Developing an intermediate care unit for older people with mental and physical illnesses

Mental illnesses, such as delirium, dementia and depression, are common among older people in acute care. A rehabilitation unit was set up to aid independence.

AUTHORS Andrew Madaras, RMN, RGN, CPT, CPN(Dip), is senior intermediate care nurse; Claire Hilton, MD, MRCPsych, is consultant old age psychiatrist; both at Greenview Unit, Woodland Hall care home, Stanmore, Middlesex.

ABSTRACT Madaras A, Hilton C (2010) Developing an intermediate care unit for older people with mental and physical illnesses. Nursing Times; 106: 30, 18-19. Intermediate care is an integral part of healthcare for older people with physical illness. It can provide rehabilitation and enable early hospital discharge, but people with both mental and physical illnesses have frequently been excluded from intermediate care services. This article describes a 12 bed, nurse led rehabilitation unit for older people with mental and physical health needs. The ethos is to promote independence and allow patients to achieve their objectives no matter what their age and ongoing limitations.

INTRODUCTION

Mental healthcare has seen the creation of innovative, dynamic, proactive clinical services in recent years, but these have been primarily for adults of working age (Royal College of Psychiatrists, 2009). Clinicians who have chosen to work in the less glamorous field of mental healthcare for older people have seen funding find its way to just about every other sector (National Audit Office, 2010).

In 2008, Harrow Primary Care Trust announced it was to establish an intermediate care rehabilitation unit for people recovering from physical illness who also have mental health needs. This was to be a pioneering unit, not just clinically but also in its interagency management as a joint venture between Central and North West London Foundation Trust, NHS Harrow, Harrow Social Services and Care UK, a private healthcare provider.

BACKGROUND

More than 16% of the UK’s population is now aged 65 or older (Office for National Statistics, 2010), and older people occupy two thirds of NHS beds (Royal College of Psychiatrists, 2005). The concept of intermediate care was introduced by the National Beds Inquiry (Department of Health, 2000) in an attempt to meet the demands for acute inpatient care resulting from this ageing population. The National Service Framework for Older People (DH, 2001) defined objectives for intermediate care:

- Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long term residential care.”

People with mental illness—often those who have an impaired motivation for rehabilitation because of dementia, delirium or undertreated depression—have usually been excluded from intermediate care services. However, the Care Services Improvement Partnership (2005) emphasised that intermediate care for this client group should be an integral part of provision. Therefore, Greenview intermediate care unit opened in November 2008.

PRACTICE POINTS

- Mental illness in older patients on medical and surgical wards needs accurate diagnosis to enable rehabilitation.
- Mental illness in older age does not preclude rehabilitation and return home.
- A holistic approach to physical and mental health is vital.
- Rehabilitation work with older people who are mentally and physically ill is both challenging and extremely rewarding.

THE GREENVIEW UNIT

Greenview is a 12 bed unit in the 72 bed Woodland Hall care home, and is managed by Care UK. Located on the ground floor, each single room has an en suite toilet and washbasin, while the unit has a physiotherapy room and dining and sitting room areas. A registered nurse is in charge at all times, supported by healthcare assistants, and a registered mental health nurse is on duty during most daytime shifts. The rehabilitation team includes a full time physiotherapist, occupational therapist and senior mental health nurse, and a half time psychiatrist trained specialty doctor. A consultant geriatrician and consultant old age psychiatrist advise on the management of physical and mental health conditions respectively. There is also input from a GP and a psychologist.

The unit’s skill mix has been achieved by multiagency working – the mental health staff are from a specialist mental health trust and other staff are employed by the primary care trust and Care UK. Obtaining equipment—such as installing phone lines and computers—has been problematic as the building is the responsibility of one organisation and the equipment another.

ADMISSION TO GREENVIEW

Mental illnesses, especially delirium, dementia and depression, are common among older inpatients on general medical wards. Each requires different treatment and has different effects on the potential for rehabilitation. The
psychiatric diagnoses of people admitted to Greenview have included delirium, depression, dementia (including vascular, Alzheimer’s and Lewy body types), alcohol problems, schizophrenia, personality disorder and frontal lobe brain systems secondary to a cerebral bleed or postoperative after brain tumour removal. Delirium, both with and without dementia, is the most common.

