research comprised three parts. The first analysed Hospital Episode Statistics data for all admissions from the ten care homes located within a PCT, between 2003 and 2005. This provided an overview and found admissions varied between homes and over time and infections were the most common admission diagnosis. The second part was case studies that examined the 19 admissions from a 35 bed local nursing home during 2006. Most residents had dementia and nine died in hospital and three soon afterwards. The final part comprised semi-structured interviews with 13 residents from four local nursing homes following recent hospital admissions to obtain their views on hospital admission and care. Most considered their admissions unavoidable and most expressed high levels of satisfaction with hospital care, but it is nursing home care they valued most. The four nursing home managers were interviewed about each of these admissions to confirm the details and give their opinion on the appropriateness of the admissions.

This study found that GPs appear to be responsible for most admissions and although there is potential to reduce admissions, residents continue to need and benefit from care that is only available in an acute setting. The results indicate that new models of care are needed to reduce avoidable admissions and provide better end of life care in care homes. A ‘Home for Life’ nursing home care model is advocated as a means of achieving both.
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CHAPTER 1 INTRODUCTION

It is government policy that the number of emergency hospital bed days is reduced (Department of Health DH 2005a) and Primary Care Trusts (PCTs) were required to meet a Public Service Agreement (PSA) target to reduce inpatient emergency bed days by 5% by March 2008 (DH 2005a). Attempts to meet this target led to a focus locally and nationally on hospital admission avoidance and analysts predicted that NHS organisations would find meeting the target a challenge (Farr 2005).

Older people are heavy users of urgent care services and it is the view of the Department of Health (DH 2006a) that a proportion of older people would benefit from alternatives to admission. The rate of admissions of people aged over 65 with "ill defined" conditions is increasing more rapidly than younger people and as the population ages this trend is likely to continue (Walsh et al. 2008). However this retrospective analysis of Hospital Episode Statistics (HES) for all emergency admissions for England (Walsh et al. 2008) could identify trends but not explanations. This demonstrates the value and limitations of HES even when analysed nationally. It is suggested that lack of access to primary care services and the new 'Out of hours care' systems may be contributory factors (Walsh et al. 2008).
Although there has been little work on access to and use of acute hospital services by residents in long-term care (Godden & Pollock 2001) there is reputed to be a lot of anecdotal evidence that residents in care homes are frequent and often inappropriate attendees at Accident & Emergency (A&E) departments (Gulland 2007). Yet, the Royal College of Nursing (Gulland 2007) points to the lack of national data to support the assumptions that care home residents are clogging up A&E departments. However, they have been identified as a group whose emergency admissions could potentially be avoided (Change Agent Team 2006) and locally it was suggested that the potential of care homes to contribute to a reduction in emergency admissions to meet the target should be explored.

Little is known about the factors that lead nursing home residents to be admitted to hospital as emergencies as the only information routinely available is from the NHS Hospital Episode Statistics (HES) data base which is useful in identifying the scale of admissions. It also includes demographic details, admitting hospital, admission and discharge address or if hospital death, admission diagnoses and hospital length of stay. Even when these data are complete they only provide a useful snapshot of admissions at a point in time rather than a full picture of events and the surrounding circumstances and influences and the opinions of residents and staff involved.
The few UK published studies in this field provide limited insight and none include the views of residents on their hospital admissions (Beringer & Flannigan, 1999; Bowman et al., 2001; Godden & Pollock, 2001; Read, 1999; Zaatar, 2001) (Appendix 1). These are small studies which lack depth and are considered likely to include a degree of subjectivity and over simplification of the issue. Although there is a lack of existing UK research in this field the evidence available would suggest that there is potential for more of the health care needs of nursing home residents being met outside secondary care thus avoiding or diverting some hospital admissions (Kane et al. 2003; Snape et al. 1999).

Interestingly two studies that speculated the number of hospital admissions that could be avoided (Beringer & Flannigan 1999; Elphinstone 2000) had similar predictions. A Northern Ireland study (Beringer & Flanagan 1999) involved hospital doctors completing questionnaires on all nursing home residents occupying hospital beds on two specified days and concluded that 9.6% of residents could have been managed in their nursing homes. Although not care home specific, a study that classified the appropriateness of all acute admissions to two London hospitals (Elphinstone 2000) deemed 9.8% inappropriate. This could suggest that the rate from care homes may not be higher than the overall rate of inappropriate admissions. As approximately 10% is the only suggested rate of potentially avoidable admissions it could be regarded as a benchmark.
Hospital admissions are expensive episodes of care for the provider and therefore a reduction would have the potential for significant cost savings. A single ambulance journey is estimated to cost £166 (DH 2007a) and the cost of a short stay for medical emergencies £1,690 (NHS Institute for Innovation and Improvement 2006). Although cost reduction is a main driver in hospital admission avoidance treating people outside hospital when possible is enshrined in government policy since the publication of the NHS Plan (DH 2000a). This plan stressed that older people "must receive the right care at the right time in the right place" (DH 2000a:71).

This research study aims to provide essential insight into why residents of local nursing homes were admitted to hospital and the scale of local care home hospital admission. Residents' perceptions on health care provision within their nursing home, their experiences and outcomes of hospital admission are an important part of the study. The findings are intended to inform a local hospital avoidance strategy and the commissioning of person-centred services to support hospital admission avoidance.

In order to establish the most comprehensive picture of the current care home resident emergency hospital admission situation, a mixed method approach
combining qualitative and quantitative methods was considered the most appropriate. The study comprises three component parts; local HES data analysis, case studies examining the emergency hospital admission activity of a local nursing home and face to face interviews with 13 residents of four local nursing homes, following their recent emergency hospital admissions. This combination of methods provides a PCT locality, a nursing home and individual resident perspectives.

The thesis is comprised of five further chapters. Chapter two reviews the literature relevant to the study - national policy agenda, long-term care, nursing homes, primary care, emergency hospital admissions and user involvement. The gaps identified in previous studies and the literature is discussed. This chapter ends with an explanation of the rationale for the research and the research questions.

Chapter three explains the theoretical principles underpinning the study and why an inductive approach and the interpretivist paradigm fit with the study. Contrasting theoretical models - the bio-medical model and social model of continuing care are explored and the person-centred care model is identified as the underpinning philosophy for the care of older people. A model focusing on
residents' living-dying trajectory provides a framework in which to consider the research, is described.

Chapter four describes the study design which is made up of three parts; local HES data, case studies of the hospital admission activity of one nursing home and interviews with nursing home residents who had recent emergency hospital admissions. The mixed methods used in data collection and data analysis including the ‘Framework’ system (Ritchie & Spencer 1994) used to analyse residents' interviews are described. Sampling, ethical issues and issues of rigour are also addressed.

Chapter five explains the findings of each of the three parts of the study. The first part - HES data, provides a profile of local homes and residents who had admissions, an overview of local hospital admission activity and comparison between different types of homes. The second part discusses the admission activity of an individual local nursing home by comparing each of the admissions using a case study approach and discussing the factors identified that contributed to residents' emergency hospital admissions. Finally the findings of the resident interviews which formed the third part of the study are presented with a focus on their perceptions.
The final chapter discusses the findings of the study as a whole and in relation to previous studies and to best practice. How the methodology and methods chosen created new knowledge, the strengths and limitations of the study and recommendations for future research are discussed. The findings of the study, recent policy and literature are then used to develop a proposed model which would provide alternatives to avoidable emergency admissions.
CHAPTER 2 LITERATURE REVIEW

2.1. Introduction

This literature review was undertaken in early 2005 to inform the research proposal and was updated in 2007 and again in 2008 to include new literature.

Search strategy

The literature search was undertaken using databases including CINAHL, MEDLINE, King's Fund and DH-DATA: Health Administration & Toxicology (DHZZ) and the British Nursing Index. The Department of Health, Commission for Social Care Inspection, Healthcare Commission, Audit Commission and Help the Aged websites were accessed for the policy context of the study.

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Literature was reviewed from 1990 as by this time the closure of NHS continuing care wards was underway as was the expansion of the nursing home sector. The rationale for the inclusion of literature was to provide a historical perspective and the context to the study. Variations and combinations of key words used included: older people, emergency hospital admissions, hospital admission avoidance, nursing homes, long-term care, primary care and GPs. In the light of issues that emerged from the research that had not initially been identified as pertinent, further searches were conducted on the new subject areas in 2008 to inform the discussion. These were dementia, end of life care and advance care planning.

Only five UK studies on the emergency hospital admission of care home residents were identified (Appendix 1). Studies from America relating to the hospital admission of nursing home residents were included and are used only to give background, make comparison and inform future practice due to the difference in the UK and USA healthcare systems. Studies from other countries, for example Australia and Holland were included as they informed the discussion as their approaches have been successful in achieving hospital admission avoidance and are therefore useful in proving evidence for new models of care. Analysis of the literature revealed the following main themes: national policy agenda, long-term care, nursing homes, primary care and emergency hospital admission and each of these will be discussed in turn.
2.2 Policy Influences

2.2.1 Introduction

Since the launch of the NHS Plan (DH 2000a) a series of government initiatives with the cross cutting themes of improving the care of older people and reducing unnecessary hospital admissions have been published and are now described. This sets the current study in context of the changes in approach and service provision intended by national policy direction.

It has been a long standing government policy to reduce the number of hospital beds and they have fallen by 31% in the past 20 years, having already fallen by 40% in the preceding 45 years (NHS Confederation 2006). Yet in the past 20 years hospitals have treated a 57% increase of in-patients (NHS Confederation 2006). This report explains that one of the ways a reduction in beds can be achieved is when changes in emergency care reduce hospital admissions and although providing care away from hospital can be more challenging many patients prefer not to be in hospital beds if they can avoid it.

The Department of Health (DH 2004a:4) describes older people as ‘the core business of the NHS’ as they are the biggest users of health and social care services. The changing demographics of British society therefore present a
tremendous challenge as in 2007 there are more people over 65 years than under 18 (DH 2006a) and people over 65 currently make up 16% of the population but account for 43% of the NHS budget (DH 2007a). The over 85s are the age group most likely to need residential and nursing home care and this is the fastest growing segment of the population with the numbers set to double by 2020 (DH 2006b) which has implications for service delivery.

2.2.2 Service re-design

It is explicit in the National Service Framework for Older People (DH 2001a) that unnecessary admissions should be avoided. For example Standard 2 suggests that properly targeted assessment and active care management promote older people’s independence through preventing deterioration and managing crisis, which may reduce the demand for services by ensuring that services are appropriate to needs. Standard 3 states that older people will have access to a new range of services to promote their independence and prevent unnecessary admission to hospital and set a target of avoidable admission schemes benefiting 70,000 more people each year. Yet a national survey of intermediate care found that the majority of services were supporting discharge rather than preventing acute admissions (Martin et al. 2007) and it is not known if the targets set have been met.
The need for planning whole systems change to achieve better outcomes for older people has been identified (DH2004a). This is to be met through matching needs with a spectrum of services across health and social care settings, including collaboration with independent providers (DH 2004a). Using process mapping to reduce the number of people admitted to hospital inappropriately and developing care pathways involving all relevant organisations, including the independent sector, are effective means of jointly agreeing an ideal service and identifying gaps in current services (DH 2004a). Although involving the independent sector is mentioned in several policy documents there is no local experience of their being invited to participate in any service review. The Audit Commission (2004) suggest that the need to reduce pressure on acute hospitals and shorter lengths of stay is the driving force behind providing services to older people in their homes within a whole system response. As care homes are also older people's homes this would make them eligible for these services.

This is in keeping with the Department of Health's approach for the future of older people's services which includes a timely response to needs identified or crises and services being pro-active to identify problems ahead of crises (DH 2004b).
The DH vision puts a focus on meeting individual's needs;

"The common thread which runs throughout is supporting the well-being of older people by providing the right services in the right way to meet their needs and aspirations" (DH 2004 b: 56).

The Healthcare Commission (2004) points out that patients use services provided by different health and social care organisations in the NHS and the private sector, and that particularly patients who have complex needs and long-term conditions may often receive care from more than one organisation. The importance of capturing the experience of patients across these organizations is stressed although the difficulty in achieving this is acknowledged, as individual organisations do not generally deal with how care is delivered at the boundaries between organisations. As Primary Care Trusts are responsible for driving improvements in services across the healthcare system in their area it is suggested (Healthcare Commission 2004) that they have a responsibility to coordinate the collection of information on patients' journeys and accountability for addressing the issues that are raised.

These sentiments are in line with key principles expressed in Better Health in Old Age (DH 2004b) which stresses the importance of working across organisational boundaries rather than separate organisations focusing only on their specific responsibility and listening to older people and engaging them in policy design.
Although policy makes recommendations, without any impetus to implement the guidance, there is no guarantee that it will be followed, for example to date there is no evidence of care home residents being involved in the redesign of NHS services.

The NHS Improvement Plan (DH 2004c) predicts that in primary care GPs will increasingly be working with more diverse teams to enable patients’ needs to be met in new ways in the community rather than in hospital although it is not known to what extent this is happening.

2.2.3 Hospital admission avoidance

Although evaluative evidence of schemes which prevent unnecessary hospital admission is scarce the NSF proposes that intermediate care can be effective in breaking into the spiral of unnecessary hospital admissions (DH2001a). The potential was identified through the National Beds Inquiry (DH 2000b) which concluded that for older people, around 20% of bed days were probably inappropriate and would be unnecessary if alternatives were in place.
A good practice guide to avoiding and diverting admissions to hospital (DH 2004d) was produced by the government and is explained in some depth due to its significance. It highlights the emphasis the NSF (DH 2001a) places on providing the right care to people in the right place at the right time. Reservations have been expressed about the use of the term 'inappropriate admissions to hospital' as admission to any service is only 'inappropriate' when there is a suitable available alternative in place and 'avoiding or diverting admission' is considered more suitable terminology (DH 2004d).

This report (DH 2004d) describes an Audit Commission model which would transform services from the current 'vicious circle' to a 'virtuous circle' which includes maintaining older people's independence, containing crises and preventing admissions. It is acknowledged that a relatively small number of people are heavy users of health and social care and that by targeting these individuals and offering more intensive review and management unplanned admissions may be avoided (DH 2004d). Although this guide is aimed at hospital admission avoidance across the board care homes are given particular mention but as little is known about hospital admissions from care homes it cannot be assumed that they are an issue. However care homes may be seen as an achievable target for admission avoidance due to the twenty-four hour care available.
Assertive Outreach is suggested to include:-

- The identification of frequent users of services and offer increased monitoring and rapid intervention
- Support residents and train staff in care homes to identify early signs of changes in their client’s condition to prevent further deterioration and refer or manage the patient as appropriate
- Community nurse liaison with care home staff to support the development of care plans for individuals with complex needs and help educate staff
- To develop care pathways across primary, secondary and social care for those with chronic disease.

It is made explicit in this guidance (DH 2004d) that admission to an acute setting should only be considered when other community options are not available and safety of the older person is compromised. ‘Step Up’ intermediate care services such as the ability to carry out a range of nursing treatments such as intravenous fluids and rehabilitation are suggested and ensuring that care home residents have access to specialist community nurses, for example, tissue viability and chronic obstructive pulmonary disease. Interestingly there is no differentiation between residential and nursing homes despite the presence of registered nurses in nursing homes or mention of GPs role with care homes and their part in hospital admission and key role in admission avoidance.
A report (NHS Institute for Innovation and Improvement 2006) on short stay emergency care describes improvements in the emergency care process with the stated aim of reducing the overall number of beds occupied by managing more patients out of hospital and reducing lengths of stay. To achieve this, the interface between acute and community care is crucial and a whole system approach designed to avoid unnecessary admissions and facilitate timely discharges is required. It is suggested that an integrated call centre is the access point for GPs requesting further care for their patients with the aim of streaming patients to the most appropriate service (NHS Institute for Innovation and Improvement 2006). A menu of options would include telephone advice, primary care attendance (out of hours and daytime response), emergency care practitioner attendance and paramedic attendance with or without transfer to an integrated Emergency Care Centre (ECC) for more detailed assessment.

These centres (ECCs) would include primary care, social care, mental health and acute secondary care to enable a definitive decision to be made about the patient's management. All decisions to admit will have detailed prescribed case management plans and a date and time for discharge identified at the point of admission. It is suggested that this service would especially benefit Out of Hours services and care home residents who require services outside surgery hours. Specific recommendations for care homes are included and it is suggested that
the pre-planning of care home residents could include scenario planning to avoid hospital admission and timely return to the care home after admission (NHS Institute for Innovation and Improvement 2006). There is no evidence of this approach being adopted and would require the involvement of GPs as care home residents are their patients but it is suggested they may be problematic due to their workloads.

2.2.4 Valuing older people

'A New Ambition for Old Age, next steps in implementing the National Service Framework for older People' (DH 2006a) states that in the next phase of health and social care reform older people's needs must be central and they and their representatives should be involved in care planning as citizens and service users to help improve services. Professor Ian Philp, National Director for Older People cautions that:

"Although overt age discrimination is now uncommon in our care system there are still deep rooted negative attitudes and behaviours towards older people" (DH 2006a:2).

This is significant as older people are more likely than younger people to become seriously ill and to face the prospect of dying (DH 2006a). However it is suggested that the current focus on age discrimination may lead to hospital admission for curative treatment when palliative care is more appropriate.
2.2.5 Influences on medical practice

The report ‘Acute medical care: The right person, in the right setting, first time’ (Royal College of Physicians 2007) says that out of hours care outside of hospitals is largely inadequate and that patients go to hospitals because there is nowhere else for them to get the care they need. They suggest that an expansion in the range of services offering acute medical care outside traditional hospitals is needed and stress the importance of new services being evidence based. This highlights the value of understanding what factors lead patients to be admitted to hospital in order to help identify the potential demand for and appropriateness of the development of various services. This was the approach of the current study.

Although the national Director for Older People is himself a geriatrician, the British Geriatrics Society (BGS) (Mulley 2007a) argue there has been a lack of engagement with geriatricians in the formulation of policy, but agrees that the hospital model has its limitations and that there are many opportunities for new ways of working which should be based on good evidence.

Geriatricians have suggested that the British government has had a naive failure to recognise that a policy intervention aimed at reducing acute hospital bed days that works in one local health economy may not be so effective in another
(Ebrahim 2001; Grimley Evans & Tallis 2001). This highlights the importance of local studies to determine local needs.

2.2.6 Outcomes for older people

The White Paper ‘Our Health, Our Care, Our Say’ (DH 2006b) creates opportunities to align the planning, commissioning and delivery of health and care to frail older people. The intended aim was not only to improve outcomes but also achieve financial savings by reducing the overall demand for expensive hospital services. It is suggested that a key principle is that of timely identification of problems, treatment to prevent crisis and rapid response to crisis when it occurs. Whether admitted or provided with alternatives to admission, early access and review by specialist multi-disciplinary old age related teams will improve outcomes for patients and be an efficient use of resources (DH 2006b).

Where and how the NHS provides services needs to change as existing services were not designed with older people’s services in mind. This is the view expressed in the most recent report by the National Director for Older People which begins by stating that:

“reconfiguring our specialist services to bring care closer to home will make a big difference to the lives of older people” (DH 2007a:1).
The key elements of older people's care are described as including general hospital care when needed combined with quick access to new specialist centres and partnership around the needs and wishes of older people and their families. This will be achieved by building a second ring of community specialist health and care services supporting primary care teams. The end result of reconfiguring services will be reduced need for acute care (DH 2007a) which is a similar claim to that of the NSF six years earlier (DH 2001a).

2.2.7 Dementia Care

Despite the high prevalence of dementia in older people the government policy documents, admission avoidance guidance and reports of UK hospital avoidance initiatives no reference to the hospital admission of residents with advanced dementia have been identified. This is probably due to the fact that dementia has not been a priority for the Department of Health or NHS and it is only recently that policy specifically directed towards older people’s mental health issues is being addressed (House of Commons 2008). The first ever national dementia strategy is expected to be produced by the Department of Health late in 2008 (DH 2007b).

The current study was undertaken prior to The Mental Capacity Act (MCA) 2005 (Department of Constitutional Affairs 2005a) being introduced in England in 2007.
This Act provides a statutory framework for protecting vulnerable people unable to make their own decisions and has the potential to improve end of life care for older people (Abley 2008) as Lasting Powers of Attorney (LPA) can be appointed by a person to make decisions on their behalf. This change in the law even permits an LPA refusing "life sustaining treatment" and it has been suggested that the MCA 2005 should be used as an opportunity to embed questions regarding LPAs or advanced directives into the admission process (Jerram 2008). It is suggested if nursing homes adopt this approach there is the potential to reduce inappropriate hospital admissions in the future.

2.2.8 Policy outcomes

As readmissions continue to rise (DH 2008a) this would suggest that the raft of policy initiatives described have had limited impact. This is the view of Hudson (2006) who argues that despite an avalanche of policy initiatives the position remains fragmented and confused and suggests that private finance initiatives, foundation trust status and practice based commissioning have led to fragmentation rather than a whole system approach. In addition the flurry of activity has not addressed the problem of expensive and inappropriate use of acute hospitals nor has mental health and end of life care been well addressed (Hudson 2006).
Evaluations of the impact of recent policy initiatives is limited and research to support the implication of the NSF for Older People (DH 2008b) reported it is still too early for the research to draw conclusions about effectiveness. This is despite the NSF being launched in 2001 with a series of milestones for its implementation. The studies (DH 2008b) have produced some findings which confirm there has been a lack of progress, for example, the continuing needs of older people require more attention and that there is a need to enhance the role of the GPs for most needy patients. An interesting observation of these studies (DH 2008b) by the Director General for Social Care, was that even with firm policy and resources, local structures, relationships, the competing interests and demands of professional groups are important factors.

2.2.9 Conclusion

It is clear that many of the policies described reiterate the same rhetoric and were intended to achieve significant service redesign leading to improvement in the care of older people and a reduction in avoidable emergency hospital admissions. However, despite the plethora of policies launched by the Department of Health since 2000 with the exception of some admission avoidance initiatives evidence of degree of change intended appears limited. It is suggested that the lack of mechanisms to co-ordinate the wide range of potential
partners, robust implementation and evaluation strategies, targets and incentives may have constrained change.

2.3. Long-term care of older people
Long-term care of older people began in the UK over 300 years ago and was nurtured through Poor Laws in the Victorian workhouses and it was not until the 20th century that institutional care was designed to meet their needs (Help the Aged 2006). With the advent of the National Health Service in 1948 the care of older people with long-term health needs became hospital based within the emerging specialty of geriatrics, under the supervision of consultant physicians. Patients only left these units when specialist care was needed, such as abdominal emergencies or repair of hip fracture (Beringer & Flannigan 1999).

NHS long-term care facilities and local authority residential places were drastically reduced in the last twenty years of the twentieth century (Avards et al. 1998). This led to a huge expansion in care homes which are now the major provider of long stay care for frail older people in the UK (Turrell 2001). Morris (2007) suggests there is very little difference between those residents receiving NHS funded continuing care and other nursing home residents. The re-designation during recent decades of older people’s care services from ‘health’ to ‘social’ masks the fact that many residents have substantial health care needs. While some needs may be met by staff within homes, most will require input from
doctors, pharmacists, therapists, specialist nurses and other services from outside the home (Heath 2007).

The structural changes in the funding and provision of long-term care which took place throughout the 1980s and 1990s largely removed the responsibility for funding and providing long-term care from the NHS and devolved the responsibility for medical care from hospital specialists to GPs. The effect of these changes and their implications for the healthcare needs of frail residents in long-term care has never been properly evaluated (Godden and Pollock 2001). In addition there has been little work on access to and use of acute services by care home residents, indeed there is a perception that the home is the end point of care (Godden and Pollock 2001).

Since no coherent planning or overall policy review has been devoted to long-term care, the needs of chronically ill older people and their families are "uneasily and incompletely responded to" (Avards et al. 1998:1). This view was shared by a joint working party of Royal College of Physicians, Royal College of Nursing and British Geriatric Society (RCP 2000). Their statements are quoted below as they exemplify the situation;
“It is a paradox that older people with the greatest need for consistent, creative and effective care now live in care homes denied the traditional essence of interdisciplinary care” (RCP 2000:2)

“Care home residents have often become medically dispossessed in spite of their complex health care needs which may contribute to avoidable ill health and acute hospital admissions” (RCP 2000:3)

Research by the Healthcare Commission (2004) suggests that older people in nursing homes may not receive the same level of care as their community counterparts and a national survey of access to NHS services by care homes for older people in England (Jacobs et al. 2001) found that access to specialist nursing support and therapy was limited.

In order to improve the range of comprehensive medical, nursing, rehabilitative, social and psychological care for vulnerable elderly care home residents the return to specialist involvement in long-term care has been advocated (Avards et al. 1998). They suggest that this would be the functional merger between secondary and primary care and the care home sector. Expectations and recommendations of the BGS (BGS 1997) included all older people having equitable access to a full range of specialist opinion and consultant input being available. Yet a national census of care home residents by Bowman et al. (2001) found that only five per cent of homes had direct contact with a geriatrician and
twelve per cent with a psycho-geriatrician and there is no local evidence of the BGS recommendations having been implemented.

Yet the closure of long-stay hospital facilities should have been accompanied by investment in community medical services and reinvestment in the acute hospital care of older people (Beringer & Flannigan 1999). New investment was needed in order to provide geriatric medicine beyond the hospital walls and that geriatricians are key stakeholders in the future of long-term care (Young & Philp 2000). These views are supported by Turrell (2001) who considers that ‘over burdened’ GPs are also crucial and suggests inappropriate hospitalization may be avoided by agreeing how to involve them as well as access available to community based specialists.

The literature demonstrates how the care environment and medical provision for this group of older people has changed, without changes in the health care provision available in primary care, leaving them with little access to acute specialist care other than by emergency hospital admission.
2.4. Care home provision

2.4.1 Introduction

This section describes the context of the current study by providing background information on the client group, the setting of care and key issues. The Care Standards Act (2000) (DH 2000c) introduced the term "care home" with residential homes becoming care homes (personal), providing board and personal care and nursing homes became care homes (with nursing) and are intended for those older people who need regular or constant nursing care (Bajekal 2002; Froggatt 2004). Nurses are required to be registered with the NMC and are responsible for the provision of nursing and personal care for residents to the standards laid down in the Care Standards Act 2000 (DH 2000c). All care homes are currently registered with and inspected by the Commission for Social Care Inspection (CSCI) whereas previously all residential homes came under the auspices of local authority social services and nursing homes local NHS authorities.

In 2004, an estimated 410,000 older people lived in residential and nursing homes across the UK in 15,700 private, voluntary and local authority homes with single home businesses accounting for just over half of all care homes and nursing homes having on average 44 beds (Office of Fair Trading (OFT) 2005). Ninety percent of care homes are located within the independent sector.
with 13% percent being run by voluntary organisations and just over 7% by local authorities (CSCI 2007).

For most older people moving into a care home is a lasting decision (OFT 2005) and is often precipitated by a critical event, usually hospital admission, for example Stilwell & Kerslake (2004) found this to be the case for 78% of admissions. Researchers from the Personal Social Services Research Unit (PSSRU) found the median length of stay for publicly funded nursing home residents to be one year (PSSRU 2001).

The proportion of people living in care homes increases with age, for example although only 0.7% of the 65-74 age group are care home residents (OFT 2005), this rises to just under 17% of people aged over 85 (International Observatory on End of Life Care (IOELC) 2008) and 25% for the over nineties (OFT 2005). In the year 2000 the average age of older women residents in care homes was 85.6 years, compared to 74.8 for those living in private housing (DH 2002a).

Older people living in care homes in the UK have substantial and complex needs (Heath 2007) and this population has become increasingly frail and dependent
over the last twenty years (Morris 2007). A dependency study (PSSRU 2001) found that nursing home residents were considerably more dependent than a decade previously which is in line with an earlier national audit (St George's Hospital Medical School 1999) which found that the care needs of residents had risen since admission. More recently, over 75% of care home residents have been classified as severely disabled with 91% of nursing home residents being classified as severely disabled (OFT 2005). Severely dependant residents present with many clinical diagnoses including cardiovascular disorders, rheumatological diseases, strokes and neurodegenerative diseases (Challis et al. 2000; RCP 2000). Most recently the CSCI (2006) found that 82% of older people in care homes have a long standing illness and 48% have two or more chronic conditions.

In addition care home residents experience more chronic illnesses than any other group and can benefit from health promotion (Heath 2007). Although many care homes aim to promote health, external support in respect of nutrition and weight control, exercise, adequate sleep, stress management, safety and drug management is largely absent (Challis et al. 2000; O'Dea et al. 2001; Sackley et al. 2004).
There is growing evidence that the contribution of doctors, other professionals and specialist services for older people is limited in care homes (Help the Aged 2006) although in theory care home residents can access NHS services (Heath 2007). Input from occupational therapists and physiotherapists have been found to be sparse and speech and language therapy is virtually non-existent in most care homes, despite the enormous difference they can make to older people’s functioning and quality of life (Bowman et al. 2001).

Registered nurses make up 30% of care staff in nursing homes (Royal College of Nursing 2004a) but care home managers working outside the parameters of the NHS do not have access to the level of support available in the NHS (Nazarko 2002). A study of care home providers (English Community Care Association et al. 2004) suggests a skill mix review in order to identify staff numbers and qualifications required to match resident care needs and improved service provision. They also suggest cross learning opportunities for care home and NHS staff. The BGS suggest that some homes could become centres of excellence and the concept of teaching nursing homes should be seriously considered with opportunities for academic appointments (Mulley 2007a).
There is a perception that staff feel undervalued and threatened by the increasing, often critical gaze of those outside the care home setting (Nicholson 2007). They can be isolated from wider professional networks and expertise and concerns have been expressed about how agencies work together to ensure that the long-term needs of older people living in care homes are met (Help the Aged 2007). The BGS acknowledges that many care homes have felt 'locked out' of the mainstream NHS services, yet there are important opportunities to enhance and extend the care provided to older people in these facilities (Mulley 2007a). Care homes working in partnership with the NHS is advocated by the care home sector (English Community Care Association et al. 2004).

Although significant numbers of the most elderly, physically and mentally frail older people live in UK nursing homes, the literature reviewed has demonstrated that the sector has evolved in response to circumstances rather than in a planned way and the majority of the related research and guidelines have focused on a social rather than a health model. There is insufficient evidence both locally and nationally about the health needs of older people residing in nursing homes and the reasons for admission to acute hospitals as emergencies. Yet high quality nursing home care can prevent or forestall hospitalization and reduce length of stay (Turrell 2001). While this is the researcher's standpoint gaps in local
knowledge need to be addressed before hospital admission avoidance strategies can be developed.

Care homes must play a crucial part in realising the Government’s vision for health and social care (DH 2006b) but in order for this to be achieved care homes “need to be brought in from the cold and their potential harnessed” (Help the Aged 2006:7).

Most care home residents report high levels of satisfaction with the care they receive, for example 78% would recommend their home to a friend (OFT 2005). However, over the years concerns have been expressed regarding the quality of care provided in care homes (Help the Aged 2006). The CSCI, an independent regulatory body in England was set up to apply and monitor the National Minimum Standards set out in the Care Standards Act 2000 (DH 2000c). Still quality of care remains an issue particularly as what constitutes quality of care in care homes is not clearly defined despite it contributing significantly to older people’s quality of life (Help the Aged 2007).
Quality of care issues are pertinent to the focus of the current research and as pain management, dementia, end of life care and advance care planning were identified as key issues they will be discussed in turn in the following section.

2.4.2 Pain management

The management of pain is an important issue as it affects many care home residents for example a recent report (Picker Institute 2007a) found that although nearly three quarters of residents surveyed experienced pain in 85% of cases it was not discussed with a doctor or nurse. Several UK studies highlight the multiple and interrelated problems caused by its inadequate treatment in older people who are care home residents (Heath 2007). For example, Bowman et al. (2001) found a significant proportion of residents did not receive adequate pain control. Allcock et al. (2002) found that 69% of care homes did not have a written pain management policy and 75% did not use a standardised pain assessment tool.

Most GPs in an Open University study (Katz 2003) did not feel that either residential or nursing homes should or could manage pain control which needed to be delivered through a syringe driver. By contrast Froggatt (2000) found that
when staff in care homes were trained in palliative care, but GPs were not, conflicts occurred for example regarding pain management.

These findings may indicate a lack of awareness of the importance of pain management within the care home sector and highlights the need for improvement in pain assessment and management, with multidisciplinary expert input and staff education (Heath 2007).

2.4.3 Dementia

In addition to physical illnesses and disability the residential and nursing home sector is dominated by the care of people with dementia (Forsyth 2007) and cognitive impairment is a major reason for care home admission. It is a huge cost to healthcare systems for example institutional care alone in the UK cost £4.1bn in 1998 (Comas-Herrera et al. 2003) and as a result it has been suggested that improvement in understanding of the consequences of dementia is of key importance (Xie et al. 2008). Dementia is a progressive terminal illness (National Council for Hospice and Specialist Palliative Care Services (NCHPCS) 1998) and 60,000 deaths a year are directly attributable to dementia (Alzheimer's Society 2007). Official statistics show 3% of deaths were due to dementia in 2005 but it may have contributed to 13% (House of Commons 2008) as dementia is rarely
listed as a cause of death because an estimated 90% of people with dementia ultimately die from pneumonia (Burgess 2004).

Dementia is a significant issue as recently it is estimated that two thirds of people living in all care homes have some form of dementia (CSCI 2008). An earlier study of 40,843 BUPA care home residents (Continuing Care Conference 2006) found that 82% of residents were either; confused, forgetful, depressed or agitated. Although over 40% of people with dementia die in nursing or residential homes (McCarthy et al. 1997) few staff have specialist nursing qualifications or training in dementia care (House of Commons 2008). CSCI (2008) also identified a lack of care home staff training on dementia despite analysis showing a significant relationship between staff training and development and residents’ well-being.

**Palliative care in dementia**

Palliative care is defined by the World Health Organisation (WHO) as care that "improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement" (WHO 2002).

It is about shifting the focus from cure to comfort (Burgess 2004) and it has been suggested that there is a need for new palliative treatment approaches to be
developed, particularly for patients dying with dementia (Zvi Aminoff 2005). Such a model is the suggested approach for inpatient care (DH 2005b).

An American study (Lamberg et al. 2005) found that the hospital transfer of nursing home residents dying with advanced dementia was rarely consistent with a palliative approach except when the treatment necessary to promote comfort was unavailable in the nursing home setting for example, fracture repair.

Palliative care for the dying person with dementia has been identified as a neglected topic in relation to policy, planning and training (Burgess 2004) and there is a dearth of research into their end-of-life needs (NCHPCS 1998). Chatterjee (2008) suggests that people with dementia receive sub-optimal end-of-life care with inadequate palliation of symptoms (Morrison & Sui 2000; Mitchell et al. 2004; Aminoff & Adunsky 2005).

McCarthy et al. (1997) conclude from their study of dying patients with dementia that this group has significant healthcare needs at a level comparable to those of cancer patients. Members of Parliament forming the all-party Public Accounts Committee recently suggested that dementia should be given the same
resources as cancer (House of Commons 2008). As the care of residents with dementia is an important issue in care homes it has relevance to this study.

Forbes et al. (2000) argue that residents' reduced cognitive capacity and the lack of advance directives mean that the nursing home population is especially vulnerable to either over or under treatment at the end of life. They also stressed that residents with advanced dementia may have been admitted to hospital inappropriately for what described as "clinically appropriate and evidently futile interventions". Some authors feel passionately about the inappropriateness of such admissions for example Purdy (2002) refers to it as 'brutal hospitalisation' and Kleinfeld (2003) refers to residents receiving 'futile but gruelling procedures'.

Despite the most diligent care, patients with dementia will eventually lose the ability to swallow food and liquids as dementia progresses and the use of artificial nutrition and hydration in the final stages of dementia is a controversial and emotive subject (Holmes 2008). The National Institute for Clinical Excellence (NICE 2006) and Alzheimer's Society (2007) believe that it is inappropriate for a person with advanced dementia to be given artificial hydration and nutrition for the sole purpose of prolonging life. Instead treatment should be focused on
maximising quality of life and comfort and decisions made on an individual basis (Holmes 2008).

Hertogh (2006) questions why so many people with dementia are still exposed to hospital interventions in the face of death when there is growing recognition across the globe that these people are entitled to appropriate palliative care. He considers that there is an urgent need to identify whether interventions such as artificial feeding, antibiotics and artificial re-hydration can truly contribute to quality of life of people with advanced dementia. Burgess (2004) suggests that aggressive therapies such as intravenous antibiotic therapy, percutaneous endoscopic gastrostomy (PEG) or gastric nasal feeds only serve to prolong the life of a patient who is terminally ill and also add to the trauma of death.

In the Netherlands Hospital admissions and the use of burdensome interventions such as artificial feeding and re-hydration are avoided as a result of nursing home physicians being experienced in the management of advanced dementia, symptom control management and advance care planning (Hertogh and Ribbe 1996). This care planning is undertaken in conjunction with residents and families around the treatment of complications and exacerbations of the dementia process. This approach was adopted back in the 1990s (Hertogh and Ribbe
1996) and it has been so successful that the hospital admission of nursing home residents with dementia is now rare (Hertogh 2006).

**Terminal care in dementia**

Little is known specifically about the needs of people dying from dementing illnesses, particularly in nursing home settings or how decisions about end of life treatments are made (Forbes *et al.* 2000) but it has been identified that people with dementia have markedly decreased survival rates compared to those without dementia (Waring *et al.* 2005).

2.4.4 End of life care

Seventeen per cent of all deaths occur in care homes (DH 2008c) and recently it has been reported that almost 100,000 over 85 year olds die in the care home sector each year (Makin 2008). Feedback from Strategic Health Authorities and external stakeholders had identified the need to improve end of life care in care homes as a priority (DH 2006a). This had already been raised in a previous report; "Better Health in Old Age" which highlighted that:

"With older people there is a big gap between the care they receive in hospices and care homes, yet over one quarter of the over 65s die in care homes where quality is very variable." (DH 2004b: 102).
Although residential care for older people is one of the most researched areas of social policy, little attention has previously been paid to the circumstances and care of dying persons in homes (Peace et al. 1997). These sentiments were reiterated a few years later by Katz and Peace (2003) who reported a surprising dearth of information about what happens to older people deteriorating and dying. They attribute this to the lack of research into the ways older people die and causes of death. They contend that until recently there has been little debate into appropriate policies which might determine possible sites and quality of care for older people who are dying. Finally given the large numbers of people dying in care homes questions are raised as to why palliative care has not reached this client group (Katz and Peace 2003). In a re-evaluation of residential care Peace et al. (1997) suggested that the future debate needs to look closely at developments in the hospice environment and palliative care skills. There is evidence that this has begun to happen in recent years, for example through the Gold Standards Framework in Care Homes (Partridge 2008).

In their study of terminal care in residential and nursing homes Komaromy et al. (2000), found that although care home staff were committed to providing quality end of life care for residents, barriers to good practice included a lack of knowledge of palliative care. The Department of Health (DH 2004e) identified this
as an issue and are committed to promoting end of life care training for care home staff.

Sidell and Komaromy (2003) reported that OU studies funded by the Department of Health found that there was a strong desire by homes to keep residents as long as possible, despite the extra burden that providing terminal care could place on staff. This typical view was expressed not only by managers but also by care home staff that, residents should stay in their own home in familiar surroundings and the philosophy that it was the resident's home for life was much in evidence. Residential home managers recognised that they were not able to care for people who needed more intensive input and acknowledged that on occasions the home was the wrong place for someone to die (Sidell & Komaromy 2003).

Home managers were usually dependent on the support of GPs to retain the dying person in the home (Sidell & Komaromy 2003). The decision to transfer a resident to hospital involved a negotiation with the GP and the relatives whose wishes were always adhered to (Sidell & Komaromy 2003). Managers reported on occasions being pressurised by families to transfer residents to hospital and some relatives had unrealistic expectations about what could be done.
The nature of multiple, often chronic health problems, such as many older people who are care home residents experience over a period of time, makes it difficult to define when someone can actually be said to be dying (Froggatt 2001; Henwood 2001). It has been found that 42% die following a long period of general deterioration (Sidell et al. 1997). This uncertainty about end of life can lead to impersonal, reactive and inadequate care (Sidell & Komaromy 2003; Kristjanson et al. 2005).

While hospital transfers are known to be inevitable in some cases and necessary due to medical needs and complications (Nicholson 2007), UK studies have found that the hospitalisation of dying patients may be unnecessary and inappropriate (Katz 2003). The Help the Aged (2006) report highlights the need for further research into decisions resulting in residents being admitted to hospital during their last days of life.

The NHS Confederation (2006) found that the majority of people would prefer to die in their own home and it could be perceived that the same would apply to people for whom a care home is home. This was the finding of an American study by Mezey et al. (2002) who reported that when residents’ wishes about hospital transfer were sought there were lower levels of hospitalisation as more residents
preferred to die at home. In the OU study (Katz 2003) only one GP involved a dying resident in the decision to admit to hospital and they did not see communicating with relatives as an important part of caring for dying residents. A stated aim of the NHS Improvement Plan (DH 2004c) is to ensure that in time all people at the end of their life, regardless of their diagnosis will be given a choice of where they wish to die and how they wish to be treated. An initiative related to resident choice, the use of advance directives is likely to facilitate this and in so doing it is suggested that the number of inappropriate hospital admissions will be reduced (Nicholson 2007).

A number of national initiatives are being implemented to improve the experience of dying in care homes. Three tools are being promoted are the Gold Standards Framework (GSF), Preferred Priorities for Care Plan (PPC) and the Liverpool Care Pathway (LCP) (Henry et al. 2007). GPs are crucial to the adoption of these tools and the RCN Advisor for Older People suggests that PCTs have a role in supporting homes with their implementation (Duffin 2008).

The Gold Standard Framework (GSF) (Thomas 2003) aims to improve the end of life care provided to older people in the community by improving communication with GPs, primary health care teams and palliative specialists and a modified
version has been developed specifically for care homes. Key staff are trained in the management of the GSF Supportive Register which records patients on the programme and how to reduce the need for crisis hospital admissions (Healthcare Business 2007). The national lead for the Gold Standard Framework reports that the GSF toolkit has low uptake with only 600 out of 28,000 care homes having adopted it in the past four years since it was made available (Duffin 2008). This would indicate that GPs are not supporting care homes to improve end of life care despite it being a government priority.

The Preferred Place of Care model (DH 2004e) (now Preferred Priorities for Care Plan) (PPC) requires advance care planning to be undertaken within care homes. This includes engaging residents and their families in discussion about options and preferences which help staff anticipate residents' needs and moves from reactive to positive care. It has been reported that this approach reduces unnecessary admissions to hospital and allows residents to live out their days in a comfortable environment with familiar staff that have cared for them throughout (Healthcare Business 2007).

The Liverpool Care Pathway is designed for use with patients in the last few days of life once it is known that they are dying. It promotes good communication
between all concerned and facilitates the meeting of patients' psychosocial and spiritual needs as well as symptom control (Makin 2008).

Although these initiatives have received clinical and government support (Help the Aged 2006) some reservations have been expressed (Nicholson 2007) as it was not initially clear how these initiatives translate to non-cancer settings. Nicholson (2007) also cautions that introducing these tools into the complex culture of care homes may create more tension and burden for staff. However initial feedback from care homes is overwhelmingly positive (Healthcare Business 2007) as they facilitate sensitive end of life care which utilizes the valuable skills of nursing home nurses. Care homes in a part of England that has embraced the use of these tools reported a 12% reduction in hospital admissions and an 8% decrease in hospital deaths among older people (Duffin 2008).

