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When should older people go into care?

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The number of people aged 65 and over in the UK will increase by 81% between 2000 and 2051 and represent over one-quarter of the population. Over the same period, the number of dependent older people is projected to increase by 113%.[1] These changes have huge implications for health and social care including the acute medical take.

Where do older people live?

The 2001 census of England and Wales indicated that 95.5% of over 65-year-olds live in the community.[2] Between 1991 and 2001 the proportion of over 85-year-olds living in care homes fell from 23% to 18%.[3] There has also been a large increase in sheltered housing and care at home,[2] in line with UK government policy to provide more care at home.

What is a care home?

The term 'care home' encompasses both residential and nursing homes, including those specialising in dementia care. In England, the Commission for Social Care Inspection registers and inspects care homes.

- *Residential homes*: staff assist with personal care and are on duty 24 hours a day. Meals and laundry services are provided. Residents should require no more nursing care than can be provided by a visiting district nurse.
- *Nursing homes* in which qualified nursing care is provided 24 hours a day.
- *Dual registered homes*, which provide both residential and nursing care, are increasing in number. They have the advantage of enabling residents to change to a higher level of care without moving home.
- *Care homes for the elderly mentally infirm* cater for people with dementia who have specialist care needs and/or behavioural symptoms such as wandering or aggression, if not caused by a reversible condition (eg delirium). Many residents in non-specialist care homes have significant cognitive problems,[4–6]

Key Points

Disease and disability rather than social factors should be the main factors which lead to care home admission

Comprehensive multidisciplinary assessments should be carried out before older people move into care and after the alternative options have been considered

Within care homes, cognitive problems as a result of dementia and stroke disease are abundant

The needs of frail elderly patients represent a challenge to the acute physician; they will become increasingly important with the changing population demographics

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with or without a formal diagnosis of dementia.[7] All care homes require that staff have skills to manage residents with dementia but, importantly, not all patients with dementia need care in a specialist home.[8]

Relevance to the acute medical take

Thirty-five per cent of general medical admissions in the UK are 75 years old or over (excluding those admitted to geriatric medicine).[9] The term 'geriatric giants' describes a number of common syndromes:

- confusion (present in over one third of general medical inpatients)[10]
- immobility
- falls (in older people comprise up to 5% of new casualty attendees)[11]
- incontinence.

People presenting with these symptoms are often described as having 'social problems' and given the unfortunate pseudodiagnosis of 'acopia', suggesting the lack of an underlying remediable cause. However, these symptoms are invariably precipitated by physical illnesses.

A thorough clinical assessment must be made so that reversible factors can be identified and treated.

Admission to a care home may follow acute hospital admission with a severe illness associated with a loss of independence. The decision to move into a care home should be determined by an individual's wishes and needs, including medical, nursing, social and financial, and after consideration of all the alternatives.

A small proportion of care home residents may be only in temporary residence for reasons such as:

- respite care
- intermediate care: short-term placement for promoting functional independence
- transitional care: temporary hospital placement until the care home of choice is available.

What are the alternatives to care homes?

Sheltered housing in which each resident has their own flat contained within a complex. Support to residents ranges from a warden on-site 24 hours a day to a community alarm system through which help can be obtained at any time. Wardens are often the first contact point in an emergency and provide a daily check on residents but do not officially give personal care.

Extra care housing, a newer concept attempting to marry the benefits of residential care with the higher level of autonomy offered by sheltered housing. It is intended for those less able to live independently but who neither need nor want the level of supervision provided in a residential home. Residents have their own front door to their property but carers are on-site providing 24-hour support. Services offered vary in the individual schemes, but help with meals and personal care is usually provided.

Social care within own home, which may take different forms:

- formal carers (paid staff provided independently or by social services), frequency of input depending on availability and needs
- informal carers (family members or friends)
- options such as day centres and respite care may be available to support informal carers.

What are the risk factors for going into care?

Many studies have looked at risk factors for care home use, especially for the 63% of older people who move into permanent nursing care directly from hospital.[12] Physical disability, cognitive problems and chronic diseases are the major risk factors (Table 1).[4–7,13] Medical morbidity (in particular, dementia and stroke disease) and the associated physical dependence, rather than general frailty or social needs, are the main reasons for nursing home admission.

