A Hospital Palliative Care Ward for Elderly People

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Summary

In order to improve inpatient facilities for terminal care for elderly people, a special ward has been opened to maximize the quality of remaining life and to achieve 'death with dignity'. The ward is based within a geriatric department and in a District General Hospital. The work of the first year is described. It is considered to have been successful.

Introduction

People aged 65 years and above receive palliative care in hospital, hospices and the community. In hospital this is given in the acute and long-stay beds of geriatric departments and in other acute wards. The standard of care given by hospices has led to greater awareness of the medical treatment and supporting care of dying patients. Existing facilities and management of the palliative care of elderly people may not always give the setting for patients to 'die with dignity' and with psychological and counselling support for them and their relatives. Care is more likely to be successful when staff are wholly and specifically committed to achieving it. Much progress has been made in the domiciliary care of dying elderly patients, but it is not always possible to fill the gaps in care for those who might be considered to be the most vulnerable.

The rapidity of decline in a patient's medical and physical condition may make admission to hospital imperative. Patients are often admitted to the general ward where the primary disease was treated initially where they are in company with many having acute therapy. There is constant pressure to speed admission and discharge, and this tends to produce an urgent atmosphere in acute wards.

The long-stay geriatric ward tries to provide a caring and homely environment and is suitable for the final days of some elderly patients, but the ward also has to cater for the more long-term needs of the chronically ill who are not expected to die in the near future.

The psychology of old age includes for most a degree of acceptance of the inevitability of death, but it does not alter and may enhance the desire for a dignified end without pain and anxieties. It was considered that another facility within the geriatric department of a District General Hospital might serve this purpose.

Methods

A 12-bedded palliative care ward (Charles ward) was created in February 1989 when some long-stay beds on an acute District General Hospital site were being reorganized with a change of use. No additional funding was available and the resources required were from the budget of the geriatric department. It was thought that patients admitted would die on the ward and there would be little intermittent care as with younger age groups, because of multiplicity of disease, mental frailty and probable social isolation.

The initial plan was to admit patients from the two District General Hospitals in the Portsmouth District and from within the geriatric department. The patients considered were those thought to be likely to live for two to four weeks. This prognostic constraint

was soon abandoned, and patients were also admitted from the community. Most patients are seen by a consultant geriatrician prior to admission, but a minority are admitted directly after discussion with the general practitioner (GP). The medical staff are two members of the Consultant team who give about two sessions of time with 24-hour cover from GP clinical assistant sessions. Junior medical staff or other consultants in the department provide emergency cover. Paramedical staff have been called in if required, and especially the speech therapists who have helped with swallowing problems.

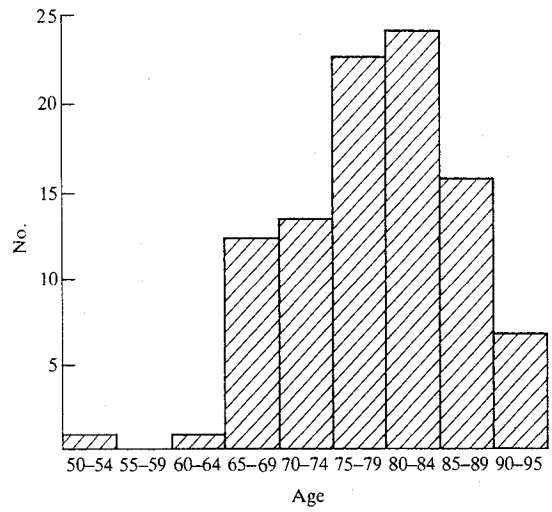

Figure 1. Age distribution of admissions to a palliative care ward for elderly people.

Results

During the first year, from 1 March 1989 to 28 February 1990, there were 128 admissions with 118 deaths. The admissions represent 7% of the admissions to that part of the geriatric service in this District General Hospital. One hundred and one patients had cancer and 27 had other medical conditions. Four patients were found to need long-stay care. Three patients with cancer were able to be discharged with the promise of readmission if required.

A survey of postcodes of the addresses of patients showed the facility was used by patients resident throughout the District. Three patients who were staying temporarily with local relatives came from other Districts. A recording form was introduced and of the 95 patients reviewed the age range was 52–95 years with an average age of 82–83 years (Figure 1). Although the policy was to admit patients aged over 65 years, one patient of 52 years who needed urgent admission with terminal cancer was accepted. Men comprised 44% of the patients and women 56%; 37% were married, 23% single and 40% widowed or divorced; 63% were living alone. Although classified as a long-stay ward, the activity was high compared with a similar sized long-stay ward to which 23 patients were admitted over the same period.