Research has shown that care home staff would like training to help them provide better end of life care for residents (Nicholson 2007) and it is suggested that educational strategies in palliative care for GPs will need to reflect the needs and preferences of care home residents (Shipman et al. 2001). Yet Katz (2003) found that GPs did not consider palliative care approaches appropriate as older people experience a gradual deterioration in health and that pain control was fairly
straight forward to manage in this population. They saw themselves as patient advocates and based on their experience held the common sense assumption that older people do not favour intervention.

Although the majority of palliative care is provided within the primary care setting it is a relatively small part of a GP's workload as an average GP's list is estimated to include only 20 patients per year who are dying (Barclay 2001). Of the twenty patients five are likely to be dying from cancer, 15 from non-malignant disease and only eight will die under the care of the GP (Barclay 2001). It could therefore be suggested that GPs have limited experience in the care of the dying and may therefore influence hospital admission decisions. Yet central to the implementation of good clinical practice in this field will be the GP who must be supported by a multidisciplinary, person-centred, specialist palliative dementia team (Hughes and Robinson 2006).

Person-centred care is now considered the suitable approach to the care of older people (DH 2001a) and person-centred palliative care depends on careful and compassionate communications between patient, family and health care staff (Seymour and Hanson 2001). In addition it is suggested that the use of the tools highlighted above would provide a framework for this to be achieved. In addition
an informed understanding of, and support for advance care planning between care home staff, residents and relatives is identified as being important to help ensure quality care at the end of life (IOOELC 2008).

2.4.5 Advance care planning

ACP is defined as:

"the process of discussion between an individual and their care providers and takes place in the context of an anticipated deterioration of an individual's condition in the future, with the expected result that the individual will lose their capacity to make decisions and/or ability to communicate their wishes to others" (IOELC 2008:x).

An ACP discussion might include the individual's concerns, their important values or personal goals for care; their understanding about their illness and prognosis; their preferences for types of care or treatment that may be beneficial in the future and the availability of these (IOELC 2008). Good practice includes a record of residents having a discussion on issues like the use of invasive technologies with GPs before it being recorded. Although this involves the commitment of and more work for GPs it could be useful when treatment decisions have to be made, especially 'out of hours' (Butterworth et al. 2008).
ACP is integral to person-centred health care because it ensures a person’s right to participate in future healthcare choices and in end-of life decision making (IOELC 2008; Butterworth et al. 2008). Of particular relevance to this study, it is suggested that ACPs appear to play an important role in ensuring that residents are not hospitalised to die (Pekmezaris et al. 2004; Degenholz et al. 2004; Mitchell et al. 2007).

Although ACP is widely used in other countries e.g. US, Australia and Canada it is a relatively new intervention in the UK (IOELC 2008) reflecting the historically unclear legal status of advance statements in the UK (Seymour et al. 2004). The legal framework of ACP has been defined in the MCA and the Code of Practice (Department of Constitutional Affairs 2005b) sets out clearly what all stakeholders must do to comply with the law including requiring care workers to support people so that they can make decisions.

As care homes initiate and co-ordinate ACP (IOELC 2008) they need to be prepared for undertaking this role and the Department of Health has identified the need for help for staff and will be issuing guidance on writing advance directives (Butterworth et al. 2008).
It is suggested that the commitment of GPs to the ACP process will be critical to its successful implementation in care homes, it is essential in achieving person-centred care and has the potential to transform end of life care in homes and considerably contribute to the hospital admission avoidance of care home residents.

2.5 Policy influences on Primary Care

2.5.1 Introduction

The increase in community based long-term care facilities has led to increased demand on GP and primary health care services (Crosby et al. 2000). Medical responsibility for care home residents fell by default rather than design upon the heavily burdened shoulders of the GP (Black & Bowman 1997). Although nursing and residential homes have been extensively evaluated there are gaps in knowledge regarding the demand for and the role of the GP and primary health care services in supporting residents in these establishments (Crosby et al. 2000). Perhaps as care homes are rightly viewed as homes for living in rather than mini hospitals, standards for good practice have concentrated on the quality of everyday life, which may account for the lack of focus on access to and standards of health care (Goodman & Woolley 2004).
As already alluded to above, Crosby et al. (2000) stress that the shift in responsibility for long-term care from the NHS to the private sector had led to the transfer of care from the consultant to GP without any concomitant transfer of resources. Goodman and Wooley (2004) agree that primary care has not been adequately resourced nor developed to take over the health care of older people in residential long-term care.

A King's Fund report (Dixon et al. 2004a) suggests that as the population in England ages, growing numbers of patients will need help, managing complex multiple conditions over sustained periods. They suggest that better primary care and better integration between primary and secondary care can play a significant part in reducing the use of expensive and disruptive hospital stays for older people with chronic conditions. Much greater investment is needed in developing clinician - manager relations within PCTs and between PCTs and their providers (Dixon et al. 2004a).

A review of the literature by Heath (2007) clearly identified that older people living in care homes have substantial health care needs and yet the literature is unequivocal that there are wide national variations in service provision. This means that main stream NHS multi-professional services are not universally
available to care home residents. This situation is contrary to national policies such as the National Service Framework for Older People which states that;

"NHS services will be provided regardless of age on the basis of clinical need alone." (DH 2001a:16)

As there is considerable evidence that older people in care homes are not receiving the healthcare services that are their right, Help the Aged (2006) suggests that primary care organisations review their provision. This is essential in order to ensure that care home residents have access under the NHS to all services including GP, specialist medical, nursing, therapies and all screening services and medical reviews (Help the Aged 2006). An integrated approach to the care of older people, which will allow them to get the best possible treatment regardless of institutional or professional boundaries is advocated by the NHS Alliance and both the Royal College of Physicians and the Royal College of General Practitioners (DH 2004b).

The Commission for Social Care Inspection (CSCI 2006) states that primary care organisations should acknowledge and act on their responsibilities to support healthcare provision within care homes.
2.5.2 GPs

Care homes in this study could be described as following a GP and primary medical model (Crilly et al. 2006) as the patient and service provider have prior knowledge of each other and the provider is able to deliver medical care over time. Older and more vulnerable patients value the relationship they have with their GP and the continuity of care they provide and the GP accesses specialists and diagnostic tests leading to a potential reduction in hospitalizations (Pereira & Pearson 2003). Mainous and Gill (1998), highlight that advantages to continuity with a physician are based on the belief that in a long-term patient-physician relationship a knowledge base is accrued. Williams (2004) suggests that while this model is beneficial in managing chronic illness and delivering preventative services it does not provide for acutely unwell patients when the GPs do not visit out of hours.

The report of Health Select Committee (House of Commons Health Committee 2004) states that under the new General Medical Services contracts resources are allocated to practices according to patient need and are weighted to take account of the needs of residents in residential care. Yet many GP practices still request fees to be paid by care homes simply to secure NHS medical care to their residents (English Community Care Association (ECCA) 2008). This is despite the recommendation that the practice of the payment of retainer fees
should be abolished, as every patient registered with a GP should have a right to a service without the payment of fees (Health Select Committee 2004).

Despite charging for their services the preparation for GPs to undertake their role in care homes would appear to be lacking as only 40% have had any postgraduate training in the care of older people with multiple pathology (Morris 2007). This she asserts, results in frail older people in care homes receiving substandard treatment (Morris 2007). Interestingly one PCT has agreed to pay a GP £12,000 - £15,000 to provide services to a new nursing home with a clear specification of the services the GP will be expected to provide specifically around reducing inappropriate admissions to hospital (ECCA 2008).

Studies have found that nursing home residents required more input from general practice than people of the same age residing in the community (Kavanagh & Knapp 1998; Pell & Williams 1999; Jacobs 2003). There is also evidence that GPs find it difficult to cope with the workload that care home residents add, for example Bowman et al. (2001) reported that GPs were becoming overwhelmed by the needs of care home residents, particularly when added to the demands of increasing numbers of frail older people in community settings. This may explain
why a national census of care home residents (Bowman et al. 2001) found that 21% of homes had no regular visits from GPs.

Crosby et al. (1998) found GPs were struggling to institute regular medical reviews of care home residents and review rates for this client group have been found to be lower than for older people living in their own homes (Zermansky et al. 2006). Despite financial incentives for GPs to increase their focus on managing chronic disease (DH 2005a), Brooks and Cox (2005) found that nursing home residents were not receiving regular reviews of their long-term conditions.

2.5.3 Hospital admission avoidance initiatives

Evidence indicates that prevailing health needs of care home residents are inconsistently managed and Goodman and Wooley (2004) suggest that many health problems could be avoided or improved with primary care nursing support and intervention. This has been the experience from the Evercare programme in the United States, which shows that nurse practitioners prevented hospital admissions (Kane et al. 2003). A range of successful initiatives in operation throughout England have been reported including community based specialist nursing teams to support care homes for example, Proctor et al. (1999) and
Anderson (2004) whose remit has included a focus on hospital admission avoidance. A nurse-led team in the west of England (Wild 2008) allowing people to remain in council residential homes by bringing in specialist care during episodes of illness reported averting the hospital admission of residents and being greatly valued by residents and staff. A new initiative in the St Helens area, designed to support care home staff to care for residents who are unwell and avoid hospital admissions is described in Gulland (2007). It includes a learning package for care home staff and access for nursing home nurses to a district nurse for advice between 9am and 5pm. As 30% of nursing home staff are registered nurses specialising in the care of older people, it is unclear as to the exact nature of the district nurses’ input and the effectiveness of this service is not reported.

The Change Agent Team (2006) suggest a role for community based rapid response teams in care home hospital admission avoidance and this approach has been adopted in some areas. For example a multidisciplinary team in the north of England, linked closely to the local Rapid Response and Rehabilitation Teams, with a remit to prevent avoidable admissions. This led to hospital admissions from one nursing home being reduced by almost a third with an estimated saving of 165 bed days and £33,000 over a nine month period. This demonstrated the benefits of multi-professional working for the health and well-
being of nursing home residents in addition to the financial savings achieved (Help the Aged 2007). Some London PCTs have also set up multi-disciplinary intensive case management teams (Hayes and Martin 2004).

Another approach by Liverpool PCT was to set up a single point of access aimed at reducing the number of unnecessary attendances to emergency care, including care home residents. This offers GPs alternatives to hospital admission 24 hours a day and has reported being successful, although details have not been published (Jones and Norbury 2007). Access to a consultant for advice or a visit if required is also an option (Jones and Norbury 2007) although it is not known the impact they have on hospital admission avoidance. This approach is in line with the BGS view, that the involvement of geriatricians in care homes may reduce inappropriate admissions from care homes (Mulley 2007b).

There appears to be enormous potential for developing new roles and new ways of working, offering a range of multi-professional healthcare services to care homes (Help the Aged 2006) although evaluation of admission avoidance initiatives is limited requiring urgent investigation (Help the Aged 2007).
2.5.4 Conclusion

Despite the large numbers of frail older people in long-term care in the UK, there has been little research into the quality of health care they receive (Turrell et al. 1998). Published studies have tended to focus on individual health related issues, for example pressure ulcers (Sheils & Roe 1999); continence (Roe & Sheils 2000); oral health (Simons et al. 2000) and the provision of palliative care (Froggatt et al. 2002). However more information on medical needs and care within care homes is considered necessary to inform the development of good practice (Turrell et al. 1998). More importantly care home residents must be able to make informed choices about their care and a move away from a view based on needs as defined by professionals to one founded on listening to their preferences (Help the Aged 2006).

2.6 Emergency Hospital Admissions

2.6.1 Introduction

Over 65 year olds account for 40% of all emergency admissions (DH 2000a) and occupy 65% of acute hospital beds. In 2004/2005 there were 4,428,680 emergency admissions to acute hospitals in England (NHS Institute for Innovation and Improvement 2006). Emergency admissions have changed over time by Strategic Health Authority, diagnosis and length of stay with an overall 28% increase in emergency admissions since 1997 and a 6% increase between
2003 and 2004. Of the diagnoses creating a significant number of admissions, pneumonia and acute bronchitis rose by more than 20% and urinary tract infections by 11% (Farr 2006). With admission rates escalating and an increase in admission diagnoses which have the potential to be treated outside secondary care, it is understandable that targets to achieve change were considered necessary.

Although the emergency hospital admissions which are the focus of admission avoidance (DH 2004d, DH 2005a) have not been clearly defined it is inherent that they are admissions that have the potential to be avoided by alternative treatment approaches. For example, through intermediate care services (DH 2001a) or by the active management of long-term conditions (DH 2005a). It therefore excludes admissions for surgery or treatments not available outside secondary care.

2.6.2 Hospital bed days
Despite the ongoing rise in emergency hospital admission rates a 6% overall reduction in hospital bed days was achieved in 2005 with only two English Strategic Health Authorities not achieving a reduction (Farr 2005). North West London SHA (where this study is located) showed the largest rise in emergency admissions which were up by 14% in 2005, but they also recorded an 8%
reduction in emergency bed days which was one of the highest. As the PSA target (DH 2005a) is to reduce emergency bed days, reducing length of stay is an alternative or additional approach to reducing the number of emergency admissions but the potential to achieve further reductions may be limited if a significant reduction, as is the case locally, has already been achieved. It is clear that SHAs will have to concentrate their efforts if trusts are to meet the government’s target of a 5% reduction in emergency bed days by 2008 (Farr 2005).

2.6.3 High impact users

Patients with multiple emergency admissions have been identified as a high risk group for subsequent admission and substantial claims have been made for interventions designed to avoid admission of such patients (Roland et al. 2005). High impact users are often patients with long-term conditions and it is the government’s view that significant numbers can be avoided (DH 2004c). Around 3% of people with long-term conditions account for 37% of emergency hospital admissions of people aged over 75 (DH 2004b).

The first ever analysis of national hospital data to identify the impact of patients who have at least three emergency hospital admissions a year (Dr Foster
Intelligence 2006) suggested that more than a million emergency admissions could be better managed outside hospital. This is a significant claim as it would achieve a reduction of almost a quarter of all emergency admissions. In apparent contradiction to the claims by Dr Foster Intelligence (2006) a national analysis of follow up of people aged 65 and over with a history of emergency admissions looked at individual patients who had at least two emergency admissions in 1997-1998 (Roland et al. 2005). Their admissions were counted for the next five years and compared to the general population of the same age. Over this period admission rates and bed use in the high cohorts fell to the mean rate for older people. Although patients aged 65 and over with two or more admissions were responsible for 38% of admissions in the index year, they were responsible for fewer than 10% of admissions in the next year and just over 3% five years later.

This may demonstrate the value of monitoring admissions over several years rather than one year which in isolation would have presented a very different picture. The study by Roland et al. (2005) may indicate that many problems are resolved by a second admission or that the second admissions were for a different problem and that multiple admissions are not always due to long-term conditions. Both these studies described illustrate the complexity of the issue and Dr Foster Intelligence (2006) would suggest potential for hospital admission
avoidance as the number of admissions by these 'high impact users' varies tenfold depending on the part of the country.

2.6.4 Equity of access

As most hospital admissions occur in the three years preceding death (Dixon et al. 2004b) and life expectancy of a frail older person entering a nursing home is one year (OFT 2005) it would be reasonable to anticipate emergency admissions. Otherwise it could suggest discrimination against this vulnerable group if they were not accessing the expertise available only in the acute sector. The Royal College of Physicians (1994) stressed that care home residents should have full access to acute hospital services where necessary and it is acknowledged that many older people will need care in hospital at some time (Healthcare Commission 2004). In the past some hospitals had policies that denied particular treatments to people on the basis of age but this is now rare (DH 2002b). The introduction of the NSF for Older People (DH 2001a) is likely to have influenced this as it aims to root out age discrimination and ensure that NHS services are provided on the basis of clinical need rather than age related eligibility criteria. The Healthcare Commission (2004) found national trends for treating older people encouraging as there is evidence that they are now getting better access to treatment.
Yet Morris (2007) asserts that older people admitted to hospital often have their medical complaints put down to old age with phrases like “social admission”, “acopia”, “inappropriate admission” or “bed blocker” used when they have a perfectly treatable illness which would benefit from intervention. Decisions to admit older people need to be based on assessment of each individual’s needs, priorities and the patient’s capacity to benefit from treatment (DH 2007a).

2.6.5 Older peoples’ admissions

Older people are more likely to have prolonged length of stay once admitted (DH 2006a) and a large prospective observational study undertaken in England (Carpenter et al. 2007) found that lengths of stay for admissions with conditions common in older people were 40% longer for people with physical disability than the predicted length of stay related to the condition. It is therefore likely that nursing home residents have longer hospital stays. Sidell and Komaromy (2003) and Carpenter et al. (2007) found stroke, fractured neck of femur, myocardial infarction, acute respiratory infection, chronic obstructive airways disease and falls to be the most common reason for the hospital admission of older people.

Despite the increasing focus on emergency hospital admission avoidance, treatment in hospital is an important part of the network of healthcare of
older people (Healthcare Commission 2004; DH 2004d.) and care home residents should have full access to acute hospital services where necessary (Royal College of Physicians 1994).

Balancing risks with therapeutic opportunities and the need for hospital admission is a common dilemma (Bowman et al. 2001) as hospital admission poses various hazards for older patients (Creditor 1993; Ganguli 2003; Healthcare Commission 2004). The risks of hospital acquired infection (NHS Innovation and Improvement 2006) is a particular concern as they may be life threatening (DH 2007a) and falls and delirium are also complications of hospital admissions.

2.6.6 Admissions at end of life

A retrospective cohort analysis of the English hospital episode statistics database, using the data set for all post-neonatal deaths occurring in English NHS hospitals has been undertaken (Dixon et al. 2004b). It reported that while the average number of bed days spent in hospital in the period before death did not increase with age, the older age groups account for a larger number of admissions and bed days in the three years before death, due to the fact that as age increases, a higher proportion of people are in the final stages of their lives. These findings concur with previous studies (Cohen 1994; Himsworth & Goldcare
1999) that have shown that the highest proportion of costs for acute care are incurred in the final years of life, no matter what age that happens to be, and the total costs of acute care are greater in older people simply because this age group makes up a larger proportion of dying people (Zweifel 1999; McGrail et al. 2000). These findings are consistent with Seale and Cartright (1994) who calculated that 22% of hospital bed usage was by those in the last year of life and the majority are older people.

2.6.7 Care home admissions
There is no national data on the emergency hospital admission of care home residents but older people are heavy users of urgent care services when it is considered that a significant proportion could benefit from alternatives to admission (DH2006a). However, residents in care homes are considered less likely to be admitted to hospital than older people from domestic homes (Field and Froggatt 2003).

Yet there is a perception that care home residents are frequently admitted to hospital unnecessarily because private care staff have no other way of accessing care. For example Professor George Alberti, Department of Health emergency care tsar, suggested that every care home for older people should employ a full-
time NHS nurse. In his opinion such a scheme would drastically reduce the number of admissions from private care homes (Change Agent Team 2006) although there is no evidence to support this claim. Although a hospital admission avoidance initiative reported that many inappropriate referrals to A&E departments involved care home residents but it is of limited value as it did not indicate the scale of admissions or why they were considered inappropriate (Davis 2006).

Acute admissions of older people from nursing homes have been seen as inappropriate by nursing home nurses (Read 1999). As nursing homes are subject to regulations requiring 24 hour registered nurses supervision, Bowman et al. (2001) question the rationale of acute hospital admission for straightforward treatments such as fluid replacements and antibiotics. An American study (Fried et al. 1997) compared outcomes between nursing home and acute hospital treatment for residents with pneumonia and found similar mortality over the first two weeks but more than double the mortality at two months in the group transferred to hospital. In the UK a study by Bowman et al. (2001) found high admission rates due to infections suggesting that trials are justified for in-situ treatment, providing opportunities for innovation by GPs and with PCTs being responsible for all costs of both hospital and community care there are real incentives for change.
Major difficulties have been encountered in monitoring care home admissions due to poor data recording and inaccuracies in NHS coding (Godden and Pollock 2001). Roland et al. (2005) conclude that simply monitoring admission rates cannot assess interventions designed to reduce admission among frail older people as rates fall without any intervention. In addition, the effectiveness of hospital admission avoidance initiatives cannot be judged by tracking admission rates without a control group.

Godden and Pollock (2001) argued that a prospective study is required to ascertain the risk factors for admission and to what extent admissions from care homes are appropriate and avoidable. It is particularly pertinent as Beringer and Flannigan (1999) warn that with the increasing dependency of nursing home residents that the rate of acute hospital admissions is likely to rise.

However it is speculated (Bowman et al. 2001) that half of hospital admissions by care home residents could be avoided by a combination of better chronic disease management, admission assessment processes, in-situ treatment and the availability of comprehensive information for visiting doctors. An audit of acute admissions from care homes found that 20% of patients were discharged back within three days as they had fairly trivial or self-limiting conditions and 10% died.
within three days, with both categories being considered inappropriate (Snape & Santharam 1997).

The hospital admission rate of care home residents due to infection was found to be double that of their counterparts living in their own houses, although outcomes were similar with a 40% mortality rate (Yates et al. 1999). Only a few UK published studies relating to the hospital admission of care home residents in the UK have been identified, Bowman et al. (2001); Beringer & Flannigan (1999); Godden & Pollock 2001, Read (1999); Zaatar (2001) and are summarised in Appendix 1.

Alternatively the health care system in the USA has meant that the hospital admission of older people from nursing homes has been well researched and while direct comparisons may be inappropriate they are worthy of some consideration. Studies from the 1970s and 1980s revealed 17-26% of nursing home residents were hospitalised each year, admissions often resulted in adverse outcomes and were expensive episodes of care (Stark et al. 1982; Bergman & Clarfield 1991) and many were considered avoidable (Kayser-Jones et al. 1989; Zimmer et al. 1988). A German study which analysed nursing home admissions suggested that hospital admissions could be reduced by
improvements in nursing home care which focused on prevention by therapy and case management (Specht-Leible et al. 2003).

2.6.8 GPs

Studies informing the background to this research study that relate to GPs and hospital admissions were undertaken in the previous decade, but as more recent studies have not been identified they are considered of value. The fact that this has been the subject of studies over a considerable period of time would indicate that it has been a longstanding issue which has not been resolved.

It is GPs who are seen as playing a vital role as the gate keepers to secondary care (Hogan 2000) and in the UK substantial variation exists in emergency admission rates between general practices (Reid et al. 1999). Differences in GP emergency admission rates are seen as complex and multi-factorial reflecting a combination of factors such as bed availability and the behaviours of both GPs and hospital doctors (Blatchford et al. 1997). GPs either influence or determine the nature of care and site of death of dying people in care homes (Katz 2003) and they decide whether dying residents are admitted to hospital or alternatively if they are willing to retain dying residents in the home which means them taking responsibility for their total care needs. Very little is documented on their attitudes
to providing care for dying care home residents. In a study (Avis et al. 1999) district nurses reported that not only did GPs lack basic knowledge about palliative care but they also misjudged the capability of care home staff.

Fox (1995) suggested that reasons why GPs are less willing or able to follow cases include increased workload, increased sophistication of medical technology and the threat of litigation and patient expectations. This was also highlighted in a report by the National Association of Medical Managers (cited in Payne 1996:18) which attributed an increase in acute admissions to a combination of higher expectations of patients and GP’s feeling less able or willing to cope with seriously ill patients. The Health Protection Agency (HPA 2005) in the context of emergency hospital admissions due to influenza, reported GPs being increasingly cautious as they felt potentially vulnerable to criticism if they did not admit patients to hospital where oxygen and resuscitation facilities are immediately available.

When judged by consultants or against agreed guidelines 10% and 15% of referrals from primary to secondary care were considered inappropriate. Some inappropriate referrals have been ascribed to lack of alternative services or poor communication between the hospital and GP (Jones Elwyn & Stott 1994). GPs on
a Royal College of Physicians Working Group (Houghton & Hopkins 1996) reported that situations leading to potentially inappropriate referral to secondary care included difficulty contacting junior doctors on call and the inability to contact consultants for advice.

2.7 User involvement

In recent years guidance on obtaining feedback from patients and involving them in improving services has been an increasing focus (DH 2000a; NHS Modernisation Agency 2002) as a patient-centred healthcare service can only be achieved if the needs, concerns and views of patients are taken into account (Healthcare Commission 2004). This emphasis reflects a broader focus in society on the participatory rights and responsibilities of citizenship and participatory democracy (Braye 2002). It has been identified through considerable experience that patients want shared decisions and respect for their preferences, smooth transitions and continuity of care (Picker 2007b). Although it has been acknowledged that older people may not have the expectation to be consulted or the desire to be empowered in this way as traditionally they have trusted professionals with their care the "doctor knows best" scenario prevailing (Bernard 2007).
But older people should be involved as citizens and not just as users of care services and strategic approaches must involve older people as partners from the start. The Healthcare Commission (2004) suggest that a range of different means is needed to involve them especially those whose voices are seldom heard. Older people in care homes are amongst the most vulnerable and should have choice and a voice (Bernard 2007). But the King's Fund is of the opinion, in relation to the care home sector

"The focus is frequently on outputs and activities rather than outcomes valued by older people." (Banks 2007:6)

Guidance from the Change Agent Team states that the approach to avoiding and diverting admissions to hospital should include a jointly agreed older people's strategy and that "it is vital that this strategy includes user and carer input." (DH 2004d:3). As a local strategy is an intended outcome of the current research residents who have had emergency hospital admissions and nursing home managers views are considered essential. A failure to accept the validity of patient views has been reported (Social Care Institute for Excellence 2004) and the Commission for Healthcare Inspection (2004) found that patient and public involvement seldom informed PCTs' commissioning decisions. So despite user involvement being national government policy it can not be assumed that their views will have the intended outcome.
2.8 Gaps in the literature

There has been little research into the health care, care home residents receive. The reasons residents are admitted to hospital as emergencies is unclear as there is no national data on care home resident hospital admissions and few UK studies have been identified (Appendix 1). The only information available to localities is the HES data base which provides a snapshot rather than a full picture of admissions and the surrounding circumstances. There is no evidence that UK care home residents have ever been consulted about their views on or experiences of hospital admission as published studies have been limited to studies of medical records.

2.9 Conclusion

Despite the many policy initiatives since 2000 whose aims included reducing reliance on secondary care, their impact is questionable as hospital admissions continue to rise. There is evidence from some localities that admission avoidance initiatives have been successful and other countries have had success in reducing admissions of nursing home residents.

Care home residents have substantial and complex needs and GPs provide medical care, but concerns have been raised about their capacity to manage this
workload and residents' access to specialist services is limited. There is a consensus that care homes are inadequately supported by primary care and reports that residents are admitted to hospital as emergencies in order to access care.

Although residents have reported high levels of satisfaction with the care they receive continuing concerns have been expressed about standards. Care homes have been slow to adopt advance care planning and national end of life care tools and although residents have been found to choose death at home instead of hospital, concerns have been expressed about end of life care in care homes. Although dementia affects two thirds of care home residents none of the policy documents aimed at improving the care of older people and hospital admission avoidance mention dementia and few care home staff or GPs have had specialist training in dementia care. Palliative rather than curative approaches to the treatment of advanced dementia are widely advocated.

Although there is a lack of UK research in the field, the evidence available suggests there is the potential for more of the health care needs of nursing home residents being met outside secondary care, avoiding some admissions. New approaches will need to be developed within care homes and within primary care
to meet the needs of care home residents and avoid further increases in the use of secondary care.

2.10 Research question

The research questions to be answered by this study are:

What factors lead older people in nursing homes to be admitted to hospital as emergencies?

Secondary research question;

How do residents and their nursing home managers view their hospital admissions?

2.11 Purpose of the study

In line with national government policy the local NHS primary Care Trust is required to reduce avoidable emergency hospital admissions (DH2005a). The intended outcome of the research is to inform a local hospital admission avoidance strategy by identifying how the needs of nursing home residents can be best met and their emergency hospital admissions avoided. It is the aim of the researcher that the strategy developed will be resident centred so obtaining residents views are an important part to the study. This achieves the ‘user input’ suggested by the Department of Health (DH 2004d) when admission avoidance
policies are being developed. The participation of residents and nursing home managers will provide users and carers’ perspectives on the health care provision within the nursing home, the experience and outcomes of hospital admission and their opinions on hospital admission avoidance, including personal preferences. This research could potentially lead to a reduction in the number of emergency hospital admissions and the number of bed days occupied by identifying changes in practice and services required to best meet resident’s needs and preferences.
CHAPTER 3 METHODOLOGY

3.1 Introduction
This chapter discusses the theoretical principles underpinning the study. Various theoretical models are explored to identify a suitable theoretical framework for the study. The methodology chosen for the study is explained.

3.2 Theoretical perspectives
An interrelationship exists between the theoretical stance adopted by the researcher and the methodology and methods used (Crotty 2003). For this study an inductive approach has been adopted as this paradigm of enquiry does not set out to corroborate or falsify a theory: it attempts to establish patterns, consistencies and meanings (Gray 2004). Data are analysed to see if any patterns emerge that suggest relationships between variables with the aim of constructing generalisations and relationships that move the researcher towards discovering a binding principle. To ensure reliability the researcher uses multiple cases (Gray 2004).

In order to clarify a research design various epistemological perspectives were explored. As social constructivism emphasises the importance of culture and context in understanding what occurs in society and constructing knowledge
based on this understanding (McMahon 1997), this was the philosophical perspective adopted for the study. Constructivism proposes that 'truth and meaning do not exist in some external world, but are created by the subject's interactions with the world' (Gray 2004:17). From this stance subjects construct their own meanings through their social interactions with each other and the objects in the environment (Crotty 2003).

A theoretical paradigm linked to constructivism is interpretivism (Gray 2004) which is a major anti-positivist stance which looks for "culturally derived and historically situated interpretations of the social world" (Crotty 1998:67). The interpretive process is considered particularly useful when little is known about the phenomenon under review and the aim of the study is to understand something in context (Benton 2000) by studying phenomenon in their natural environment (Green and Thorogood 2004).

An example of the interpretivist approach is symbolic interactionism. It is derived from the work of George Herbert Mead who aimed to develop a way of conceptualising human behaviour that focused on people's practices and lived realities, although it was Herbert Blumer who coined the term (Gray 2004). Blumer (1969) summarised the perspective as people act towards things based
on the meaning those things have for them; and these meanings are derived from social interaction and modified through interpretation. Thus meanings are not fixed or stable but are revised on the basis of experience.

In order to understand the process the researcher is required to study the subject’s actions, objects and society from the perspective of the subject themselves which in practice means discovering first-hand what is happening. As the focus in this study is on meanings and understanding what is happening using multiple methods to establish different views of a phenomenon, using small samples researched in depth or over time, in order to construct theories or models is suggested (Gray 2004).

Interpretivism characterizes much qualitative health research related to understanding phenomena such as symptoms and health behaviours for people (Green and Thorogood 2004) and was considered the most suitable approach to answering the research question. It is considered to fit with what Morse (1992) describes as an interpretive study characterised by three main features; the emic (individual) perspective, the holistic perspective and an inductive interactive approach of inquiry between the researcher and the data.
3.3 Theoretical framework

A theoretical framework provides a supporting structure that can offer ways to evaluate and explain problems, provide meaning and understanding while facilitating meaning of the data (Klein & Zedeck 2004). Various models were explored to identify a suitable framework in which to consider the research study.

3.3.1 Bio-medical model

Firstly the bio-medical model was considered as it is a dominant model of disease in the UK and is the model of care that is still the predominate means of providing healthcare to older people in continuing care settings (Blackwell Group 2005) as this study relates to hospital admission, medicine is a key consideration. The bio-medical model is based on the assumption that disease is generated by specific aetiological agents which lead to changes in the body’s structure and function (Bowling 2002). In this model medicine is perceived as viewing the body as a machine where malfunctions can be repaired or replaced and the disease treated but not the illness which is the subjective experience of the dysfunction. The concept of wellness is particularly stressed with the state of being in good health accompanied by good quality of life and strong relationships (Lakhan 2006). There have been many challenges to the traditional medical model as it focuses too narrowly on the body and on technology (Bowling 2002) rather than people in the social context in which they live (Lakhan 2006). Although medical
care is important it is suggested that this approach does not meet the holistic needs of older people who are care home residents especially when they are coming near to the end of their lives and have multiple pathologies including dementia. A model that emphasises the socio-cultural aspects of care might be more appropriate.

3.3.2 Social Model of Continuing Care

Alternatively the social model focuses on improving the quality of life for residents living in the facility by endeavouring to create a full and meaningful life for each person (Blackwell Group 2005). Applying the social model to residents with serious health problems requires changes to the attitudes, roles and expectations of residents, families and staff and mechanisms should be in place to assist residents with short term health crisis so that they don't have to leave the home for treatment (Blackwell Group 2005). Within the social model of continuing care death is treated as a normal part of life, unlike the medical model and staff working with dying residents and their families identify and help meet their needs while continuing to support the resident group (Blackwell Group 2005). There is the perception that care homes have adopted a social model, however, there have been concerns expressed that the focus on health care may be compromised as a result (Mulley 2007b).
A central plank of the NHS Plan (DH2000a) is the provision of good medical care which is patient-centred and focuses on treating people as individuals with respect for their dignity. It also includes people having a greater say in the NHS and services centred on their needs. A model that encompasses both health and social care is suggested as it combines the meeting of both health and social care needs.

3.3.3 Person-centred care model

A 'person-centred' approach to care facilitates meeting both health and social care needs. Person-centred means different things to different people, for example individualised care, a value base or a phenomenological perspective (Brooker 2007). A contemporary definition by Brooker (2004) suggests person-centred care includes four elements; valuing people, treating people as individuals, looking at the world from the perspective of the person and recognising that all human life is grounded in relationships.

Kitwood's (1988) work on dementia grew out of disillusionment with the limits of the bio-medical approach to care and argued that as medicine was focused almost exclusively on cure it neglected those whose condition was not amenable to cure (Small et al. 2007). It has been remarkably influential and has
engendered a new ethos of care for all older people, which recognises that the medical model although making important contribution has limitations (Nolan et al. 2001).

Person-centred care as developed by Kitwood (1988) drew on Roger's (1961) work on client-centred psychotherapy, an approach that derived its values from existential phenomenology rather than objectification, hierarchy and difference (Small et al. 2007). This client-centred approach involved a deliberate attempt to create a new balance of power, control and responsibility between therapist and client (Morton 1999). Similarly in focusing on the person, person-centred care moves away from an overtly pathological model and provides a therapeutic rationale for staff (Kitwood 1988). This involves practitioners attempting to understand the experience of illness and disability rather than simply being able to identify symptoms and cause of disease and learning to see the person behind the condition (Nolan 2000). Kitwood's theory (Kitwood 1988), was underpinned by the need to rebalance the technical framing of dementia from the dominance of the 'medical model' to complementing it with a philosophy that was constructed from 'personhood' and 'person-centred' values.
This led to work on individualised care planning by those working in services for older people who were concerned to understand the people they cared for at a deeper level (Brooker 2007). It is suggested that advance care planning is integral to person-centred health care because it ensures a person's right to participate in future healthcare choices and in end of life decision making (IOELC 2008; Butterworth et al. 2008). Interestingly, person-centred care is not mentioned in the National Minimum Standards, Care Home Regulations for Care Homes for Older People (DH 2003a). Although there is an emphasis on an individual approach to health and social care and a focus on privacy and dignity the person-centred approach is not explicit.

In order to deliver person-centred care Liaschenko (1997) suggests that person-centred knowledge is required. It is defined as comprising 'case knowledge' combining biomedical knowledge of a particular medical condition, 'patient knowledge' of the case to understand the impact of the condition on the individual and 'person knowledge' based on understanding the person in the context of their life (Liaschenko 1997). This combination of knowledge is required in long-term therapeutic relationships (Liaschenko 1997) like those required in care homes if person-centred care is to be achieved. Therefore, it is suggested that while care home staff may possess all three types of person-centred knowledge doctors, especially those from out of hours services who have not met the older person,
base admission decisions on 'case knowledge' unless they engage with residents and care home staff.

Nolan et al. (2001) suggest that an integrated policy framework that unites the perspectives of all those involved is what is needed for person-centred care is to be realised. Such an integrated policy framework has been progressed through the National Service Framework for Older People (DH 2001a). Person-centred care is enshrined as one of its key principles (Small et al. 2007) and it states that all older people should be treated as individuals and receive appropriate care that is arranged around their needs. There is a specific focus on assessment and its value in hospital admission avoidance. Dignity in end-of-life care is stressed and includes older people having choice about treatments and care options, access to specialist palliative care teams and support to remain in their homes until death if that is their wish.

Prior to the implementation of the NSF (DH 2001a) Clark (1995) found that although person-centred care was expounded in the policy rhetoric realising such an ethos requires a reorientation of professional practice where an understanding of the experience of illness is cultivated rather than simply the disease. Brooker (2007) suggests that it is a mark of success that person-centred care is now the
way we talk about appropriate care provision in the UK but acknowledges that it is a challenge to get it into everyday practice. Following the review of this model of care it is suggested that it is an appropriate approach to the care of all older people in care homes.

Care homes have been described as; “complex systems where people are both living and dying, and there is a need to develop a culture of care which values both.” (Help the Aged 2006:56)

As the majority of older people who live in nursing homes, die in nursing homes, often over an extended period, it is suggested that a combined person-centred and palliative model would address both quality of life and a ‘good death’. When the person-centred model was evaluated against a palliative care model the matching of the paradigms was clear as both are motivated by concern for the person rather than the diagnosis (Hughes et al. 2006). An illustration of how a palliative care approach (Hughes et al. 2006) can be mapped on to person-centred care is shown in Table 3.1.
Table 3.1 Psychological needs of people with dementia and aspects of palliative care (Hughes et al. 2006:8)

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<tr>
<td>Attachment</td>
<td>Support to person &amp; family</td>
<td>Importance of sensitive communication</td>
</tr>
<tr>
<td>Comfort</td>
<td>Symptom control</td>
<td>Quality of life</td>
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<tr>
<td>Identity</td>
<td>Integration of psychological, social and spiritual aspects</td>
<td>Whole person approach</td>
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<tr>
<td>Occupation</td>
<td>Affirmation of life</td>
<td>Respect for autonomy</td>
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<tr>
<td>Inclusion</td>
<td>Support to person &amp; family</td>
<td>Care of person and family</td>
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A model relating specifically to care home residents may be helpful as it illustrates the type of person-centred approach required depending on where individual residents are on the life-death continuum. One such model is that of Travis et al. (2001).

3.3.4 Living-Dying Model

A living-dying model (Table 3.2) (Travis et al. 2001) suggests that most permanent care home residents are in what they describe as a ‘Living-Dying’ state and acknowledging this trajectory allows for the blending of active treatment with palliative care.
Table 3.2 Living–dying in long-term care. Source Travis et al. (2001:154)

<table>
<thead>
<tr>
<th>Intervals in a resident’s Living-Dying trajectory</th>
<th>Treatment modality</th>
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<tr>
<td>Living</td>
<td>Active treatment</td>
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<tr>
<td>Living – dying (point at which most permanently placed residents enter nursing home care)</td>
<td>Blended care (active treatment and palliative care) ↔ Hospitalisation or other aggressive curative care may be appropriate</td>
</tr>
<tr>
<td>Dying</td>
<td>Transitional care concluding with a palliative plan of care focusing on symptom management</td>
</tr>
<tr>
<td>Death</td>
<td>Palliative care with specialized hospice care to manage the final transition for the resident and family</td>
</tr>
</tbody>
</table>

Sidell and Komaromy (2003) point out that this model avoids making artificial distinctions between living and dying and suggest if care homes operate with a longer notion of dying trajectories the scope for applying palliative care in its broadest sense would be facilitated. They suggest this would help residents who suffer from debilitating chronic illnesses and avoid the sometimes unseemly and traumatic act of transferring someone out of the home at the point of death. It is suggested that the Living-Dying Model (Travis et al. 2001) is useful for care homes as it highlights appropriate care approaches to meet changing individual resident’s needs and the avoidance of inappropriate emergency admissions to hospital.
3.3.5 Conclusion

This review of theoretical models indicates that an integrated person-centred and palliative care model would facilitate both quality of life and 'good deaths' (DH2008c) for nursing home residents. It is therefore considered the appropriate approach to the care of nursing home residents and been adopted as the theoretical framework for this study and has informed the design and methods.

3.4 Mixed Methods

Methodology refers to the strategy or overall approach chosen to answer a research question (Holloway & Walker 2000; Potter 1996) and for this study mixed methods was considered the most suitable strategy. This approach has a long history and continues to be advocated (Coyle & Williams 2000; Mactavish & Schleien 2000; Creswell 2002; Maggs-Rapport 2000). The integration of qualitative and quantitative research methods is one of the cross-cutting methodological themes in the Medical Research Council Health Services Research Collaboration (Adamson 2005). Creswell (2002) argues that only using qualitative or qualitative falls short of today's approaches.

However, the appropriateness of using a mixed method approach has led to considerable debate in the literature. According to traditional views each
It is now the view of most researchers that both methods can be used in a complementary way and that it is the research question that is of the utmost importance (Teddie & Tashakkori 2003). This is over and above the choice of method or the paradigm that underlies the method and it is suggested that pragmatism may have greater resonance with more applied areas of research, including health services research (Teddie & Tashakkori 2003). In the light of the above discussion the researcher selects the method which best suits the task in hand (Adamson 2005).
As the mixed method approach offered both a broader and a more detailed picture of the phenomenon to be studied it was considered the most appropriate to answer the research question and was therefore the chosen methodology for this study. Data sources included; quantitative data from HES data, qualitative from semi-structured interviews and a combination of quantitative and qualitative from case studies. Combining methods provided an overview of the phenomenon across the locality, an in depth view of one site and individuals perspectives and experiences.

Quantitative data is often described as providing information on 'what' happens (Young 2004) while qualitative data can provide answers to 'why' it might happen. In this study quantitative data from the HES database provided an overview of the scale and range of the issues associated with hospital admission and qualitative the insight into why admissions took place. By combining these two approaches it was hoped voice would be given to both validated clinical meaning of the subject and shared views and values of participants own experiences and avoid the shortcomings of singular methodologies (Young 2004).

Integrating different methods requires equal weight being given to each (Moran - Ellis et al. 2006); but although this study has combined quantitative and
qualitative approaches it was not the expectation that both would make an equal contribution to understanding the phenomenon. Instead methods were combined as one is seen to support or explain the findings of the other with the intention of giving added depth and quality to the findings (Moran-Ellis et al. 2006).

3.5 Qualitative methodology
A qualitative approach is most appropriate when answers to what, how and why questions about social aspects of health, illness or healthcare are required (Green and Thorogood 2004) especially studies that focus on meaning with flexible research strategies. Qualitative methods aimed at achieving detailed or 'thick' description rather than explanation are particularly suited to informing health service planning and policy (Green and Thorogood 2004). This is due to their ability to answer important questions that cannot be answered solely from a quantitative perspective for example the process and meaning of interventions for those providing and receiving them (Green and Thorogood 2004). Qualitative approaches have been found to be well suited to identifying the concerns and priorities of patients and to facilitate the promotion of their interests to the extent that the qualitative researcher in healthcare is in a sense the patients’ advocate (Dixon-Woods et al. 2005). Therefore qualitative approaches were considered suitable for this study as the views of residents were particularly important so that
the outcome of informing a local hospital admission avoidance strategy would include a 'user' perspective.

In the past user involvement has adopted a user satisfaction with services approach and instead an approach exploring user experience is advocated (Picker 2007b). User experience captured by qualitative research provides the opportunity to uncover those areas which patients themselves are most keen to talk about. It is pointed out that these approaches that break down the patient experience into detailed reporting on what happened with a particular provider at a specific point in time provides results that are factual rather than evaluative. This enables a patient to reflect their good experience of the service as a whole, or of constituent parts of it, while also reporting those elements that provided a poorer experience. In this way, even a very satisfied patient can contribute to identifying areas for service improvement (Picker 2007b). The approach advocated by Picker (2007b) is adopted by the researcher in the current study.