Attempts have been made to provide screening tools which identify patients at risk of admission to institutional care (for example the Leeds Elderly Assessment Dependency Screening tool).[14] However, the identification of risk factors is not sufficiently discriminating: patients with the same level of cognitive problems and functional status may be admitted to care homes or be cared for in their own home. Studies in the USA estimate that for every nursing home patient there are two to three people with similar

Table 1. Recognised characteristics of people in care homes.

Physical illness	Stroke Parkinson's disease Comorbid illnesses (including cardiovascular, respiratory and rheumatological disease)
Physical disability	Declining mobility and function Communication difficulties Pressure sores Falls Poor nutritional state Incontinence or indwelling catheters
Psychiatric illness	Dementia, especially if behavioural symptoms are present Depression Poor self-rated health scores
Other	Increasing age (only a small proportion enter care under the age of 80) Female sex: women survive longer than men Living alone Carer strain Patient or family wish for placement Hospital admission Previous use of respite care

functional levels living at home.[12] Factors influencing the decision to move into care are:

- local alternative options
- availability and health status of informal or formal care givers
- finances.[7,12]

The average length of stay in a nursing home in the UK is 16 months, probably indicating that nursing home residents are growing increasingly frail at the point of admission, and that end-of-life care within homes is an increasingly important aspect of care.

What are the financial considerations?

Care home funding for patients in England and Wales is provided by social services or patients themselves. Those who are self-funding may choose a home, providing that the home will accept them. People reliant on social funded care are assessed for the level of care they require. If the assessment indicates that the person could be cared for at home with supporting care, the placement will not be funded. Hospital doctors caring for older people may sometimes unwittingly cause distress to them or their relatives by indicating that care home placement is the most appropriate option, when subsequently a social worker feels that alternative options still warrant exploration.

Patients and their families may change their decision about care home placement when the financial implications are made clear. If an elderly person is a home owner, this reduces the likelihood of care home entry.[15]

What is the role of comprehensive geriatric assessment?

There is good evidence that comprehensive geriatric assessment (CGA) by a multidisciplinary team reduces admission to care homes for patients at risk of admission. CGA comprises assessment and treatment of reversible factors (including medical, functional, psychological, social and environmental) by a geriatrician or old-age psychiatrist, nurse, physiotherapist, occupational therapist, social worker and other staff (eg speech and language therapists, dieticians). The benefits are greatest in dedicated management units for frail older people. Patients with problems such as poor mobility or cognitive impairment may be enabled to live at home if there is:

- accurate diagnosis and treatment
- assessment of the home for adaptations and equipment, for example, mobility aids and newer technologies such as remote monitoring systems
- support, including day centre and respite care.

A recent systematic review of CGA has shown a reduction in hospital readmissions and entry to care homes as well as improvement in both quality of life and cognition at 12 months. Overall for every 100 patients undergoing CGA, three more will be alive and in their own homes compared with usual care.[16,17]

Patient choice and the Mental Capacity Act

Older people often have very clear views about the appropriateness or otherwise of care home admission for themselves, sometimes based on inaccurate information. Introductory visits or respite admissions before a crisis point is reached can help people come to regard long-term admission as less unacceptable.

When there are concerns about risk and safety of individuals returning to their own home from hospital (expressed by members of the multidisciplinary team or relatives) an assessment of mental capacity must be made. A patient is deemed to have capacity unless shown otherwise. If a patient lacks capacity, it may still be possible for them to stay at home with the support of social services and community mental health teams. This must be considered before a move into permanent care is made in their best interests.

Following the introduction in April 2007 of the Mental Capacity Act (2005), when local authorities and NHS trusts are making important decisions about a change of accommodation for a patient who lacks capacity, they are now required to appoint an independent mental capacity advocate (IMCA) to represent that individual if there are no family or friends to support them.[18] The IMCA's advice must be taken into account in the decision.

If a patient has capacity and wishes to go home despite concerns from the multidisciplinary team, plans should be made to ensure the risks are minimised as far as possible. In difficult cases or where there is disagreement (eg between the team and relatives), a second opinion should be sought, usually from an old-age psychiatrist.

Conclusions

Many identifying factors may precipitate a move into care, but the decision for any individual is influenced by comorbidity, family, financial support and local services. Alternatives to care home admission must be considered, and the level of care should be determined by an individual's needs not by their diagnosis. The key in ensuring that long-term placement is the right move is CGA. Frail elderly patients' needs are complex and challenging to the acute physician and will become increasingly so with the changing population demographics.

Conflicts of interest

None declared.

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