Figure 2 shows length of stay: 19 (15%) stayed longer than 40 days and 15 (12%) were in

Table I. Principal diagnosis

Cancer (n = 101)	%	Other (n = 27)	%
Primary unknown	19	Stroke	64
Lung	17	Dementia	9
Large bowel	11	Multi-system failure	9
Stomach	10		
Pancreas	10	Cardiac disease	9
Breast	9	Liver failure	4
Prostate	9	Other	4
Brain	6		
Lymphoma	5		
Other	4		

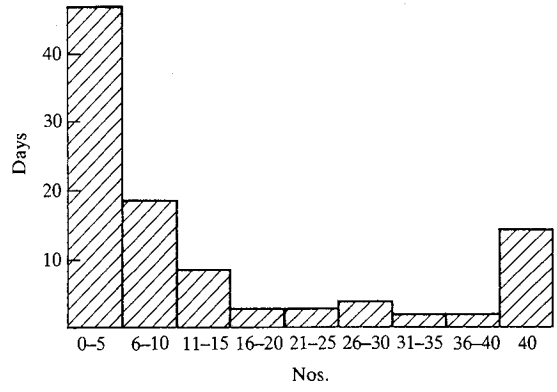

Figure 2. Length of stay.

Table II. Source of referral (n = 128)

	%
General medicine	42
Community	23
Surgery	12
Geriatric medicine	17
Oncology	5
Psychiatry	1

the ward less than 24 hours before they died. Despite this very short period no criticism was received from relatives. The mean length of stay was 13.9 days. Sources of referral are shown in Table II. The patients from the community included three from nursing homes.

Disability was estimated for each patient, using the Barthel scale 0–20, 0 being the most dependent. Fifty-six patients (44%) were totally dependent (score 0) and a further 46 (36%) scored (1–3).

The mean drug expenditure for each admission was £50.70. The most expensive drug used was high-dose diamorphine. Details of grades and numbers of nursing staff are shown in Table III. The nurse allocation per bed at 1.04 whole-time equivalent (w.t.e) per bed is below the national recommendation of 1.46 [1]. In addition there has been support from ward clerk (0.125 w.t.e.) and housekeeper (1.6 w.t.e.).

Table III. Nurse allocation (12 beds)

	Whole-time equivalents		
Grade	Day	Night	Total
H	0.5	—	0.5
G	—	—	—
F	—	—	—
E	3.0	2.24	5.24
D	2.53	—	2.53
C	0.35	—	0.35
B	—	—	—
A	1.63	2.24	3.87
Total	8.01	4.48	12.49

A simple and direct questionnaire for relatives was introduced. The near relative or friend who visited most was approached during the patient's stay whenever the nurse in charge judged it would be appropriate. Of the 31 asked 29 responded, but because of the nature of the work it was not thought right to approach relatives in every case. The questions concerned consultation regarding transfer, the helpfulness of the staff to the patients and visitors, and the patient's accommodation. Also enquiries were made if adequate answers had been given by staff to questions about the patient's condition and if additional facilities should be provided. All the replies obtained were very supportive. Comments made included 'Everything is perfect', and 'I did not think it possible for a patient to die with dignity in the National Health Service', 'You could not ask for anything better'. A questionnaire for staff showed that the main concerns were shortness of time for counselling patients or relatives, and lack of regular junior medical staff cover.

There were 48 letters or cards of thanks and donations of cash totalled more than £3500, which compares very favourably with donations to other parts of the department. In addition there have been many quite substantial gifts including television sets, a microwave oven and a syringe driver. All letters and gifts were acknowledged in writing. No written complaints have been received.

Discussion

Time to adjust must be allowed before transfer from other wards for both patient and relatives to accommodate the change from 'curing' to 'terminal care'. The family and patient must always be consulted before transfer takes place and explanations given. This helps to avoid misunderstandings about the reasons for the patient's transfer and guides expectancy.

During the project it became clear that the main reasons for admission were physical dependency, social isolation, the need for adequate pain control, feeding problems, fear and uncertainty and mental confusion, either singly or in combination. The major problems related to feeding when ethical dilemmas concerning

tube feeding arose especially for stroke patients. Fear and uncertainty, especially related to social isolation, led to a high requirement for counselling time including during the night.

Support for relatives and carers took considerable nurse time and the Hospital Chaplain gave much time. A need for additional chaplaincy and nurse time has been highlighted.

We intend to bring nurse staffing to the National mean levels. All the nurses who worked on the ward were experienced in the care of elderly people but none had specific post-registration certification in the care of the dying, but wished to be part of the project. Additional training needs have been recognized and acted on. Multi-disciplinary working and sharing appeared to provide satisfactory mental, emotional and spiritual support.

There is a need for regular junior staff help which will also assist in their training. A recent report [2] suggests that pre-registration House Officers had not received sufficient guidance on breaking bad news and on pain control. Medical staff time will have to be increased by additional consultant sessions.

Improved social work and physiotherapy are needed. Consumer mediated schemes derived from questionnaires are being explored within the financial year. It is hoped to introduce a quality-of-life assessment soon.

The Staff have been impressed by the extraordinary gratitude of patients and relatives for the palliative ward setting for elderly patients, and even difficulties which arise are somehow more readily forgiven. Relatives appreciate the siting of the ward within the District General Hospital and in the largest centre of population. Visiting is easier than to some of our long-stay hospitals.

We believe the ward has achieved the aim to provide 'death with dignity' for some elderly patients and offers support for carers and relatives. It provides an extra facility within the Geriatric Department and thus gives more choice. Although terminal-care facilities in the community are responsible for a large proportion of such care of the elderly, provision of a high quality of service in hospital palliative care will need to be continued.

Acknowledgements

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