3.6 Quantitative methodology

Although the methodology in this study was predominately qualitative, quantitative elements of data collection also formed an important part of this study. Silverman (2006) suggested that one of the main ways to combine
quantitative and qualitative research is engaging in a qualitative study which uses quantitative data to locate the results in a broader context. In this study PCT wide hospital episode data was used to contextualise the nursing home study. Hospital admission questionnaires and interviews also yielded quantitative data and as Silverman (2006) suggests simple quantitative tabulations have been used as it is a means of achieving greater validity in a qualitative study.
CHAPTER 4 METHODS

4.1. Introduction

The design of the study can be considered the structural framework for implementing a research project as it is concerned with converting research questions into projects (Robson 2002). This research is made up of three component parts;

1. Local Hospital Episode Statistics (HES) data analysis
2. Case studies of the hospital admission activity of one nursing home for a year
3. Interviews with nursing home residents following hospital admissions

The HES data for 2003-2004 was analysed at the end of 2004 and this contributed to establishing the justification for the research. The data for 2004-2005 were analysed simultaneously with parts two and three of the study during 2006.

Parts of the study Table 4.1

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
</tr>
</thead>
</table>
      | Literature search  
      | Research proposal |
| 2006 | Data collection and analysis  
      | Part 2 Case studies  
      | Part 3 Resident interviews |
| 2007 | Writing up  
      | Literature review updated  
      | New areas added in light of study findings |
| 2008 | Further literature review to inform discussion |

The combination of these three separate approaches was considered the most appropriate in answering the research question as they provide an overview of
local care home admissions, in depth insight into the issues surrounding admissions and the user perspectives of residents and the views of their managers. The intention was that together these three components would provide a comprehensive picture of the issues which then could be used to inform a resident centred admission avoidance strategy. The methods used in the study will be described following the three parts of the study and will be referred to as 'HES data', 'case studies' and 'resident interviews.'

4.2. HES Data

For the first part of the study retrospective hospital episode statistics data for all 10 care homes within the Primary Care Trust for the preceding two years (2003-2004 and 2004-2005) was used to provide an overview of the issue. This is a means of identifying how often health-related events occur in different groups of people which is useful for example in assessing the usage of health care interventions by particular client groups and in monitoring variations between localities (Martin 2005). Computerised hospital discharge registers, known in England as the Hospital Episodes Statistics (HES) database captures all episodes of inpatient care in the NHS and records administrative, admission and clinical details. The HES database identified the care home residents by post code and the data was used to establish a baseline for particular characteristics.
and the rationale for repeating the exercise a second year was to allow comparisons to be made and help identify normal patterns and variations.

4.3 Case studies

The second part of the research was a prospective study as it was felt that obtaining detailed information on all nursing home admissions from one local nursing home over a one year period would provide insight into what happened currently. By identifying the background and factors that led to hospital admissions the researcher aimed to consider how some admissions could potentially be avoided. As the aim of case study research is to develop as full a picture as possible of a setting or events (Pontin 2000a) it was considered an ideal approach.

A case study is described as

"an empirical inquiry that investigates a contemporary phenomenon within a real-life context" (Yin 2003; 13).

Yin (2003) suggests that the larger the number of cases that can be studied the better as this contributes to the generalisability of findings. Each resident who had an emergency hospital admission formed an individual case study and as seventeen residents were admitted to hospital, this provided opportunities for comparisons between cases. Case studies involve working with a variety of data
sources (Pontin 2000a) which in the case of this study was documentary analysis to complete resident admission questionnaires and interviews with the nursing home manager.

4.3.1 Hospital Admission Questionnaire
The use of a questionnaire is suggested when facts and information on experiences are required and the demographic information is useful on constructing profiles of participants and exploring their correlation with other attributes (Parahoo 2006). The Hospital Admission Questionnaire (Appendix 2) collected both quantitative and qualitative data on each of the nineteen hospital admissions from one nursing home over a one year period. It was developed by the researcher to provide detailed information on each person as an individual, their nursing home admission and stay, their hospital admission and the outcome.

As it was administered by the researcher it was possible to extract descriptive material from individuals nursing home records which contributed to understanding of the phenomenon and meant direct quotes could be taken from records which can be illuminating. Records are a valuable source of data in retrospective health care research (Parahoo 2006) and the Hospital Admission...
Questionnaire was a useful tool to record the information pertinent to the study and this format facilitated data analysis.

4.3.2 Interviews with Nursing Home Manager

Interviews were conducted with the manager of the nursing home on each of the nineteen hospital admissions during the one year period to obtain her views on the admissions and suggestions on hospital admission avoidance. This was an additional research strategy adopted in order to gain the fullest picture of the admission activity of a typical local nursing home. The manager is the ideal person to involve as she has a thorough knowledge of residents and a good understanding of primary and secondary care systems and drivers for change. This opportunity was also used to discuss any queries of the researcher's from the completion of questionnaires. As the same information was being collected on each admission a semi structured interview guide was used (Appendix 3).

4.4 Interviews with residents

In order to successfully engage with older people researchers must ensure that their project truly reflects their concerns (Mountain 2003). Little is known about how nursing home residents view their experience of hospital admissions as no published studies of admissions have been identified which included the views of
the client group. As hospitalisation has known risks and is perceived as being something which they may prefer to avoid it was anticipated that they would welcome the opportunity to express their views. Holloway et al. (1998) suggest that in order to understand hospitalization it is logical to ask patients about their experiences.

By consulting the group being researched and considering them as part of the process, rather than making assumptions about what is relevant for them, enables research to truly benefit those on whom it focuses (Edwards et al. 2003). Barnes (1997) stresses that involving older people in research into services for them, provides a feeling of inclusion, promotes citizenship and makes participants feel empowered. Empowerment is an abstract concept that is considered fundamentally positive (Kuokkanen & Leino-Kilpi 2000).

It is the intention that involving nursing home residents will enrich the study findings by the researcher being more reflective and responsive to their concerns (Bright & Green 2003). It is important that key stakeholders have a voice (DH 2004d) and interviewing them provides the opportunity for them to influence the hospital admission avoidance strategy to be developed using the results of this study.
Interviewing different people with different experiences means that emergent categories and themes may be used to develop theories about people's experiences of health and illness and hospital admission from which analytical generalizations may be made (Strauss & Corbin 1990). While it is hoped that this study will benefit the wider community of nursing home residents in the future, there is the potential that individual participants would derive some benefit, for example some may enjoy the attention and the opportunity to tell their story.

As well conducted interviews is a powerful tool for eliciting rich data on people's views, attitudes and meanings that underpin their lives and behaviours (Williams & Keady 2008) this methodology was chosen as the views of nursing home residents were important to achieving the aims of this study. Interviews are a suitable research method as participants can give a considered verbal response when they may be less likely to commit themselves in writing if they feel the information is confidential (Gray 2004). As well as being a means of gathering information about a person's values, preferences and attitudes they can identify variables and relationships (Cohen & Manion 1997) and be used with other research techniques to follow up on issues.
A semi-structured interview guide was used as this approach facilitates interviewees recounting their experiences on the topics the interviewer wishes to cover (Jackson et al. 2008)). It allows for the probing of views and opinions where it is desirable for respondents to expand their answers when the objective is to explore subjective meanings that respondents ascribe to concepts or events (Gray 2004). The interview process provides opportunities for respondents to be asked to clarify what they have said (Gray 2004). Issues arising that may not have been anticipated can be pursued (Pontin 2000b) while not originally part of the interview schedule, help towards meeting research objectives. The language used in the semi-structured interview guide (Appendix 4) was designed to not be either over complicated or simplistic in order to encourage interviewees to give full and appropriate answers to the questions (Barriball & While 1994).

Skill is required in order to encourage interviewees to tell their stories to ensure that full and representative data are collected during the interview (Hammersley & Atkinson 1995). As the researcher is an experienced nurse working with older people and skilled in the communication with this client group, problems in establishing and maintaining rapport were not an issue. Although interviewing is a time consuming research method (Pontin 2000b) the sample size of thirteen meant it was manageable.
4.5 Sampling

Purposive sampling which means explicitly selecting participants who it is intended will generate appropriate data (Green & Thorogood 2004) was the approach adopted. The initial intention was that all residents from one nursing home who were admitted to hospital during the data collection period would form a comprehensive sample. Based on hospital admission data for 2003 – 2004 the number of potential participants was likely to range between 12 and 16 over a six month period. However, it became apparent that even by extending the time for data collection a sufficient sample would not be available from the nursing home identified as the research site. (Although 17 residents were admitted to hospital during the twelve month period only two met the inclusion criteria). Therefore in order to achieve an adequate sample, following ethical review, three other local nursing homes were added as research sites which yielded a total of 13 interview participants. As a result four out of the six local nursing homes became part of the study and included participants from private, NHS and voluntary homes.

Sample

As each emergency hospital admission from the nursing home formed a case study (Part 2 of the study), this was a comprehensive sample as all of the residents who were admitted to hospital over a one year period were included. This meant the entire hospital admission activity of a nursing home could be
studied. This was considered a sufficiently long time scale and facilitated capturing any seasonal variations and generated enough case studies to provide insight into nursing home admission activity.

Small samples are adequate for qualitative studies (Parahoo 2006) although it is suggested that it is the purpose for which the sample is required that dictates the size. Therefore a sample size of 12-14 was considered appropriate for interviews with residents (Part 3 of the study). The inclusion criteria was all residents who had emergency hospital admissions and were well enough to be considered as interview participants and had the capacity to give informed consent. The final part of the sample was the nursing home managers of the four nursing homes whose residents were the thirteen interview participants. They consented to their homes being research sites, agreed to being interviewed and demonstrated commitment to the project. As this meant that four of the six local nursing home managers contributed their views on hospital admissions and as they represented the private and voluntary sectors and the NHS this sample was also suitable.
4.5.2 Sampling sites

The sampling site for the Hospital Episode Statistics data (Part 1 of the study) was a North West London NHS Primary Care Trust which is not identified to maintain confidentiality and the hospital episode data was analysed for admissions for all 10 care homes within the locality of the PCT.

The site of the case studies (Part 2 of the study) was a well established private nursing home operated by a major national provider and the home and the organisation were supportive of the study. It is registered with the Commission for Social Care Inspection (CSCI) for 35 ‘physically disabled elderly’ and the local PCT contracts a proportion of the beds for NHS continuing care for local residents and the remainder are occupied by privately funded residents. One local GP practice is contracted to provide medical care to all of the residents holds a weekly ‘surgery’ at the home by a designated partner in the practice and visits from other GPs from the practice on a call out basis. The PCT provided the Out of Hours GP service. Although there are many factors making each home unique this home was selected as it was perceived as being a fairly typical nursing home.
The sampling sites for the interviews with residents (Part 3 of the study) were four local nursing homes. One was the home in the nursing home study described above and another a 61 bed private home operated by one of the largest national care home providers with most residents being privately funded and a few NHS continuing care funded. Another was a 39 bed NHS nursing home operated by the local PCT to provide NHS continuing care and the fourth was a 50 bed home run by a national charity. The two private and one NHS home had similar medical arrangements and the fourth home run by the charity had its own in house medical provision.

4.6 The Role of the Researcher
At the time of the nursing home study the researcher was employed by the local PCT as a consultant nurse for older people and had a role in monitoring the PCT contract with the nursing home which formed Part 2 of the study. This meant there was already a well established professional relationship with the home that supported access and co-operation. As the researcher also has considerable experience in the private nursing home sector she had professional credibility with the home manager and staff. By the time the interviews were undertaken with residents of the other three homes the researcher was no longer an employee of the PCT but herself a nursing home manager. As her previous role had included contact with two of the other three homes good professional
relationships, with the nursing home managers had been established. Although the fourth home did not have involvement with the PCT the researcher and home manager were known to each other professionally which facilitated support.

4.7 Ethical considerations

Ethical approval for the study was obtained from the Central Office of Research Ethics Committee (COREC) and the University of Surrey Ethics Committee. Copies of approval letters are found in Appendix (12)

In planning and conducting the research consideration was giving to the four main ethical principles of autonomy, non-maleficence, beneficence and justice (Beauchamp & Childress 2001). Autonomy refers to freedom of the individual to make independent decisions and the principle includes being honest, respecting privacy, maintaining confidentiality of information and gaining consent. The information sheet was designed to help potential interviewees make an informed choice to participation and nursing home managers were involved in gaining consent to eliminate any possibility of coercion by the researcher. Data were securely stored and coded to maintain participant confidentiality by allocating a letter to identify each home and a number to each participant. Non-maleficence means not intentionally allowing risk or harm to another. Therefore at any
indication of a participant being upset in any way interviews would be immediately terminated. Beneficence includes respect for autonomy, avoidance of harm and contributing to the welfare of others. Interviewees were reassured that it was their perogative to change their mind about participation at any time and this would have no effect on their treatment and care.

The researcher negotiated access to the nursing home residents and their records via the nursing home managers. As the nursing home managers are registered nurses bound by the Nursing and Midwifery Council Code of Conduct (NMC 2004) there was a requirement to handle issues arising as a result of research with professional integrity. The researcher was aware of her responsibility to ensure that participants received appropriate care while involved in research and of reporting adverse events or suspected misconduct through appropriate systems (DH 2005c).

4.7.1. Issues of Consent

While significant numbers of nursing home residents may have a degree of cognitive impairment (Forsyth 2007; CSCI 2008), it was expected they many would nevertheless be able to participate in interviews. The researcher adopted a similar stance to that of the RCN who consider it improper to readily dismiss their
intellectual ability as the majority of older people who demonstrate confusion are rarely confused about everything (RCN 2004b). It is acknowledged that while undertaking research ethically with vulnerable groups is difficult, they are often 'invisible' in research, which places extra demands on researchers to involve, but also protect those involved in studies (RCN 2004b).

The researcher was concerned that unequal distribution of research participation violates the ethical principle of justice and under representation of this group of older adults not only decreases the generalisability of results to the group but also limits the relevance of research findings (Crane et al. 2004). In view of these concerns and to enhance the participation of groups who cannot give informed consent to research involvement an additional question about who applicants propose would give consent on behalf of an incapacitated adult was added to COREC forms (COREC 2005). Yet by law no adult can give consent on behalf of another adult incapable of giving consent although those close to the incapacitated person should be involved in decision making, unless the older person had made it clear earlier that they did not wish such involvement (DH 2001b). As an alternative gaining 'negotiated' consent in research with older people with mental health problems, including those with dementia, has been suggested (Grout 2004). This is a triad approach involving the older person, a relative and a staff member. The competence of the research subject to make the
decision is influenced by the complexity of the information, the level of the
decision required and their capacity to comprehend and make a decision (Cable
et al. 2003).

In the case of this study as the consent required was for residents to be
interviewed about their recent hospital admission, it was considered likely that
some residents could consent to this. It was proposed that when issues of
capacity arose that they would be discussed on an individual basis with the
resident, nursing home nurse and next of kin/significant other, and the researcher
informed accordingly to avoid any potential for research coercion and protect the
vulnerable participant.

As the researcher was keen to include the voices of those not often heard and
ensure the research findings were as representative of the nursing home
population as possible using a negotiated consent approach for potential
participants who were unable to give informed consent was proposed. Although
in this way consent could have been ethically obtained for potential participants
who were unable to give informed consent, it did not achieve local ethical
approval. Although the NHS Ethics Committee (COREC) considered negotiated
consent a laudable approach they were of the opinion that the inclusion of
research subjects who lacked capacity could invalidate the research as they could not be considered reliable witnesses. This was a valid opinion which had to be reluctantly adhered to but meant that the vast majority of nursing home residents could not be included in the study. This demonstrates the difficulty in conducting research in nursing homes that is representative of the client group.

Three days after discharge from hospital, residents who met the inclusion criteria were given the information leaflet (Appendix 5) explaining the study. About a week after hospital discharge the researcher visited each of the residents to introduce herself and provide verbal information about their proposed involvement in the project. A convenient date and time was agreed for the interview to take place within the following two weeks. This time scale was considered appropriate as it was soon enough for the hospital admission experience to still be fresh in participants' minds yet it allowed them time to reconsider all the information.

Consent was obtained using a consent form (Appendix 6) prior to the commencement of each interview. It was anticipated that some participants may have reservations about the use of the tape recorder to record their interviews but all agreed without hesitation. Consent forms were signed by the researcher as
well as the participant and witnessed by a member of nursing home staff. Copies of consent forms were retained by participants and filed in their individual nursing home records. Although they all consented to being interviewed they were reassured that they could withdraw their consent at any time or ask to have the tape recorder turned off.

Despite all participants expressed willingness to participate the researcher was mindful that being reminded of recent events, especially if they included unhappy memories related to health problems surrounding their admission, could potentially cause anxiety and distress. It had already been agreed that interviews would be terminated at the first sign of distress and with the permission of participants the home manager or deputy were identified as the named persons to deal with issues arising from interviews. Fortunately no incidences occurred making this necessary.

4.7.2 Confidentiality

Participating homes and residents were assured that the identity of the nursing homes or participants would not be disclosed. Residents' names were not recorded on tape recordings of interviews; instead each recording was coded and participants were assured that tapes would be destroyed at the end of the study.
Residents and home managers were interviewed in private to ensure confidentiality within the nursing homes.

4.8 Data collection

4.8.1 HES Data (Part 1 of the study)
This data was supplied by the Primary Care Trust Information Management department on the request of the researcher as this was facilitated by the support of the Chief Executive of the PCT for the project, as it was of interest to the organisation.

4.8.2 Case studies (Part 2 of the study)
Following research ethics approval being granted the study was discussed in depth with the nursing home staff and nurses confirmed their support and willingness to fulfil their proposed role in data collection. (The manager was already familiar with the study and had agreed to the home being a research site prior to the ethics application).

The GP practice which the residents were registered with was informed by letter (Appendix 7) of the proposed study involving their patients, prior to its
commencement. The doctors were invited to meet with the researcher for further information and discussion of the study, but no response was received.

**Hospital Admission Questionnaires**

The Hospital Admission Questionnaire (Appendix 2) was developed by the researcher when preparing the research proposal and the research questions informed the structure and the questions asked which followed a logical sequence and were easy to understand and answer (Parahoo 2006).

It was intended that questionnaires would be completed by the nursing home nurses involved in each respective admission, which would then be checked by the researcher against residents' nursing home records for any clarification and to ensure accuracy. Immediately prior to the data collection period a meeting was held between the nursing home nurses and the researcher to inform the nurses about the study and their role in data collection. They were familiarised with the questionnaire and reported finding it 'user friendly' and initially they appeared enthusiastic about being involved in the project. However, they failed to complete questionnaires for all of the first three admissions despite reminders and cited lack of time as the reason.
All questionnaires were therefore completed by the researcher from the examination of residents' nursing home records although this meant that data collection was more time consuming for the researcher. However this approach facilitated the same degree of accuracy as any gaps in record keeping or ambiguities were resolved during the nursing home manager interviews and reduced any possible data collection variables. The researcher was informed by the nursing home manager each time a resident was either discharged back to the nursing home following an emergency admission or a resident died in hospital. It was then arranged for the researcher to complete the questionnaire and interview the manager during the same visit.

*Interviews with nursing home manager*

The nursing home manager was supportive of the research project and consented to being interviewed. The setting chosen was a quiet sitting room away from the work environment, distractions and interruptions. Interviews took place approximately one week after each of the 17 residents involved in the 19 admissions had either been discharged back to the nursing home from hospital or had died in hospital. Interviews were tape recorded and transcribed verbatim prior to analysis.
4.8.3 Interviews with Residents

For Part 3 of the study the four nursing home managers informed the researcher each time a resident who was a potential interview participant was discharged back to the nursing home following an emergency admission to hospital. The nursing home managers identified residents who met the inclusion criteria for the study and as already explained potential participants were given a copy of the Resident Information Leaflet (Appendix 4) three days after discharge from hospital. The information leaflet was written following guidance from the NHS on preparing patient information (DH 2003a) and had received ethics committee approval. Following an introductory meeting with the researcher all 13 identified potential participants agreed to be interviewed.

Gray (2004) suggests that it is worth considering the implications of conducting interviews with people who are from a different ethnic, social or cultural group than that of the interviewer. Residents, for whom English is not their first language was also a concern and require extra time (Butt & O'Neil 2004). As interviewees are well known to nursing home staff guidance was sought on an individual basis and although English was not the first language for several participants it did not present a problem. At the appointed time of interview the researcher confirmed with the nursing home manager that the resident was well
enough to participate and all participants signed consent forms immediately prior to the commencement of their interview.

Interviews were tape recorded to ensure that all the data generated were captured. This allowed the interviewer to concentrate on the process of listening, interpreting and re-focusing the interview, observing the respondent and thinking of the next question (Gray 2004). The recordings helped capture what was said as well as what was not said and the way the interviewee spoke about their views including pauses and tone of speech (Pontin 2000b). Recording also meant that transient data could be turned into permanent data that could be analysed over a longer period of time away from the interview site (Gray 2004).

As suggested (Gray 2004) handwritten notes were restricted to jotting down key words and relevant non-verbal behaviour, for example what was noticed about participants during the interview and any initial analytical points which were considered relevant while fresh in the researcher's mind (Pontin 2000b). The start and finish time of each interview was also noted.
The following advice from the literature on interview technique was followed - It is important to build respect between the interviewer and interviewee in order that rapport is established so that the interviewee is relaxed and the interview gets off to a good start (Gray 2004). This was achieved by describing how the interview was to be conducted, how long it would last, the general subjects to be covered and providing participants with the opportunity to ask any questions.

The researcher was aware that participants may be influenced by the impression created by the appearance, dress, accent, ethnicity and social background of the interviewer (Oppenheim 1992) and attempted to manage this, for example by smart casual dress. Language that was accessible to the participants was used and a position of social neutrality adopted (Gray 2004). The researcher was aware that participants may find one to one interviews intimidating (Green & Thorogood 2004) and therefore adopted a relaxed and friendly approach while remaining objective, professional and detached (Gray 2004).

The trusting environment is considered fundamental for the participation of older people in research (Picot et al. 1996) and participants need to be in a place where they feel safe enough to answer questions that may be difficult or awkward without fear of being overheard (Pontin 2000b). The best place for interview is
considered to be a private space that the participant feels is theirs (Green & Thorogood 2004). As participants were nursing home residents they each had their own individual bedrooms and were interviewed in their own familiar environment. The participant and researcher faced each other at a slight angle with a small table in between to create a safe distance as sitting too closely, face to face may be confrontational and threatening (Gray 2004).

Gray (2004) suggests that interviewers keep control during an interview and minimise long winded responses and digressions which means channelling the interview back onto the right track if necessary. Some participants deviated from the focus of the interviews to related issues but the interviewer accorded them respect by showing interest in all they wanted to say. Green and Thorogood (2004) alert interviewers to the pitfall of not acknowledging experiences that were most salient to the participants.

During interviews many participants were keen to talk about their in-patient hospital experience rather than issues around their nursing home to hospital transfer itself which was the focus of interview questions. However although these responses did not contribute directly to answering the research question they yielded valuable data to inform the outcome measure of the research. At a
suitable time participants were reminded tactfully of unanswered questions and although more time consuming this approach had positive outcomes.

Verbal and non-verbal communication was used to provide appropriate feedback, for example head nodding and occasional verbal acknowledgement to provide reassurance and assistance (Gray 2004). At the end of the interview the researcher asked the participants if there was anything they may wish to add that was not covered in the interview as it is known that respondents often make valuable comments when the interview has ended.

4.9. Issues of Rigour

Rigour is the means by which integrity and competence are demonstrated (Aroni et al 1999). Within the naturalistic paradigm of qualitative research, demonstrating robustness using validity, reliability and generalizability have been questioned (Tobin & Begley 2004). An alternative application of rigour suggested by Denzin and Lincoln (2000) is that of 'goodness'. This moves qualitative researchers away from the language of positivist concerns of validity and reliability to a more illuminative approach offering evidence of goodness (Tobin & Begley 2004). Goodness is not seen as a separate construct but as an integral and embedded component of the research process and therefore it is
recommend that the essence of 'goodness' is reflected throughout the entire interpretative study (Arminio and Hultgren 2002). For example it is demonstrated from the underpinning epistemology and theory that provides the philosophical stance, gives context to and informs the study through to the recommendations and implications for professional practice. In this study the researcher has followed this overarching principle.

4.9.1 Trustworthiness

Lincoln and Guba (1985) introduced the concept of 'trustworthiness' to provide naturalistic inquirers the opportunity of new ways of expressing validity and reliability and generalizability and refined the concept of trustworthiness by introducing criteria of credibility, dependability, confirmability and transferability. Credibility compares with internal validity and the fit between respondents' views and the researcher's interpretation in this study can be demonstrated through an audit trail. Likewise dependability which is comparable to reliability can be confirmed in this way as others can examine the transcripts of the interviews, the data analysis and the reported findings. Confirmability compares with neutrality and objectivity and the data confirms that the interpretations are consistent with the study findings.
Transferability which is comparable to external validity refers to the generalizability of the study is more problematic as the study has found that the many factors involved mean that circumstances for each care home is unique and changed over time. Although it therefore can not be claimed that the precise results of the study are generalizable the broader issues are likely to be applicable elsewhere.

Although Green & Thorogood (2004) argue that generalizability is important for researchers to make claims that the research is useful as is the theoretical import of their findings and the extent to which they refer to a similar setting or population other than the study itself needs to be considered. Secondly they suggest that generalizability needs to be considered to ensure the credibility of the research otherwise findings may be deemed interesting rather than evidence. As this study is aimed specifically at informing local policy generalizability was not a primary aim but the approaches used in this study could be adopted to answer the same research questions elsewhere. As suggested by Green and Thorogood (2004) in this study it is the concepts rather than the narrow findings that could inform understanding in similar contexts and recommendations transferable as more widely applicable. Thus conceptual generalisations could be made where the findings will raise awareness of practitioners and policy makers.
4.9.2 Triangulation

Using multiple methods enables triangulation to be used, which is a way of confirming the accuracy of one’s data (Foss & Ellefsen 2002). The intent of data triangulation in research is to use two or more aspects of research to strengthen the design and the validity of the findings (Thurmond 2001). For example in the case studies, the design facilitated a comparison of the information obtained for the hospital admission questionnaires, by the researcher from residents’ records with that from the nursing home manager interviews. In addition the information from the residents’ interviews was clarified by the nursing home manager interviews.

4.10 Data Analysis

As the study involved mixed methods from two different research paradigms different methods of data analysis were applied to the quantitative and qualitative data collected.

4.10.1 Analysis of HES data

The quality of the presentation of this data meant that it was time consuming and complex to analyse. For example the first year’s data (2003-2004) containing the details of 145 admissions was received on 18 full sheets of A4 with many
duplicated entries that were not immediately obvious. Due to recording omissions the data were not fully complete but this was minimal. The data had to be extrapolated on an individual patient basis and put unto EXCEL spreadsheets, which was useful in quantifying each of the 19 units of analysis that could then be presented in a variety of charts and tables to explain the findings.

Descriptive statistical analysis involved simple numerical calculations or percentages of incidences or differences, for example between individual homes, between residential and nursing homes, deaths and diagnoses. As this was the first time this data had been examined locally it provided a baseline. The exercise was repeated for 2004-2005 which provided the opportunity to make comparisons between the two separate data sets and elicited some trends, consistencies and unexplained differences.

4.10.2 Analysis of case studies

*Hospital admission questionnaires*

The information on each of the 19 admissions from the 22 questions on the hospital admission questionnaires was put onto charts and tables which made it easy to see the overall picture of each admission as well as overall admission activity emerging. This facilitated simple calculations to identify overall numbers
and percentages for specific units of analysis. In addition charts were used to summarise each individual case and this combination of charts facilitated analysis of the findings. A chart summarises the most pertinent data from the 17 case studies (Appendix 10).

**Analysis of Nursing Home Manager Interviews**

The interviews with the nursing home manager on each admission were transcribed and the semi-structured interview guide identified the themes for content analysis and a chart was used to tabulate the information under these headings (Appendix 3). This chart was studied in conjunction with the charts from the analysis of the hospital admission questionnaires to validate that information and to add to the information already charted on individual cases. These interviews achieved the joint aim of validating information on admissions and eliciting opinion on admissions and admission avoidance.

**4.10.3 Analysis of interviews with residents**

The nursing home managers were asked for information on admissions immediately after interviews took place to supplement and verify information from interviews. This included residents’ date of hospital admission, confirmation on reason for admission, hospital treatment, lengths of hospital stay and adverse
outcomes of admission. This information is summarised in Appendix 11. They were also asked for their opinions on the appropriateness of admissions in order to gain a professional carer perspective. This information was charted and this facilitated calculations on each of the themes. This overview was completed prior to the analysis of resident interviews.

Tape recordings of the 13 resident interviews were transcribed verbatim by the researcher. Various analytical frameworks for the analysis of qualitative data were considered for the interviews and qualitative elements of the hospital admission questionnaires for example Burnard (1991) as it provided a set of clear steps to guide the process. This was dismissed as it required the involvement of two other researchers but another structured system 'Framework' (Ritchie & Spencer 1994) that offered a focused coding procedure and manageable analytical process was selected.

Framework (Ritchie & Spencer 1994) was considered appropriate as it offers an analytical process that attempts to represent the beliefs and feelings of participants while providing insights and explanations for behaviour in a systematic and truthful way. The key objectives and characteristics of qualitative
analysis identified in Framework are; defining concepts, creating typologies, finding associations, providing explanations and developing strategies.

Framework analysis was developed by the National Centre for Social Research (http://www.scpr.ac.uk/) and it is explicitly geared towards generating policy and practice orientated findings (Ritchie & Spencer 1994; Green & Thorogood 2004). It is described by the National Centre for Social Research as 'a content analysis method which involves summarising and classifying data within a thematic framework.' The key difference between 'grounded theory' approaches and Framework is that the integrity of individual respondents' accounts is preserved throughout the analysis, rather than the deliberate attempt to 'fracture' the data in order to open up new avenues for analysis (Green & Thorogood 2004). This appealed to the researcher as direct quotes can have a powerful impact and using participants' phraseology in results maintains their profile in the study.

Reflecting this focus on maintaining the integrity of respondents' narratives the first step in framework is 'familiarization' with the data. This involves listening to tapes and re reading transcripts until the researcher is closely familiar with them in their entirety enabling key ideas and recurring themes to be listed. During this stage thoughts and conceptualisations occurred and a feel for the overview of depth and richness of the data developed.
Following on the second step is a thematic analysis to identify a thematic framework into which data is sorted. In this study broad themes were apparent due to the semi-structured interview format and six key categories emerged; views on admission, reasons for admission, hospital treatment, treatment outcomes, adverse outcomes and perceptions on hospital experience. These will be discussed later in greater detail.

The third step in framework analysis is the process of applying codes to the whole data set in a systematic way which is called 'indexing'. Each interview transcript was carefully studied and a different colour applied electronically to each part of the text referring to each of the six categories. The analysis part of framework analysis entails comparison both within and between cases.

This is facilitated by the fourth step called 'charting' which involved rearranging the data according to this thematic content, either case by case or theme by theme. Various themes from each admission were cut and pasted and put in separate folders and as these contained only extracts of data and they were referenced back to the original transcript.
The final stage of 'mapping and interpretation' examined the relationships between the codes. This involved using tables to physically explore the relationship between the concepts and the typologies developed from them and associations between the concepts. Patterns and connections were looked for from within the data; by applying this practice and involving the researcher's ability to interpret and synthesise the data, while incorporating judgements and meaning, conclusions were gradually drawn.

4.11 Conclusion

As described above the three pronged approach to the study meant different methods of data collection and analysis were required, adding to the complexity of a small local study. The 17 case studies and 13 interviews with residents proved adequate samples to produce the data required, with the HES data to answer the research questions. The hospital admission questionnaires and interview schedules facilitated data collection and Framework proved a suitable method of analysis.
CHAPTER 5 RESULTS

5.1. Introduction

The presentations of the findings of this study are as follows; first the key results from the analysis of the HES data, followed by the case studies and then the interviews with residents.

5.2. HES data

The data used was taken from the HES data base held by the PCT which is the only central source of care home admission data for the locality.

These data have limitations as on occasions it was incomplete with for example the diagnosis on admission not recorded. On other occasions the diagnosis recorded did not indicate the reason for admission for example diagnoses of dementia and senility. Sometimes the reason for admission recorded did not indicate the underlying medical condition for example seizures and syncope. Despite the limitations it is anticipated that the analysis of this data will be useful in informing the admission avoidance strategy as it provides for the first time, an overview of care home admission activity across the locality over two consecutive years.
During year one there were a total of 145 admissions with 62 different diagnoses recorded on admission (Appendix 8) and during year two there were 130 admissions due to 68 different diagnoses (Appendix 9). This illustrates the complexity of hospital admissions from care homes and the challenges of hospital admission avoidance.

5.2.1 Profile of care homes involved

There were a total of 10 care homes located within the area with accommodation for 436 older people. Five of the homes were residential (registered with the Commission for Social Care Inspection as care homes personal care) with 177 beds. The other five were nursing homes (care homes with nursing) with 221 beds. Four residential homes were in the voluntary sector and the other was operated by the local authority. Two nursing homes were operated by different major national providers, two by the local primary care trust and the other by the local authority meaning that the four sectors operating care homes in the England are represented i.e. private for profit, voluntary, council and NHS.

To set these results in context Figure 5.1 and Figure 5.2 show how the beds are spread over residential and nursing homes and the total number of admissions from each home for each of the two years studied.
5.2.2 Profile of Residents admitted

The average age of residents admitted increased from 82.5 years in year one to 85 years in year two which is consistent with the national trend of care home residents becoming increasingly elderly. During year one 56 residents were
admitted from residential homes and 61 residents were admitted from nursing homes, meaning that 29.4% of care home residents had emergency hospital admissions during the year. During year two 43 residents were admitted from residential homes and 56 from nursing homes meaning that 23.2% of care home residents were admitted during the year.

There was a 23.2% reduction in the number of residents admitted from residential homes and an 8.2% reduction in the number of nursing home residents admitted between year one and year two. Therefore 15.4% less care home residents were admitted during year two than during year one.

5.2.3 Hospital Admissions

As some residents were admitted more than once in year one there were a total of 70 admissions from residential homes and 75 admissions from nursing homes. In year two there were a total of 53 admissions from residential homes and 77 admissions from nursing homes. Therefore admissions from residential homes decreased by 24% while admissions from nursing homes increased by 2.6% during the second year. Therefore on average there were fewer than three admissions per week which is a relatively small number if input from other health care professionals was to be considered either as a central referral point for all
potential hospital admissions or to actively provide services an alternative to admission. No seasonal variations were found.

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<th>Table 5.1 Hospital Admissions from Care Homes</th>
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<td><strong>Year 1</strong></td>
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Although there is considerable variation in admissions between individual homes and between the two years some patterns are apparent. The most common reason for admission was a wide variety of infections which accounted for 35.9% of admissions in year one and 25.4% in year two.

The second most common reason for admission was fractures which accounted for 7.6% of admissions in year one rising to 15.4% of admissions in year two. This is despite the increased focus on falls prevention due to the NSF for Older People (DH 2001a) and the introduction of a local falls service. A reduction in falls resulting in fracture could have been anticipated rather than a 45% increase. A variety of heart conditions accounted for 7.6% of admissions in year one and 14.6% in year two. Although stroke is mainly a condition affecting older people
and considered a medical emergency requiring hospitalisation strokes only accounted for 2.8% of admissions in year one and 3.1% in year two.

Due to poor recording, the admission diagnoses were missing for 6.2% of admissions in year one and 6.1% in year two. During year one the remaining 40% of admissions had 38 different diagnoses recorded and in the second year the remaining 35.4% of admissions had 37 different diagnoses recorded. Again this demonstrates the complexity of the health needs of the care home population and the possible need for a variety of approaches if a significant reduction in emergency hospital admissions is to be achieved. The numbers of admissions in each category of diagnoses for each year is shown in Figure 5.3 and lists of all hospital admission diagnoses are presented in Appendices 9 and 10.
5.2.4 Readmissions

During year one 18.8% (n=22) of residents (n=117) admitted had more than one admission and in year two 20.2% (n=20) of residents (n=99) had more than one admission, with subsequent admissions tending to be for different reasons. Contrary to general expectation that better management of long term conditions would prevent repeated hospital admissions this finding does not support this notion.

Interestingly nearly half of residents in the current study who had more than one admission died in hospital suggesting that they had serious irreversible health problems, although this does not mean their admissions were appropriate.
5.2.5 Length of hospital stay

In year one care home residents accounted for a total of 2,724 hospital bed days (1,242 days by residential home residents and 1,481 by nursing home residents). This is the equivalent to 7.5 hospital beds being continuously occupied by this population at considerable financial cost to the local primary care trust. In year two all the care home residents accounted for a total of 2,418 hospital bed days as usage by residential home residents fell to 947 days and nursing home residents to 1,471 days. This means there was an 11% reduction in hospital bed day usage between year one and year two. This is largely because of a 24% reduction in hospital lengths of stay of residential home residents as nursing home residents' length of stay only decreased by 0.7%.

Of note an 11% reduction in bed days occurred between the two years without the government target of a 5% reduction in emergency bed days being a driver. It is suggested that the increasing demand for hospital beds and other government targets especially the four hour limit on stays in accident and emergency departments may have been influencing factors.

The length of stay of care home residents in hospital ranged between one and 123 days in year one with the mean length of stay per resident being 19 days in
year one. In year two lengths of stay varied between one and 124 days with the mean length of stay increasing by 0.5 days to 19.5 days. As some lengths of stay appear unduly long there may be potential for achieving the government target of reducing emergency bed days by focusing on facilitating timely discharges.

5.2.6 Deaths in hospital
A wide range of causes of deaths was recorded the most common being infections followed by cardiac and pulmonary diseases and fractures. Interestingly none of the 47 deaths over the two years were due to a cancer. From the analysis of this data it is not possible to establish if residents were admitted for acute treatment which was unsuccessful or if they were admitted for end of life care. 23.9% of residents admitted in year one died in hospital. 30.4% (n=17) residential home residents (n=56) died in hospital compared to 18% (n=11) nursing home residents (n=61). It could be speculated that residential home residents were more likely to be admitted to hospital for end of life care than nursing home residents due to the twenty four hour care of registered nurses being available in nursing homes.

Yet in year two 13.9 % (n=6) residential home residents (n=43) died in hospital compared to 23.2% (n=13) nursing home residents (n=56). As considerably more
nursing home residents admitted died in hospital than residential home residents in year two this would appear to disprove the notion that residential home residents are more likely to be admitted for end of life care. As overall 19.2 % of residents admitted in year two died in hospital it means there was a 4.7% reduction in the number of residents admitted, dying in hospital in year two than in year one.

5.2.7 Comparison between residential and nursing home admissions
It could be anticipated that residential homes would be higher users of hospital beds in order for residents to access health care. Yet the number of residents admitted, the total numbers of admissions and hospital bed days utilised were similar for both residential and nursing homes in year one. In year two there were considerably fewer residents admitted from residential homes who accounted for less admissions and fewer hospital bed days. Therefore, the data does not provide any evidence that local nursing homes are currently less reliant on emergency hospital care or that their residents are discharged quicker due to the registered nursing care available to them in their homes.

It could be speculated that residential homes were well supported by the district nursing service and nurse specialists. There may also be a lack of awareness
among hospital staff of nursing expertise within nursing homes that could facilitate the more timely discharge of their residents.

5.2.8 Comparison between NHS and private nursing homes

The admission rate from the two NHS nursing homes was 24.6% compared to a 41% admission rate from the three private nursing homes. Therefore the admission rate for private nursing homes was 16.4% higher than the NHS homes. However the hospital bed days occupied by the admissions from NHS nursing homes was 45% greater than that by private nursing homes meaning that although NHS homes had fewer hospital admissions their use of the acute hospitals was greater. From the hospital episode statistics alone it cannot be determined why hospital lengths of stay were considerably longer for this client group.

5.2.9 Conclusion

While these results show many similarities between homes and types of homes and between the data for year one and year two there are also notable differences especially between the two years. For example 11% reductions in both admissions and bed days during the second year were particularly interesting but inexplicable. Neither can the considerable reduction in admissions
due in infections and increases in admissions due to fractures and heart conditions in year two.

These findings illustrate the value of analysing the admission data for two consecutive years and the need to examine findings in depth. Otherwise admission avoidance strategies introduced using the information from one year's data could have led to this considerable reduction being attributed to new initiatives.

However these findings provide a baseline against which future analysis can be compared and could be particularly useful in measuring the impact of admission avoidance strategies when they are being evaluated. This analysis clarifies the complexity of the subject and the wide range of admission diagnoses may be an indication that many admissions may be unavoidable and that avoidance strategies may require a variety of approaches if they are to be successful.

5.3 Case studies
5.3.1 Introduction

The hospital admissions from one nursing home during a one year period (2006) form the second part of this study. Each admission formed an individual case
study and the findings are derived from the analyses of 'Resident Hospital Admission Questionnaires' completed by the researcher through examining the nursing home records of each of the residents who had hospital admissions. Transcripts of interviews with the nursing home manager on each of these admissions provided additional information. This insight into the annual hospital admission activity of a local nursing home will be valuable in informing a hospital admission avoidance strategy which is the intended outcome of the research.

5.3.2 Hospital Admissions

During the year there were 19 emergency hospital admissions from this 35 bed nursing home, involving 17 residents equating to a 48.6% hospital admission rate. When compared to local HES this level is considered a high rate of admissions. A chart provides a summary of the admissions (Appendix 10) and it is clear from the information recorded in the nursing and medical nursing home notes that all residents were very ill prior to being admitted to hospital.

The gender mix of residents admitted, eleven females to six males was representative of the usual make up of the nursing home population. Residents' ages ranged between 67 years and 93 years and although the average age was 83.5 years the majority were in the over 85 age group (Figure 5.4).
The length of time they had been resident in the nursing home prior to their hospital admission varied between two days and nine years with 41% being admitted to hospital within a month of becoming resident in the nursing home, which could indicate that new admissions have considerable medical needs. They were subsequently admitted to hospital due to a variety of acute medical situations which fall into the following categories – infection, cancer, long-term conditions, strokes and end stage dementia (Figure 5.5).
Most residents were admitted after being seen by their own GP or a partner in the practice, with three being admitted by the Out of Hours GP service and one by a nursing home nurse (Figure 5.6). In total the GP practice providing the medical service to the home instigated nearly 80% of the admissions and when GPs from the Out of Hours service are included a total of 94.7% of all admissions were the responsibility of doctors as a nursing home nurse only arranged one.
With one exception when a resident was admitted at 23.00 hours, admissions took place between 11.00 and 19.00 hours (Figure 5.7)
Nearly 60% of admissions took place on either Thursdays or Fridays with only three being at weekends (Figure 5.8).

Admissions were evenly spread throughout the year with the exception of April which had five (Figure 5.9) although there is no explanation for an increase during this month.
The total number of hospital bed days taken up by the 19 admissions was 150 with a range of one to 33 days and each admission averaging 7.9 days. 26.3% of admissions only lasted one day and 79% of admissions lasted a week or less (Figure 5.10)
An important finding is that 63% of admissions either resulted in death in hospital or soon afterwards (Figure 5.11), with 21% dying within 24 hours of admission to hospital and 47.4% (n=9) dying within a week of admission. Partners in the GP practice admitted two of the four residents who died within 24 hours, the Out of Hours GP service one and a nursing home nurse one. The residents' own GP admitted the remaining five who died within a week. It is interesting that GPs who were familiar with residents did not admit patients for whom death was imminent but did admit residents for whom remaining life turned out to be short.