**Referral and assessment**
Most patients admitted to Greenview have been treated for physical illness at Northwick Park Hospital, although some are admitted from home. Referral is via the health and rehabilitation team, who screen referrals for potential admission to Greenview or an intermediate unit for people without mental health problems.

Greenview’s senior nurse or specialty doctor assesses patients to ascertain their suitability for the unit; this includes getting information on any contact they have had with local mental health and social services departments and, where appropriate, a collateral history. This process also provides an opportunity to explain the purpose of the assessment and the goal of intermediate care to the family. Potential new patients are usually assessed within one working day.

The initial assessment also identifies the physical conditions that may benefit from rehabilitation. Any physical illnesses need to be stable or resolving before admission.

**Rehabilitation**
Following admission, assessment and treatment are holistic and multidisciplinary. Goals are determined with patients and appropriate close relatives and friends. Physiotherapy and occupational therapy programmes work towards these goals. Progress is monitored clinically and using rating scales, including the Health of the Nation Outcome Scales for Elderly People (HoNOS 65+), Barthel Index (Barthel and Mahoney, 1965).

The team aims to respond to cultural and religious needs: a piano was wheeled into the room of one patient; another wanted a local newspaper to see the football results. The needs of carers and their ability to support patients on discharge are also explored. Social workers are often involved in discharge planning and organise home care, meals on wheels and day care.

It is crucial that members of the multidisciplinary team understand each patient’s home environment. To enable this and help them to achieve their goals, patients have a home visit with the occupational and physiotherapists. This enables adequate assessment of the patient’s physical and practical strengths and needs, and also their response to the home environment.

At least one multidisciplinary meeting with the family or main supporters is arranged. When appropriate, the patient also attends this meeting. Discussion revolves around the needs of both patient and carers, weighing up risks and benefits of discharge home or elsewhere, and what can be done to enable discharge. When necessary the team also educates carers about dementia and delirium.

**DATA FOR THE UNIT**
In its first year, Greenview treated 72 patients; there was a female to male ratio of approximately 2:1 (47 women, 25 men), with mean ages of 84 and 81 years respectively. Mean duration of stay was 55 days (range 16-120) – longer stays were associated with both difficulties in arranging long term care and with readmission to hospital for acute illness before return to Greenview.

On discharge, 58% of patients returned to their own homes and 25% were discharged into permanent residential or nursing home care. Seven were transferred back to hospital for treatment of acute medical conditions and one was transferred to the mental health unit. Three patients died.

Barthel Index scores showed a mean improvement of 22 points, from 57 on admission to 79 on discharge. The mean HoNOS 65+ scores showed an improvement from 21 on admission to 13 on discharge.

By comparison, the Denham unit – working with older people with physical illness alone – during the same time period admitted 158 people (gender ratio 2:1; mean ages women 85, men 83). Mean duration of stay was 23 days (range 1-103 days); 71% were discharged home. Comparing the two units, the difference in discharge home rates is not quite statistically significant (Fisher’s Exact Test, 2 tail p = 0.0507).

**CONCLUSION**
Rehabilitation for older people who have both mental and physical illnesses is clearly possible. However, it often proceeds slowly, which is not easily compatible with the bed demands in a busy general hospital.

The findings at Greenview support the establishment of a specialist unit for patients recovering from physical and mental illness, especially delirium. During the unit’s second year, it is hoped discharge home rates will improve and lengths of stay shorten. A more detailed pre-admission assessment process, developing staff skills and a more streamlined liaison with other agencies should all contribute to this.

Management by a multiagency collaboration between the NHS and private sector has not always been straightforward. However, the newly formed clinical team has enjoyed developing skills to work at this interface between mental and physical health. The team is unanimous in its philosophy of care to allow older people to achieve their goals in life.

**REFERENCES**