![Figure 5.11: Outcomes of Admissions](image)

In addition to the nursing home manager clarifying information from the researcher's review of the resident records, she was asked if in her opinion admissions could have been avoided. She considered four of the nineteen
admissions to have been avoidable, three who were residents presenting with infections related to advanced dementia and the resident that the night nurse sent to hospital although it was obvious she was dying. Although the manager felt that almost 80% of the admissions were unavoidable she offered suggestions as to how some could potentially have been avoided if other services had been available and the change in culture required for significant change. These insights contributed to the identification of some of the factors contributing to hospital admissions.

5.4 Factors leading residents to be admitted to hospital

Data analysis of case studies identified a range of factors which are discussed within the following five categories – Medical problems, Access to treatment, GPs, Influence of families and Nursing home nurses.

5.4.1 Medical problems

Seventy percent of nursing home residents, who were subsequently admitted to hospital, had been admitted to the nursing home from hospital and a further 12% from an NHS nursing home that was closing. For them to have been assessed as needing twenty four hour nursing care would indicate that they had substantial pre-existing medical problems. In fact 42% had been admitted to the nursing
home for NHS funded continuing care, 12% for palliative care and most of the remainder due to the effects of dementia. On admission to the nursing home most residents had combinations of three different diagnoses from a range of 34 different medical conditions, by far the most common recorded being dementia among 70.5% of the residents.

It is clear from the nursing home nursing and medical records examined to complete the Resident Hospital Admission Questionnaires that all seventeen residents were very ill immediately prior to being referred to hospital on each of the nineteen occasions (two residents had two admissions each). The presence of existing medical conditions is important as three quarters of hospital admissions were related to medical conditions which residents had prior to admission to the nursing home. Most commonly dehydration and infections associated with advanced dementia and residents with existing cancers requiring blood transfusions. The only admissions due to new conditions were one each for mitral valve collapse, cerebral vascular accident, investigations which diagnosed cancer and perforated bowel due to inoperable cancer.

Although long term conditions were a factor in a few admissions for example one resident with complex Parkinson’s disease who collapsed and did not regain
consciousness within an hour was admitted to hospital. Another resident who was an insulin controlled diabetic became dehydrated due to vomiting and diarrhoea and developed urinary and chest infections was admitted as these conditions led to her diabetes being dangerously out of control. It would therefore appear that none of the admissions could have been avoided by better management of long-term conditions. As most emergency hospital admissions are associated with existing diagnoses it is suggested if approaches to care and services available remain unchanged that the numbers of emergency hospital admissions of nursing home residents could be predicted to a degree.

5.4.2 Access to Treatment

It is clear from the nursing home records and nursing home manager's interviews that the GP practice with which residents were registered provided a good service to their patients within the home. They monitored residents during scheduled weekly visits and responded quickly when called due to changes in residents' conditions. Before making decisions to admit their patients to hospital residents GPs examined them and on occasions they took advice from hospital doctors before making the decision to admit. As this was the situation in 79% (n=15) of admissions (n=19), the lack of in house medical attention by the GP practice was not a factor that led residents to be admitted to hospital.
Alternatively, on occasions had the treatment GPs provided been successful this would have prevented residents being admitted to hospital, for example when oral antibiotics were prescribed and treatment was unsuccessful it led to residents being admitted for intravenous antibiotic therapy. As this service was not available in the community at the time hospital admission was the only way for local GPs to access it for their patients. In addition to hospitalisation being required for IV antibiotics and fluids, two residents were admitted for blood transfusions as they are not currently available in the nursing home setting.

According to the nursing home manager one of the reasons a resident transferred to hospital was to have an ECG as the GPs or nursing home nurses are not familiar with undertaking this procedure there is no ECG machine available in the home. One resident was referred to hospital by her own GP for an ultrasound scan as she complained of abdominal pain and nausea. This investigation confirmed that she had an inoperable abdominal mass and as she was very frail the hospital decided to keep her there overnight rather than transfer her back the same day. So on this occasion although investigation was the reason for hospital transfer, it was compassion for a frail elderly lady that was the factor leading to the overnight admission.
Currently the only way local GPs can access the expertise of consultant physicians or geriatricians in a timely manner is to send patients to hospital as emergencies as senior specialist doctors are not commissioned to provide a domiciliary service to the local independent nursing homes. In the case of the resident with Parkinson’s disease already mentioned the GP rang his hospital specialist for advice but was advised to admit the patient to hospital so that he could access the specialist care that appeared to be needed.

Similarly when a resident had a severe stroke and although in his clinical judgement the GP considered hospital admission inappropriate he contacted the hospital consultant as he knew it was current policy that a stroke patient must be treated as a medical emergency. As a result the resident was admitted to hospital on the advice of the consultant.

An ‘unsafe’ hospital discharge forty-eight hours earlier led to a new nursing home resident being readmitted to hospital in order to access the treatment she required. This patient had been discharged from an acute hospital at 6pm on a Friday evening in an unresponsive state and was therefore unable to eat and drink. As a result although the nursing home staff identified that she had a urinary tract infection on admission to the nursing home she was not alert enough to
swallow and be treated orally with antibiotics. She had been prescribed sedation in hospital which is likely to have contributed to her drowsiness and she also had MRSA. The fact that she stayed in hospital for thirty – three days after being readmitted is an indication that her condition required further hospital treatment rather than nursing home admission.

5.4.3 GPs

Although GPs with the medical centre providing medical care for the nursing home concerned were informed of this research study none availed themselves of the offer to discuss it. Therefore the perceptions described here are subjective potential influences drawn from the data rather than based on facts or clarified by the GPs involved.

As already described GPs were attentive to nursing home residents’ needs and if their treatment was unsuccessful they did not hesitate to admit them to hospital in order for them to access treatment. There is no evidence of residents being denied access to hospital treatment due to age or mental or physical frailty. GPs tended to make admission decisions without discussion with nursing home nurses, although at times family members were a factor in altering medical decisions.
Admitting nursing home residents to hospital was the advice given on the few occasions GPs phoned hospital consultants when they may have been attempting to provide the best care while avoiding hospital admission. All residents who were sent to hospital were admitted and treated before either dying in hospital or being discharged back to the nursing home which would indicate that they were ill and either hospital doctors considered admission for treatment appropriate or patients were too ill to be transferred back to the nursing home. There is no evidence that the hospital ever challenged the appropriateness of admissions. Out of Hours GPs did not hesitate to admit residents to hospital and did so on all three occasions they were contacted by the nursing home at weekends, without seeing the patients.

It is notable that GPs admitted the majority of residents (60%) immediately before weekends when their service provision is taken over by the Out of Hours service. As doctors were responsible for 95% of hospital admissions the factors that influence their admission decisions will be critical to the success of an admission avoidance strategy.
5.4.4 Influence of families

Pressure from residents' families was definitely a factor leading to admissions. Some families clearly had unrealistic expectations of what could be achieved by their relatives being admitted to hospital and on other occasions although they understood it was likely to be futile they felt it was their duty to ensure that everything possible was done to save their loved one. There appeared to be a lack of recognition of dementia as a terminal illness and some families chose to preserve life at all costs. Doctors communicated with families if they were present and it appears that on occasions they admitted residents if that was what relatives wanted even when it contradicted their clinical decision making. On the other hand there is no evidence that families who were not present when the doctor visited had an opportunity to be involved in decision making suggesting that family involvement was entirely opportunistic rather than a medical policy to consider their views.

Alternatively not consulting families could have been a factor which led to admissions which otherwise may have been avoided had these relatives had the opportunity to express a preference for their loved ones not to be admitted to hospital when it was unlikely to have a positive outcome. One next of kin expressed the view that she did not consider her sister's admission appropriate as she had developed complications of advanced dementia. Her wishes were
ignored by the Out of Hours GP who sent her to hospital without seeing her so on at least one occasion ignoring the views of relatives was also a factor leading to admission.

5.4.5 Nursing home nurses

Within the nursing home sector, medical attention is usually accessed as a result of nursing home nurses identifying issues that require medical intervention. Residents' nursing home records used revealed that the nursing home nurses were proactive in identifying and responding to the medical needs of their residents by contacting the GP practice to request visits organised depending on the urgency of the resident's condition. As a result during normal working hours doctors visited and commenced treatment for residents and only sent them to hospital if the treatment was ineffective. It could therefore be concluded that the observation and clinical decision making skills of the nursing home nurses contributed to residents receiving timely medical attention in the home rather than in hospital.

On the other hand there is no documented evidence that nurses advocated for residents to prevent avoidable admissions being arranged by doctors. In the view of the manager this should have been the case in two out of three of the
admissions arranged by Out of Hours services, whom when called by nurses were told to send the residents to hospital rather than come to assess them. Interestingly the nursing home manager commented that as the Out of Hours doctor told the nurse to ring 999 she had "no choice but to do it" (case study 4) This may suggest a lack of interdisciplinary working and perhaps nurses lacking the confidence to challenge quick medical decisions by a doctor who has no prior knowledge of the patient.

There is also the possibility that the nurses involved may not have successfully communicated to the on call doctors that the residents concerned had advanced dementia and had been slowly winding down over a period of time making in the professional opinion of the manager the admissions inappropriate and avoidable. Therefore a lack of the professional development of nursing home nurses may have resulted in their inability to competently discuss ill residents which may have been a factor in these admissions.

On the one occasion that a night nurse arranged the emergency admission of a resident who collapsed suddenly did so as a result of panic and fear that she would be criticized for inaction even though her clinical knowledge meant she knew the resident was already dying. It is the perception of the manager that the
nurse should have provided end of life care for this resident in the nursing home rather than subjecting her to a hospital transfer when her inevitable death was imminent. The nursing home nurse was therefore a factor which led to one of the nineteen hospital admissions.

5.4.6 Conclusion

It is apparent from the analysis of the case studies that there is a wide range of factors associated with medical conditions, assess to treatment, GPs, relatives and nursing home nurses which all contribute to the emergency hospital admission of nursing home residents.

It is suggested that the most important finding is that nine out of the seventeen residents admitted died in hospital within a week; four of whom died within one day of admission. Four of the residents who died in hospital within a week of admission had end stage dementia. On two occasions admissions were arranged by doctors at the request of relatives despite the inevitability of death making the justification for using an expensive resource inappropriately questionable. It is suggested that these are admissions that should have been avoided in the interests of providing appropriate end of life care for residents. Two other residents with advanced dementia died soon after their hospital discharge and
another two residents who have advanced dementia survived admission due to the commencement of gastric feeding, but their quality of life is questionable.

Although the out of hours doctors were only responsible for three of the nineteen admissions it is noteworthy that each time they were called, which was always at the weekends they never visited but instigated hospital admission. This does raise the question if there is a connection between seven out of nineteen admissions being on Fridays and just before Out of Hours services taking over for the weekend. Therefore it could be suggested that the GPs admitted residents at the end of the week if they felt they were likely to be hospitalised anyway. As GPs were not involved in the study this suggestion has not been discussed but as nearly 60% of admissions occurred on Thursdays and Fridays the coincidence is questionable.

As doctors were responsible for 18 out of 19 admissions they will obviously be key in achieving any reduction in admissions and out of hours doctors will need to be committed to any admission avoidance strategies if they are to be successful.
5.5 Interviews with residents

5.5.1 Introduction

The results of the third and final part of the study from the analysis of the 13 interview transcripts of the nursing home residents who were admitted to hospital as emergencies are described. The views of nursing home residents form an important part of this study. The participants were residents from four different nursing homes coded A, B, C and D. The aim of the interviews was to identify factors which lead to older people in nursing homes being admitted to hospital and to obtain their views on hospital admission. A chart provides an overview of the 13 cases (Appendix 11)

5.5.2 Overview of residents' admissions

These residents were all articulate and could be described as medically stable and in the 'living' phase rather than the 'living/dying' of most long-term care residents (Travis et al. 2001). Medical emergency situations led to all thirteen residents being admitted to hospital and with two exceptions all participants understood that hospital admission was unavoidable. Both of the residents who did not consider their admission necessary were very ill. One had advanced stomach cancer and was admitted for a blood transfusion and a review of his symptom control. The other was a resident with type 1 diabetes who had vomiting and diarrhoea and had become difficult to rouse and had developed chest and urinary tract infections.
Residents were accepting of admission and although they did not feel that they were involved in the decision they were not concerned by this. The majority (n=11) were admitted to hospital after being seen by their own doctor or a partner in the practice. The remaining two residents suffered falls and were admitted to hospital following 999 calls. The reasons that the 13 residents were admitted to hospital varied and are summarised in five categories (Figure 5.12).

Length of hospital stay ranged from one to 23 days and averaged 10.5 days. All residents (including the two who did not consider their admissions necessary) reported benefiting from hospital admission and most were highly satisfied with their hospital experience. Within this small sample, those participants who appeared to have the most complex health problems and dependency issues had considerably longer lengths of hospital stay and were more likely to suffer complications of hospital admission and had more complaints about their hospital experience.
The managers of the four homes that participants were admitted to hospital from, were of the opinion that all of the 13 admissions were unavoidable, including those of the two residents who disagreed and all admissions had positive medical outcomes. The two residents who had infections that required intravenous antibiotics were complex cases who in their opinion required to be managed in an acute hospital setting. The three key categories that emerged as a result of data analysis of interview transcripts are residents' views on their nursing home experience, residents' views on being admitted to hospital and residents' views on hospital care. Analysis is described following each of these categories.

5.5.3 Residents' views on their nursing home experience

Although the interview had not intended to explore residents' views of their nursing home experience, findings arising from the analysis of the interview transcripts showed what participants valued in their nursing home environments. This insight is important as it influenced their views on admission to hospital and their expectations of the care received and led to comparisons being drawn between nursing home and hospital care. It is suggested that this could be expected as these interview participants are used to living in a care environment where they are looked after by nursing staff, which sets them apart from other community dwelling older people. This view is supported by a resident who found his hospital experience “in complete contrast” to his nursing home experience.
(D13) suggested that his expectations of hospital care may have been unrealistic because he was “spoilt” in the nursing home. One resident (A2) was particularly explicit about her views which were supported by other participants. They are described here as they provide insight into what nursing home residents value in their usual environment and what they expect when admitted to hospital. Views relating to this category are described within the following three themes – “I like it here”, Attitudes, Standards of care and Choice and control.

“I like it here”
This theme seems to encompass the experiences of all the residents interviewed. As the nursing home was a “familiar environment” (A2) it provided a sense of security which meant some were reluctant to leave to be admitted to hospital. For example one resident (A1) reported “I didn’t want to leave for hospital – I would rather have stayed here.” Another likened the nursing home environment to that of a “big hotel” which was “top class” and had a “nice atmosphere” (A2). Another said “I like it here, the staff are very nice, very pleasant” (C5).

Attitudes and standards of care
In addition to the environment the attitudes and values demonstrated by the nursing home staff were clearly appreciated by participants. It was felt that staff
were able to empathise with residents and provided care that was person-centred and considered to be of high quality. In addition to staff having time to provide care, their friendliness and companionship was valued. These attitudes are encapsulated in the following typical resident’s comments:

"Staff know what it is like being you and they find out what we like – it is the little things that mean so much. Staff time that is what is so important, I love to talk – I love company. It couldn't be better – no I can't be bothered – they really care here" (A2).

Choice and control

The choice and control available in the nursing home was also important for example “You can have a cup of tea when you like” (A2). Another resident from a different home which had exceptionally good medical care provision commented "we are well looked after medically, you wouldn't get this sort of treatment outside – you would probably have to wait to see the doctor" (D9). He also mentioned that being in the nursing home meant he was not a burden to his family as he perceived that having medical problems meant “then you are a handicap to your relations” (D9).
5.5.4. Residents’ views on being admitted to hospital

This second key category that emerged from the analysis of interview transcripts describes contrasting views on admission and includes the themes of “I just had to go” and “I didn’t like it one little bit.”

“I just had to go”

Most residents were aware that they needed urgent medical attention that could only be provided in hospital and were therefore accepting that their situation meant that admission was unavoidable. For example “I didn’t mind” (C7) and others although of the prospect of admission said “I didn’t like it one little bit” (D9) and “Not very pleasant” (C5) were quite resigned as understood their admissions were unavoidable.

This was also the opinion of two residents who were admitted with chest infections primarily for intravenous antibiotics who could potentially have been treated without an emergency admission to secondary care. For example one said “I could see and feel the need - there was no alternative” (B4) and another “They couldn’t do anything here (nursing home), I didn’t worry, I just had to go” (B3). Even when asked if treatment had been available in the nursing home to meet her needs and whether she would have preferred to have been treated in the home or gone to hospital she replied
"Actually I can't imagine because they couldn't do anything here (B3)"

This highlights an assumption among nursing home residents that acute illness results in emergency hospital admission. This perception is important as participants would therefore not express the view that they would have preferred treatment within the nursing home if they did not have any concept of this being a possibility.

Although admission to hospital did not tend to be discussed with residents this was either because they were too ill at the time of transfer to hospital to consent to admission or there was tacit understanding that it was essential, for example "Well there was no question about it because it was so painful had I been asked I could only have said yes" (B4).

"I didn't like it one little bit"

The two residents who considered their hospital admissions avoidable and expressed their preference for treatment in the nursing home had numerous health problems and histories of multiple previous admissions. One stated that "it wasn't fair" and that "I would have much rather have been treated in the nursing home but you see when you are ill you don't have any choice" (A2).
5.5.5 Residents' views on hospital care

This third and final key category is the most extensive as it is the area that generated most comment. It is made up of the following six themes – "They looked after me well", "God if I ever have to go back there", "I was a nuisance", "They just treat you like a lump of meat", "The usual thing – you wait for people" and "It was just too busy". Some participants drew comparisons between their nursing home care and care received in hospital, for example "It was like being here" (nursing home) (B3) and "It is in complete contrast to here" (D13) which would indicate that nursing home experiences influenced expectations of hospital care.

"They looked after me well"

Most residents described positive experiences of their care in hospital for example "I thought the hospital was very good" (C8), "They looked after me very well, it was marvellous, they sorted me out well" (C5), "It was fine they looked after me very well" (C6), "They looked after me well to be honest the nurses do a marvellous job" (D9) and "No complaints" (B3).

"God if I ever have to go back there"

However a few residents did not have positive experiences for example "Please God if I ever have to go back there (hospital) I don't know what I would do. I
wouldn't be able to face it now I know what to expect" (D13). The factors that led to negative experiences are described using themes identified from data analysis – nurses' attitudes, standards of nursing care, choice and control and hospital environment although there is a lot of overlap between the themes.

"I was a nuisance"

Some residents did not feel valued due to attitudes displayed by nurses for example one reported "They don't always have respect for older people. They seem to write us off" (D13) and "I was a nuisance, I felt unwanted – everything was too much trouble – they don't care" (A2). One resident felt her disabilities were not respected, "You don't use your wheelchair – you lie in bed for hours" (A2). This resident perceived the attitudes she experienced were not specific to her "It is how they were. It wasn't because of me. Nothing changed because of me." Others described experiencing more positive attitudes for example "They (the nurses) were there for me" (D10).

"They just treat you like a lump of meat"

Some residents found that the standards of nursing care they experienced did not match their expectations for example "The standard of nursing has dropped enormously – nurses are expected to know" (B4) and "The staff now you would
think that they knew what they were doing but they don’t "(A2). This resident felt that "They didn't do their best – they were not good nurses by any means." These comments were from residents who felt that fundamental nursing care was lacking as continence was not well managed and both developed grade 4 pressure ulcers in hospital. Poor moving and handling was also an issue described by one of these residents and another who was admitted due to stroke said "They just treat you like a lump of meat – dead meat, they know I have a bad arm and a bad leg but they are too busy and they grab hold of me and it hurts" (D12).

Yet others were impressed by the care they received and had confidence in the nursing staff for example "The nurses look after you well" (D9) and "I was looked after hand and foot – I am proud of the little girls (nurses) – they look after you so well" (D10).

"The usual thing, you wait for people"

Participants described experiencing a lack of choice and loss of control which is highly significant as it was something they considered important when referring to their nursing home experience. Waiting for attention was a significant issue for a number of residents for example one said "It was the usual thing, you wait for
people. They say they will be right back but they never come back" (C8). Another said "They don't bother to say 'wait a minute' or anything like that even if it is life threatening if they said 'I'm too busy and I can't get to you yet' it helps a bit" (D13). This gentleman found it frustrating not being able to attract attention of nurses when he saw them "She flies by – they fly by. They are like a load of rabbits running." He felt particularly vulnerable at night as he was dependant on staff due to his immobility "Well in the night you know if you are not prepared as regards reaching for something, anything like a drink or tissues you could be gasping for water and it miles away – that is regular things like that" (D13). Waiting for assistance also led to anxiety and distress for others for example "You could ring the bell until you are blue in the face – I used to ring when I wanted a bedpan or something but they would take no notice. I would wait for hours and finish up with a messy bed – you had to rely on these people who couldn't care less" (A2).

This resident described feeling a loss of control in hospital as she was not listened to when she was anxious to be discharged back to the nursing home, "My son had to fight to get me out of the hospital – they wanted to keep me in hospital" (A2).
"It was just too busy"

The busy hospital environment was in contrast to some residents' usual nursing home experience for example "The hospital itself was similar to this but it was just too busy" (D12). Yet one described the hospital as "It was like being here" referring to the nursing home (B3). Another said "Things were lax" (A2) and a resident who felt his hospital experience was in contrast to the nursing home described nurses as "being organised to a certain extent but there are lots of bits and pieces when you are a person who wants help." (D13). A resident complained that he had a three hour trolley wait in Accident and Emergency and felt that he was not told his diagnosis of stroke soon enough (D12). Another resident expressed sympathy for nurses working in such a busy environment "It is an ungrateful job; they come round with your prescriptions and then someone else comes and says nurse, nurse" (D10). Concern was expressed at low staffing levels "Where have all our nurses gone?" (D13). Noise was also an issue "It should be quiet but it isn't, it only takes two nurses to come in and it is Bedlam. Too noisy, there is no excuse for it" (D12) and another was irritated by the fact "The television was on with the children's programmes" (D13).

Finally several residents commented that they were dissatisfied with hospital food for example "The only grumble was the food" (D11) and another contrasted her
experience of hospital food to that in the nursing home "In hospital you don't get what you like to eat" (A2).

5.5.6 Conclusion

It is suggested that residents' positive experiences of nursing home care influenced their expectation of hospital care and although most participants were satisfied with their hospital care some found the things they valued in the nursing home (nurses' attitudes, standards of nursing care, choice and control and the care environment) lacking in hospital.

It was clear from the interviews with participants that the attitudes and values of the staff are the foundations that underpin their positive experiences within the nursing home environment. These experiences are realised through the staff's ability to empathise with residents and provide quality care and attention to meet their individual needs with kindness and friendship. Having choice and feeling in control within a familiar, relaxed environment where they feel secure contributes to high levels of resident satisfaction being achieved. These insights are crucial in inform a resident centred hospital admission avoidance strategy. The contrasting views of residents between the two environments of care are illustrated in Figure 5.13.
Although the nursing home and hospital experiences of participants do not directly contribute to answering the research question (Factors leading residents to be admitted to hospital), analysis of this information is of paramount importance as it provides invaluable insights into what is important to residents.

5.6 Summary of study findings
This study confirms that the hospital admission of care home residents is a complex issue. Part one of the study (HES data) found that residents had on average 65 different diagnoses on hospital admission and rates of admissions varied between homes and over time. For example, the rate of admissions from
residential homes was almost a third less in the second year and overall there was an 11% reduction in admissions and bed days compared to year one. Overall admissions rates for residential homes were similar to nursing homes despite the difference in the skill mix and staffing levels. On average over the two years, 22% of all residents died in hospital and there were only 1.5% more residential home than nursing home resident deaths, which could suggest similarities in end of life care between the two types of care home. There were on average three hospital admissions of care home residents per week whose length of stay was on average 19.2 days, and the equivalent of seven and a half hospital beds being utilised by care home residents throughout the year.

Parts two and three of the study (case studies and interviews with residents) identified that doctors instigate almost all hospital admissions of residents. Both these parts of the study found that residents' own doctors were attentive and only arranged admissions after they had visited and assessed residents, whereas when the out of hours service was contacted they never visited but arranged immediate hospital admission.

The average length of hospital stay was much shorter for residents in the nursing home study at 8 days (compared to 19.2 days found in the HES data) but this
could be at least partially attributed to the hospital death rate of residents in the nursing home study being more than double. The rate of admission to hospital was 46% in the nursing home study compared to 26.3% in the HES data which may suggest that the admission activity of this home was not typical of local homes. The hospital length of stay of residents who were interviewed was 10.5 days which could be considered reasonable when compared to the previous two samples as this cohort all survived acute medical treatment and were able to consent to interview. Their average age was also a few years less at just under 80 years than the samples in part 1 and part 2 who were 83.7 and 83.5 respectively.

All residents who were interviewed benefited from their hospital admissions and all but two considered that their admissions were unavoidable. The nursing home managers agreed that the admissions of all residents interviewed were appropriate as did the manager in the nursing home study with the exception of the residents who had advanced dementia, many of whom either died in hospital or soon afterwards. Most residents interviewed expressed high levels of satisfaction with hospital care although they valued their nursing home care more.
All three parts of the study consistently found infections, falls, long-term conditions and stroke to be the main reasons for hospital admission. As a result of this study it would appear that there is potential to reduce local hospital admissions of nursing home residents, although some will continue to need and benefit from emergency care that is only available in acute hospitals.
CHAPTER 6 DISCUSSION

6.1 Introduction

This chapter is comprised of three parts. The first part presents a discussion of the study findings in relation to previous studies on the emergency hospital admission of care home residents. The findings of this study (the factors that led nursing home residents to be admitted to hospital as emergencies) are then discussed in the context of the current literature and related policy. As a result a ‘Home for Life’ nursing home care model is proposed. The value of this model is described, drawing on recent policy, literature and published hospital admission avoidance initiatives, which provided the rationale for this model.

The second part critiques the methodology and discusses how the study created new knowledge, the strengths and limitations of the study and suggestions for future research.

The final part addresses the implications of the study findings in relation to practice and policy and recommendations for clinical practice and the conclusion of the study.
Part 1

6.2. Comparison of admissions with published studies

The analysis of HES data provided an overview of local rates of admission, reasons for admissions, length of hospital stay and deaths in hospital. The findings are discussed in relation to the limited literature and with reference to the case studies and resident interviews, as all contributed to providing insight into local care home hospital admissions.

6.2.1 Rates of admission

Substantial variations in admission rates between homes have been identified in previous studies (Bowman et al. 2001; Blatchford et al. 1997; Reid et al. 1999) and this was also the finding of the current study. It is suggested that this may be due to the fact that most admissions are instigated by GPs and local care home residents are registered with different surgeries. Yet the variation in admission rates between the two years' data makes the influence of GPs less conclusive although this could be because care home populations keep changing (OFT 2005).

The HES data examined found that the average rate of all care home admissions was 34.5% and the admission rate in the case studies was 54.3%. In two studies
(Godden & Pollock 2001; Bowman et al. 2001) that included care home admission rates they were very similar. Godden and Pollock (2001) found an admission rate from residential and nursing homes to be 26.4% whilst Bowman et al. (2001) found the rate of admissions from nursing homes to be 27.8%. These rates are between 8.1% and 6.7% lower than what the current study found, although Bowman et al. (2001) admitted that they had almost certainly underestimated admission rates from nursing homes due to postal code omissions on hospital records. Despite both studies being published in 2001, as they were undertaken in the mid-nineties the higher local admission rate may reflect the changes in care home populations over the intervening years.

From the HES data it is not possible to determine how many care home residents admitted to hospital had dementia but 70.5% of residents admitted in the case studies had a diagnosis of dementia. This finding is in line with a UK survey which found that 67% of patients with dementia had been hospitalised in the last year of life (McCarthy et al. 1997). Interestingly an American study of the hospitalisation of nursing home residents (Lamberg et al. 2005) found 19.2% of those with advanced dementia had admissions in the last six months of life. Since the care of residents with advanced dementia in the UK results in higher reliance on secondary care than that experienced in the USA this would indicate there is
considerable potential for reducing the emergency admissions of this resident group.

In both the case studies and HES data parts of the current study, admissions occurred throughout the year and did not increase during holiday periods or over Christmas as found by Godden and Pollock (2001) or over the winter period as found by Beringer and Flanagan (1999).

6.2.2 Comparison of residential and nursing home admission rates
Godden and Pollock (2001) found the rate of admission to hospital to be 8.9% higher in residential homes than nursing homes and considered that this demonstrated the importance of nursing input and suggested a relationship between hospital admissions and levels of nursing care. Although the current study found the admission rate from nursing homes to be 5.6% lower than that for residential homes in year one the nursing home admission rate was 4.9% higher than that for residential homes in year two. This was due to an unexplained reduction in admissions from residential homes.
The rate of admissions from nursing homes in the current study was 12.1% higher than that found in the Godden and Pollock (2001) study. It could be suggested that this may indicate that the 24-hour presence of registered nurses may not be achieving its maximum contribution to hospital admission avoidance, the increasing complexity of nursing home residents' conditions or the impact of the more recent system for providing out of hours services.

The current study revealed a 10.3% reduction in overall admission rates between year one and year two. This occurred against a backdrop of 24% reduction in the number of admissions from residential homes and a 2.6% increase in admissions from nursing homes. This is an interesting finding as there is no explanation for this considerable reduction in admissions from residential homes.

6.2.3 Length of hospital stay

As the government target is to reduce hospital bed days, reducing lengths of stay is an alternative or additional approach to reducing admissions. This approach has already had success in North West London where this study described is located. Despite being the Strategic Health Authority area with the largest rise in emergency admissions in the country it had one of the highest reductions in emergency bed days, achieving a decrease of 8% in a one year period (Farr
The HES data examined in this study found that total bed days were reduced by 10.3% in year two without any hospital admission avoidance strategies being introduced.

As the HES data found the average length of stay to be similar for residential homes and nursing homes and over the two years as it was 18.7 days for year one and 18.5 days in year two the reduction in bed days is attributable to the reduction in admissions rather that shorter hospital stays by residents. These findings are consistent with the only published study reporting the hospital length of stay of nursing home admissions (Bowman et al. 2001) which found that the average was 19 days. Yet this is in contrast with the case studies which found the average length of stay to be eight days but as 52.9% of residents died within a week of admission a lower average length of stay could be expected.

Length of hospital stay has been identified as 40% longer than that normally predicted for conditions like stroke, fractured neck of femur and falls if patients already have a physical disability (Carpenter et al. 2007). This was not a factor in the nursing home study as only one of these residents had a stroke and none had fractures but would be applicable to a considerable proportion of the residents within the HES data.
A systematic literature review of factors affecting outcome in older medical patients admitted to hospital found routinely collected patient information, for example, age, gender and diagnosis does not determine outcome (Campbell et al. 2004). Instead they found that it was measures of function and cognition that are strongly related to length of stay. As 91% of nursing home residents have been classified as severely disabled (OFT 2005) longer lengths of stay could therefore be anticipated for this population. Yet the twenty four hour presence of registered nurses within nursing homes is a resource not routinely available to older people with disabilities and their expertise could potentially facilitate earlier discharge, although neither the case studies nor resident interviews provided evidence of this.

Godden and Pollock (2001) found that admissions from care homes for fractured neck of femur had shorter length of stay than those of older people living in the community, which may indicate timely discharges due to the 24 hour care available. The one resident interviewed in the current study who was admitted due to a fractured neck of femur had a length of stay of twelve days. This could potentially have been shorter due to the nursing and therapy available in his nursing home environment.
6.2.4 Short admissions

An audit of admissions from nursing homes by Snape and Santharam (1997) found that short admissions were inappropriate as 20% of residents admitted were transferred back within three days as they had fairly trivial or self limiting conditions. The HES data analysed in this study found that over the two year period only two residents were sent to hospital and not admitted. One had complained of dizziness and the other was a gentleman with urinary catheter problems. In year one only 4.8% of admissions who survived had hospital stays of under three days although in year two this had doubled to 10.7%. Yet there is no indication that the majority of these admissions were inappropriate as the diagnoses given were a variety of acute heart conditions, fractures, head injury, epilepsy, malignancies and anaemia. Only the three admissions due to infections are questionable but from the HES data it cannot be ascertained if they could have avoided admission or if patients made speedy recoveries.

The only short admissions in the case studies that survived hospital admission were residents with terminal cancer requiring blood transfusions and review of symptom control and two of the residents interviewed had short admissions due to falls related trauma. As all other case studies, spent longer in hospital it would appear that they required significant treatment. Therefore this study did not identify short admissions for trivial conditions to be a factor.
6.2.5 Deaths in hospital

A UK study by Godden and Pollock (2001) which quantified the deaths of care home residents soon after hospital admission, found that 3.6% died within 24 hours of admission. Interestingly the two years HES data examined for this study found that 3.8% of residents admitted died within three days of admission. As this is a relatively small number, this would suggest that admissions occurring during the last days of life are not a major issue locally.

Yet these findings are in contrast to the admission activity identified in the case studies undertaken during the following year as 35.3% of all residents admitted died within three days. By comparison according to the HES data this home only had an average of 8.3% of residents admitted dying in hospital within three days of admission over the previous two years. As admission data is only available for this one home for that year it is not possible to determine if the increase is indicative of a changing trend or a unique situation in one home in one year.

The current study found only a slight variation in the number of residents admitted who died in hospital between in year one and year two with an average death rate of 21.6%. This is similar to the study by Bowman et al. (2001) which found that 19% of hospital admissions from nursing homes resulted in death. The 52.9% death rate of residents admitted in the case studies could therefore be said to be much higher than what would be expected.
6.2.6 Summary of admissions

Hospital admissions from care homes have been described as complex and multi-factorial (Blatchford and Capewell 1997) and this study has confirmed that this is the case making the achievement of a reduction in admissions challenging. Yet surprisingly according to Roland et al. (2005) admission rates fall without any intervention although no explanation for this was given. Interestingly this was the case when the two years HES data were compared in this study as the number of residents admitted from residential homes dropped by 24% within a year, for which there was no explanation. This would suggest that there is value in localities continuously monitoring admissions.

This study found although there are similarities between the three parts of the current study and with the UK published studies there are also differences which are summarised in Table 6.1
Table 6.1 Summary of emergency hospital admissions

<table>
<thead>
<tr>
<th>Admission detail</th>
<th>Part 1 HES data</th>
<th>Part 2 Case studies</th>
<th>Part 3 Interviews</th>
<th>Published studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical diagnoses on hospital admission</td>
<td>Infection 31% (n 85) Fracture 12% (n 33) LTC 12% (n 33) Stroke 3% (n 8)</td>
<td>Infection 58% (n 11) Fracture 0% LTC 16% (n 3) Stroke 5% (n 1)</td>
<td>Infection 23% (n 3) Fracture 15% (n 2) LTC 23% (n 3) Stroke 23% (n 3)</td>
<td>Infection 24% Fracture Unknown LTC Unknown Stroke 5%</td>
</tr>
<tr>
<td>Average no of bed days</td>
<td>18.5</td>
<td>8</td>
<td>10.5</td>
<td>19</td>
</tr>
<tr>
<td>Short admissions discharged</td>
<td>8% (n 22)</td>
<td>10.5% (n 2)</td>
<td>15.5% (n 2)</td>
<td>20%</td>
</tr>
<tr>
<td>Readmission rate</td>
<td>20% (n 55)</td>
<td>10.5% (n 2)</td>
<td>0%</td>
<td>Unknown</td>
</tr>
<tr>
<td>Deaths in hospital</td>
<td>22% (n 60)</td>
<td>53% (n 10)</td>
<td>0%</td>
<td>19%</td>
</tr>
<tr>
<td>Deaths within 48 hours of admission</td>
<td>4% (n 11)</td>
<td>30% (n 6)</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>Age of residents</td>
<td>84</td>
<td>83</td>
<td>80</td>
<td>82</td>
</tr>
</tbody>
</table>

As average hospital lengths of stay remained constant over two years and were similar for both types of care home this would indicate potential for earlier transfers of care. In line with published studies (Bowman et al. 2001; Godden &
Pollock 2001) the HES study found that around a fifth of residents admitted died in hospital yet in contrast the case studies found half of residents died suggesting that some of these admissions were avoidable. Had there been a focus on identifying residents who were nearing the end of life and the provision of palliative care within the homes it is suggested that potentially up to a fifth of admissions could have been avoided.

As the only UK studies to mention admission rates were Bowman et al. (2001) and Godden and Pollock (2001) there was limited opportunity to make comparisons. However, as local rates were higher than both, this would suggest there is potential for a reduction in admissions.

| Table 6.2 Rates of emergency hospital admission of care home residents |
|-------------------------|-------------------------|-------------------------|-------------------------|
| 34.5%                   | 54.3%                   | 26.4%                   | 27.8%                   |

6.3 Factors leading nursing home residents to be admitted to hospital

The three parts (HES data, case studies and resident interviews) of this research study have identified the factors contribute to resident admissions. The findings of each of the three parts of the study have been described in the earlier results.
section and will now be discussed together in relation to the literature. The factors are listed on Table 6.3.

| Table 6.3 Factors leading nursing home residents to be admitted to hospital |
|---------------------------------|-----------------|
| **Access to treatment**         | **Medical conditions** |
| **GPs**                         | **Out of Hours service** |
| **Families**                    | **Nursing home nurses** |

6.3.1 Access to treatment

It has been claimed that care homes were sending dying residents to casualty departments because they could not get doctors to come out (BBC News 15.8.05). The problem was attributed to fewer doctors being available to assist "peaceful" deaths at residential homes due to the new 'out-of-hours' contracts for GPs. Professor George Alberti, the emergency care tsar at the Department of Health also had concerns (Change Agent Team 2006) and reported that many older residents were being admitted to Accident and Emergency Departments from care homes because private care staff had no other way of accessing care.
A study by Barnes (cited in Gulland 2007:7) reported that a major problem leading to hospital admission was that homes got little support from primary care and for many homes the only way they could get any medical help was via A&E attendance. It does not explain if residents' GPs or out of hours doctors or both refused to visit when residents were referred by care home staff. Although a local hospital doctor (Partridge 2008) claims that it is often the junior untrained carer who is left with the decision of whether or not to hospitalise a dying care home resident she does not provide any details of this.

While it is not possible to determine who instigated the admissions in the HES part of the study this is in contrast to the findings of the case studies and the resident interviews as the nursing homes doctors were attentive and only admitted residents after assessment, the exception being Out of Hours services. However, despite this study not providing evidence of homes having to send residents to hospital to access medical care, in view of the literature it would appear that this is an issue that needs to be addressed if hospital admissions are to be reduced.
6.3.2 Medical Conditions

All three parts of the study found that care home residents required treatment for medical conditions that is only available in hospital. The current study found that residents had a wide variety of medical diagnoses on admission to hospital (Appendices 8 & 9) with infections and heart disease accounting for an average of 41.7% of all hospital admissions from care homes over two years. This is fairly similar to the study by Bowman et al. (2001) which found that these conditions accounted for 47% of admissions.

Infections

The current study found that 35.9% of admissions in year one and 25.4% in year two were due to infections although as the source is HES data the reduction cannot be accounted for. The rationale for the hospital admission of nursing home residents for straight forward treatments such as antibiotics and fluid replacement and has been questioned (Bowman et al. 2001) as registered nurses are continuously on site. While the case studies found that 58% of admissions were due to infections and although residents were treated with intravenous antibiotics in hospital their conditions were complex. For example one was semi comatose due to unstable insulin dependent diabetes. Another was unable to maintain oral hydration after successful treatment for infection had gastric feeding commenced during her 33 day hospital stay.
This highlights the importance of using other more detailed sources of information to inform admission avoidance strategies than HES data which does not provide sufficient depth of information on individual cases and if used in isolation it could give unrealistic expectations for the introduction of intravenous therapy within care homes.

As a considerable proportion of admissions due to infections were residential home residents this may have made the nursing care they required in addition to intravenous therapies difficult to achieve in their usual environment. However other options to emergency admission to acute hospital could be a suitable alternative, for example admission to intermediate care beds in a community hospital or to a nursing home which had access to community intravenous therapies.

Bowman et al. (2001) suggested that the high incidence of infection identified in their study justified trials of nursing home based intravenous therapy and suggested using hospital outreach teams to augment the role of homes’ nursing staff. Although the current study could not determine if hospital admissions could have been avoided through access to intravenous therapies outside acute
hospitals, the availability of such services is likely to positively impact on hospital admission avoidance to some degree and therefore should be considered.

However, the HES data found that over half of deaths in hospital were the outcome of unsuccessful treatment of infections and over half of the residents admitted with infections in the nursing home study died in hospital or soon afterwards. It has been suggested that the aggressive treatment of pneumonia in demented patients might cause suffering whereas initiating good palliative care might lead to less suffering (van der Steen 2002). This study reported when not only the severity of suffering but also duration were considered, patients in whom death was highly likely did not suffer higher levels of discomfort when they were not treated with antibiotics compared to those who were. As high percentages of residents who had infections did not survive despite intravenous therapy the appropriateness rather than the location of treatment is the consideration.

Long-term Conditions

The NHS Improvement Plan (DH 2004c) announced plans for supporting people with long-term conditions and reported that the pilot phase led to a reduction in hospital admissions. This was followed by a long-term conditions strategy (DH 2005a) which reported that significant numbers of hospital admissions related to
long-term conditions and could be avoided. Reducing admissions for people with long-term conditions is the proposed strategy for achieving the 5% reduction in emergency bed days (DH 2005a). The approach suggested is that vulnerable people who are most at risk due to highly complex multiple long-term conditions and very high users of secondary care are targeted to reduce reliance on hospital care. The suggested selection criterion includes frequency of hospital admission and length of stay, co-morbidities, poly-pharmacy and frequency of GP consultations. The case studies and resident interviews parts of the current study found that most residents met these criteria with the exception that they were not high users of hospital care, as each only had one short admission. For each of the two years that HES data were studied only a few residents accounting for an average of 4.2% of admissions annually would be classified as 'high impact users.' Even then with the exception of one of these residents having two of her admissions for chronic obstructive pulmonary disease, all other repeat admissions were for different reasons, usually infections and fractures.

An earlier study, the only one identified of acute admissions from care homes to mention long-term conditions (Bowman et al. 2001) speculated that a significant proportion could be avoided by better chronic disease management. Yet only 25% of the 57 randomly selected hospital records examined in this study had diagnoses recorded that could be classified as chronic diseases. Therefore this
report provides limited evidence that better management of chronic diseases could have such a positive impact on reducing admissions from care homes.

All three parts of this study found similar incidences of admissions relating to long-term conditions with 16.5% in the HES data, 17.6% in the case studies and 15.4% in the resident interviews. Although long-term conditions were a factor in local care home hospital emergency admissions in parts 2 and 3 of the study they were all considered unavoidable as essential treatment was only available in hospital.

A new computer programme called Patients at Risk of Re-hospitalisation (PARR) (King’s Fund 2007) has been launched to enable primary care trusts to identify patients most at risk of emergency re-admission to hospital in the next year so that they can target care for these patients with chronic long-term conditions. From the results of the current study it would appear that the use of this tool is unlikely to have much impact on hospital admissions from local care homes although it may have an impact in other care home localities or in the future.
Considering the existence of risk factors for admissions it could be suggested that hospital admissions due to long-term conditions of care home residents could potentially be higher and it may be the case that they are avoided due to the supervision and care available. It is interesting that the guidance on supporting people with long-term conditions (DH 2005a) does not mention care homes although this sector had already been identified as a target for hospital admission avoidance (DH 2004d). The results of the current study indicate that meeting the target by focusing on long-term conditions as suggested (DH 2005a) would not be an effective way of local care homes contributing to achieving it.

**Dementia**

The management of residents who have dementia is of particular concern and relevance as dementia affects 64% of care home residents (Alzheimer’s Society 2007) and affected 64.7% of the residents in the case studies making dementia the most common condition contributing to hospital admission.

Although there is no precise definition of end stage dementia the terminal phase tends to be marked by severe declines in functional status, severe limitations of cognitive and communicative abilities and susceptibility to life threatening infections (Hurley and Volicer 2002). They describe individuals as being usually
bed bound, having extreme swallowing difficulty and being typically mute which describes the condition of the residents in the case studies. Despite its high prevalence Hergoth (2006) found that many physicians often do not recognise dementia as a terminal condition. Interestingly a UK study (Sayers & Perera 2002) found that doctors were more inclined to view the demented patient as terminally ill rather than patients with cancer and reported being less likely to admit the former patients to hospital. This is in contrast to the case studies as both residents' own GPs and the Out of Hours medical service admitted residents with dementia to hospital when they were approaching the end of life, which was the case in almost one third of the admissions. It would appear that there was a lack of acceptance of dementia as terminal condition and residents were admitted to hospital for intravenous antibiotics and fluid replacement because they had developed chest or urinary tract infections and had lost the ability to swallow. For example on one occasion when this was the case although the attending GP wrote "poor prognosis" in the nursing home notes he still arranged for the resident to be admitted to hospital. This gentleman had been a nursing home resident for eight years due to dementia which had advanced to end stage and despite intravenous therapies in hospital he died there two days later.

This was not an isolated incident but a regular scenario and potentially the admissions of this group of residents not only could but should have been
avoided. Had it been accepted that cure was unrealistic and invasive treatment inappropriate residents could have remained in the nursing home for palliation and appropriate end of life care. The absence of programmes which provide a framework in which to plan ahead for end of life care would appear to be a main factor in hospital admissions.

It has been suggested that accepting positively the approach of death is probably one of the hardest tasks of clinical care (McCarthy et al. 1997) and may explain why doctors in the case studies chose to admit residents to hospital as transferring care avoided this decision making.

Although dementia is a terminal condition it is rarely listed as the cause of death on death certificates as in end stage dementia death typically results from pneumonia, cardiovascular disease or decreased fluid intake (Allen et al. 2003). For this reason it was not possible to determine if hospital deaths in the HES data were due to dementia but this was found to be the case in the case studies.

As most residents in the case studies already had advanced dementia when they were admitted to the nursing home, it is likely that it was already too late for them
to have been able to participate in advance care planning. However lengths of nursing home stay would have provided opportunities for relatives, nursing home staff and GPs to have discussed and planned the end of life care of residents together.

The identification of the hospitalisation of residents with advanced dementia as they approached death is considered the most important finding of this research as it is suggested that the admissions of this group of residents could and should have been avoided. In light of the prevalence of dementia across UK care homes if appropriate end of life care was universally adopted for all residents within the care home setting, the impact could be considerable on hospital admission avoidance as well as end of life care.

End of life care
Better end of life care for care home residents has been identified as a national priority (DH 2006a). While all older people should have access to treatment to meet their individual needs (DH 2001a), Help the Aged (2006) has suggested that further research is needed into residents being admitted to hospital during their last days of life. This is an indication that this is a neglected area of research to which this local study will make a small contribution.
The case studies in the current study found in addition to 29.4% of residents being admitted to hospital when they had end stage dementia 17.6% had end stage cardiac conditions. Therefore nearly half were admitted to hospital with terminal conditions. These findings are consistent with Caplan et al. (2006) who described reasons for poor outcomes of admissions as residents being in the final stages of terminal diseases, particularly dementia but also end stage cardiac, respiratory and non-dementing neurodegenerative diseases.

The study of the appropriateness of hospital admissions from care homes (Read 1999) found that 30% of homes had experienced admissions being arranged to provide terminal care on the insistence of the client’s family or locum GPs, even though nursing staff did not feel the admission was appropriate. Similarly the case studies found this happened on occasions and although nursing home records indicated that residents were nearing the end of life and died soon after hospital admission the clinical rationale for most of these admissions was not recorded.

Patients gave a vote of confidence in the overall care provided by NHS hospitals in the largest national survey (Healthcare Commission 2007) with just two percent rating the overall care they received as “poor”. Similarly most of the
residents interviewed as part of the current study expressed high levels of satisfaction with hospital care and were accepting of hospital admission when it was unavoidable, but it was their nursing home care they valued most. This was due to the nursing home environment, the degree of choice and control, and the attitudes of nurses and standards of nursing care.

A recent study by Green et al. (2008) comparing older people’s care experience in community and acute hospitals revealed similarities in perceptions between the two care settings. The variations included more negative comments about staff attitudes, noise and bustle and food within the acute setting and positive comments about choice and the physical environment in community hospitals. These findings have similarities to how residents interviewed in the current study perceived the acute hospital setting in comparison to their nursing homes. Although residents' preferred place of care at the end of life was not discussed in this study, the evidence would suggest that end of life care in the nursing home is likely to be the preferred option, unless hospitalisation is unavoidable for clinical reasons.

As this study found that residents with terminal conditions accounted for nearly half of hospital admissions it is suggested that more appropriate end of life care
provided in the nursing home setting would be the logical focus of the hospital admission avoidance strategy.

6.3.3 Medical staff

Consultants

The HES data examined for the current study found that there were fewer admissions from an NHS nursing home that had regular input from a consultant physician specialising in medicine for older people than the other nursing homes which only had on site medical input from GPs. Although on this occasion it was not possible to directly attribute the lower rate of admission to the consultant input but it is suggested that it may have been a factor. The only study (Cantle et al. 1995) that compared admission rates between nursing homes and long stay NHS care found a six fold higher acute bed usage by nursing home residents than NHS continuing care patients. Although this report did not give any explanation for such widely differing admission rates consultant input in the NHS environment is in contrast to the normal medical support in nursing homes and could therefore have been a factor in lower admission rates.
GPs

The impact of the lack of ‘in house’ medical care on hospital admission has already been discussed above under ‘access to care’ and is reiterated by a local hospital doctor who reports that primary care cover for nursing homes, both day to day and out-of-hours can be patchy and varies widely between areas (Partridge 2008). Yet the new ‘primary care led’ NHS builds on the position of General Practitioners as the first point of contact for patients and the gateway to hospital and specialist medical care (Howse 2007). The role of GPs in the hospital admission of care home residents is demonstrated in a UK study of 40 care homes (Read 1999) which found that 90% of homes reported that it was always GPs that instigated hospital admission. Similarly the current study found that almost all hospital admissions were instigated by GPs.

It would appear from the case studies that the prevailing medical culture was to admit ill nursing home residents to hospital rather than hospital admission avoidance being a focus. Although there is a government target to reduce the number of hospital emergency bed days individual medical practices have not been targeted locally. As there is no apparent incentive for GPs to avoid admitting their ill patients to hospital this may be a key factor leading to the hospital admission of nursing home residents. As doctors are therefore the most
dominant factor in hospital admissions their role is examined in depth to gain understanding of the issue.

The threat of litigation has been cited in the literature (Fox 1995) as a factor influencing doctors' admission decisions. In the context of the inappropriate hospital treatment of residents with advanced dementia, Hertogh (2006) suggested that "legal" factors influenced medical decision making. As a standard of the NSF for Older People (DH 2001a) is to ensure that older people have equal access to treatment this may have motivated GPs to seek active treatment for residents by hospital admission. This was the perception of the nursing home manager interviewed as part of the current study and although it is purely subjective it could explain some of the admissions that could be considered avoidable. As the case studies focused on the hospital admissions it did not include insights into the care of the other residents or discussions with the doctors concerned. It is therefore unknown how likely the doctors were to admit acutely ill residents to hospital or how end of life care was managed for other residents and without this information it is even more difficult to judge if the threat of litigation was a factor. However, as hospital admission occurred even when prognoses were known to be poor, the only obvious rationale (unless when admission was at the request of relatives) would appear to be the avoidance of any potential accusations of ageism or neglect.
Sayers and Perera (2002) reported that it was claimed that a practice of withholding life prolonging treatment in cases of advanced dementia had developed in this country although admitted that little is known about what actually occurs or the reasoning used by doctors to support their decision to withhold treatment. Their study compared non-treatment decision making by general practitioners and geriatricians regarding nursing home residents aimed to identify whether the doctors' decisions were informed by ethical and legal reasoning. It found that little attempt was made to link decision making with these concepts and suggested that there may have been non-recognition or denial of the ethical consequences of failure to admit. This was attributed to deep seated medical and societal reluctance to accept that intentionally withholding life prolonging treatment may equate with intentionally causing death. In their study only three of 35 doctors reported that they would admit a patient with end stage dementia (immobile, doubly incontinent and non-communicative) who develops severe pneumonia. Although participants in their study did not make it explicit it was suggested that the presence or absence of personhood influenced admission decisions. There is no evidence that this was a consideration in the current study as doctors admitted residents with dementia who were approaching the end of life.
By couching their decision making in non ethical terms the doctors in the Sayers and Perera’s (2002) study differ from Dutch doctors. Van Thiel et al. (1997) cited needless prolongation of life, low quality of life, undignified dying and medical futility as reasons supporting their non-treatment decisions and this approach means that in Holland residents with end stage dementia are rarely admitted to hospital (Hertogh 2006). Quality of life is one of the most important outcomes of health and social care, especially when cure is no longer an option (Martlew 1996; O’Boyle 1997) and prolonging life at any cost is considered less important than the quality of life lived (Clark 1995). The case studies did not find any evidence of quality of life being considered in the admission decisions relating to this group of residents.

The Audit Commission (2002) reported that many general practitioners receive insufficient training on dementia or support from specialists. More recently GPs have been criticized by the Government’s all-party Public Accounts Committee (House of Commons 2008) for their lack of knowledge of dementia and reported that dementia is never formally diagnosed in up to two thirds of cases. Due to the high prevalence of this terminal condition within care homes and the number of hospital admissions in the case studies relating to end stage dementia, it is suggested that GPs lack of knowledge of dementia led to admission decisions rather than more appropriate end of life care. The National Institute of Clinical
Excellence (NICE) guidance on end-of-life care for people with dementia (NICE 2006) states that a balance of evidence-based and values-based medicine is needed in the decision making process.

It is suggested that this requires GPs to assess residents to confirm a diagnosis of dementia and have in-depth knowledge of the disease trajectory, the active treatment and palliative care options (NICE 2006). Experts agree the best way of making decisions about the care of people with advanced dementia would be through consensus among healthcare professionals, the family and carers with consideration of the patient's known or perceived wishes, beliefs and values (Caron et al. 2005). Yet the current study found that GPs made most hospital admission decisions without discussions with the nursing home staff, who knew the residents and families well and they only communicated with families if they happened to be present.

Studies have shown that pressure from families has been identified as a factor contributing to the hospitalisation of nursing home residents (for example Kayser-Jones 1989; Hertogh 2006). In the case studies, on occasions residents for whom GPs recorded "poor prognosis" in the nursing home notes were admitted to hospital following discussions with devoted families. This would indicate that
GPs accommodated relatives’ requests, even when such admission decisions contradicted their clinical opinion.

Payne (1996) suggests that the fact GPs feel less able or willing to cope with seriously ill patients can increase acute admissions. The current study did not identify any evidence of this as in the case studies GPs instigated treatment which was unsuccessful prior to making admission decisions which would suggest that they considered admission to be the only option available for residents to achieve life sustaining treatment. In the case of the admissions of the residents interviewed, hospital treatment was the only option considered appropriate. On occasions GPs admitted residents on the advice of hospital consultants which would suggest that they were undecided as to the appropriateness of admissions and would have been receptive to alternatives had they been suggested by their specialist colleagues. These findings are in contrast to the Out of Hours service discussed below.

Travis et al. (2001) found that many care homes do not have a clear medical decision making process and the transition of residents from active to palliative care modes were often delayed by indecision or inaction by the key decision makers. By admitting residents with terminal conditions to hospital, GPs and out
of hours services in the case studies absolved themselves from making these difficult decisions. This is similar to the findings of Lacey (2005) who reported that GPs tended to take positions inconsistent with expert palliative care guidelines such as in the use of antibiotics and hospitalisation for residents with end stage dementia. This may be because GPs largely depended on their own experience and that of their colleagues to inform their decision making rather than using explicit evidence from research, as was found in a UK study of knowledge management in primary care (Gabbay & le May 2004). Similar approaches were identified in a Scottish study by Hubbard & Themessl-Huber (2005) which found that traditional patterns of working influence services that are used so even when doctors knew of a range of services they continued to use those familiar to them. It was suggested that “old habits die hard” and the example is given of GPs continuing to refer patients to hospitals and the importance of GPs not only being aware of alternatives but having confidence in other services is highlighted. Although this was not an issue in the current study as alternative services to admission were not available locally, had they been appropriate. However, it highlights the importance of including GPs in the development of services contributing to admission avoidance if they are to be utilized. In addition as GPs are the providers of medical care to nursing homes and are responsible for most hospital admissions they will therefore be crucial to any reduction in admission.
It could be coincidental that most residents in the case studies required admission on Thursdays and Fridays or it could be speculated that it may have been because GPs had more confidence in hospital care than that available through their Out of Hours colleagues. Alternatively there may have been concern that these colleagues would be critical of the additional workload or that the GPs had not accessed specialist care sooner.

*Out of Hours services*

Since the introduction of the new contract for GPs in England (Statutory Instrument 2004 no 291 The National Health Service (General Medical Services GMS contracts) Regulations 2004 HMSO London) the responsibly for the provision of Out of Hours GP services shifted from GP practices to NHS Primary Care Trusts. The GMS contract means that GPs are only responsible for patients between 8am and 6.30pm every weekday amounting to 52.5 hours per week. Out of hours services are responsible for their patients the rest of the time and are considered to play a crucial role in controlling demand on other parts of the NHS (Royal College of General Practitioners 2004). The RCGP questioned whether an adequate workforce to provide effective out of hours cover could be found and warned the Health Select Committee that more onward referral would result (RCGP 2004). The case studies found this to be the case as although Out of
Hours services were only contacted on three occasions they always admitted residents rather than visiting to assess them.

The fact that GPs arranged so many admissions at the end of the week could suggest that it may not be coincidental as it was prior to handing over the medical care of their patients to out of hours medical services. This could raise the question as to whether GPs had more confidence in hospital care for their nursing home patients than that of their out of hours colleagues. Alternatively it could be suggested that they avoided leaving the Out of Hours service to cope with seriously ill patients because they considered the additional workload involved excessive for them to manage. It could also be argued that they may have had concerns that their management of acute illness would be criticized by their Out of Hours colleagues. This is speculative but attempts to explain the disproportionate number of admissions prior to weekends.

The approach of the Out of Hours service to hospital admission identified in this study contradicts Department of Health guidance (DH 2007a) which states that decisions to admit older people to hospital need to be based on an assessment of each individual's needs and priorities and the patient's capacity to benefit from treatment. This report advised that this should be decided before the resident
leaves the home so that they are not transported unnecessarily. It has been suggested (Bowman et al. 2001) that the availability of comprehensive information for visiting doctors on the clinical status and prognosis of individuals in care homes could avert a large number of hospital admissions. Although the case studies did not find any evidence of such communication between the residents’ GPs and the Out of Hours medical service the doctors involved could have discussed the situations with the nursing home nurses who had the advantage of knowing residents as individuals as well as their complex medical histories. However it is suggested, if residents have advance care plans and those who are approaching the terminal phase are on end of life programmes, out of hours doctors will have clear guidelines to follow if they are contacted.

It is apparent from the literature that the performance of ‘out of hours’ services is not just a recent, local issue. The only UK reference to the impact of Out of Hours services on care home hospital admissions identified found that occasionally the on call GP insisted on admission despite the staff’s recommendation (Read 1999). Therefore even if the nurses involved had advocated better for residents their views may have not been taken into account. Two Australian studies of nursing home care (Montalto 2001; Crilly et al. 2006) suggested that out-of-hour’s medical cover contributed to hospital referral. Interestingly a recent study of all acute admissions in Southampton (Chambers 2007) found that patients admitted
unnecessarily had been admitted during out-of-hours periods. It is suggested that out of hours services will need to be made aware of their role in hospital admission avoidance when strategies are developed if they are to be effective.

6.3.4 Families
Although families were only involved in three of the admissions in the case studies they were an important factor as these admissions could potentially have been avoided.

Lack of knowledge or awareness of the individual's preference regarding end of life care is known to cause emotional burden and stress for family members (Allen et al. 2003). It may not be surprising that family members have been found to make treatment decisions that would preserve their own peace of mind after the death of the resident and expressed the importance of knowing that they had done all they could so that their conscience was clear (Forbes et al. 2000). Therefore they felt compelled to treat the treatable even in late stage dementia and supported hospital admission for intravenous antibiotic therapy for the treatment of pneumonia. Forbes et al. (2000) also found that although relatives could accept death in the context of a big event like a heart attack they had difficulty accepting common features of advancing dementia such as pneumonia.
as evidence that the end of life was approaching. This is in line with the current study found that relatives of residents with advanced dementia requested hospital treatment even when the doctor told them it would be futile. This highlights the case for family involvement and education, advance care planning for appropriate end of life care in accordance with the residents' preferences, the reassurance of relatives and the avoidance of inappropriate emergency hospital admissions.

Interestingly the case studies found GPs only discussed residents' conditions with relatives or involved them in hospital admission decisions, if they happened to be present which was infrequently the case. This could be considered evidence of the dominance of a medical model rather than a more person-centred social model. Although GPs admitted residents at the insistence of relatives there was one case study where a resident with terminal dementia was admitted to hospital by the out of hours service against the wishes of her devoted sister. This illustrates the importance of having systems in place so that relatives who advocate for vulnerable residents have their wishes considered.

6.3.5 Nursing Home Nurses

Nursing home nurses are responsible for accessing medical care for their residents when indicated and GPs are only likely to see residents when staff
highlight that attention is required (Hughes and Robinson 2006). The current case studies and the resident interviews found this was through contacting GP surgeries or out of hours services and the evidence from both is that nursing home nurses accessed medical attention in a timely and professional manner.

A literature review by Crilly et al. (2006) on continuity of care of acutely unwell nursing home residents found that insufficient numbers of adequately trained nursing home staff and pressure from them for residents to be admitted were reasons for hospitalisation. The current study did not identify these issues and the RCN state that nursing home nurses are committed to what they do and want to keep their residents in their own home (Gulland 2007). This was true of the four nursing home managers involved in the current study who expressed a preference to continue to care for their residents who were unwell.

In contrast to the literature (BBC News 2005; Change Agent Team 2006; Guilland 2007; Partridge 2008) only a few hospital admissions were arranged by nursing home nurses. The only occasions when nursing home nurses were responsible for arranging hospital admissions were when an ambulance was called for a resident whose condition unexpectedly deteriorated rapidly and two occasions when an ambulance was called, as the residents required urgent hospital treatment following trauma. Two out of three were considered appropriate by the nursing home managers and the study illustrates that nurses handled medical
emergencies and the deterioration in residents' conditions appropriately. Although in this study nursing home nurses were only found to be a minimal factor in the emergency hospital admissions, their role is central to the care provided and accessed by nursing homes and therefore warrants further discussion.

All residents interviewed expressed high levels of satisfaction with the nursing home care they received and valued the way they were treated in their respective nursing homes. This has been described in the results section but is relevant to discussion as their satisfaction appears contradictory to the literature. For example, Davies (2001) states that there is growing awareness that many long-term homes in the UK are failing to meet the needs of older people. She suggests that studies indicate that older people in care homes feel that their physical needs are largely met but that care aimed at maintaining their psychological well-being is more elusive. No specific evidence is offered to support this claim other than citing media reports and campaigns by organisations representing older people. Peace et al. (1997) suggest that characteristics of institutionalization still pervades many homes and regimes give residents little opportunity to exercise choice and Katz and Peace (2003) cited examples of lack of choice as when to take a shower or schedule meals. Yet this research found that choice within the nursing home was a recurring theme and highly valued by interview participants.
and missed in hospital. Participants appreciated the nursing home staff and it is to their credit that residents were highly satisfied with the values apparent in the four nursing home environments.

The study of care home hospital admissions by Godden and Pollock (2001) found that hospital length of stay for nursing home residents was shorter than that of residential home residents. This could be attributed to the fact that as 30% of the staff in nursing homes are registered nurses (Royal College of Nursing 2004a) they could potentially facilitate earlier discharges by their ability to care for frail older people once their acute condition had stabilised. It has been suggested (Crilly et al. 2006) that skilled nursing home staff could decrease the length of hospital stay for their residents to the benefit of other patients requiring hospital care. Yet the analysis of the HES data for the current study did not find this to be the case as admissions from residential and nursing homes had similar lengths of stay. This would suggest that there may be considerable potential for nursing home nurses to reduce hospital lengths of stay by transferring residents back to their familiar environment sooner. It is suggested that hospital discharge teams may not always be aware of the care and expertise available within the nursing home environment and that there is a need for better communication between sectors.
The inability of nursing home staff to administer and monitor intravenous therapy has been identified as a reason for hospital transfer (Crilly et al. 2006) which is indicated in all three parts of the current study. Nurses could be influential in avoiding some admissions due to infections if they were enabled to develop skills required. Although the current study indicated that as such therapies may be required infrequently by individual nursing homes, accessing a community based intravenous therapy service may be more appropriate than training nursing home nurses and ensuring their competence is maintained.

An advanced practice nursing role has been introduced as part of the 'Hospital In Nursing Homes' initiative in Australia (Crilly et al. 2006) in order to ensure that residents received timely care in the nursing home rather than being admitted to hospital. Montalto (2001) found that 'Hospital in the Home' initiatives increased resident satisfaction. Although the current study found high levels of resident satisfaction with both hospital and nursing home care residents were most satisfied with the care they received in their nursing homes. This may indicate that if treatment was available without hospital admission that it would be preferable to residents. However as nursing homes are primarily homes for older people to live in and not mini hospitals (Goodman & Wooley 2004) it is suggested that care is needed to ensure that their primary aim is not compromised by the creation of a more medical environment.
Godden and Pollock (2001) inferred that only nursing home residents benefited from nursing input which is the case on a continuous twenty-four-hour basis but residential homes have the support of NHS community nursing services. As the only data relating to residential homes examined in this study was the HES data, it is not possible to evaluate the impact of district nursing on the emergency hospital admission of local residential home residents. Although there was no changes in district nursing input to account for the reduction in residential home admissions in year two it is possible that their input contributes to hospital admission avoidance.

The case studies within the current study found that the nursing home nurses did not always agree with medical decisions to admit residents. If residents had a poor prognosis they considered a palliative approach within the nursing home more appropriate than emergency admission for acute care. In the nursing home where the case studies were undertaken it was not the culture for doctors to discuss residents' conditions or options with the nurses caring for them and nurses did not feel empowered to challenge doctors' decisions. This could be described as the opposite to inter-disciplinary working which is advocated for effective holistic health care (Clark & Seymour 1999). It is suggested if the nurses in the case studies had been empowered to advocate for residents and
successfully challenged medical admission decisions which they had the rationale for considering inappropriate, some admissions could be avoided.

As most nursing home residents have dementia there are significant training needs for staff to ensure that all receive training in all aspects of dementia (DH 2005d) including a palliative care approach (NICE 2006) and skill is required to provide good person-centred care. It is also suggested (DH 2005d) that homes develop good links with specialist services such as community mental health teams for older people, but the nursing home where the case studies were cited found that staff had limited training in dementia care and no contact with community mental health teams.

As already discussed this study found that residents with advanced dementia were admitted to hospital and died there and there is no evidence that the nursing home nurses discussed the disease process or likely prognosis with residents or their relatives. They may have lacked the education in the support families needed as was found to be the case in a study by McCarthy et al. (1997).

A study of end of life care for residents with dementia and the roles of families and health care professionals (Gessert et al. 2001) suggested that health care professionals should take the lead in discussing death with residents and found
that relatives had limited understanding of the natural progression of dementing conditions.

Caron et al. (2005) reported that it often happened that next of kin insist on hospital admission in the case of acute illness in their demented relative because of their limited knowledge of the disease trajectory. Similarly an Australian study (Caplan et al. 2006) found that most families said that previously no one had explained the progression of dementia to them or told them that their relative was actually dying. They expressed relief at being informed as it allowed them to think more clearly about what treatment would be helpful and what was not.

The case studies found that although the residents’ acute illness was discussed with relatives the underlying diagnosis of dementia was not. It could therefore be suggested that had the nursing home nurses prepared relatives for the likely outcomes of their family member’s dementia they may have been less likely to advocate hospital admission. In addition to nursing home nurses knowledge of residents, as they build up relationships with their relatives they are ideally placed to inform and support them through residents’ final stages of dementia.
6.4 Summary of discussion

This study found that many hospital admissions were unavoidable as residents required surgery and specialist medical treatments that are not available elsewhere. There was considerable variation in admissions between homes and over time and local admission rates were considerably higher than reported in previous studies. Residential and nursing homes had similar admission rates which is in contrast to a previous study and indicates that the registered nursing contribution may not be being fully realised locally. Although hospital lengths of stay were found to be similar to previous studies at 19 days there is potential for some to be shorter. Infections were the most common reason for admission and half of admissions in the case studies were due to terminal phases of dementia and heart disease. The number of admissions resulting in death is similar locally to previous studies with some residents admitted at the end of their lives although this is not considered good practice. If most of these admissions could be avoided a 20% reduction could be achieved.

GPs were responsible for most admissions and were attentive to residents but both GPs and Out of Hours services admitted residents to hospital to access treatment when on occasions their condition and prognosis indicated that palliative care rather than curative treatment was needed. GPs only involved relatives in admission discussions if they happened to be present and neither
GPs or out of hours doctors tended to involve nursing home nurses in admission decisions demonstrating a lack of multidisciplinary working.

Care home staff and GPs lack training and expertise in the care of people who have dementia yet as most care home residents have dementia it is not surprising it was the most common hospital admission diagnosis with some residents being admitted to hospital by doctors at the end of their lives. A considerable number of these emergency admissions could have been avoided and more appropriate end of life care could have been provided within the nursing home. Yet in the UK it is not unusual for older people with dementia to be hospitalised in the last year of life although this is much less likely in other countries.

Primary care support to care homes is lacking locally as well as nationally, although policy proposes that emergency care, palliative care and mental health teams provide support across the community to improve care and avoid unnecessary admissions. Advance care planning and national end of life care tools were not in use locally although they have government support and there is some evidence to support their effectiveness. No admission avoidance initiatives, for example call centres had been introduced locally despite policy to support
new initiatives and evidence of their effectiveness. There is no evidence that the care of nursing home residents has changed despite the many government policies in the preceding years.

Although concerns have been expressed in the literature about standards of care in nursing homes and their ability to provide end of life care nursing home nurses state a preference to continue to care for their residents. This applies even when they are ill and dying rather than their being admitted to hospital, if admission can be avoided. Although most residents expressed high levels of satisfaction with the hospital care they received they valued nursing home care most which would suggest if care is available outside hospital this would be preferable.

It would appear that while nursing homes are social care environments with the emphasis on person-centred care, yet when residents' health deteriorates, care is dictated in line with the traditional bio-medical model. For example doctor's lack of involvement of residents and relatives in decision making failed to recognise that life is grounded in relationships. Also the care of residents with end stage dementia focused on medical treatment of symptoms rather than the impact of the condition on the individual and their family.
This study has found that while many hospital admissions are unavoidable, it also identified that some residents' needs could have been better met outside acute hospitals. New approaches and services will need to be developed to meet these needs within the nursing home setting, for example residents with end stage dementia. The need for a new model of care has been identified by Crilly et al. (2006) whose study of continuity of care for acutely unwell older adults from nursing homes examined current models within health care systems. This concluded that none adequately allowed for the provision of continuous care for acutely unwell residents and suggested that a model of care that provides for this population would benefit both residents and providers.

A model that links the ideology of government policy to the delivery of care at clinical level to improve resident experience has been developed from the findings of this study, recent policy and literature as well as the experience of admission avoidance initiatives implemented elsewhere.

6.5 The 'Home for Life' model

6.5.1 Introduction

A 'Home for life' nursing home care model is suggested (Figure 6.1) to improve residents' experience by providing them with the most appropriate care to meet
their needs especially at the end of life. This approach will not only reduce avoidable emergency hospital admissions but allow residents to die in their own homes, unless hospitalisation is in their best interest. The main elements of this model are described with the rationale for their inclusion in future practice, under the following headings; family involvement, advance care planning, call centres, consultant input, community support teams, community mental health teams and end of life care.

6.5.2 Family involvement

Families are important to residents and to the delivery of person-centred care (Brooker 2004). Not only is it good practice to involve families in the care of residents (DH 2003a) following the Mental Capacity Act 2005 (Department of Constitutional Affairs 2005a) if nominated by the person receiving care, family members gain the right to be consulted about care decisions. Although this Act had not been implemented at the time of this study it is likely to lead to regular family involvement in the future. This will require a change in practice as the case studies found doctors only involved relatives if they happened to be present.

In addition to being consulted Allen et al. (2003) suggest the education of family members is essential for them to make informed decisions. Relatives would
particularly benefit from being given information on the progress of dementia and involved in advance care planning as described by Caplan et al. (2006) and Butterworth et al. (2008).

6.5.3 Advance care planning

It is likely that advance care planning could have avoided some of the admissions in the case studies and allowed residents to die with dignity in their own familiar environment but ACP is not routinely offered in care homes in England and Wales (Butterworth et al. 2008). Yet the involvement of residents in decisions concerning their care is considered key to best practice (Help the Aged 2007) and it has been suggested that for some residents advance care planning could enable more informed decisions to be taken (Bowman et al. 2001). Discussions regarding the nature and intensity of interventions should acute illness occur in the context of the individual's prognosis and preferences may provide more humane as well as more efficient health care for older people (Bowman et al. 2001; Nicholson 2007).

Forbes et al. (2000) advise that advance care planning is initiated upon admission to the nursing home and is the beginning of a communication process that continues over time and is prompted by changes in the individual's physical
condition. This would help prepare residents and relatives for the likely progress and outcomes of the resident’s condition, hospital admissions would be avoided and residents’ end of life care needs more appropriately met.

When terminally ill nursing home residents were consulted about hospital transfer, hospital admission rates reduced as most residents wanted to die in their nursing home (Mezey et al. 2002). An Australian study by Caplan et al. (2006) found that when the preferred place of death was determined as part of advance care planning all 84.4% chose the nursing home. Relatives reported that they were happy with good deaths amongst friends and loved ones in the nursing home. Advance care planning led to a reduction of 22.6% in hospital admissions being achieved in the first year and an overall decrease of 35.4% in three years. Due to ACP the hospital admission of nursing home residents in Holland is now rare and not only is financial saving achieved but more appropriate end of life care delivered (Hertogh 2006). These studies demonstrate the impact of ACP on achieving person-centred palliative care within the nursing home instead of the hospital admissions and indicates the huge potential of adopting ACP in the UK.
6.5.4 Admission avoidance initiatives

As the reduction in emergency bed days is a new imperative for the NHS this would explain that although localities are implementing initiatives, published evidence of their effectiveness is limited, but reports would suggest that they can have a considerable impact on emergency bed days. However initiatives have been successfully implemented for nursing home residents in the USA and have been in place for over a decade. For example Zimmer et al. (1998) reported achieving an 88% reduction in admissions but as very different health systems prevail it is difficult to translate approaches into the UK context, but it would indicate that there is potential for initiatives to be effective.

Call centre

An emergency care pathway illustrates how patients should be treated in order for best health outcomes and value for money to be achieved (NHS Institute for Innovation and Improvement 2006). It suggests that all referrals are via an integrated call centre for GPs requesting further care for their patients, with the aim of appropriately streaming patients, using an assessment process to the most appropriate service from a menu of options.
A single point of access for all non 999 calls which offers GPs alternatives to admission twenty four hours a day has proved successful in Liverpool (Jones & Norbury 2007). As the current study found GPs were responsible for nearly all hospital admissions having a system that required them to explain their rationale for deciding to admit residents would mean that all potential admissions were scrutinised. Decisions would be shared between the GP involved and someone with clinical knowledge who is familiar with local alternatives to hospital admission. This would be of particular benefit to out of hours services as the current study found their doctors always admitted residents without assessing them. It would also provide doctors with the opportunity to discuss individual cases with other health care professionals and consider options which they may not otherwise be aware of. It is suggested that if all admissions were via an integrated call centre this would have avoided the admission of residents who had a poor prognosis and died soon after hospital admission. Clearly for such a system to operate a comprehensive range of alternative services would need to be available.

Consultant input

The BGS perceives that the involvement of geriatricians would reduce inappropriate hospital admissions of care home residents (Mulley 2007b). This approach is proving effective in Liverpool (Jones & Norbury 2007), although no
detail as to the specific input by the consultants is included or the extent of reductions in admissions. Also an outreach team led by a consultant geriatrician in Nottingham estimated that 190 bed days had been saved over a four month period (Snape et al. 1999) but again the detail of how this was achieved has not been published.

Accessing geriatricians via hospital based consultant clinics has been suggested (DH 2007a) for community residents to be seen within 24 hours which may benefit less seriously ill or less frail older people. The residents who were admitted as emergencies in the current study would not have been well enough to travel to an outpatient clinic. It is suggested that in the case of nursing homes it would be more appropriate for GPs to be able to access geriatricians for advice by telephone or request that the geriatrician visits the resident in the nursing home.

The study by Sayers and Perera (2002) found that almost all the GPs participating said they would allow the relative's preference to override their admission decisions. Yet geriatricians said relatives would not change their decisions which were mostly not to admit, demonstrating the additional value of consultant involvement to admission avoidance. It is suggested that better access
to specialist medical opinion would be valued support for GPs. Their expertise could assist them in managing residents in the nursing home rather than admitting them to hospital as well as helping them to decide whether the focus of care should be curative or palliative.

*Community support teams*

The Department of Health (2007a) states that community specialist health and care teams aimed at reducing the need for acute hospital services need to be developed to support primary care teams. A multidisciplinary support team linked to Rapid Response and Rehabilitation teams in Flintshire reported a 31% reduction in admissions to secondary care from one nursing home over a nine month period saving an estimated 165 bed days and £33,000 (Heath 2007). This would indicate the potential benefit of such teams to nursing homes although their exact input and how this avoided hospital admissions was not explained.

The inability of nursing home staff to administer intravenous therapy has been sited as a reason for hospital transfer (Crilly *et al.* 2006) and it is suggested that this is a service that could be provided by a community support team. This type of treatment being made available within the nursing home environment is
appreciated by residents (Montalto 2001) and the findings of the current study would suggest that this would be the preferred treatment option locally.

*Community mental health teams*

Although the majority of care home residents have dementia nursing home staff and GPs have been found to have limited knowledge and expertise in this important sphere of practice. As well as multidisciplinary education input from specialists is therefore indicated. A government report Securing Better Mental Health for Older Adults (DH 2005d), suggests that mainstream and specialist services working together to improve care could minimize unnecessary emergency hospital admissions. The findings of the nursing home study would support this approach due to the high prevalence of dementia and the hospital admission of residents at the end of life. At the time of this study local nursing homes did not have any input from specialist mental health services but the implementation of the new dementia strategy (DH 2007a) may help facilitate this.

6.5.5 End of life care

Seymour and Hanson (2001) suggest that geriatrics and palliative care from their earliest days have embraced a set of strikingly similar concerns. Both attend to symptom control, while advising the judicious use of investigations and rejecting
highly invasive and aggressive treatment modalities, both make the person and the family the unit of care and led the way in developing multi-disciplinary models of care. In so doing parallel discourses of patient centred care, quality of life, dignity and autonomy have been developed (Seymour & Hanson 2001). This demonstrates the negative effects of the dismantling of NHS long-term care for older people and a return to this ethos is advocated for future models of care.

Ensuring dignity at the end of life is one of the aims of the New Ambition for Old Age (DH 2006a) and facilitating best practice in delivery and education in end of life care, in care homes is considered a means of achieving this. The National Minimum Standards (DH 2003a) states that residents should be able to spend their final days in their own rooms surrounded by their personal belongings, unless there are strong medical reasons to prevent this, yet this was not the case in the nursing home study. In line with government good practice guidance, a planned approach to the end of life care of nursing home residents needs to be adopted and all parties will need to have education and training to prepare them for this different approach.

It has been suggested that older people with multiple health problems deteriorate over time making it difficult to define when someone is actually dying (Froggat
Yet a 'good death' can only be achieved if staff recognise and take the necessary responsibility in managing the process of dying (Nicholson 2007). This appeared to be lacking in the present study. GPs will be required to make these decisions and appropriate onward referrals to ensure residents’ needs are met. This could be to community palliative care teams, mental health teams, Out of Hours services, specialist nurses, allied healthcare professionals, emergency response teams, medical consultants, hospital or hospice care. Residents need to have access to a range of expertise to meet their needs which is not currently available locally. Implementing the Gold Standards Framework and Liverpool Care Pathway and Preferred Priorities for Care Plan can improve the quality and co-ordination of end of life care as they facilitate communication between care providers, GPs, primary health care teams and palliative specialists (Thomas 2003). As they are also aimed at avoiding crisis hospital admissions they could be particularly helpful for Out of Hours doctors as they have no previous knowledge of or contact with the patient and as found in the current study are likely to admit dying residents to hospital.

Another main benefit of using end of life care tools is seen as the introduction of choice and control over residents preferred place of care during their final days and the reduction of unnecessary emergency hospital admissions at the end of life (DH 2006b). Instead residents are afforded the dignity to live out their lives in
a comfortable environment with familiar staff that have cared for them throughout (Healthcare Business 2007).

End of life care in dementia

Hospitalisation no longer meets the treatment goals of residents with end stage dementia and comfort and care can be adequately delivered within the nursing home (Lamberg et al. 2005) despite this the case studies found residents were admitted to hospital.

Careful assessment is considered a precursor to effective treatment (Allen et al. 2003) and the importance of clinical assessment in order to define prognosis is stressed by. It is suggested that this is used to differentiate between patients at immediate risk of death from those who may benefit from clinical interventions. Expected death within a six month period would deem patients appropriate for palliative rather than acute care (Rozzini et al. 2007). GPs need to be able to decide if a curative or palliative approach is warranted (Caplan et al. 2006). Assessment and sound clinical decision making is key to all residents having their individual needs respected and met by either the most advanced technological and pharmacological interventions or palliation (Rozzini et al. 2007). Zvi Aminoff & Adunsky (2005) found that patients with end stage dementia
experienced considerable suffering and stress the importance of assessment of suffering in this patient group who cannot communicate.

Yet as already explained doctors have limited experience of advanced dementia and do not receive any specific training with regard to medical treatment approaches (Hergoth 2006). Despite this the NICE dementia guideline (NICE 2006) requires them to assess the palliative care needs of people close to death and communicate the result with other health and social care staff. In the light of the findings of this study the multidisciplinary involvement of mental health and palliative care specialists and geriatricians could provide support to GPs and nursing home nurses and significantly reduce the number of nursing home emergency hospital admissions.

The care of residents with end stage dementia is likely to be time consuming for GPs when specialist training, advance care planning, discussions with relatives and nursing home staff and providing or arranging in situ end of life care are taken into account. It is suggested that it may therefore be difficult to get the commitment of GPs unless they can be incentivised.
An American study of end of life decision making for nursing home residents with dementia (Forbes et al. 2000) found that family members had poignant, unresolved emotional needs stemming from their loved one’s illness and nursing home placement. Participants reported needing assistance in processing difficult and painful emotions and a lack of informational and emotional support by the nursing home which would have helped them understand the trajectory of disease and what decisions might impede a natural death and comfort or palliative care options.

Relatives may be more ready to choose palliation as a goal of care if they have established close relationships with care providers over time (Lamberg et al. 2005). Although this was not the case in this study a proactive approach to communication and family involvement could alleviate much of the stress experienced by relatives. It is suggested if residents were better informed they would be less likely to advocate hospitalisation and this would facilitate appropriate end of life care for this group of residents and make a significant contribution to hospital admission avoidance.
6.5.6 Summary of the "Home for life" model

The 'Home for life' nursing home care model proposed acknowledges the living - dying continuum (Travis et al. 2001:154) and focuses on meeting the resident's assessed needs throughout their nursing home journey. As well as meeting residents' health and social care needs, achieving the highest possible quality of life and a comfortable death in their own home is the ultimate aim.

Central to an appropriate model is continual access and equity in service provision, empowerment for the older person and his or her family and a physical and social environment within which health can be achieved (McMurray 2003). Also an interdisciplinary approach to care and education is considered essential (Masterson & Maslin-Prothero 2005) with residents, families, nursing home staff, GPs, Out of Hours services and all external health care professionals being included.

Fundamental to this proposed model of care is a person-centred approach which values the person as an individual and supports them and their families to make informed decisions about care choices and plan for the future. Residents would continue to have access to a range of acute services to meet their assessed needs, including emergency admission to secondary care when appropriate.
However the focus would shift to residents having their needs met within the nursing home when possible and when appropriate, palliative care rather than curative treatment. In order to achieve this in addition to the current community service provision, for example GP and other health care professionals, they would also have access to specialists, for example medical consultants, community mental health and end of life care teams.

The main elements of the proposed model have been described with evidence to support their inclusion and this demonstrates that it is a credible model that can realistically be adopted for the benefit of residents. Although the intended outcome of the study was to inform an admission avoidance strategy the study has identified the need for this new model of care which will not only achieve a reduction in hospital admissions, but better outcomes for residents.
Figure 6.1 ‘Home for Life’ Nursing Home Care Model

- Community Specialist Palliative Care Team
  - GP & Out of Hours Services
  - Community Mental Health Team
  - Allied Healthcare Professionals
  - Specialist Nurses

- Community Rehabilitation Team

- Living/Dying

- Medical Emergency

- O.P. Clinics

- Call Centre

- Acute hospital
- Community Hospital
- Hospice
- Emergency Response Team
- Geriatrician

- Person-centred Health and Social Care

- Recreation
- Activities
- Dentist
- Optician
- Podiatrist
Part 2 The second part of the chapter discusses how the methodology chosen and the design of the study created new knowledge, the strengths and limitations of the study and suggestions for future research.

6.6 Critique of methodology and methods
As little was already known about the subject locally and nationally, the inductive approach, constructivism epistemology and theoretical perspective of symbolic interactionism, adopted in the study proved appropriate. The interpretative process facilitated understanding the phenomenon in context and encompassed both the emic (individual resident) and holistic perspective (nursing home) and answering the research questions.

The findings of the case studies was in contrast to the theoretical framework of integrated person-centred palliative care underpinning this study, although it was useful in defining good practice and a yard stick with which to compare current practice. The models and principles within the framework provided the basis for the model proposed as a result of the study. The methodology chosen for this study has facilitated answering the research question and provides the evidence to inform a local hospital admission avoidance strategy which was the intended outcome of the study.
6.6.1 Methods

The inductive approach found that there are many factors involved in the hospital admission of care home residents and highlighted that it is possible to draw inaccurate conclusions when only HES data, which is the only data routinely available, are used. Whereas by undertaking a local study using a mixed method approach the reliability of the findings is enhanced.

As this study aimed to ensure that the opinions of nursing home residents were considered when a local hospital admission avoidance strategy was formulated, interviews were considered an essential research method. Engaging with users is in line with Bernard (2007) who believed that older people in residential care should have their voices included so that commissioners and providers can be influenced and shape services in the way residents want. In addition the Change Agent Team (DH 2004d) made it very clear that the approach to hospital admission avoidance advocated, included a strategy that had user and carer input. The current study found that nursing home residents were keen to be interviewed and discuss their hospital admission and nursing home experience and by including four homes as research sites the sample size proved adequate.

Had HES data and interviews been the only methods used the hospitalisation of residents with dementia at the end of life would not have been apparent, but this important unexpected issue was identified through the detailed examination of a nursing home's hospital admission activity. This part of the study benefited from
the case study method's ability to compare cases and to synthesise both qualitative and quantitative evidence. The three pronged approach to the study proved successful in providing a comprehensive picture of the issue locally.

6.6.2 Data collection and analysis
Although some difficulties were experienced with the data collection (already explained in Chapter 4) the questionnaires and interview schedules were successful in capturing the relevant data to answer the research questions. The methods of analysis for both the quantitative and the qualitative data were successful although analysis of HES was tedious due to the way it was presented on receipt.

6.7 Original contribution to new knowledge
The factors that lead nursing home residents to be admitted to hospital as emergencies is a neglected area of research in the UK (Appendix 1) but the subject has become a focus of attention nationally, in recent years due to government targets and escalating costs. Locally the issue had never been examined and as a result of this research the factors leading to local admissions have been established. Although this was a small study any additional more recent contribution to the limited research evidence available is likely to be beneficial.
Most significantly no published studies have been identified that have included the views of nursing home residents who had experienced hospital admissions. None have examined the hospital admission activity of one nursing home over a period of time. Although HES data has been used in a few studies none have examined and compared the care home data for homes within a PCT locality and no studies have compared the data for two consecutive years.

Although as local circumstances vary there may be limitations to the generalisability of the study findings, theoretically however, the findings contribute to the limited body of knowledge on issues surrounding the emergency hospital admissions of care home residents. This study highlights the need for repeated local studies and as the methodology chosen proved effective in this study it could be used as a template to replicate the study elsewhere.

For the first time nursing home residents have been asked about emergency hospital admission and it is clear from this study that they are accepting of and grateful for emergency hospital care when it is needed but have an overall preference for nursing home care. This is the only evidence that care home residents are likely to support hospital admission avoidance initiatives when appropriate. Although previous studies have ascertained nursing home residents’ views on nursing home care, residents have not previously been asked for their views on emergency hospital admissions. Neither have they had the opportunity
to contribute to research on the quality of hospital care they have received or compare their experiences between hospital and nursing home.

The findings of this study and the literature reviewed have provided the evidence for a proposed ‘Home for life’ nursing home care model (Figure 6.1). This is aimed not only at hospital admission avoidance, but quality of life and dignified end of life care for nursing home residents. The study shows that recent policy initiatives have not been implemented; the findings demonstrate that change in practice is needed and the literature reviewed provides the evidence for this model. The implementation of this model is realistic and would improve nursing home care, reduce reliance on secondary care and save money.

Despite the evidence to support this model it is acknowledged that it is theoretical and although some components have proved successful as a model it is untested. It will therefore require piloting and evaluation before its implementation and time before its success can be proven. The views of nursing home residents should be central to ongoing evaluation.

6.8 Strengths of the study
Although this was a small study it included an examination of all admissions for all care homes within a PCT making the findings pertinent locally. In addition as one home was studied and residents interviewed this study has encompassed
district, unit and individual perspectives. Nursing home managers not only verified case studies and resident interviews but expressed a professional opinion on the appropriateness of hospital admissions, providing a professional carer perspective on the relevant issues.

6.9 Limitations of the study

- This research was a small local study. The HES data examined was for 2003-2004 and 2004-2005 and although it provides an overview of the situation locally more up to date data may have been more meaningful.
- As most nursing home residents have dementia the views of those interviewed cannot be considered representative of the nursing home population.
- Despite the case studies producing interesting findings, they may not be generalizable as although the home appeared typical of local homes, each home uses different GP practices, although locally the same Out of Hours service is used.
- Although doctors instigated almost all of the admissions in the case studies and the residents interviewed following admissions, they have had no input to the research.
- As the case studies were all of the residents who had hospital admissions, the research did not include the care of other residents in that nursing home or provide insight into whether other ill and dying residents avoided hospital admission or how they were treated.
• Relatives were not included in the study although their views on hospital admissions would have added another dimension.

6.10. Suggestions for future research
As the case studies and previous studies identified that Out of Hours services was a factor contributing to avoidable emergency admissions and these are relatively new services, it is suggested that such services are the subject of larger more in depth studies. In the light of the findings of this study and the literature reviewed future research should focus on educational strategies designed to promote the adoption of a palliative approach to caring for residents with advanced dementia and the improvement of end of life care within nursing homes.

Part 3 Includes implications for practice and the conclusion of the study
6.11 Implications for practice
This study found that emergency admissions warrant local monitoring on a regular basis to ensure that PCTs are aware of the care being delivered to their local care home population and use the information to ensure their needs are met.

The residents’ interviews found that hospital nurses did not have enough time meeting the needs of nursing home residents when they are under their care.
This study has also found that they would benefit from opportunities to examine their attitudes and values in relation to frail older people and becoming more aware of what is important to nursing home residents.

To comply with recent policy initiatives, good practice guidelines and the findings of this study, new approaches to care need to be adopted and new services need to be developed to support care home residents; especially those with advanced dementia and nearing the end of life. GPs and care home staff need to develop their knowledge and skills in order to provide better care for the majority of residents. Care homes need to become part of a whole systems approach and residents should have equitable access to NHS support.

There is an urgent need for care homes across the UK to introduce advance care planning and implement national tools to improve end of life care. GPs need to adopt a more interdisciplinary, family centred approach to care and include families and care home nurses in decisions about treatment options and admission decisions and only admit residents when there is no alternative.

6.12. Conclusion

Many care home residents need and benefit from treatment that is not available outside acute hospitals and this study reinforces the view that general hospital care, when needed will remain a key element of the care of older people (DH
2007a). It is acknowledged that an increase in the number of older people being admitted to hospital than previously is to be expected, as in the past they were denied access to various treatments due to ageism, but fortunately this is now rare (DH2002b).

The current study has found that although there are many commonalities there are many variables in nursing homes and their residents, so that no nursing home can be described as typical. For example, the current study even found considerable differences between the two NHS nursing homes operated by the same PCT, highlighting the need for regular, local studies to identify local needs and the services required to meet them.

While nursing homes adopt a person-centred, primarily social care model it is clear that the traditional medical model takes over when residents become acutely ill or their health deteriorates. While previously NHS long-term care focused on symptom control and avoiding unnecessary interventions, promoted quality of life, family centred and multidisciplinary working, care homes are professionally isolated and health care provision is determined by GPs. A new model is needed to include the return to the previous ethos of care and care homes need to be part of a whole systems approach to care.
In contrast to the literature (BBC News 2005; Change Agent Team 2006; Guilland 2007; Partridge 2008) only a few hospital admissions were arranged by nursing home nurses. GPs have been described as the gate keepers of secondary care (Howse 2007) but this study found that neither they nor their out of hours colleagues had any hesitation in admitting residents to hospital. Therefore it is suggested that a more appropriate analogy would be that GPs hold the key to secondary care as they are responsible for almost all admissions and will therefore be crucial to any change in practice. They decide, often without consulting relatives or conferring with nursing home nurses, if residents access hospital care and where residents end their days. On occasions they admitted residents even when prognosis indicated that curative treatment was unlikely to be successful. Rather than being deprived of hospital treatment it would appear that at times they were subjected to it unnecessarily. In addition, as out of hours services failed nursing home residents and as there is other evidence that these services contribute to avoidable admissions (Read 1999; Montalto 2001; Crilly et al 2006; Chambers 2007), a change in their approach will be required if future admissions are to be avoided. It is suggested that the approach of GPs and out of hours services identified, is to be expected as their frame of reference is the bio-medical model described earlier. Their theoretical stance could be described as a constructivist epistemology as truth and meaning are created by experience and related to the context of the phenomenon. As already discussed research has shown that GPs perpetuate what is familiar and are influenced by the practice of colleagues. Although the need for a change in practice by GPs and out of hours doctors has been identified this helps explain the existing practice which appears to be socially constructed to reflect a bio-medical culture.
As nearly a fifth of all deaths occur in care homes and this study found avoidable admissions resulted in death in hospital, end of life care for residents, warrants urgent attention. While the policy and tools are available, support with their implementation is required and in reach services will need to be developed.

As this study found that both hospital admission rates and lengths of stay for nursing home residents were similar to residential homes, it would appear that the potential contribution of nursing home nurses may not be being maximised. There is potential for hospital admissions from nursing homes to be reduced and individual lengths of stay shortened due to the 24 hour availability of the expertise of registered nurses.

Although most residents interviewed expressed high levels of satisfaction with hospital care they valued nursing home care most which would suggest if care is available outside hospital this would be preferable.

As well as hospital admission avoidance achieving financial savings for the NHS it is suggested that changes in service provision provides an opportunity to develop services that better meet the needs of care home residents. This is the view of the government who made it clear in its guidance on hospital admission avoidance (DH 2004d) that this work should focus on improving outcomes for
older people. The Department of Health's vision for the future of older peoples' services states that:

"the common thread which runs throughout is supporting the well being of older people by providing the right services in the right way to meet their needs and aspirations" (DH 2004c:56).

The 'Home for Life' nursing home care model developed as a result of this research (Figure 6.1) shares this vision and its adoption will integrate the NSF standards so that nursing home residents are neither discriminated against nor subjected to treatment which is not in their perceived best interest. As this study found that a fifth of care home emergency admissions result in death, it is suggested if this model was adopted 20% of admissions would be avoided.
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St George's Hospital Medical School (1999) Nursing Home Placements for Older People in England and Wales; A National Audit 1995-1998. Department of Geriatric Medicine, St George's Hospital Medical School, London.


## APPENDIX 1 UK Studies on Care Home Admissions to Hospital

<table>
<thead>
<tr>
<th>Source</th>
<th>Title / Aim</th>
<th>Methodology</th>
<th>Findings</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beringer T &amp; Flanagan P (1999) The Ulster Medical Journal Volume 68, no1, pp 27-29</td>
<td>“Acute medical bed usage by nursing home residents.” Study undertaken in 1996/1997 to identify numbers of residents in 1300 acute medical beds</td>
<td>Survey undertaken by ‘medical practitioners’ of acute medical beds in Northern Ireland. All beds were audited, using a pro-forma, circulated to a nominated geriatrician in every NI hospital with acute medical beds, on a single day in June and repeated in January.</td>
<td>• 84 nursing home residents occupied 6.5% beds available in June 1996 &amp; 125 residents 9.6% of medical beds in Jan 1997, representing .91% &amp; 1.36% of NH residents • 4% rise was considered a seasonal variation. • LOS 23 days for June &amp; 11.2 days for January • Considered that 9.6% patients could have been treated in nursing homes • Most common reasons for admissions given were chest infections and strokes. • Estimated cost of treating nursing home residents in hospital between £4,600,000 and £6,800,000 per annum</td>
<td>• “Assessing doctors judged…” the appropriate ness of admissions – no indication of admission criteria or experience of the doctor carrying out assessment s. • No involvement of residents, GPs or NH nurses. • No information to support the assertion that some admissions could have been avoided • From the pro-forma details given it appears ‘judgement s’ were made on the basis of diagnosis. • Not clear if the beds included was all the acute beds available • No comment on variation of LOS</td>
</tr>
<tr>
<td>Source</td>
<td>Title / Aim</td>
<td>Methodology</td>
<td>Findings</td>
<td>Remarks</td>
</tr>
<tr>
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</tr>
<tr>
<td>Bowman CE, Elford J, Dovey J, Campbell S and Barrowclough H (2001) Postgrad Medical Journal 77, 40 - 42</td>
<td>&quot;Acute hospital admissions from nursing homes: some may be avoidable.&quot; Study undertaken in 1994 involving 898 nursing home beds in the catchment area of the Weston General Hospital, Avon</td>
<td>Retrospective survey of admissions over 1 year, cases identified from patient administration system and hospital records. Random sample of medical records for ½ of acute medical emergencies from nursing homes examined and a questionnaire used to record admission characteristics.</td>
<td>• 250 emergency admissions, 4652 bed days • mean rate of admission / nursing home bed / year .34 • Mean LOS 19 days, maximum 92 days • 65% improved, 19% died, outcome unclear for remaining 16% • Multiple diagnoses commonplace • 47% admitted due to infection, heart disease or stroke, 21% due to fractures • Unclear diagnosis for remainder • Complications of chronic diseases greatly exceeded new diagnoses as cause of admission • 17 hip fractures – 50% mortality rate • Suggest resourced infection management and day care for transfusions</td>
<td>• Some admissions classified as 'immediate' and others 'emergency', but terms not defined. • Study limited as retrospective and only hospital notes used. • Background research team unclear. • No indication as to how the study findings were used in the 6 years from completion to publication. • No indication if any residents had more than one admission. • No detail on admissions due to infection.</td>
</tr>
<tr>
<td>Source</td>
<td>Title / Aim</td>
<td>Methodology</td>
<td>Findings</td>
<td>Remarks</td>
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<tr>
<td>Godden S and Pollock AM (2001) Health and Social Care in the Community 9 (6), 367-374</td>
<td>&quot;The use of acute hospital services by elderly residents of nursing and residential care homes.&quot; Study undertaken in 1997/1998 involved 232 care homes and 3204 residents Cited as only UK population based study to analyse use of acute sector by care home emergency admissions Study aimed to compare hospitalisation rates (by cause of admission, hospital death and LOS) of care home residents with older people admitted from own homes, and describe trends in admissions.</td>
<td>Study was a retrospective analysis of a year's hospital admission data for one health district. Hospital admission data was analysed and care home admission rates were calculated and relative risks compared to the community using Epilinfo. Admission by diagnoses was calculated and hospital mortality rates. The Mann-Whitney U-test was used to compare hospital lengths of stay.</td>
<td>• 847 admissions equivalent of 26.4% of beds • Admission rates higher for residential homes (31%) than nursing homes (22%) • Relative risk of 1.39 of admission from a home • Difficulty in monitoring admissions due to poor quality recording and NHS coding • 63% of over 85 year olds admitted from care homes died compared to 36% from own homes • 3 fold risk of admission for falls for care homes • No difference between care home and own home admissions LOS except fractured NOF stays shorter for care home residents • Commonest reason for admission was diseases of respiratory system 160. Deaths (230).</td>
<td>• The complexities of identifying population groups within a locality are highlighted and of accessing admission data. • Detailed admission diagnoses information, statistically analysed and well presented. • Study demonstrates the importance of nursing input and suggests a relationship between hospital admissions and levels of nursing care. • Study identified the extent care home residents occupied hospital beds and how this compared to those living in their own homes but did not comment if admissions were appropriate or not.</td>
</tr>
<tr>
<td>SOURCE</td>
<td>Title / Aim</td>
<td>Methodology</td>
<td>Findings</td>
<td>Remarks</td>
</tr>
<tr>
<td>--------</td>
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</tr>
<tr>
<td>Read S (1999) Nursing Standard Vol 13 No 33 p32-35</td>
<td>&quot;Inappropriate admissions to hospital: the views of nursing and residential homes.&quot;</td>
<td>Questionnaires drawn up by representatives of care homes, and piloted in 10 homes before being circulated and completed by care home staff. No detail of the questionnaire content or discussion on how data was analysed. Researcher admits problems with sample and questions due to her lack of experience.</td>
<td>• 60% of admissions due to new problems for residents  • 40% exacerbation of pre-existing illness  • 46% of homes had experienced the readmission of a resident within 2 weeks of care home admission from hospital  • Reasons for admissions in order of prevalence CVA and cardiac, falls and fractures, infections, dehydration and IV therapy, medical investigations, psychiatric and rehabilitation  • 30% of care homes identified inappropriate admissions as those to provide terminal care on the insistence of the client’s family or the locum GP  • 80% of admissions arranged by GPs</td>
<td>• Although the study was specifically focused on the views of care homes it was staff and not residents or relatives who participated.  • The role of the GP in care home admission to hospitals is highlighted.  • Although 30% could identify occasions when they felt admissions could have been avoided this was not quantified  • Link between admission avoidance and staff training.  • Results presented in a clear and simple way.</td>
</tr>
<tr>
<td>SOURCE</td>
<td>Title / Aim</td>
<td>Methodology</td>
<td>Findings</td>
<td>Remarks</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Zaatar A</td>
<td>&quot;A suitable case for treatment?&quot; Study undertaken in 1999 in 47 Nursing</td>
<td>Health Authority commissioned study undertaken by a university over a 9</td>
<td>• 66% response rate</td>
<td>• It is not clear if the author was the researcher.</td>
</tr>
<tr>
<td>(2001) HSJ</td>
<td>Homes in Sefton, Merseyside to identify the level of emergency referrals</td>
<td>month period. Retrospective census questionnaire sent to all nursing</td>
<td>• Consensus on A&amp;E referral criteria</td>
<td>• Report focuses on the study findings without supplying detail of how it was undertaken.</td>
</tr>
<tr>
<td>19.04.2001</td>
<td>from nursing homes to primary care and A&amp;E, and whether they were</td>
<td>homes. Prospective survey referred to but no details given. GP interviews</td>
<td>• Moderate correlation between the number of beds in the home and the</td>
<td>• The focus is more on NH referrals to GPs as only the number of A&amp;E attendances is mentioned without differentiating between those admitted and discharged from A&amp;E.</td>
</tr>
<tr>
<td></td>
<td>appropriate from the perspective of the GP, A&amp;E and the nursing home.</td>
<td>mentioned but no numbers given and no information on how data was</td>
<td>number of referrals, average .41 per home per month</td>
<td>• Report very unstructured and difficult to follow.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>collected or analysed.</td>
<td>• Inappropriate referrals not a significant issue</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Suggests that a protocol for classifying &amp; prioritising, emergency</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>referrals from care homes to GPs should be considered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Suggests the role of a specialist nurse should be examined</td>
<td></td>
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</tr>
</tbody>
</table>
APPENDIX 2
RESIDENT HOSPITAL ADMISSION QUESTIONNAIRE

Resident Code...........
To be completed by nursing home nurse involved in the admission

1. Male  Female (please circle) - Date of Birth ............................................

2. Date of Admission to Nursing Home ..........................................................

3. (A) Place admitted to Nursing Home from
Hospital    Home    Other (please circle)
(B) Give details
........................................................................................................................................

4. Reason given for admission to the Nursing Home
........................................................................................................................................

5. Main diagnoses on admission to the Nursing Home
........................................................................................................................................

6. List any previous admissions to hospital from the nursing home
(1) Dates of admission(s)
........................................................................................................................................
(2) Reasons for admission(s)
........................................................................................................................................
........................................................................................................................................
(3) Date of discharge(s)
........................................................................................................................................
........................................................................................................................................
(4) Outcomes of admission(s)
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

7. (A) Summary of health problems immediately prior to this hospital admission
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
(B). Describe any actions taken to avoid admission
........................................................................................................................................
........................................................................................................................................
8. Summary of GPs pre-admission assessment / content of GP referral letter

9. (A) Admission instigated by: - doctor - resident - relative - nursing home
(Please comment)

10. Admission arranged by: - own doctor - partner in GP practice - GP - Co-op - other (please circle)
(Please comment)

11. Name of admitting hospital

12. (A) Transport to hospital: 999 call - booked LAS ambulance - other
(B) Transport arranged by: ........................................................

13. Date of admission ........... Day .............. Time ...... (24hr clock)

14. Summary of hospital treatment

15. Length of hospital stay (in days) .............................................

16. Date of discharge ..................................................................

17. (A) Outcome of admission ---------- please circle

   Returned to NH     Discharged elsewhere     Died in hospital

(B) Please give details

18. If the resident returned to the Nursing Home, list any changes in clinical management or follow up arrangements

19. Additional information or comments

Signature of nurse ................................................

Print Name ................................................

307
APPENDIX 3
INTERVIEW SCHEDULE: SENIOR NURSING HOME NURSES

Interview date.............Staff code.............
Resident code...............  

1. What factors contributed to her / his hospital admission?

2. What would you say is the outcome of the hospital admission?

3. In your opinion was admission to hospital appropriate? Yes / No

4. If yes, why do you think it was?

5. If no, why do you think it was not appropriate?

6. In your opinion could it have been avoided? If so how?

7. What do you think could be done to avoid future hospital admissions?

8. Any other comments?
APPENDIX 4
RESIDENT INTERVIEW SCHEDULE

Interview date..............................................

Resident code............................................

1. How long have you been in the nursing home?

2. I understand you were in hospital recently - How did you feel about going to hospital?

3. What do you think caused you to be admitted to hospital?

4. How were you involved in the decision (to go into hospital)?

5. What was your stay in hospital like?

6. What did the hospital do for you?

7. Is the health problem resolved? Yes / No

8. If not what else could be done about it?

9. Do you think you could have avoided going into hospital?

10. What would you have liked to have done?

Any comments you would like to make that were not covered by my questions?
EMERGENCY ADMISSIONS OF OLDER PEOPLE FROM NURSING HOMES TO ACUTE HOSPITALS

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?
To find out how nursing home residents feel about going into hospital as little is known about their views, yet the views of residents are really important and should be taken into account when planning services in the future.

Why have I been chosen?
All residents of your nursing home who are admitted to hospital over a six month period are being invited to take part in the study in order to get as wide a range of experiences and views as possible. It is therefore likely that around 14 residents will be eligible to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason. A decision to withdraw at anytime or a decision not to take part, will not affect the standard of care you receive.

What do I have to do?
If you decide that you would like to take part you will be asked to give your written consent to being interviewed and to the interview being tape recorded. You will be given a copy of the signed consent form to keep. Interviews are likely to last an hour.

Who will be doing the interviews?
Mary Clay who is doing the study as part of a course at the University of Surrey and she is also a consultant nurse employed by the local NHS Trust.
Who else is involved?
Every resident who is admitted to hospital over a six month period and providing they give their consent, their relatives or friends can be interviewed as well. Your GP will be informed.

What happens if I agree and then change my mind?
You are free to change your mind at anytime – even after the interview has started.

What happens should I find any part of the interview upsetting?
If this happens the interview will stop immediately and you will be given support and advice.

Will the information I give be kept confidential?
Yes. Interviews will take place somewhere private, like your own room. Your name will not be recorded on tape or on any written report and tapes will be erased at the end of the study.

What happens afterwards?
The interview will be transcribed and analysed and you may be asked to check it for accuracy and to see if you agree with the conclusions. A summary of the report of the study will be available to you soon after it is completed and no later than December 2006.

How do I get more information?
Mary will arrange to come and meet you a week after your discharge from hospital and answer any questions you may have.

What happens next?
Mary will arrange to come back and see you again a week later and if you agree to take part will ask you to sign a consent form and arrange a time that suits you for the interview.

Thank you for reading this.
Resident Consent Form

Primary Care Trust

3rd September 2005

CONSENT FORM - Resident

Title of Project:

Emergency Admissions of Older People from Nursing Homes to Acute Hospitals

1. I confirm that I have read and understood the information sheet dated 3rd September, 2005 for the above study and have had the opportunity to ask questions

2. I understand that my participation is voluntary and that I am free to withdraw at anytime, without giving any reason

3. I agree to take part in the above study

4. I give my permission for my nursing home records be looked at by Mary Clay

5. I have no objection to my next of kin/significant other being interviewed

6. I agree to my doctor being informed that I am taking part in the study

Name of Resident Date Signature

Name of Witness Date Signature

Researcher Date Signature

1 for resident; 1 for researcher; 1 to be kept with nursing home notes
APPENDIX 7
GP LETTER

Dear Dr

I am writing to let you know that I will be undertaking a research study at.......................... Nursing Home over the next six months. This will involve interviewing residents following discharge from hospital after their emergency admissions.

This study is part of a Doctorate of Clinical Practice and will be supervised by the University of Surrey. Approval for the study has been granted by the local Research Ethics Committee.

I am enclosing an abstract and an information leaflet but would be pleased to provide further information if you would like to contact me.

I look forward to sharing the findings of the study with you in due course.

Yours sincerely

Mary Clay
Consultant Nurse for Older People
## APPENDIX 8
### Part 1 HES Data - DIAGNOSES ON HOSPITAL ADMISSION YEAR 1 (2003-2004)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of admissions</th>
<th>Diagnosis</th>
<th>Number of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute gastritis</td>
<td>2</td>
<td>Gastrointestinal haemorrhage</td>
<td>3</td>
</tr>
<tr>
<td>Acute vascular disorder of intestine</td>
<td>1</td>
<td>Haematuria</td>
<td>1</td>
</tr>
<tr>
<td>Adjustment of pacemaker</td>
<td>1</td>
<td>Intracranial haemorrhage</td>
<td>2</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaemia</td>
<td>3</td>
<td>Infection &amp; inflammatory reaction due to internal joint</td>
<td>1</td>
</tr>
<tr>
<td>Acute upper respiratory infection</td>
<td>1</td>
<td>Leg ulcer</td>
<td>1</td>
</tr>
<tr>
<td>Acute lower respiratory infection</td>
<td>11</td>
<td>Left ventricular failure</td>
<td>5</td>
</tr>
<tr>
<td>Attention to gastrostomy</td>
<td>1</td>
<td>Lobar pneumonia</td>
<td>2</td>
</tr>
<tr>
<td>Bronchopneumonia</td>
<td>3</td>
<td>Main bronchus</td>
<td>1</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervix uteri</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calculus of gall bladder</td>
<td>1</td>
<td>Malignant neoplasm of bone</td>
<td>1</td>
</tr>
<tr>
<td>Congestive cardiac failure</td>
<td>4</td>
<td>Mechanical complication of catheter</td>
<td>1</td>
</tr>
<tr>
<td>Constipation</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convulsions</td>
<td>1</td>
<td>Ocular laceration</td>
<td>1</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>3</td>
<td>Orthostatic hypotension</td>
<td>1</td>
</tr>
<tr>
<td>Decubitus ulcer</td>
<td>1</td>
<td>Phlebitis</td>
<td>1</td>
</tr>
<tr>
<td>Diseases of the biliary tract</td>
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<td>Pneumonia</td>
<td>11</td>
</tr>
<tr>
<td>Dementia</td>
<td>5</td>
<td>Pneumoni</td>
<td>7</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2</td>
<td>Pulmonary embolism</td>
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<td>Diverticulitis</td>
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<td>Renal failure</td>
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<tr>
<td>Dizziness</td>
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<td>Respiratory failure</td>
<td>1</td>
</tr>
<tr>
<td>Duodenal ulcer with haemorrhage</td>
<td>1</td>
<td>Retention of urine</td>
<td>1</td>
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<tr>
<td>Dysphagia</td>
<td>1</td>
<td>Senility</td>
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<tr>
<td>Dysarthria</td>
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<td>Septicaemia</td>
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<tr>
<td>Epilepsy</td>
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<td>Unknown</td>
<td>9</td>
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<tr>
<td>Entercolitis due to C Diff</td>
<td>1</td>
<td>Unspecified abdominal pain</td>
<td>1</td>
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<tr>
<td>Fractured upper end of tibia</td>
<td>1</td>
<td>Unstable angina</td>
<td>1</td>
</tr>
<tr>
<td>Fractured neck of femur</td>
<td>7</td>
<td>Urinary tract infection</td>
<td>8</td>
</tr>
<tr>
<td>Fractured lower end of femur</td>
<td>1</td>
<td>Volvulus</td>
<td>1</td>
</tr>
<tr>
<td>Fractured upper end of humerus</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fractured shaft of humerus</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrojejunal haemorrhage</td>
<td>1</td>
<td>Total diagnoses</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total admissions</td>
<td>145</td>
</tr>
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</table>
## Appendix 9

### Part 1 HES Data - Diagnoses on Hospital Admission Year 2 (2004-2005)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of Admissions</th>
<th>Diagnosis</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>1</td>
<td>Lack of co-ordination</td>
<td>1</td>
</tr>
<tr>
<td>Acute renal failure</td>
<td>2</td>
<td>Left bundle branch block</td>
<td>1</td>
</tr>
<tr>
<td>Anaemia</td>
<td>1</td>
<td>Left ventricular failure</td>
<td>2</td>
</tr>
<tr>
<td>Asthma</td>
<td>1</td>
<td>Leg ulcer</td>
<td>1</td>
</tr>
<tr>
<td>Arthrosclerotic heart disease</td>
<td>1</td>
<td>Low back pain</td>
<td>1</td>
</tr>
<tr>
<td>Ataxia</td>
<td>2</td>
<td>Lower respiratory infection</td>
<td>2</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>4</td>
<td>Lung cancer</td>
<td>1</td>
</tr>
<tr>
<td>Bronchopneumonia</td>
<td>4</td>
<td>Malignant neoplasm of stomach</td>
<td>1</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>2</td>
<td>Malignant neoplasm of prostate</td>
<td>1</td>
</tr>
<tr>
<td>Chest pain</td>
<td>3</td>
<td>Mild cognitive disorder</td>
<td>1</td>
</tr>
<tr>
<td>Complications of implants</td>
<td>1</td>
<td>Mechanical complications of gastrostomy</td>
<td>1</td>
</tr>
<tr>
<td>Complication of urinary catheter</td>
<td>1</td>
<td>Myocardial infarction</td>
<td>1</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>5</td>
<td>Neoplasm of lung</td>
<td>1</td>
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<tr>
<td>Congestive cardiac failure</td>
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<td>Not known</td>
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<tr>
<td>Constipation</td>
<td>1</td>
<td>Observation</td>
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<td>Convulsions</td>
<td>1</td>
<td>Phlebitis</td>
<td>1</td>
</tr>
<tr>
<td>Dementia</td>
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<td>Pneumonia</td>
<td>10</td>
</tr>
<tr>
<td>Depression</td>
<td>2</td>
<td>Pulmonary embolism</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1</td>
<td>Retention of urine</td>
<td>1</td>
</tr>
<tr>
<td>Dizziness</td>
<td>1</td>
<td>Respiratory failure</td>
<td>1</td>
</tr>
<tr>
<td>Duodenal ulcer</td>
<td>1</td>
<td>Senility</td>
<td>2</td>
</tr>
<tr>
<td>Dysphagia</td>
<td>1</td>
<td>Septicaemia</td>
<td>1</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>1</td>
<td>Sialoadenitis</td>
<td>1</td>
</tr>
<tr>
<td>Fractured lower end of radius</td>
<td>1</td>
<td>Spontaneous pneumothorax</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Intestinal obstruction</td>
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</tr>
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<td>Joint pain</td>
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<td>Days in NH prior to hospital admission</td>
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<td>---------------------------------------</td>
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<td>28.09.06</td>
<td>51</td>
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<td>16</td>
<td>82</td>
<td>13.12.06</td>
<td>14</td>
</tr>
<tr>
<td>17</td>
<td>91</td>
<td>08.12.06</td>
<td>21</td>
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## APPENDIX 11 Part 3- Interview Participants Hospital Admissions

<table>
<thead>
<tr>
<th>Case code</th>
<th>AGE</th>
<th>Date of hospital admission</th>
<th>Person arranging hospital admission</th>
<th>Hospital length of stay in days</th>
<th>Reason for admission</th>
<th>Hospital treatment</th>
<th>Complications of hospital stay</th>
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<tr>
<td>A1</td>
<td>71</td>
<td>25.09.06</td>
<td>Own doctor</td>
<td>4</td>
<td>Blood</td>
<td>Blood transfusion</td>
<td>None</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Transfusion &amp; review of symptom control</td>
<td></td>
<td></td>
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<tr>
<td>A2</td>
<td>81</td>
<td>04.08.06</td>
<td>Partner in practice</td>
<td>5</td>
<td>UTI, vomiting &amp; diarrhoea &amp; unstable diabetes</td>
<td>Intravenous antibiotics &amp; IV fluids</td>
<td>Grade 4 pressure ulcer</td>
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<tr>
<td>B3</td>
<td>70</td>
<td>31.01.06</td>
<td>Own doctor</td>
<td>9</td>
<td>Aspiration pneumonia</td>
<td>IV antibiotics</td>
<td>None</td>
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<tr>
<td>B4</td>
<td>73</td>
<td>24.10.06</td>
<td>Own doctor</td>
<td>14</td>
<td>Chest infection</td>
<td>IV antibiotics</td>
<td>Grade 4 pressure ulcer</td>
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<tr>
<td>C5</td>
<td>82</td>
<td>03.04.06</td>
<td>Own doctor</td>
<td>21</td>
<td>Stroke</td>
<td>Acute care &amp; Rehabilitation</td>
<td>Weight loss</td>
</tr>
<tr>
<td>C6</td>
<td>77</td>
<td>11.06.06</td>
<td>Partner in practice</td>
<td>6</td>
<td>Respiratory distress</td>
<td>Steroids, Oxygen &amp; nebulisers</td>
<td>None</td>
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<tr>
<td>C7</td>
<td>81</td>
<td>28.07.06</td>
<td>Own doctor</td>
<td>14</td>
<td>Stroke</td>
<td>Acute care &amp; Rehabilitation</td>
<td>None</td>
</tr>
<tr>
<td>C8</td>
<td>92</td>
<td>21.11.06</td>
<td>999 Call</td>
<td>1</td>
<td>Fall</td>
<td>X-ray &amp; 3 sutures to head wound</td>
<td>None</td>
</tr>
<tr>
<td>D9</td>
<td>78</td>
<td>19.12.06</td>
<td>Own doctor</td>
<td>8</td>
<td>Acute cardiac problems</td>
<td>Review of drug regime &amp; angioplasty</td>
<td>None</td>
</tr>
<tr>
<td>D10</td>
<td>78</td>
<td>25.10.06</td>
<td>Own doctor</td>
<td>3</td>
<td>Fall &amp; fractured knee</td>
<td>X-ray &amp; analgesia</td>
<td>None</td>
</tr>
<tr>
<td>D11</td>
<td>86</td>
<td>22.11.06</td>
<td>999 Call</td>
<td>12</td>
<td>Fall – fractured neck of femur</td>
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<td>Weight loss</td>
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<tr>
<td>D12</td>
<td>80</td>
<td>19.11.06</td>
<td>Own doctor</td>
<td>23</td>
<td>Stroke</td>
<td>Acute care &amp; Rehabilitation</td>
<td>Weight loss</td>
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<tr>
<td>D13</td>
<td>87</td>
<td>22.3.06</td>
<td>Own doctor</td>
<td>20</td>
<td>Perforated bowel post hernia repair</td>
<td>Bowel surgery &amp; colostomy</td>
<td>None</td>
</tr>
</tbody>
</table>
Mrs Mary Clay
Kensington and Chelsea Primary Care Trust
Courtfield House
St Charles Hospital
Exmoor Street
London W10 6DZ

15 November 2005

Dear Mrs Clay

Full title of study: Emergency admissions of older people from nursing homes to acute hospitals - a case study
REC reference number: 05/Q0401/127

Thank you for your letter of 31 October 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
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<tr>
<td>Application</td>
<td></td>
<td>19 September 2005</td>
</tr>
<tr>
<td>Investigator CV</td>
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<td>20 August 2005</td>
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<tr>
<td>Protocol</td>
<td>1</td>
<td>14 June 2005</td>
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<tr>
<td>Covering Letter</td>
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<td>Summary/Synopsis</td>
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<tr>
<td>Interview Schedules/Topic Guides</td>
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<tr>
<td>GP/Consultant Information Sheets</td>
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</table>

An advisory committee to North West London Strategic Health Authority
Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

With the Committee's best wishes for the success of this project

Yours sincerely

[Signature]

Chair

Email: achakraborty@hhnt.org

Enclosures:

- Standard approval conditions
- Site approval form

Copy to: Mr Vasso Vydelingum
University of Surrey
European Institute of Health and Medical Sciences
5th Floor, Duke of Kent Building
Stag Hill, Guildford
Surrey GU2 7TE

SF list of approved sites

An advisory committee to North West London Strategic Health Authority
Ms Mary Clay
E I H M S

Dear Ms Clay

Emergency admissions of older people from nursing homes to acute hospitals - a case study (EC/2005/135/EIHMS) - FAST TRACK

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: **22 December 2005**

The list of documents reviewed and approved by the Committee under its Fast Track procedure is as follows:-

Document Type: Application
Dated: 30/11/05
Received: 05/12/05

Document Type: Research Proposal
Dated: 15/06/05
Received: 05/12/05

Document Type: Appendix 1 - UK Studies on Care Home Admissions to Hospital
Received: 05/12/05

Document Type: Appendix 2 & 2 - Project Schedules
Received: 05/12/05

Document Type: Appendix 3 - Resident Hospital Admission Questionnaire
Received: 05/12/05

Document Type: Appendix 4 - Information Sheet
Version: 2
Dated: 31/10/05
Received: 05/12/05

Document Type: Appendix 5a & 5b - Consent Forms
Dated: 03/08/05
Received: 05/12/05
This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research, and with the condition set out below.

- That you forward copies of approval letters from the host trust, for the Committee's records.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

I would be grateful if you would confirm, in writing, your acceptance of the condition above, enclosing the requested documents.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
Dr K Horton, Supervisor, EIHMS
Dr V Vydelingum, Supervisor, EIHMS
Title
Why do care home residents get admitted to hospital as emergencies?

Abstract

Background
NHS Primary Care Trusts (PCTs) are required to reduce reliance on secondary care and care home residents have been identified as a group whose emergency admissions could potentially be avoided, although little is known about their use of acute care. The aim of this research was to identify the factors leading to admission, the scale of local admissions and the views of residents on hospital admission. This research is located within a London PCT and ethical approval was obtained from the local NHS ethics committee and the University of Surrey.

Participants and methods
A mixed method approach was adopted and the study included the analysis of local Hospital Episode Statistics (HES) for two consecutive years, a study of the emergency hospital admission activity of one nursing home for one year and interviews with 13 residents from four local nursing homes following hospital admissions.

Results
GPs instigated almost all emergency hospital admissions and both residents and nursing home managers appreciated the quality of the service they provided. GPs admitted residents to hospital either when they needed medical attention that was not available outside acute hospitals or when residents were very ill and were not responding to curative treatment. In comparison, ill and dying residents were admitted by Out of Hours services without assessment. Most residents considered their admissions unavoidable as did their nursing home managers and while most were highly satisfied with the hospital care they received some expressed higher overall satisfaction with their nursing home care. The HES data analysis found admissions from residential and nursing homes were broadly similar with around a quarter of residents having admissions each year and an average length of hospital stay of 19 days. Although there were similarities between homes and between the two years there were also considerable variations. Residents were admitted with a wide variety of admission diagnoses, the most common being infections. Around 20% of resident admissions resulted in death in hospital.

Conclusion
While residents require and benefit from medical care that is not available outside the acute hospital setting, there is the potential for some emergency admissions to be avoided, especially those of nursing home residents with advanced dementia, at the end of their lives.

Key words: care home residents, emergency hospital admission, dementia, end of life

Introduction
Older people are heavy users of urgent care services [1], yet treating people outside hospital when possible has been enshrined in government policy since the publication of the NHS plan [2] which stressed that older people

“must receive the right care at the right time in the right place”
Although treatment in hospital is an important part of the healthcare of older people [3] it the Department of Health’s view that a proportion of older people would benefit from alternatives to admission [1] and admission to an acute setting should only be considered when other community options are not available [4]. As hospital admissions are expensive episodes of care [5], cost is an additional driver and it is a government target that the number of emergency bed days is reduced [6]. Yet the rate of admission of people over 65 for ill defined conditions is rising and as the population ages this trend is likely to continue [7]. It has been suggested that a lack of access to primary care services and the new Out of Hours services may be contributory factors [7]. Better end of life care for care home residents has been identified as a national priority [1] and it has been identified that research is needed into residents being admitted to hospital during their last days of life [8].

Although care home residents have been identified as a group whose emergency admissions could potentially be avoided [9], little is known about the factors that lead residents to be admitted to hospital as emergencies, as only a few UK studies have been published [10,11,12,13]. Yet there is reputed to be a lot of anecdotal evidence that residents are frequent and inappropriate attendees at Accident & Emergency departments [6,14] although the Royal College of Nursing points out there is no national data to support this claim [14]. The only information routinely available on hospital admissions is the NHS Hospital Episode Statistics (HES) database and while this can identify trends it cannot offer explanations [7]. Despite the lack of research in this area the evidence available [15] would suggest there is potential for more of the health needs of nursing home residents being met by primary care, thus avoiding some hospital admissions.

Older people are “the core business of the NHS” [4], yet the National Director for Older People reported that existing NHS services were not designed with older people in mind and suggested that where and how the NHS provides services needs to change [16]. A similar view is shared by the Royal College of Physicians suggesting that an expansion in the range of services offering acute medical care outside traditional hospitals is needed and stress the importance of new services being evidence based [17]. These reports highlight the value of understanding the factors that lead care home residents to be admitted to hospital in order to inform the development of future models of care.

Methods
A mixed method approach was considered appropriate to obtain the most comprehensive insight into the issues and the study therefore comprises three phases as follows;

1. Local Hospital Episode Statistics (HES) data analysis
2. Case studies of the hospital admission activity of one local nursing home over a year
3. Interviews with nursing home residents who had hospital admissions.

HES data analysis
Retrospective HES data for all ten local care homes for 2003-2004 and 2004-2005 were identified by postcode. Analyses was undertaken to provide an overview of the recent situation, establish a baseline for particular characteristics and identify commonalities and variations between homes. The data for a second year were analysed to allow for
comparisons to be made between two years and to identify any normal patterns and trends. The data for each admission was transferred to EXCEL spreadsheets which facilitated quantifying each of the 19 units of analysis.

**Nursing home case studies**

A case study approach [18] was adopted to prospectively examine the admission activity of one nursing home throughout 2006. The researcher collected both quantitative and qualitative data from nursing home records using a Hospital Admission Questionnaire designed for the study to provide detailed information on each resident as an individual, their nursing home admission and stay, and their hospital admission and outcome. This data collection format facilitated analysis and comparisons between cases. Semi-structured interviews with the nursing home manager were conducted to complement the documentary analysis and to obtain her views on each of the appropriateness of each admission. The information on each on the 19 admissions from the 22 questions on the hospital admission questionnaires was transferred to charts and tables illustrating the themes and summarising each of the case studies to facilitate analysis and description of findings.

**Resident interviews**

Identifying residents' perceptions on health care provision within their nursing homes, their experiences and outcomes of hospital admission, was considered important to inform future models of care. No published studies have included residents' views on hospital admission yet it is considered good practice that service users are involved in the review and planning of services [4]. The inclusion criteria were all residents who had had recent emergency hospital admissions, were well enough to be interviewed and had the capacity to give informed consent. During 2006 using the above criteria 13 residents of 4 local nursing homes were identified by their nursing home managers and all were invited to participate through a ‘Resident Information Leaflet’ outlining the study and their role. All gave written consent to being interviewed and to interviews being tape recorded. Semi-structured interviews were conducted following a planned format to ensure that participants recounted their experiences on the topics the researcher needed to cover [19]. A content analysis method which involves summarising and classifying data within a thematic framework, ‘Framework’ [20] was used to analyse interview transcripts.

**Results**

**HES data**

The five residential and five nursing homes located within the PCT, accommodated a total of 436 residents and they accounted for 145 admissions during year one and 130 in year two, making the average admission rate 26.3%. Individual lengths of stay varied between one and 124 days with an average of 19 days for both residential and nursing home residents for each year, which is the equivalent of 7 1/2 acute hospital beds being continuously occupied by care home residents and represents considerable cost to the PCT. Overall admission rates and hospital lengths of stay of residents from nursing and residential homes were similar. This would suggest additional potential to reduce admissions from nursing homes and the number of bed days utilised by more timely discharges, due to the 24 hour registered nursing care available in nursing homes. The most notable difference between the two years was an 11% reduction in admissions from residential homes and an 11% reduction in hospital bed days for which there is no explanation. There were 62 different medical diagnoses recorded on admission to hospital...
in year 1 and 68 in year 2, with the most common being infections, fractures and heart conditions (Figure 1) and around half were due to a wide variety of different diagnoses.

**Reasons for admissions Figure 1**

![Figure 1 Reasons for Admission](image)

Although approximately 20% of residents had more than one admission, second admissions tended to be for different reasons and half resulted in death in hospital. On average approximately 20% of residents admitted from both residential and nursing homes died in hospital each year with over half of deaths due to unsuccessful treatment of infections.

**Nursing home case studies**

Accessing treatment for medical conditions, GPs and Out of Hours services were found to be the main factors contributing to admissions, with residents' families and nursing home nurses contributing to a minor degree. During the year 17 residents, mostly aged over 85 years had 19 emergency hospital admissions and as the nursing home has 35 beds this represented an admission rate of nearly 50%. The length of nursing home stay prior to emergency hospital admission varied between 2 days and 9 years with 40% being hospitalised within a month of their nursing home admission. Most residents (79%) were admitted to hospital following assessment either by their own GP or a partner in the practice, and 16% by the Out of Hours service, without residents being assessed. Therefore doctors were responsible for 95% of admissions as only one was by instigated by a nursing home nurse. There was no seasonal variation and although admissions took place on each day of the week 60% were on Thursdays and Fridays. On admission to the nursing home most residents hospitalised had combinations of three medical conditions from a range of 34 different diagnoses, by far the most common recorded being dementia affecting 65%. It is clear from the nursing home notes that all residents were very ill prior to admission to hospital and although a variety of conditions precipitated admissions 58% were due to infections (Figure 2).

**Figure 2 Medical conditions precipitating hospital admission**

![Figure 2](image)
Although the average length of hospital stay was 8 days, 80% of admissions lasted a week or less with 26% lasting only one day. As with one exception the very short admissions resulted in death this meant that 21% of residents died within 24 hours of admission and a total of 53% of residents admitted died in hospital. This could have been predicted as half of the residents admitted had terminal conditions; either end stage dementia or cardiac conditions. As a few residents died soon after discharge back to the nursing home 70% of residents admitted did not derive any lasting benefit from emergency hospital admission.

Admissions were not discussed with relatives unless they happened to be present and on two occasions residents were admitted at their behest despite GPs recording that they each had a “poor prognosis.” One of these residents who had advanced dementia had been resident in the nursing home for nine years and died in hospital with pneumonia within 48 hours of admission. Doctors did not involve nursing home nurses in their admission decisions and on occasions although they disagreed with the decision they were not empowered to advocate for residents.

**Resident interviews**

Medical emergency situations led to the admissions and 85% of residents considered their admissions unavoidable and their 4 nursing home managers considered that all were. All residents reported benefiting from admission and although they reported not having been involved in admission decisions they were not concerned by this. Most were highly satisfied with their hospital experience but those who had the most complex health problems and dependency issues tended to have longer hospital stays, suffer more complications and had more negative comments about their hospital experience. All residents valued the familiar environments and sense of security their nursing homes provided and suggested as they were ‘spoilt’ there this may have led to unrealistic expectations of their hospital experience. They particularly appreciated the attitudes and values demonstrated by the nursing home staff and how they empathised with them and provided care that was person-centred and they felt they had choice and control over their lives and also commented positively on the in house medical care they received. While most residents also expressed high levels of satisfaction with hospital care some felt they were not always respected by staff or listened to and reported having to wait for attention as nurses were always busy, continence was not always being well managed and 15% developed grade 4 pressure ulcers in hospital. The resident interviews confirmed that nursing home residents need and benefit from care that is only available in acute hospitals but also indicate that except when hospital admission is essential for clinical reasons they would prefer to receive care within their familiar nursing home environment.
Discussion
Hospital admissions from care homes have been described as complex and multi-factorial [21] and this study has confirmed that this is the case making the achievement of a reduction in admissions challenging. Yet surprisingly it has been found that admission rates can fall without intervention [22] and interestingly this was the case when the HES data was compared for two years as the number of residents admitted from residential homes reduced by 24% in the second year. There is no explanation for this except that care home populations are constantly changing.

When the findings of each of the three phases of this study are compared with the few published studies identified [12, 13] the rate of admissions locally is considerably higher which would indicate potential for a reduction. Other common findings are that infections are consistently the most common reason for emergency admissions, the average local length of hospital stay at 19 days is similar and over 20% of hospital admissions end in death in hospital. This would indicate that if residents who are nearing the end of life had palliative care provided within the nursing homes that at least a fifth of admissions locally and nationally could potentially be avoided.

This study found dementia was the most common condition contributing to hospital admission as it affected 65% of residents and most significantly over a quarter had advanced dementia and despite intravenous treatment for infections died in hospital. Yet research [23] found when both the duration and the severity of suffering was considered in patients whose death was highly likely, they did not suffer higher levels of discomfort when they were not treated with antibiotics compared to those who were. GPs need to be able to decide if a curative or palliative approach is warranted [24] so that residents can have their individual needs respected and met by either the most advanced technological and pharmacological interventions or palliation [25] and despite a NICE dementia guideline [26] requiring doctors to assess the palliative care needs of people close to death this study found that this was not always the case.

The National Minimum Standards [27] states that residents should be able to spend their final days in their own rooms surrounded by their personal belongings, unless there are strong medical reasons to prevent this, yet this study found this was not the case. Implementing the Gold Standards Framework, the Preferred Priorities for Care plan and Liverpool Care Pathway improve the co-ordination and quality of end of life care [28] but they had not been adopted in any of the homes in this study. Yet using national end of life care tools means that residents have choice and control in their final days and unnecessary emergency hospital admissions are avoided [29].

Conclusion
Although the mixed methods approach proved successful in achieving the aims of the study it is acknowledged that this was a small local study and as only hospital admissions were studied it does provide insight into whether other ill and dying residents avoided admission. Also as most residents have dementia the views of those interviewed cannot be considered representative of the nursing home population.

This study has found that while nursing homes are social care environments with the emphasis on person-centred care, when residents' health deteriorates care is dictated in line with the traditional bio-medical model. There appeared to be a failure to
acknowledge that care homes are "complex systems where people are both living and dying there is a need to develop a culture of care which values both" [8 p5]. In light of the prevalence of dementia across UK care homes if appropriate end of life care was universally adopted for all residents not only would this have a significant impact on hospital admission avoidance it is suggested residents would receive more appropriate end of life care.

As GPs and Out of Hours services provide medical care to nursing home residents and are responsible for most hospital admissions their role is key to any change in practice. Government policy and targets have provided opportunities nationally to test new ways of working which "bring care closer to home" that "will make a big difference to the lives of older people" [16 p1]. It is suggested that new models of care are needed to achieve this and to reduce avoidable admissions.

Key points

- Nursing home residents require specialist care that is only available in acute hospitals
- GPs and Out Of Hours Services are responsible for most hospital admissions
- As rates of admission and hospital length of stay are similar for nursing and residential home residents this would indicate potential to reduce admissions and shorten hospital stays of nursing home residents due to the 24 hour availability of registered nurses
- Dementia is the most common admission diagnosis and approximately 20% of admissions could be avoided if end stage dementia was identified and good end of life care provided in nursing homes for residents with dementia and other terminal conditions

Conflicts of interest
None

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References


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Mary T Clay

Policy Politics and Power

Doctorate of Clinical Practice
2005

I declare that this essay is wholly my own work, except where acknowledged specifically
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Mary T Clay
Policy analysis
NURSE LED DISCHARGE

Introduction

This policy analysis relates to a local policy developed by the author to support the implementation of nurse led discharge across an acute hospital NHS Trust (Appendix 1).

The policy was initiated due to pressure on hospital beds and the drive to meet the government’s accident and emergency (A&E) and waiting list targets (DoH 2002a). Bed days were being lost while patients waited to be seen by medical staff on their planned day of discharge as due to other commitments like seeing patients in admission wards and being in surgery meant they were not available until later in the day. Introducing nurse-led discharge was recommended by the local Emergency Services Taskforce, so that patients could be discharged earlier in the day, freeing up beds for admissions from the A&E department and waiting lists.

Although nurse-led care has been expanding over the past decade there is no clear definition of what constitutes a nurse-led service (Garbett 1996) but a review of nurse-led services (Cuncliffe et al 2001) found that although the majority of nurse-led services involved a shift of professional boundaries, they involved working in partnership with medical staff. Cable (1995) suggests that one of the main threats to developing nurse-led care is doctors’ unwillingness to relinquish certain aspects of their role, particularly decision making. The decision to discharge patients from their episode of care is an important one and if consultants are unwilling to delegate this role to nurses it will mean that this policy cannot be implemented. Due to the recognition of this critical factor a review of the doctor / nurse relationship will be part of this analysis.
It has been predicted that the most significant health care trend in the new century would be the erosion of traditional clinical boundaries between nursing and medicine and the impetus for blurring the boundaries described as coming from three directions. Firstly professionals other than doctors could provide some services at a lower cost, secondly the reduction in junior doctors’ hours and thirdly nurses own desire to increase the autonomy of the profession (Annandale 1998). These three drivers were evident when the policy background was explored.

The climate which led to the development of this policy is in line with the perceptions of Richardson and Cunliffe (2003) who suggest that nurse-led developments are influenced by NHS policy, the practice environment, local need ‘service gap’ and provision of resources, which provides a key opportunity to challenge current models of care, especially the traditional medical model.

To date most nurse-led initiatives have involved the role development of senior clinical nurses, for example nurse practitioners, nurse specialists and consultant nurses. Role expansion and the blurring of professional boundaries tend to be a key component of their roles and there is often the expectation that their roles will continually expand to take on additional roles and tasks previously undertaken by doctors. The difference with this policy it that it requires specific role development of all E, F and G ward based nurses who are less familiar with and perhaps less motivated to take on responsibilities of medical staff. They need to be convinced of how this policy fits into national policy drivers and what their legal position is regarding role expansion in relation to them as individuals if they are to be convinced that it is appropriate and safe for them to implement the policy. For this reason policies and research which impacts on their roles is one part of this policy analysis.
Nursing has a voice in the development and implementation of national policy relating to nursing, which represents the politics of the government of the day (Mulally 2001 p22). The Chief Nursing Officer described British democracy as “having the great virtue that successive administrations can depend on the impartial civil service to help turn manifesto commitments into workable policies, by turning the political ideas of elected representatives into better public services”. She describes her role as securing and maintaining a strong nursing voice in the policy process and ensuring that plans to deliver new commitments are based on the best evidence available and making sure the nursing profession is properly equipped to turn policy into practice.

Discharge of patients from hospital is an example of how she has driven the government agenda and provided guidance to change policy and simultaneously provided an opportunity for nurses to develop their roles. As this nurse-led discharge policy has its roots in nationally driven nursing policy it is important to have an understanding of how the policy has been developed and the process evolved over time so national guidance which supports the local policy will be analysed.

Patients and their families hate waiting (DoH 2001a) and the New Labour government agreed action to reduce waiting times (DoH 2002a), but stress that changes can only be delivered if nurses start to work in new ways for example by using the CNO’s 10 key roles for nurses which are described as forming the core of the development of their contribution to the new NHS (DoH 2002b). By making discharge one of these new roles for nurses laid the foundation for nurse-led discharge and gives this local policy impetus.

Despite the drivers for nurse-led discharge, the initiative being promoted by the current government and national policy to support local implementation, nurse-led discharge has been slow to develop nationally and an unfamiliar concept locally. This meant there was limited experience to draw on when developing and implementing the local policy but a
policy analysis approach supported the process. This is in line with Smith and Cantley (1985) who argue that research and analysis should be seen as an aid to the development of interactive solutions to problems by identifying the perspectives of various stakeholders and Lindblom and Cohen (1979) who suggest that this helps them to conceptualise the problem and to negotiate mutually acceptable solutions.

Policy Analysis

A useful definition of the focus of policy analysis is 'what government's do, why they do it, and what difference it makes (Heidenheimer et al 1990). Harrison (2001) points out that there are varied approaches to policy analysis making it impractical to give a consensual account but, describes policy analysis as containing three central ingredients: the policy making process, its context, and the use and development of theory. Firstly policy making is conceived as a process, rather than simply as an output of a decision or an input to management and includes several stages for example, defining what is thought to be problematic and what objectives would represent an acceptable improvement, elucidating the causal structure of the problem and elucidating measures that would intervene in this causal structure. Secondly action is seen as taking place within a context which both affects and may be affected by the policy process. (Harrison (1994) suggests in relation to health policy at a more micro level, factors such as multi-organisational and professional cultures, organisational resources and competing policy agendas will be important). Thirdly policy analysis is concerned with the use and development of explicit theory, not just the attribution of causes without understanding the causal process. Making theory explicit encourages questioning the taken for granted, for example questioning whether the facts could be interpreted in different ways or whether assumptions are out of date.

As ‘fact’, ‘value’ and ‘theory’ become closely intertwined in policy analysis (Harrison 2001), it can be difficult to use as a structure, so instead the policy analysis described, incorporates these themes.
The most appropriate policy analysis framework identified is a model suggested by Harrison (2001) which draws on the work of Gunn (1978), where Gunn’s conditions for ‘perfect implementation’ are adapted for ‘evidence based medicine’ and supplemented by Harrison (1994) who adds additional ‘conditions’ to Gunn’s. As the policy analysis undertaken relates to health care policy developed for local implementation, analysis in the context of implementation is considered beneficial (Appendix 2). Gunn’s framework has six aspects which provide the framework for this policy analysis. (Gunn’s conditions are underlined and Harrison’s are in italics).

1. That there are sufficient material resources in the appropriate combination available – resources go beyond money and skills or shortages

Changes to working conditions
The rationale for moving to nurse-led rather than traditional medically led discharge is to avoid unnecessary delays. Nurses have greater availability as they are always present on the wards, whereas doctors are considerably fewer in number and have off ward commitments.

In addition, there is a legal requirement to meet the conditions of the European Working Time Directive which means significant reductions in junior doctors’ hours (NHS Management Executive 2001). Although it is a phased approach over years, the BMA estimates that the NHS is currently losing 213,000 junior doctor hours every week since the recent reduction in hours to 58 per week (Dickson 2004). This significant reduction has already had an impact on nursing workloads which will increase further as doctors hours continue to decrease to 48 hours per week by 2009. This has implications for the discharge of patients as within the current model patients typically wait to be seen by a junior doctor on their day of discharge.
Despite a reduction of the medical workforce a bigger demand for healthcare is being created. The NHS in setting out its priorities and planning framework for 2003-2006 (DoH 2002a) highlighted the need to address ‘critical issues, particularly the Working Time Directive’ and suggested moving work from doctors to other health care professionals. Providing nurse-led services and expanding the role of the nurse, are innovative ways of re-balancing the workforce – demand mismatch (Richardson and Cuncliffe 2003). Unless this happens discharge is likely to become an even bigger issue as patients block beds waiting to see doctors whose availability is continuously decreasing. It would appear that the reduction in junior doctors’ hours is the biggest driver for the role expansion of nursing in general and for the implementation of this policy in particular.

Although decisions to discharge are currently undertaken by medical staff, nurses are already involved in the discharge process, for example doctors ask nurses who can go home (Chatterjee 2004). According to the local hospital discharge policy, ward nurses have a responsibility to ensure that patients are safe to discharge and that discharges are properly organised. Introducing a policy of nurse-led discharge would give them the autonomy to extend their role in the process.

Financial implications

Finance is not a major consideration for the implementation of this policy, as the only input required is the preparation of nursing and medical staff, which involves their understanding of its purpose, the changes in their roles and the use of the supporting documentation. In addition nurses need to be prepared for and assessed against a competency framework, to ensure they are capable of taking responsibility for the safe discharge of patients. This is of prime importance as where activities normally undertaken by Doctors are delegated to nursing staff, it is requirement that the same standards are met, as the patient is entitled to expect the same standard of service.
regardless of whether it is the doctor performing the role or it is delegated to the nurse (Hunt and Wainwright 1994).

Accountability
Legal and professional indemnity is explained in the context of the expansion of nurses’ roles (DoH 2002b). One is a constitutional standard - the rule of law, that requires nurses to act within the law and the second the minimum quality standard - the rule of negligence that requires the nurse who takes on a role or task previously performed by a doctor, to perform that role or task to the same standard as a doctor. This guidance stresses the importance of nurses being aware of the legal boundaries relating to their practice as well as sufficient training and preparation to ensure that they can perform the new role to the required standard.

Although the implementation of the policy involves delegation from doctors to nurses, nurses are accountable for their own practice and their Code of Professional Conduct requires them to obtain the competence considered necessary by them and their employers before extending their practice (Nursing and Midwifery Council 2002). This is reiterated in recent government guidance on discharge for the multi-disciplinary team (DoH 2004a), which stresses the importance of education and training to ensure staff have the right competencies from a clinical governance and risk perspective. As well as providing an effective service this approach serves to protect the public (Hunt and Wainwright 1994). Nursing leadership needs to be present Trust wide and include the support of the Director of Nursing, as well as direction at directorate level and strong leadership at ward level.

2. That there are sufficient non-material resources available -
time is a non-trivial factor, real world organisations have ongoing activities and other priorities with which new policies compete for attention.
Underpinning policy is a significant non-material resource and is therefore forms an important part of this analysis. As well as policy driving and directly supporting nurse led discharge, policy supporting changing roles which will facilitate implementation of the policy will be included as this helps identify policy drivers, as well as demonstrating how the policy fits in with the general direction government would like the nursing profession to follow.

Drivers
Government policies are the main drivers for a nurse-led discharge policy especially the national waiting time targets. Firstly there is a target to reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge, by the end of 2004 (DoH 2002a). Secondly the achievement of a maximum wait of 9 months for all inpatient waiters by March 2004, as progress towards achieving a maximum 6 month wait for inpatients by December 2005 and a 3 month wait by 2008. The objective of these targets is to improve the patient experience as one of the five key dimensions for a good patient experience is improving access and waiting. Maximising bed capacity is paramount in the achievement of these targets and the timely discharge of patients contributes to the availability of beds so a policy of nurse-led discharge would be instrumental in hospitals achieving targets, which are important as there are financial implications as well star ratings at stake.

Government discharge policy guidance
Although there is little evidence of the local nurse-led discharge policies there is national discharge guidance to support the initiative. The Department of Health launched ‘Discharge for Hospital: Pathway, process and practice’ (DoH 2003a), which provides models for good discharge practice, but Glasby (2003) suggests it is a long and bulky document which is difficult to read and provides little which is new. Interestingly the first draft did not include any reference to nurse-led discharge and after this was raised with
the CNO the final publication included one paragraph on this approach. It reported that nurse-led discharge was already occurring in some Trusts and to be successful it requires active involvement of senior nurses and medical staff in writing protocols. This document made it clear that the decision that a patient is medically fit for discharge can only be made by the patient’s consultant or by someone to whom the consultant has delegated his authority or by another doctor who is responsible for the care of the patient.

A slightly different focus is adopted in the ‘Safe to Transfer’ advice published by the Change Agent Team with input from the Reimbursement Implementation team (DoH 2003b). They describe three stages of discharge which should be addressed at the same time – a clinical decision is made that the patient is ready for transfer, a multi-disciplinary team decision that the patient is ready for transfer and the patient is safe to discharge / transfer. They explain that they deliberately do not use the term ‘medically stable’ although acknowledge it is the term in common usage and regarded as a key element of the clinical decision that the patient is ready for transfer. They suggest ‘clinical’ can include medical, nursing and therapy inputs although the consultant usually makes such decisions and that ward –based teams must ensure that they are clear about who can make the decision. They also emphasise that steps may need to be taken to ensure that no delay occurs because of the lack of availability of the clinician / clinicians concerned. This approach moves discharge to a patient centred multi-disciplinary process rather than the traditional medical or promoted nurse-led models.

A consultant nurse encouraged the DoH to produce a new government guide to hospital discharge as she felt that nurse-led discharge needed a national lead (Nursing Standard 2004a). As a result a document titled, Achieving timely ‘simple’ discharge from hospital. A toolkit for the multi-disciplinary team (DoH 2004a) was issued. It was launched jointly by the CNO and the national director of emergency care reinforcing the connection between discharge and A&E targets. The stated aim is to empower members of the multidisciplinary team to achieve effective and timely discharge for patients classified as
simple discharges. It describes 10 steps to achieve what is described as ‘nurse-initiated discharge for simple discharges’ and ‘multi-disciplinary team initiated / nurse co-ordinated complex discharges’. Although it acknowledges that discharge is a multidisciplinary process it states that nursing teams can proactively manage the discharge process seven days a week and take on more responsibility for initiating simple discharges. Three government policies relating to discharge indicated the significance of the issue and the need for changing practice.

Changing roles
This nurse-led discharge policy reflects the attitudes of government and a series of policy documents have laid the foundations for the local policy and due to their relevance to the development of this policy will be briefly described.

Health policy change and modernisation of health services introduced by the New Labour soon after it came to power (DoH 1997), brought opportunities to reconsider and challenge traditional health care roles and professional boundaries. This white paper stated the government’s commitment to encouraging and supporting the development of nursing practice in line with recent developments in the roles of nurses, for example nurse-led clinics introduced during the previous conservative administration.

This was reiterated in 1999 when the government launched “Making a Difference Strengthening the nursing, midwifery and health visiting contribution to health and healthcare” (DoH 1999), which expressed the governments desire to expand and develop nurses roles to make better use of their knowledge and skills. It made it clear that the development of nursing roles needs to be a managed process and developments based on a thorough needs assessment, consistent with government policy and designed to benefit patients. Professional competencies and additional knowledge and skills identified, appropriate education, training and competence assessment, continuing support and
supervision put in place. Significantly this is the earliest policy which makes specific reference to nursing and the discharge of patients. The example of a nurse led rheumatology ward is cited where nurses determine and arrange discharge. It goes on to state that "Investing responsibility for determining patient suitability and readiness for discharge with nurses helps to provide a more responsive service and makes appropriate use of resources and skills" (DoH 1999 p69)

The NHS Plan (DoH 2000) aims is to get rid of old fashioned demarcations between staff and provide nurses everywhere with greater opportunity to extend their roles. This strategy requires employers to empower nurses to undertake a wider range of clinical tasks. This document launched the Chief Nursing Officer’s (CNOs) 10 key roles for nurses one being to admit and discharge patients for specified conditions and within agreed protocols and another to take a lead in the way local health services are organised and in the way they are run. Nurse led discharge therefore fits into this vision for nursing.

This was followed up (DoH 2002b) by information, examples and contacts to assist managers in the implementation of the ‘CNO’s 10 key roles for nurses’ one being “To admit and discharge patients for specified conditions and within agreed protocols” p4. It described these key roles as supporting new health strategies and government policies which would enable nurses to realise their full potential to work collaboratively as part of the wider healthcare team, and in so doing could play a key part in breaking down barriers between professionals in providing a patient focused service.

A report to support the implementation of the NHS Plan (DoH 2002c), describes a vision of devolution of power and resources to the front line to give health professionals who deliver care the freedom to innovate and cut across outdated organisational and professional boundaries.
These sentiments were reiterated in guidance to help Primary Care Trusts and nurses deliver The NHS Plan (DOH 2002d) and identified facilitating earlier and smoother discharge from hospital as an example of something that needs to happen.

A joint document, ‘Freedom to practice: dispelling the myths’, by the Department of Health and the Royal College of Nursing (2003) is aimed at ‘busting the myths’ which abound. It makes it clear that unless there is a specific statutory legislation which requires a specific professional to carry out specific activities, there is considerable freedom for the development of skills. A section is devoted to the discharge of patients which states that

“Nurses and allied health professionals with appropriate competencies are able to discharge patients. There are no legal or professional reasons why nurses or pharmacists cannot transcribe TTOs and provide discharge letters.

Myths are being busted by:

Improving the discharge process so that timely decisions are made discharging patients from MAU/SAU and ward areas within agreed criteria and nurses providing discharge letters.” (DoH/RCN 2003 p11)

Rather than competing with other policy priorities implementing nurse-led discharge, not only supports the meeting of key Government targets related to star ratings, the government philosophy of expanding nursing roles and blurring professional boundaries, the timely discharge of patients is something that should be achieved as it is important to patients (Healthcare Commission 2004a).

Time

In order to facilitate the required change in practice, the nurse-led discharge policy includes all ward E, F and G nurses. Therefore time is required to prepare their significant numbers as well as to gain the support of medical staff and multidisciplinary teams.
3. That the policy to be implemented is based upon valid theory of cause and effect - attention to the need for research and evidence based practice.

The government spells out the advantages of timely discharges and the potential of nurse-led discharge to achieve it.

Rationale for service re-design

Discharging patients earlier in the day means that hospital beds can be best utilised, increasing productivity and reducing the cost of admissions, as well as helping to meet access targets. This is better for patients at both ends of their journey as it avoids waits for admission and delays in being discharged from hospital can be upsetting and frustrating for patients (Healthcare Commission 2004a). Their survey of in-patient care in acute specialist trusts in England (Healthcare Commission 2004b), describes the experiences of 88,000 adults admitted to hospital. Over one third reported that their discharge being delayed on the day they left demonstrating the value of a policy change.

When describing service re-design to meet new national standards, one of the ‘10 high Department of Health discharge policy guidance and impact changes’ to be implemented, is ‘to smooth variation in patient length of stay and patient discharge’ and ‘optimise patient flow through service bottlenecks’ (DoH 2004b). The changes are elaborated on in the Modernisation Agency’s publication (DoH 2004c), which suggests that better management of discharge could release 10% of total bed days. This report identified peak discharge time as late afternoon, yet the peak admission time is usually earlier in the day, so matching up discharge times with admission times would have a significant impact on achieving A&E waiting time and waiting list targets as they are largely reliant on bed availability. Other suggested benefits are a 50% reduction in cancelled operations and reduced likelihood of picking up hospital acquired infections.
The DoH discharge toolkit (DoH 2004a) aimed at empowering the multidisciplinary team to achieve effective and timely discharges for patients classified as simple discharges, stated that 80% of discharges fell into this category. Their focus on simple discharges is suggested as the number of patients who can be impacted upon is very large and the involvement of another agency is not required. Again the impact of moving discharges to earlier in the day is stressed.

In addition to support from DoH organisations nurse-led discharge, within clinical protocols, has been suggested by the Select Committee on Health (Health 3rd report 17.7.02). Ham (1999) suggests that this group provide an informed contribution to the policy making process as they examine issues and present a united front in party political terms. Wade (2004) suggests that the publication of 'Discharge from Hospital: Pathway, Process and practice' (DoH 2003a) is a testimony to the growing awareness of the need to shift the focus of attention from the 'front door' to the 'back door' of hospitals and services. The Healthcare Commission (2004a) cites examples of nurses fulfilling roles previously been undertaken by doctors as not only solutions to the reduction in junior doctors hours but something which can have a substantial impact on the overall capacity of a department and thereby helping trusts meet access targets.

Evidence of nurse-led discharge
Although there is limited evidence available on the success of nurse-led discharge per se, nationally the Emergency Services Collaborate reported that by matching up discharge times with admission times had a significant impact on achieving targets for A&E waiting times and admissions (DoH 2004c). A literature search revealed the following examples.

Brook (2001) describes E, F and G grade nurses in a gynaecology unit, following what is described as assessments based on nurses' professional judgement and clinical experience
to speed up the discharge of patients. In fact it appears to be as part of a care pathway approach as nurses take over responsibility at fixed points in time providing the patient meets specific criteria. Audit demonstrates positive outcomes – length of stay has been cut by half of a day for laparoscopic procedures and just over half of a day for major surgery. There is a low readmission rate and despite a reduction in beds waiting times have been halved. It is stated that nurse-led discharge increased patient satisfaction but it is unclear how this was measured.

An example is provided (DoH 2002b) of a Practice Development Unit where patients had previously waited for a house officer to come round to be discharged. As this was frequently after 9 am it delayed discharge and subsequent allocation of the bed. Now the senior primary nurses and ward manager are responsible for discharging patients, who the consultant will have previously set the parameters for discharge and the nurses ensure that all the criteria have been met. The process speeds up discharge for the patient and beds are available earlier in the day to ensure optimum bed use.

Another example was reported in the ‘News’ section, Nursing Standard (2004b). Again it relates to elective surgery and states that beds were being blocked for admissions and operations postponed while patients waited to be seen by the consultant. The new scheme initiated by a practice development nurse, saw average patient discharge times falls by five hours leading to waiting times being cut and improved bed occupancy levels.

The final example (Chatterjee 2004) is an orthopaedic ward where 10 nurses, all grade E and above, were trained to autonomously discharge patients. Their preparation included undertaking five supervised discharges before being declared competent to take over the discharge role. Over a six month period nurses discharged 61 patients, none of which were re-admitted.
Although published evidence of nurse-led discharge and its success is limited to the few examples described experience so far would suggest that if staff are competent and work within protocols they can provide a safe and effective discharge service.

In addition recent research shows that patients value the contributions of and their interactions with both nurses and doctors. They reported although feeling in awe of doctors they listened intently to what they had to say and saw them as people to gain guidance from rather than having a conversation with. Alternatively they felt on a level with nurses and that they could raise any issues with them, problem solving together to arrive at a patient focused outcome (Hartley 2004). This would suggest that providing patients had already been seen by medical staff, nursing staff would be the ideal professional to take responsibility for their discharge. Health Minister, Rosie Winterton has said that patients do not want to hang around in hospital when they are well enough to leave (Chatterjee 2004). This being the case may encourage acceptance of nurse-led discharge.

4. That the relationship between cause and effect is direct and that there are few if any intervening links.

*Most organisational endeavours require the cooperation of teams and the more links in the chain, the more likely that at least one will break down, importance of organisational culture.*

The implementation of a nurse-led discharge policy involves delegation from doctors to nurses as the overall legal responsibility for patient’s care remains with the named consultant during admission, stay and discharge This is spelled out in the report, ‘Achieving timely ‘simple’ discharge from hospital A toolkit for the multi-disciplinary team’(DoH 2004a), which goes on to explain that the consultant has responsibility for delegating appropriately and ensuring that the person taking on the responsibility has the
appropriate knowledge and skills. This report also makes it explicit that there is no legal or professional reasons why nurses or allied health professionals cannot take responsibility for the discharge process, including the decision to discharge and includes a ten point step guide to timely discharge. While this report should be instrumental in supporting local implementation, it is perceived that success will be dependant on the relationships between nursing and medicine and nurses’ ability and willingness to develop their roles. As these crucial factors may present a major challenge, it is important to examine the nurse / doctor relationship which is widely regarded as the pivotal relationship in the delivery of health care (Prowse and Allen 2002) and how nursing is developing, as it is perceived that on these the success or failure of this policy will largely depend.

Doctor / nurse relationship
Traditionally nurses have been seen as doctors’ handmaidens (McKee and Lessof 1992) and obedience rather than reasoning was essential (Buckenham and McGrath 1983). The key features of nursing following Nightingale’s reforms were the valuing of routines, the acceptance of a broad range of tasks and the acceptance of the superiority of doctors (Davies 1976).

Nursing exists within a state sponsored system of medical hegemony and will never rival medicine and have its own concordant with the state (Salter 1998). Instead since the foundation of the National Health Service, the primary political utility of nursing to the state lay in its provision of a large relatively inexpensive workforce which supported the demand – control activities of the doctors. Right up to the present nursing has been seen as subordinate to and dominated by medicine despite changing social norms which have meant the degree of servility has been steadily eroded over the years (Hunt and Wainwright 1994).
It is suggested that professional dominance is not simply a matter of subordination to those who occupy a higher position in an organisational hierarchy, but the authority is also based on the putatively superior knowledge of the professional expert Friedson (1970). Baroness Macfarlane of Llandaff and Castledine (1982) maintained that the doctor is the authority on the diagnosis and treatment of disease and the nurse on the maintenance of daily living activities. This being the case the professions compliment each other and would support the notion of doctors determining when treatment is complete and nurses then taking responsibility for discharge.

Nurses have been described as having traditionally been the eyes and ears of doctors, loyally carrying out instructions and reporting back (Hunt and Wainright 1994). The nurse became adept at suggesting a course of action to a doctor in a way that allowed him to think he had initiated it – the nurse-doctor game described by Stein (1967). In this way nurses are only able to exert influence over the process of care by manipulating individual doctors without changing the fundamental asymmetry of the power relationship (Masterson and Humphris 2000).

Research carried out by Snellgrove and Hughes (2002) involved interviewing nurses and doctors on inter-professional relationships and the 'doctor / nurse game'. Many nurses and doctors claimed to detect a move towards greater equality and away from traditional hierarchical relations. Although nurses made general statements about increased opportunities for shared decision making, this was not always supported by credible examples. Interestingly most examples of joint decision making related to discharge planning and the social aspects of care. Many doctors saw the nurse’s role as limited to carrying out tasks within the plan devised by the doctor. The researchers concluded that relationship problems existed between nurses and doctors which showed no sign of abating.
Nurses may feel they benefit from being dependant on doctors as they are shielded from responsibility as a result. This characteristic of nursing identified by Menzies (1960) but still appears to be part of current culture, was described as 'the reduction of responsibility by delegation to superiors'. Instead of taking on the responsibility for the safe discharge of patients some nurses may prefer to avoid such responsibility.

Development of nursing
The Nurse, Midwives and Health Visitor Rules Approval Order (Department of Health 1983) made the role of the nurse explicit and while complimentary to medicine not purely an extension of it. Nurse education underwent extensive reforms with the introduction of Project 2000 (UKCC 1987) which aimed to give equal credence to nurses holistic patient centred approach to care and the more technical tasks handed down to nurses from doctors (Salvage 1992).

The Scope of Professional Practice (UKCC 1992) is widely seen as having paved the way for role expansion within nursing. This was demonstrated in the findings of research to identify its impact (UKCC 2000) which found that half of nurses said it had given them confidence to develop their roles. It made it possible for nurses to define the limits of their practice and become involved in almost any area of health care practice provided they accepted individual responsibility and acquired training in the relevant skills (Daly and Carnwell 2003). 'Scope' stressed the importance of nurses developing knowledge, skills and competence to respond to the needs of patients and stressed that the principles for practice should enhance trust and confidence within the healthcare team and promote collaborative work between medical and nursing practitioners, upon which good practice and care depends. It acknowledged that nursing practice took place in the context of continuing change due to for example changes in local policies which meant that practice needs to be relevant and responsive to the needs of individual patients and have the capacity to adjust to changing circumstances.
Role expansion is described as nurses using their own initiative, making their own decisions based on their experience and education to improve practice for the benefit of patients (Hunt and Wainwright 1994). Motivation, intuition, clear guidelines and protocols as well as support from employers are also identified as being necessary (UKCC 2000).

Organisational culture

The more cynical (Dimond 1995, Denner 1995, Walters 2000, Cameron 2000, Allen and Hughes 2002), saw it as expedient as it was launched within months of the government’s plans to reduce the working hours of junior doctors (NHSE 1992) and suggested that it was issued to support the needs of medicine and management, rather than nurses and patients. In fact a follow up publication reporting on the changes in nursing practice as a result of the ‘Scope of Professional Practice (UKCC 1992), reminded nurses that practice must be viewed in the context of other forces including the reduction of junior doctors’ hours as well as the drive for cost-effectiveness in health care provision). While many nurses protested that doctors were dumping their ‘dirty work’ on an already overburdened group, many senior nurses believed the reduction in junior doctors hours represented an opportunity that was likely to command more resources and managerial support than professionally driven change. For nurses seeking greater professional autonomy it is the combination of the ‘New deal’ for Junior Doctors (NHSE 1992) and the ‘Scope of Professional Practice’ (UKCC 1992) which heralded the sort of opportunities they had been waiting for (Walters 2000).

It has been suggested that the freedom of nursing has not only been constrained by the medical profession in the past but more recently by lay management, for example under the system of management introduced in the eighties that the general manager had the authority to define the scope of nursing practice (Keyzer 1992).
Considerations

Speaking on behalf of the King’s Fund, Dickson (2004) cautioned of the danger of expanding nurses’ roles as it could undermine their existing roles. Similar concerns were expressed back in the early seventies by the Briggs Committee (Committee on Nursing 1972 p47), who feared that if nursing undertook a greater proportion of doctors’ tasks then the caring functions, to which so much importance is attached could be jeopardised. It could be argued that at least to some degree their fears have been realised. With the recent refocusing on the fundamentals of care through Essence of Care benchmarking (2001b) nursing is reminded of its professional priorities. The capacity for nursing to take on another new role has to be a consideration for the implementation of this policy. It has been suggested that developments should encompass holistic care and not just a substitution for medical tasks (Castledine 1995 and Brown 1995) and be led by patients’ needs rather than medical delegation and cost savings (Hunt and Wainwright 1994). It is suggested that in introducing nurse-led discharge contributes to holistic care and meeting patients’ needs.

Some nurses may not feel comfortable that their role has evolved in this way and make them resistors to policy implementation. Yet the most recent definition of nursing (Royal College of Nursing 2003) states nursing is “the use of clinical judgement ……”, and despite nursing having shifted from being a task orientated profession, this may not be how grass roots nurses would describe themselves. But if clinical judgment is central to modern nursing, making discharge decisions would easily be accommodated within their role. Indeed the RCN Executive Director of Nursing (Kitson 2004) sees discharge from healthcare settings as an activity that nurses should be able to undertake on their own initiative.

Co-operation

Masterson and Humphris (2000 p200) describe nursing as ‘a wonderful illustration of a profession which is constantly evolving and changing’ and suggest that with the co-
evolving processes of health need and workforce requirements a whole systems approach to role development is required and that “the current crisis in the NHS is an opportunity to think the unthinkable and let go of past constraints”.

Nursing has been described as demonstrating an admirable willingness to take on additional work to fill gaps, for example to make up for the reduction in junior doctors hours (Radcliffe 2004) and if this is the prevailing attitude locally it will positively influence policy implementation.

Delegation

Delegation from doctors to nurses is not new. The Department of Health and Social Security (1977) circular clarified the criteria nurses needed to meet prior to undertaking delegated medical tasks. By this means the state confirmed and legitimised a medically dominated hierarchy of delegation and control in the NHS and ensured that any changes in the boundary between the two professions could only occur with the consent of doctors (Salter 1998).

This was followed up in 1986 when a working party was set up by the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee to review the extended role of the nurse (DHSS 1989). The expectation expressed was that the role of the nurse would constantly change and develop and emphasised the importance of nurses being both trained and competent, with the clinical nurse to whom the nurses were accountable being responsible for carrying out assessments of competence. Sometimes controversy and dispute ensued as nurses who were trained and deemed competent refused to undertake activities on the grounds that they were too busy. In time this disappeared and it became the norm that if the nurse was trained and competent there was the expectation that she would perform the activity requested (Hunt and Wainwright 1994).
A doctor could be held legally liable if it could be shown that he delegated to a nurse activities which were outside the scope of the duties she was normally expected to perform for which she was not adequately trained or competent. Hunt and Wainwright (1994) assert that the reality was that doctors soon began to assume nurses were competent unless they protested otherwise. This history of nurses coming round to working in new ways and doctors trusting that they had the necessary competence is interesting as both are required to make this policy a reality. However, research investigating the potential for expanding nurses roles to facilitate the reduction in junior doctors' hours (Allen and Hughes 2002), found that 42% of nurses thought that they could make discharge decisions, whereas only 17% of doctors did. It is suggested that if they can be convinced of the merits of this policy as well as the authority to decide the parameters of individual discharges they will have the confidence to delegate discharge decisions to nurses, while retaining overall responsibility for the process.

Hunt and Wainwright (1994) suggested that despite nurses taking on tasks which were once the preserve of doctors, they retain the main responsibility for decision making. While this may generally be the case there is a difference in undertaking a delegated task, for example administering intravenous medication and the clinical reasoning and decision making required to discharge patients. The shift which this policy brings is the nurse’s role in decision making which is significant despite working within the parameters of discharge protocols and discharge criteria for individual patients.

It is clear from the evidence that a nurse-led discharge policy can only be implemented with the agreement of both nurses and doctors and the support of management. Even Florence Nightingale reported (Nightingale 1855, cited in Mitchell 1984) that she could not have achieved what she did had she not worked with medical authorities rather than in rivalry with them. The same applies equally to-day.

5. That the external dependency relations are minimal -
political factors such as the refusal of other organisations to cooperate in implementing the policy.

As the policy analysis being undertaken relates to a local policy which is embedded in national policy and its implementation is dependent on staff, relationships and processes within the Trust rather than 'external dependency relations'.

The policy is built upon national policy to expand the role of the nurse, whose roots are in the policies of the previous Conservative government. This New Labour government has built on the Scope of Professional Practice (UKCC 1992) - as already described it is politically expedient to do so.

The extension of nurses' role in the discharge of patients has cross party support (Health Select Committee 2002), so regardless of the government of the day this policy is likely to be retained.

6. That there is understanding and agreement on objectives of the policy and how they are to be implemented throughout the organisation; that there should be no conflicts within the implementing organisation and that everyone should clearly understand what they have to do and when.

Organisations are characterised by resistance, conflict, disagreement and misunderstanding

This policy review is not designed to include a plan for the implementation of the local policy, instead the considerations and principles for its implementation are included.

Although the rationale for this policy is sound, as already described implementing this policy involves a shift in culture and the willingness and trust of consultants to delegate to nurses and busy ward based nurses being prepared for and motivated to take on an
additional role. Convincing clinicians of its merits will be crucial. This could for example involve ‘process mapping’ to illustrate bottlenecks within the Trust and promote clinical ownership of the issue. All ward nurses and doctors need to be made familiar with the details of the government targets as previously the focus has been on A&E and surgical staff. Current lengths of stay, waiting time for discharge and patients’ perspectives on the current system could be audited to set the issue in its local context and provide statistics to benchmark against following the change in discharge policy. It is only after this background work has been done that staff will be in a position to develop a local framework for policy implementation. Multidisciplinary input should include social work and patients representatives.

The education, training and competency assessment of ward nurses can only commence following agreement of consultants, on the skills needed, the process of their acquisition and assessment to be followed. This may vary depending on the clinical speciality and local decision making, for example day surgery may opt for discharge checklists with variance measured against the norm, emergency admissions for bespoke discharge management plans or specific condition groups for protocol or criteria driven discharges (Lees 2004). Due to the onerous task of preparing the majority of the nursing workforce a pilot followed by a Trust wide phased rollout is suggested. This approach provides opportunities to learn from experience, test tools and systems and provide evidence and reassurance to make the policy a success.

The CNO saw managers as having a role in the implementation of nurse-led discharge and issued a publication ‘Developing key roles for nurses and midwives – a guide for managers (DoH 2002b). As general managers are part of the Emergency Services Taskforce which has responsibility for meeting NHS targets, are therefore seen as ‘drivers’ for the implementation of nurse-led discharge locally. The motivation of managers who will benefit from the success of the policy can be capitalised on. They
could be influential in gaining the essential medical support, accessing funding for the preparation of nurses and establishing audit measures.

Nurses have been used to 'top down' imposed change (Smith and Masterson 1996), but practitioners in new clinical roles like consultant nurses are now taking a lead in changing practice, by facilitating a 'bottom up' approach that links theory with practice (Fisher 2000). A creditable nurse lead for the introduction of a significant change in nursing practice may help give grass roots nurses, ownership of the change and by their change management style, give them ownership of the change which is likely to be a motivating factor. The importance of nursing leadership has already been discussed, but its importance in policy implementation cannot be underestimated.

Tradition and current practice mean that patients are used to seeing a doctor prior to hospital discharge and this change in practice will require their agreement. Fortunately patients appear to have confidence in nurses and have been found to be supportive of role developments for example they express high satisfaction rates with NHS Direct and surveys have found that they would be happy to be seen by a nurse at night if a GP was not available (Nursing Times, 2004). A report which involved a huge consultation (DoH 2003c) indicated that patients would be agreeable to being discharged from hospital by nurses (Hartley 2003), but resistance and conflict could occur if not considered and handled sensitively. It is current practice for patients to have discharge dates set either prior to or as soon as possible after admission. This provides an opportunity to make patients aware of the change in practice and ensure their cooperation.

Although in the context of implementing the CNO's 10 key roles for nurses (DoH 2002 b) the importance of learning from others is emphasised, unfortunately the application of nurse-led discharge and its evaluation nationally, to date has been limited so there is little information on the benefits for patients and organisations to draw upon. However the
potential for utilising physical and human resources to improve patients' experiences and achieve cost benefits are significant.

Recommendations

The term 'nurse-led' is relation to discharge is unfortunate and misleading. It is a fact that patients' discharge was and remains the responsibility of their consultants. While nurses may facilitate the discharge process it is questionable that discharge can be described as 'nurse-led' if it is dependant on consultants delegating their authority to nurses, to enable them to instigate the discharge event, either under protocols or medically set individual discharge criteria. Neither does the term 'nurse-led' promote a multidisciplinary process.

It is suggested that 'nurse facilitated' discharge is a more appropriate title than 'nurse-led', but if the change is to become normal practice it is questionable if any label is appropriate. There is a drive for a 'person-centred' approach to care (DoH 2001c), which means the patient is central to the process and has ownership, rather than a professional group. It is suggested that changing discharge practice as part of the drive for patient-centred care, is likely to get more support than the emphasis being on expanding roles for nurses and meeting government targets.

This policy analysis suggests that its implementation would be most manageable and successful if it is piloted with patients who have undergone minor elective surgery and then gradually extended to include more complex medical patients. This would provide local evidence of the policy's worth and give consultants confidence to delegate to their nursing colleagues. This approach would also provide the opportunity to pilot the supporting documentation and develop it in the light of experience.
Conclusion

This policy analysis has identified that the national policy needed to initiate nurse-led discharge has been in place since 1992 when the Scope of Professional Practice (UKCC 1992) was issued, yet the first published evidence of it taking place was 1999 (DoH 1999). Making nurse-led discharge one of the CNOs 10 key roles for nurses and launching these as part of the NHS Plan (DoH 2000) was an ideal way to make NHS managers as well as nurses and doctors aware of the innovations to be grasped. In the intervening years the Department of Health has issued the series of policy documents examined here, which refer to the importance of timely discharge in maximising bed capacity. The publications to launch and support the introduction of the CNOs 10 key roles and the three recent policy documents aimed at transforming the discharge process highlights the importance of the issue.

Despite the drivers, policy supporting role development and discharge and overwhelming government support there are few examples of local policies being implemented or evaluated. This lack of uptake could arouse suspicion of potential pitfalls. (The only ones identified refer to surgical areas where pathways and length of stays are largely predictable). The lack of sound evidence, both in terms of bed days saved and nurses capability to undertake discharge without putting patients at risk, does nothing to reassure clinicians contemplating the policy.

The evidence appears to indicate that doctors and nurses could co-operate to implement this policy although there are considerations that may make both groups resistors. For example consultants would be required to delegate to nurses while retaining responsibility for the patient throughout the process. Nurses would be required to take on and be individually accountable for another new role which they need to be trained and assessed as competent for. Some may see undertaking this new role and increasing patient throughput as an outcome, increasing already heavy workloads to a degree which they are not motivated to support.
Providing the findings of this policy analysis are taken into account the implementation of the policy could have successful outcomes. It could lead to increased job satisfaction for nurses and the joint working required between medical and nursing colleagues may improve their working relationships. The wider involvement of the multidisciplinary team may promote good interdisciplinary working. Bottlenecks will be reduced and patient flows smoother with the increased capacity achieved, assisting the Trust to meet government waiting time targets and the desired star ratings. The greatest beneficiaries will be patients, as their waits for admission and discharge will be reduced.
REFERENCE LIST


Committee on Nursing (1972) Report of the Committee on Nursing (Chair Professor A Briggs) Cmnd, 5115, London, HMSO.


Department of Health (2002c) *Delivering the NHS Plan next steps on investment next steps on reform*. London, Department of Health.


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APPENDIX 2

Gunn’s conditions for ‘perfect implementation’ adapted for ‘evidence-based medicine’
- points 1-6 with Harrison’s ‘conditions’ below

1. That there are sufficient material resources in the appropriate combination available –
   resources goes beyond money, skills or shortages

2. That there are sufficient non-material resources available –
   time is a non-trivial factor since members of real world organisations have
   ongoing activities and other priorities with which new policies have to compete
   for attention

3. That the policy to be implemented is based upon a valid theory of cause and effect
   – need for research and evidence based practice

4. That the relationship between cause and effect is direct and that there are few, if
   any, intervening links –
   Most organisational endeavours require the cooperation of teams of individuals,
   and that the more links in the chain, the more likely it is that at least one will
   break – importance of organisational culture

5. That external dependency relations are minimal –

   Political factors such as the refusal of other organisations to cooperate in
   implementing the policy
6. That there is understanding of and agreement on objectives of the policy and how they are to be implemented, throughout the implementing organisation; and that everyone should clearly understand what they have to do and when – organisations are frequently characterised by resistance, conflict, disagreement and misunderstanding.
The Nursing and Midwifery Council (NMC) (2004) believes that record keeping is a fundamental part of nursing practice. Like other fundamental areas of nursing practice, for example continence, pressure ulcers and nutrition, record keeping has been identified as a cause of concern and led the Department of Health (DoH 2001a) to develop a benchmarking programme, to improve practice. (The steps in this process equates with the change process described by Hampton (1986) where a perceived gap between objective and performance leads to, diagnosis of the situation, planning, implementing and evaluating change). Broome (1998) suggests that opportunities for change can be created by external pressures and demands and act as a catalyst and be used to the organisation’s advantage. The NMC (2004) states that “Audit can play a vital part in ensuring that quality of care that is delivered and this applies equally to the process of record keeping.” p 8

The need to maintain confidentiality of patient information applies to audit just as much as it does to record keeping itself (NMC 2004). The NMC (2004) Guidelines for Records and Record Keeping advises that audit tools should be devised at a local level to monitor the standards of records produced and to form a basis both for discussion and measurement. Including a system of peer review in the process is suggested and the point is made that whatever audit tool or system is used it should primarily be directed towards serving the interests of patients rather than organisational convenience. This guidance provided the rationale for including all 162 patients’ nursing record keeping in Audit 1 rather than a representative sample. Despite the NMC (2004) suggesting that auditing records is a means of assessing standards and identifying areas for improvement and staff development, there is no history of audit within Older People’s Services.
The Primary Care Trust is committed to Essence of Care Benchmarking (DoH 2001a) and identified the author as project leader. A project team was identified in March 2002, to represent each of 10 clinical areas constituting the service, and completed five benchmarks prior to embarking on Record Keeping in June 2004. Therefore the team undertaking this service development project had the advantage of being an established team who were familiar with Essence of Care and implementing change as part of the process. As a result resistance to change which is a common feature to consider in change management (Broome 1998) was not an issue, rather the team is part of an organisation which values change, making them more likely to contribute to the change effort. Broome (1998) suggests that change will not happen unless there is a critical mass (described as the least number of people to make change happen) of significant people is brought together. As one of the objectives was to standardise nursing documentation a representative from each area was crucial. As the team undertaking the service development had control over the timescales of the project they were empowered to ensure that the process did not cause high levels of stress which lowers performance and the facilitative leader was able to inspire and motivate the team to what Broome (1998) describes as a ‘medium level of strain’ which achieves the highest level of performance.

**Evaluation and Discussion**

**Audit 1**

**Process**

Although all patients were included, as 10 nurses were involved in collecting quantitative data, the audit proforma (Appendix 2) piloted, and staff training given it was not anticipated that the process would consume a total of 48 nursing hours. Gray (2004) cautions that by not knowing how much data to gather the process can become unwieldy and unmanageable. As this was the first record keeping audit conducted within the service the aim was to ensure an accurate baseline. On evaluation a random sample from each of the 10 areas would have been adequate. The time taken to audit a patient’s
records varied between 7 and 37 ½ minutes and directly correlated with the grade of the nurse undertaking the audit, for example the consultant nurse spent 1 ¼ hours and a D grade staff nurse 10 hours. The average time taken per nurse was 5 hours which significant for busy ward nurses.

Feedback
Feedback from the team highlighted how useful they found their participation. They valued the opportunity to reflect on record keeping practice and the rare opportunity to observe and discuss practice in another area. For 8 of the 10 participants it was their first experience of conducting an audit and they all felt the opportunity benefited their own professional development. Their main concern was the length of time it had taken them away from patient care, as due to financial constraints they were unable to be replaced. This is an important ethical issue which will be a prime consideration when planning future projects. The only practical issue they reported was competing with ward rounds and medication rounds to access records. They reported finding the audit tool simple to use despite many ambiguities being identified through data analysis.

Data analysis and findings
All data collected from each of the 10 areas was transferred to Excel spread sheets and percentages calculated for each of the 25 items (Appendix 3). Averages for each group of 5 questions, is presented in bar charts (Appendix 4).

Results showed variation between the 25 components of the audit and the 10 clinical areas audited but the most significant findings were in relation to inadequacies in many of the forms used in nursing record keeping which skewed the results significantly. For example some forms did not accommodate all requirements, such as date, time of completion, signature, and printed name. The absence of these led to varying interpretations, for example some assumed that if a Waterlow Assessment was completed it was done within the recommended timescale, whereas others gave a negative response. The lowest percentage result was nutritional assessment but the process to be followed is that all patients have nutritional screening on admission which triggers nutritional
assessment if appropriate. Record keeping formats did not accommodate the recording of nutritional screening hence the results are misleading. These are examples of a number of discrepancies within the audit tool which were not identified until the analysis stage. Although many of the audit results are invalid a key benefit of the audit is that deficiencies in many record keeping forms has been identified which senior nurses were previously unaware of and this has led to a review and update of 20 forms which make up most of nurses record keeping formats. This will facilitate better record keeping practice and enable the timeliness of assessments to be audited in future occasions.

**Lessons for re auditing**

Prior to repeating this audit significant changes to the tool will be necessary, and it will be piloted more effectively by a member of the team, prior to more in depth staff training. Although all clinical areas will be included only a random sample of 20% of patients' records will be audited, in line with Gray (2004). Although this will significantly reduce the staff time involved funding for replacement costs will be sought to ensure patient care is not compromised as a result of the audit. As evenings have been identified as being the most appropriate time to undertake the audit the plan will include staff being made available at this time.

**Audit 2**

**Process**

As this audit's purpose was to identify the degree to which patient / professional partnerships were demonstrated, evidence of high quality care and the availability of resources to support evidence based practice, the development of a qualitative tool was deemed appropriate. This corresponds with guidance (McCormack and Dewing, 1996), which points out that the type of change intervention under consideration, for example organisational or behavioural will influence whether quantative or qualitative data collection is appropriate. In line with NMC guidance (NMC 2004) a local audit tool was developed (Appendix 5) to encompass NMC Guidelines not addressed in Audit 1 and Essence of Care good practice guidelines .(Appendix 1) Due to the complexity of the
audit and the likely time involved it was agreed that a representative sample of 6 patients nursing records would be included. Due to the potentially subjective nature of the audit the matron and consultant nurse decided to duplicate the audits within a few days of each other in order for both to capture the same patients. Bias was reduced by recording direct quotes when possible to illustrate points.

Participants' Feedback
The average time taken was 45 minutes per auditor, per patient. Eliciting information to answer all 15 questions relating to the 3 separate domains of the audit was an onerous task making it appropriate for it being undertaken by the most senior nurses.

Data analysis and findings
Joint analysis by the 2 auditors showed very high inter-rater reliability, the tool was deemed fit for purpose and the process appropriate. This audit highlighted the need for considerable changes in practice. Although results showed some variation between areas involved, the majority of the issues to be addressed applied to all areas.

A key finding was minimal evidence of patient/professional partnerships, despite ‘person-centred care’ being a standard in the National Service Framework for Older People (DoH 2001b). During feedback the team reported it being an intrinsic part of practice but it was not the culture to record it.

The evidence base for care decisions demonstrated in record keeping was similarly lacking. Some areas have previously developed and implemented care plans of variable quality and others do not rely on such. The value of the developing evidence based core care plans for all key dimensions of care, for use throughout the service has been embraced by the team and will help address this issue.

The third strand of this audit, the availability of resources to support evidence based practice, highlighted a general lack of availability of information on continence, nutrition
and pressure ulcers. These three aspects of care were chosen as they are not only fundamental to the care of older people but because they were also Essence of Care benchmarks which had been completed. Despite this access to resources was very limited as was either not available or inaccessible. As a result of this audit, subject folders have been made available in all nurses' stations.

The audits undertaken to inform this project, identified many issues to be addressed. As a result the first action research cycle will soon be completed. (For details or the service development project plan see Appendix 6).
Aim - “Patients benefit from records that demonstrate effective communications which support and inform high quality care” *Essence of Care Benchmark for Record Keeping* DoH (2001a) p2

**Objectives**

- To examine practice in relation to NMC Guidelines for records and record keeping (NMC 2004)
- To measure practice against *Essence of Care* Benchmarks of Best Practice (DoH 2001a) and improve standards through the benchmarking process
- To identify change needed to meet NMC and *Essence of Care* Guidelines
- To plan, implement and evaluate change required
- To standardise nursing documentation for record keeping across the service
- To promote the principle that “good record keeping is a mark of a skilled and safe practitioner” (NMC 2004) p14
- To effectively manage change creating a new synthesis of people, resources, ideas opportunities and demands (Cornall 1995)
Theories of change and service development underpinning the process

Change
- ‘Planned approach’ developed by Lewin (1946) considered suitable for team level incremental projects (Burnes 2004)
- Action Research - a cyclical process interlinking research, action and evaluation, which is educative, involves change, aimed at improvement & involvement and researcher involved in change process (Hart & Bond 1995)

Empowerment
- Successful change requires learning, Gestalt–Field theorists (Burnes 2004)
- Understanding leads to behavioural changes (Smith et al 1982)
- Values include empowerment, openness, ownership (Hurley et al 1992)

Action
- Change at group level – theory of Group Dynamics (Schien 1988)
- Leader facilitative to promote review & innovation (Broome, 1998)
- Leader responsible for collective vision and project direction (Burnes 2004)
- Ethical principles of negotiated access and confidentiality (Gray 2004)
Benchmarking
Agree actions

Develop Audit Tools
Conduct audits
Analyse audits

Agree action plan e.g.
Update forms
Record keeping trainings
Develop core care plans
Teaching on care plans

Repeat audits

Introduce updated
record keeping forms
Introduce core care plans

Action Research Cycle Based on Hampton (1986)
Summary of Audit Findings

Audit 1  (Audit Tool Appendix 2, Audit results Appendices 3 & 4)

- 8 out of 25 audit criteria scored 80-100%
- Absence of liquid eraser use 100%, jargon free / plain English 99%, continuous & consecutive 98%, legible 89%, signed 88%, patients name on all pages 81%, drug charts written correctly 81%, free of abbreviations 80%
- Many problems identified with record keeping formats which skewed audit results e.g. no place for time, date, signature or print name on many forms
- Issues with audit tool as only 'yes' or 'no' answers so "not applicable" not accommodated and on occasions either ticked depending on the auditor

Audit 2  (Audit Tool Appendix 5)

- Limited evidence of professional / patient partnership
- Care plans and other records demonstrated limited evidence of high quality, evidence based practice
- Limited availability of resources to support evidence based practice
Implications for Service Development

• Update of all 20 record keeping forms to include date, time of completion, signatures, print names, reviews etc to improve practice and facilitate repeat auditing of timely completion

• Development of evidence based core care plans for all 7 key dimensions of care and implement throughout the service

• Accessible resources available in each of the 10 clinical areas to inform evidence - based practice

• Staff training to support the implementation of each core care plan

• Staff training on record keeping to encompass NMC Guidelines (NMC 2004) and Essence of Care Indicators of Best Practice (DoH 2001a)

• Revision of Tool for Audit 1 prior to repeating audit

• Staff training prior to repeating Audit 1

For detail of service development work plan see Gantt Chart
Appendix 6
## Benchmarks for record keeping

### Agreed patient-focused outcome

**Patients benefit from records that demonstrate effective communications which support and inform high quality care**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Benchmark of best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access to current health care records</td>
<td>Patients are able to access all their current records if and when they choose to, in a format that meets their individual needs</td>
</tr>
<tr>
<td>2. Integration – patient and professional</td>
<td>Patients are actively involved in continuously negotiating and influencing their care</td>
</tr>
<tr>
<td>3. Integration of patients records – across professional and organisational boundaries</td>
<td>Patients have a single, structured, multi-professional, agency record which supports Integrated care</td>
</tr>
<tr>
<td>4. Holding life long records</td>
<td>Patients hold a single, lifelong, multi-professional or agency record</td>
</tr>
<tr>
<td>5. High quality practice – evidence-based guidance</td>
<td>Evidence based guidance detailing best practice is available and has an active and timely review process</td>
</tr>
<tr>
<td>6. High quality practice</td>
<td>Patients' records demonstrate that their care follows evidence-based guidance or supporting documents describing best practice, or that there is an explanation of any variance</td>
</tr>
<tr>
<td>7. Security and confidentiality</td>
<td>Patients' records are safeguarded through explicit measures with an active and timely review process</td>
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Factor 2 - Integration – patient and professional partnership

Patients' care is prescribed without discussion or without negotiation with patients and or carers

Benchmark of best practice
Patients are actively involved in continuously negotiating and influencing their care

Carers are involved at the request of the patient or if patient is unable to communicate/participate in planning and negotiating their own care.

Indicators of best practice for factor 2

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- evidence of discussions or negotiations are recorded
- there is evidence available to demonstrate that discussions influenced actions
- the rationale for care and its consequences and alternatives are explained to patients and or carers
Factor 5 - High quality practice – evidence-based guidance

There are no documents available in support of high quality practice

Benchmark of best practice
Evidence-based guidance detailing best practice is available and has an active and timely review process

Evidence-based guidance = clinical guidelines, policies, procedures, protocols, consensus statements, NICE guidance etc. which are based on best available evidence and have user involvement in their development. Review Process = locally defined process of reviewing documents taking into account professionals/users/clients/patients/carers views and best available published evidence.

Indicators of best practice for factor 5

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- supporting evidence is used and what this is
- the level of evidence-base used in compiling guidance and the mechanisms for determining best practice is rigorous for instance systematic reviews
- evidence-based guidance is compiled accepted and utilised by interdisciplinary teams
- users are involved in the development of evidence based guidance, including mechanisms for involvement for more vulnerable groups for example older people, children, mentally ill, learning disability and minority ethnic communities
- a systematic review process is used and this ensures guidance remains based upon the latest evidence
- robust and rigorous audit reviews are undertaken
Factor 6 - High quality practice

Patients' records fail to demonstrate rationale or reference to evidence based guidance or documents describing best practice

Benchmark of best practice
Patients' records demonstrate that their care follows evidence-based guidance or supporting documents describing best practice, or that there is an explanation of any variance

E

NB Attainment of best practice in this factor is dependent upon attainment of best practice in Factor 5.
Evidence based guidance/supporting documents describing best practice = clinical guidelines, policies, procedures, protocols, consensus statements, etc. which are based on best available evidence and have user involvement in their development e.g. local work, published guidelines, Royal Colleges, NICE, etc. They should have local ownership, review and implementation procedures. Integrated use of evidence based guidance supporting documents = may include care pathways, proforma's and checklists as part of the predetermined documentation.

Indicators of best practice for factor 6

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- evidence-based guidance or supporting documents are used
- variance is recorded and how
- recorded variance is analysed and used to inform changes in specific patient records and supporting information.
- there is evidence of robust and rigorous clinical audit review for example peer review of quality and content of documentation
# Audit of Notes: Style and Content

## Style

<table>
<thead>
<tr>
<th>Notes set</th>
<th>1</th>
<th>2</th>
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Completed by: .................................. PRINT NAME .................................. SIGN NAME  .................... DATE

Time taken to complete form: ................................ Minutes
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Audit of Notes: Style and Content

Total number of notes: 162

1. Patients name on all pages: 81%
2. Patients preferred name noted in documentation: 56%
3. All headed sheets are K&C PCT: 56%
4. Entries are written in black ink: 72%
5. Legible: 89%

6. Dated and timed: 75%
7. Signed: 88%
8. Print Name: 43%
9. Alterations dated and signed: 54%
10. Are continuous and consecutive: 98%
11 Line drawn through any gaps 35%
12 Absence of Tipex or Whiteout etc 100%
13 Free of Abbreviations 80%
14 Jargon free and in plain English 99%
15 Identifies problem to which action refers 51%

16 Entries made by 3 or more professional groups Yes 72%
17 Manual Handling Assessment within 6 hours 41%
18 Waterlow assessment within first 6 hours 45%
19 Nutritional assessment within first 24 hours 31%
20 Falls assessment completed within 48 hours 67%
21 Drugs chart correctly written 81%
22 All entries signed and each dose record box filled 68%
23 Resuscitation status completed 70%
24 All sections of assessments completed 55%
25 Locally used tools completed in specified time 51%
RECORD KEEPING
Audit 2 qualitative

Patient No..........DOA...............Ward......................................

(A) Integration – patient and professional partnership

1. Are discussions and negotiations recorded?
   Yes / No
   If yes give example and comments

2. Is there evidence to demonstrate that discussions influenced actions?
   Yes / No
   If yes give example and comments

3. Is there evidence of the rationale for care and its consequences and that alternatives have been explained to patients and or carers?
   Yes / No
   If yes give example and comments

4. Is there evidence of patient centred short and long term SMART goal planning?
   Yes / No
   If yes give example and comments

5. Is documentation written in a way patients can understand?
   Yes / No
   Give examples and comments
(B) Evidence base

I Evidence based guidance

List that available in clinical area – policies, procedures, guidelines NICE / RCN etc relating to-

1) Continence

2) Nutrition

3) Tissue viability

II Evidence based practice

Does documentation refer to evidence based practice?

1. Continence 
   Yes / No

Give examples and comments

2. Nutrition
   Yes / No

Give examples and comments

3. Tissue viability
   Yes / No

Give examples and comments
(C) Quality and content

1) Does documentation adequately describe assessment, planning, implementation and evaluation of care?

Yes / No

Give comments

2) Does the documented nursing process match the patient’s needs?

Yes / No

Give comments

Overall summary comments

Time taken to complete.........................minutes

Completed by; ..................................................... Date.........................
<table>
<thead>
<tr>
<th>ID</th>
<th>Task Name</th>
<th>Duration</th>
<th>Start</th>
<th>Finish</th>
<th>Resource Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>E of G record keeping benchmarking</td>
<td>1 day</td>
<td>Fri 28/05/04</td>
<td>Fri 04/06/04</td>
<td>All</td>
</tr>
<tr>
<td>2</td>
<td>Develop audit tool 1 (Apr 7)</td>
<td>15 days</td>
<td>Mon 07/05/04</td>
<td>Fri 25/05/04</td>
<td>Matron</td>
</tr>
<tr>
<td>3</td>
<td>Pilot audit tool 1</td>
<td>5 days</td>
<td>Mon 28/05/04</td>
<td>Fri 02/06/04</td>
<td>Matron</td>
</tr>
<tr>
<td>4</td>
<td>Train team on audit tool 1</td>
<td>2 days</td>
<td>Fri 02/07/04</td>
<td>Mon 05/07/04</td>
<td>Consultant Nurse &amp; Matron</td>
</tr>
<tr>
<td>5</td>
<td>Complete audit 1</td>
<td>42 days</td>
<td>Mon 05/07/04</td>
<td>Tue 31/07/04</td>
<td>NC &amp; team</td>
</tr>
<tr>
<td>6</td>
<td>Analyse audit 1</td>
<td>98 days</td>
<td>Mon 28/05/04</td>
<td>Mon 27/06/04</td>
<td>Consultant Nurse</td>
</tr>
<tr>
<td>7</td>
<td>Present results to team</td>
<td>1 day</td>
<td>Fri 24/09/04</td>
<td>Fri 24/09/04</td>
<td>Consultant Nurse</td>
</tr>
<tr>
<td>8</td>
<td>Facilitate team feedback on process</td>
<td>1 day</td>
<td>Fri 24/09/04</td>
<td>Fri 24/09/04</td>
<td>Consultant Nurse</td>
</tr>
<tr>
<td>9</td>
<td>Develop audit tool 2</td>
<td>15 days</td>
<td>Mon 07/05/04</td>
<td>Fri 25/05/04</td>
<td>Consultant Nurse</td>
</tr>
<tr>
<td>10</td>
<td>Pilot audit tool 2</td>
<td>4 days</td>
<td>Mon 20/05/04</td>
<td>Thu 01/06/04</td>
<td>Consultant Nurse</td>
</tr>
<tr>
<td>11</td>
<td>Plan audit 2</td>
<td>1 day</td>
<td>Tue 06/07/04</td>
<td>Tue 06/07/04</td>
<td>Consultant Nurse &amp; Matron</td>
</tr>
<tr>
<td>12</td>
<td>Complete audit 2</td>
<td>8 days</td>
<td>Mon 05/07/04</td>
<td>Mon 12/07/04</td>
<td>Consultant Nurse &amp; Matron</td>
</tr>
<tr>
<td>13</td>
<td>Analyse audit 2</td>
<td>21 days</td>
<td>Mon 16/07/04</td>
<td>Mon 18/08/04</td>
<td>Consultant Nurse &amp; Matron</td>
</tr>
<tr>
<td>14</td>
<td>Write report on audit 2 for PCT</td>
<td>15 days</td>
<td>Mon 16/08/04</td>
<td>Fri 03/09/04</td>
<td>Consultant Nurse</td>
</tr>
<tr>
<td>15</td>
<td>Feedback to E of G team</td>
<td>1 day</td>
<td>Fri 24/09/04</td>
<td>Fri 24/09/04</td>
<td>Consultant Nurse &amp; Matron</td>
</tr>
<tr>
<td>16</td>
<td>Device action plan as result of audits</td>
<td>1 day</td>
<td>Fri 24/09/04</td>
<td>Fri 24/09/04</td>
<td>All</td>
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<tr>
<td>17</td>
<td>Agree evidence based resources</td>
<td>1 day</td>
<td>Fri 24/09/04</td>
<td>Fri 24/09/04</td>
<td>All</td>
</tr>
<tr>
<td>18</td>
<td>Have agreed resources insti</td>
<td>26 days</td>
<td>Fri 24/09/04</td>
<td>Fri 29/10/04</td>
<td>All</td>
</tr>
<tr>
<td>19</td>
<td>Update record keeping forms</td>
<td>41 days</td>
<td>Mon 01/10/04</td>
<td>Mon 27/12/04</td>
<td>Consultant Nurse &amp; Matron</td>
</tr>
<tr>
<td>20</td>
<td>Record Keeping Trainings</td>
<td>44 days</td>
<td>Fri 15/10/04</td>
<td>Wed 15/12/04</td>
<td>Consultant Nurse</td>
</tr>
<tr>
<td>21</td>
<td>Introduce new record keeping forms</td>
<td>23 days</td>
<td>Fri 07/11/05</td>
<td>Tue 08/02/06</td>
<td>Team</td>
</tr>
<tr>
<td>22</td>
<td>Agree template for core care plans</td>
<td>1 day</td>
<td>Fri 29/11/04</td>
<td>Fri 29/11/04</td>
<td>All</td>
</tr>
<tr>
<td>23</td>
<td>Agree list of core care plans</td>
<td>1 day</td>
<td>Fri 29/11/04</td>
<td>Fri 29/11/04</td>
<td>All</td>
</tr>
<tr>
<td>24</td>
<td>Agree timetable for core care plans</td>
<td>1 day</td>
<td>Fri 29/11/04</td>
<td>Fri 29/11/04</td>
<td>All</td>
</tr>
<tr>
<td>25</td>
<td>Develop core care plans</td>
<td>131 days</td>
<td>Fri 28/11/04</td>
<td>Fri 27/05/05</td>
<td>All</td>
</tr>
<tr>
<td>26</td>
<td>Teaching session for each care plan</td>
<td>120 days</td>
<td>Mon 20/12/04</td>
<td>Fri 03/06/05</td>
<td>Consultant Nurse &amp; Team</td>
</tr>
<tr>
<td>27</td>
<td>Introduce each care plan</td>
<td>120 days</td>
<td>Mon 20/12/04</td>
<td>Fri 03/06/05</td>
<td>Team</td>
</tr>
<tr>
<td>28</td>
<td>Presentation to clinical practice group</td>
<td>1 day</td>
<td>Thu 06/01/05</td>
<td>Thu 06/01/05</td>
<td>Consultant Nurse</td>
</tr>
<tr>
<td>29</td>
<td>Repeat audit 1</td>
<td>25 days</td>
<td>Mon 27/06/05</td>
<td>Fri 29/07/05</td>
<td>Team</td>
</tr>
<tr>
<td>30</td>
<td>Repeat audit 2</td>
<td>10 days</td>
<td>Mon 18/07/05</td>
<td>Fri 26/07/05</td>
<td>Consultant Nurse &amp; Matron</td>
</tr>
</tbody>
</table>

**APPENDIX 6**
REFERENCE LIST


Carnall C. Managing Change in organisations, (2nd ed.) Hemel Hempstead, Prentice Hall International (UK) Limited


Department of Health (2001b) National Service Framework for Older People, London, Department of Health


LOG BOOK OF RESEARCH EXPERIENCE

This log book is a compendium of evidence that reflects the experience of undertaking the research study. It aims to demonstrate the process and the decision making undertaken throughout the project. It is described using the following headings – search strategies and literature management, ethical issues, Research and Development permission, data collection, data analysis and dissemination strategy.

Search strategies and Literature management
The literature search was undertaken in early 2005 to inform the research proposal which was submitted to the university in June 2005. The aim was to identify research studies discussing the long-term health needs of older people in nursing homes and previous studies relating to the hospital admission of nursing home residents. Databases included were CINAHL, MEDLINE, King’s Fund and DH-DATA: Health Administration & Medical Toxicology (DHZZ) and the British Nursing Index. Variations and combinations of key words used included hospital admissions, nursing homes, long-term care, older people, primary care and GPs. Very few (five) studies relating to the emergency hospital admission of nursing home residents to hospital were identified highlighting this is a neglected area of research.

Some international studies were identified and informative although not directly comparable to UK studies due to differing health care systems. As admission avoidance and the drive to reduce the use of hospital beds is on the national agenda policy guidance continued to be issued after the initial literature review was undertaken. Regular referral to the Department of Health website alerted me to relevant documents. Similarly publications relating to nursing home care published after the literature review was written were identified by repeating searches. This was undertaken prior to writing the introductory chapter of the thesis and again prior to the submission of the first draft of the thesis and the review updated accordingly. Literature was classified by sub category for storage and easy retrieval.

In addition the university library was used to access research texts especially on case study research and qualitative data analysis. On the advice of supervisors past student
PhD theses were reviewed to learn from how others had used grounded theory and gain insight into how study findings could be conceptualised and discussed.

**Ethical issues**

An application was made in September 2005 to the local ethics committee for approval for the study and the proposal was reviewed at the October committee meeting. A form of negotiated consent was suggested in the application so that residents with dementia who were unable to give informed consent would not be excluded. While the committee understood the rationale for this there was concern that the inclusion of these residents as research participants would invalidate study findings. The committee felt that only participants who would be able to answer the simple questions detailed in the interview should be included. It was therefore agreed that only residents who could give written consent themselves would be included and ethical approval was granted in November 2005. On reflection this proved sound advice as even some of the participants identified by nursing home managers as suitable and were able to give consent had problems with recall.

At the ethics committee meeting where the research proposal was reviewed the chair also questioned the proposed interview participants being from the one nursing home and suggested that selecting participants from several homes would make the sample more representative of local nursing home residents. This advice was not followed initially as the aim was to use the one home to examine admissions from the perspectives of residents admitted, their families and the nursing home nursing staff involved. However as the nursing home approved as the research site had only produced one participant five months into the data collection period a new Part C form was submitted to the ethics committee in June 2006 to add additional homes as research sites. As this had already been suggested approval was granted as a chair’s decision. Fortunately this process only took a few weeks.

**Research & Development (R&D) permission**

The local primary care trust was fully supportive of the research proposal and R & D approval application was straightforward and involved completing the relevant forms and submitting copies of ethics application and approval and did not lead to any time delay. As the study was considered to conform to all the requirements under the
Research Governance Framework approval for the study was granted by the PCT. As I resigned from my nurse consultant’s post with the trust during the study my line manager, the director of nursing and R & D lead for the trust considered it appropriate to provide me with an honorary nurse consultant contract until my research study is completed.

Data collection
Data collection was undertaken during 2006 and included a) interviews with 13 residents from four nursing homes, b) the completion of a questionnaire detailing the admissions of each of the 17 residents admitted from one of the nursing homes and interviews with the manager of the home about these admissions and C)Secondary data collection.

a) Face to face interviews with residents
Separate interview schedules were devised for use with residents, relatives and nursing home nurses to achieve the aims of the study. As there were 28 admissions from the original research site during the previous year it was anticipated that a potential sample size of 14 could be recruited to the study during the planned six month data collection period. It was therefore surprising that only one participant was recruited within five months. Following discussion with my supervisors three other local homes were added as research sites which resulted in a total sample of 13 residents being recruited. The problem recruiting my sample delayed the data collection by six months. The intention was to study all admissions in one home by involving the residents, families and nursing staff and comparing their opinions. The rationale was that this may have either identified consensus or differing opinions between the residents, families and nursing staff involved. Instead the 13 resident interviews from a total of four homes became one strand of the study and all the admissions from the original research site another.

As a result of the interviews with nursing home residents demonstrating that admissions were unavoidable (most either involving surgery or strokes) and nursing home managers confirming that this was the case their families were not approached to be interview participants. In the light of the evidence their involvement could only have further confirmed details that had already been established and as admission
avoidance was not appropriate in any of the cases suggested alternatives were not applicable. Instead it was possible to include some relatives’ views from references in the residents’ notes and comments made by the nurse manager who was interviewed about each of the residents admitted from her nursing home.

Nursing home managers were fundamental to the recruitment of my sample. They were briefed about the study and were keen to be involved. Their role was to identify residents who met the inclusion criteria of having recently returned to the nursing homes following emergency hospital admissions providing they were able to give consent and were well enough to be interviewed. They gave the potential participants the Patient Information Sheet and notified me and arranged for me to visit the residents to explain the study. All residents approached were willing to be participants and individual interviews were arranged at a time convenient to them. The time interviews took varied between 10 minutes and forty five minutes and lasted on average twenty minutes. Nursing home managers were approached for information that some individual participants could not fully explain for example some could not articulate exact details of what lead to admission and to verify information given for accuracy.

b) Completion of questionnaires
My intention was that the nursing home nurse involved in each admission would complete questionnaires providing the details of the resident and their admission. However although the nurses had agreed to do this did not deliver. Although they had expressed initial interest they cited lack of time as a prohibiting factor and with shift patterns it was difficult for me to make personal contact to issue repeat reminders. This was a valuable lesson as I now appreciate that even when nurses agree to being involved in data collection there can be difficulty in commitment being realised. Instead I examined the 17 resident records myself in order to complete the questionnaires which took on average 30 minutes. This did not alter the data collected but the nurses missed out on a rare opportunity to be involved in a research project and it made data collection more time consuming for the researcher.

As the nurses were reluctant to participate again citing time as a factor and shift patterns making it difficult to arrange interviews the manager was interviewed
instead of them about each of the 19 admissions involving 17 residents, which took on average 15 minutes to complete.

c) Secondary data collection
It was my intention to access the PCT hospital episode data for care home admissions for an additional year but despite repeated approaches due to changes in staff and a new system prioritising requests for information this proved unobtainable. This was disappointing as having analysed two successive years data it would have been interesting to have had the most up to date picture and the opportunity to make further comparisons.

Data Analysis
For qualitative data analysis a comprehensive structure suggested to a colleague by her supervisors was found to be helpful. It is the ‘Framework’ described by Bryman and Burgess (1994) which suited both the analysis of interviews with residents and the nursing home manager and the resident questionnaires. This analytical process involves a number of distinct although highly interconnected stages and involves a systematic process of sifting, charting and sorting material according to key issues and themes. Although a well defined and disciplined approach ‘Framework’ relies on the conceptual ability of the analyst to determine meaning, salience and connections. It enables easy retrieval of the original textual material, allows between and within case analysis to be made and the analytic process and interpretations to be viewed and judged by others.

Quantative data received as computer printouts containing key information on resident admissions from the local PCT ‘hospital episode’ data base was complicated by poor recording. There was some information missing and many cases were duplicated especially if hospital stays spanned more than one calendar month they were recorded as separate episodes. Sifting and putting the information onto Excel spreadsheets for analysis was laborious and time consuming due to the complications mentioned and the volume of data involved as there were a total of 285 cases. The experience has taught me in future to identify individuals by hospital number first so that duplications and readmissions are immediately identified. This study provided the opportunity to become more familiar with Excel and its potential for the presentation
of results in graphic form. When considering the options for data analysis I attended training on the use of QSR Nvivo, although this approach was not adopted it may be useful in future projects.

When qualitative analysis of the two interview data sets (total of 30 interviews) was completed and the 285 cases from the hospital episode base subjected to quantitative data analysis it was possible to make comparisons from the three sets of findings. It was useful having several sources of related information as sometimes there was agreement and other times contrasts highlighting the value of triangulation.

**Dissemination strategy**

I plan to have the clinical / academic paper which is part of the portfolio published in Age and Ageing which is the journal of the British Geriatric Society. As it is read by senior doctors and nurses who work with older people I consider this the most appropriate readership for my study. It is my intention to have another article on a different aspect of my study published in the RCN Nursing Older People journal.

I have already written a report on the findings of one section of my data analysis for the chief executive of the PCT where my study is sited and I intend to report back on the remaining findings of my study as it was they who were interested in the topic being researched and hopefully will use the findings as intended. I presented on the practice development project to managers from across the PCT who make up the service development forum. I have already given initial feedback to the four nursing home managers who supported the study and will invite them to a presentation of the overall study findings. I will be presenting on my research study to my peers in the Older Peoples Nurse Consultant Special Interest Group of the British Geriatric Society.

In this log book of my research experience I have attempted to focus on the key issues that influenced the study and that have contributed to my development as a researcher. The classes attended during the taught modules, the PhD support group and the constructive support of my supervisors have played an important part in preparing me for and supporting me through the research process.
Doctorate in Clinical Practice

Overview of the integration of knowledge research and practice

Mary Taylor Clay
Cohort 1 (2004)

"I declare that this work is wholly my own work, except where acknowledged specifically as the published or unpublished work of others."

Word Count:

Signature:

Date: 21st December 2008
This is a reflective account highlighting how the taught elements of the programme plus the research have contributed to the integration of research knowledge into the students own area of clinical practice.

Taught elements

There were five taught elements delivered within the first year which served as a foundation for doctoral study. The five elements were professional ethics in a risk based society, advanced research methods, policy, politics and power, communities of practice and emotions, leadership and innovation in organisations.

The first taught element looked at ethical and legal aspects of practice and provided an opportunity to reflect on and discuss professional issues related to clinical practice. For the author this highlighted the complexity of the issues around the prolongation of life. Although discussed in general terms this could be related to the care of older people with advanced dementia, when this topic became relevant in the research study. The module also raised awareness of fundamental issues and professional responsibilities in relation to autonomy, advocacy, capacity and consent in relation to the care of older people who are nursing home residents and were the focus of the research study.

The second module was advanced research methods. This module included an introduction to paradigms and theoretical perspectives underpinning research. In addition ethical considerations and issues of rigour and research governance were covered in considerable depth which provided a foundation
for the research activity that followed. A wide range of methods was taught so that the author was aware of the possibilities and practicalities of utilising various approaches when undertaking the research study. The broader issues of conducting a literature search and applying for ethical approval via local NHS ethics committee were also covered.

The third module; policy, politics and power increased political awareness, for example by examining the health policies of the main political parties and participating in an organised student debate. It provided an opportunity to explore how policy is driven, developed and implemented. This module also supported the policy essay assignment which forms part of the portfolio. The analysis and critique of policy was later required to provide the context for the research project and as a result of this module the author was more aware of the role of policy and critical of its lack of influence than would otherwise have been.

The forth module, communities of practice which is a fairly recently described concept relating to knowledge management and organisational learning was introduced. This explained the importance of breaking down barriers to the sharing knowledge for the benefit of all to avoid the risk of duplicating work, reinventing wheels and failing to share best practice.

The fifth and final module looked at; leadership, innovation and change within organisations and supported the service development project. Emotions and the concept of emotional labour were examined in relation to professions
working within organisations and contributing to the change process and supporting those affected by it. The principles could be applied to clinical and research practice.

An advantage of the taught component was the opportunity to meet with professional colleagues, discuss issues and share ideas and concerns and provide and receive peer support.

The log book which forms part of the portfolio is a record of the development of research skills and provides evidence of the research process and decision making undertaken throughout the research process and serves as part of research governance.

Although there was the intention that the marked assignments of the policy essay and service development project would link and contribute to the research project, in practice this was not always applicable. For example, in the case of the author the research project had not been identified at the time of the policy essay. As the policy analysis was required to be related to clinical practice nurse-led discharge was chosen as this was a policy the author was developing and implementing within an acute NHS Trust through her clinical role as a nurse consultant. It was therefore an area she was familiar with and the essay provided an opportunity to explore the background to developing the role of the nurse to improve patient experience as well as outcomes for service providers. A combination of clinical experience and policy analysis demonstrated there were was sound rationale for local implementation but
local leadership was a prerequisite to achieving a change in practice. This assignment provided the impetus to identify the relevant national policies to support the development of a local policy and plan its implementation.

Although the topic for the research study had been identified prior to undertaking the service development project it was not possible to identify a project that met the criteria of influencing local clinical practice that was related to the research to be undertaken. Therefore one of the standards of Essence of Care clinical benchmarking (Department of Health 2001) was used as this is a process designed to improve the fundamentals of clinical practice. It involves agreeing standards from good practice guidelines, benchmarking against these through audit to establish baselines and identify change required. This is followed by an action plan to facilitate the required change and follow up audit after change has been achieved. As the author was by then a consultant nurse for an NHS Primary Care Trust and the Essence of Care lead, this service development project provided an opportunity to link education and practice. The record keeping standard was chosen as it had been identified that improvement in practice was required. Audits were undertaken by ward based nurses and the author participated in audit as well as undertaking the analysis which provided opportunity for her professional development. As well as undertaking a formal presentation on the project to the university as part of the course of study, this facilitated evidence based feedback to the organisation.
The research project was chosen as it was of interest to the then employing and funding organisation of the author, as well as being of personal interest. As a result of the study issues have been identified that were not previously apparent and the need for change in practice to improve outcomes for older people who are nursing home residents. It has highlighted the importance and value of involving residents at every opportunity in everything that involves them and their families. On reflection the study emphasised the important role of the nursing home nurse, for example in advocating for residents so that their needs are met in line with their values and choice and quality of life is maximised. Current practice in end of life care, especially for residents with dementia is concerning and as a home manager this is something that is being improved locally as a result of the doctoral research identifying the issues.

Undertaking the literature review and analysing related policy has highlighted the difficulty that can be encountered in implementing policy and research in practice. It also demonstrates the importance of sound research evidence in changing practice and improving outcomes for older people. The policy, politics and power module in the taught components emphasised the importance of health care professionals being politically astute and lobbying for change. Dissemination of research findings is therefore crucial.

The research skills that have been developed as a result of undertaking this Doctorate of Clinical Practice has given the author the confidence and the
enthusiasm to contribute to improving practice through undertaking further research studies and disseminating the results to achieve change.

The clinical paper written as part of this doctoral programme has been submitted for publication to Age & Ageing – the journal of the British Geriatric Society as its readership is largely senior doctors and nurses specialising in the care of older people. This is considered an ideal way of disseminating the research findings to an appropriate audience not only to add to the limited body of knowledge but to provide research evidence to support change.