

Multidisciplinary assessment of applicants for residential accommodation

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SUMMARY

Fifty of 62 applicants for residential accommodation underwent assessment at a geriatric day hospital. Twenty-five were suitable, 11 were suitable following rehabilitation and 14 were unsuitable for placement in residential accommodation. Around 35% of all applicants were not assessed. Seventy-nine per cent of assessed applicants, without dementia, either were unsure of how their application had been initiated or did not understand the implications of a move to residential accommodation. Twenty-two per cent of all applicants assessed were taking four or more drugs. To maximise the use of residential accommodation, all applicants should be assessed to reduce inappropriate referrals.

INTRODUCTION

Current population trends indicate an increasing number of very old people in our community for at least the next two decades.¹ This will lead to an increasing burden on both hospital and community resources. Residential homes managed by the Department of Health and Social Services in Northern Ireland form an important part of community care for the elderly. Inefficient use of this resource will not only affect the elderly in the community but will increase the length of stay of the elderly in hospital. It therefore becomes increasingly important that the limited resource of residential accommodation is closely matched to need. Recent studies in England and Scotland have shown the benefits of assessing applicants.^{2, 3, 4, 5} A district social services department, with the permission of local general practitioners, was asked to refer all applicants for residential accommodation from home for a multidisciplinary assessment at a geriatric day hospital. Present criteria for admission to residential accommodation include that the elderly person be independently mobile with or without mechanical assistance, be independent in activities of daily living (washing, toileting, dressing), or require minimal assistance or supervision only. The aim of the study was to see if multidisciplinary assessment is useful both to the applicant and to those responsible for making the final decision to admit the elderly person to residential accommodation.

MATERIALS AND METHODS

Between August 1985 and January 1987, 62 applicants for residential accommodation were referred for multidisciplinary assessment. Their mean age

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was 82.6 years (range 72–94). Applicants were followed up at six to nine months after initial assessment to determine the outcome.

The initial multidisciplinary assessment included:

- (a) Interview with a social worker to discuss the applicant's personal situation, the reasons for the application and their understanding of residential accommodation.
- (b) Medical screening to assess mental function and any underlying medical problems, especially remediable ones.
- (c) Physiotherapy and occupational therapy assessment to consider problems of mobility or ability to perform activities of daily living such as dressing and attending to personal hygiene.

Standard assessment forms were used to reduce inter-observer variation and to provide a framework for decision-making. For confused applicants, information was obtained from relatives and/or social services. For all applicants, information was sought from their general practitioner and local social services. Each applicant had the following tests carried out: mental test score,⁶ full blood count, erythrocyte sedimentation rate, a thyroid function test, serum urea and electrolytes, vitamin B12 and folate, calcium, phosphate and alkaline phosphatase levels, and a chest X-ray. A decision on suitability for residential accommodation was taken after discussion among the assessors. Any necessary treatment or rehabilitation was carried out.

If an applicant was deemed unsuitable, it was recommended whether they should remain at home with or without increased social services support, or obtain sheltered accommodation.

Following these decisions the applicants were placed in one of four groups, A, B, C or D (Table I).

TABLE I

Assessment groups decided by the multidisciplinary assessment team after the initial attendance at the geriatric day hospital

	Number of subjects	Number with dementia
A — Suitable for residential accommodation	25	} 16
B — Suitable for residential accommodation after rehabilitation at geriatric day hospital	11	
C — Unsuitable for residential accommodation	14	5
D — Did not attend	12	

RESULTS

Assessment groups

Fifty of the 62 applicants referred had multidisciplinary assessment (Table I). There were 8 males and 42 females. Four were living with relatives, the remainder were living alone — 27 with support from family and/or social services, 18 in sheltered accommodation and one with no support. Fourteen subjects were assessed to be unsuitable for residential accommodation (Group C), 13 being considered to be too fit. Of these, seven required no change in their

accommodation or level of social services support, three were recommended for sheltered accommodation and three required increased social services support at home. The remaining subject in Group C was too dependent for residential accommodation. Group B subjects (rehabilitation) attended the geriatric day hospital for a mean of 46 days (range 10–95). Eight had medical treatment as well as rehabilitation. Of the 12 applicants who failed to attend (Group D), three were dead, two had been admitted to residential accommodation as emergencies, three were in hospital, three refused to attend and one was in private care.

Follow-up

Ten of the 36 applicants in Groups A and B were in residential accommodation six to nine months after assessment, while 15 were still on the waiting list (Table II). Five of the remaining 11 were dead at follow-up. Of those in Group C, one was in residential accommodation and four were on the waiting list contrary to our recommendations. Thirty (60%) of all those assessed (Groups A, B and C) were either on the waiting list or in residential accommodation at follow-up and 20 of them attended for re-assessment. Only one showed functional deterioration and required a further course of rehabilitation. The 10 who did not attend for re-assessment were still at home.

TABLE II

Placement of applicants for residential accommodation 6–9 months after their initial assessment

Group	Residential accommodation		Home	Dead	Private care	Total
	Placed	Waiting list				
A	8	10	3	4	0	25
B	2	5	1	1	2	11
C	1	4	7	0	2	14
D	4	0	2	4	2	12
TOTAL	15	19	13	9	6	62

Mental test score

Twenty-one (42%) of all those assessed had dementia (mental test score six or less out of 10). Five of them were considered more suitable for residential accommodation for the confused elderly and one was referred for psychogeriatric assessment. Thirty-four per cent of those without dementia were considered to be too fit for residential accommodation compared with 19% of those with dementia. Fifteen of the 29 without dementia had a poor understanding of what a residential home was, and eight were unsure why or how the application had come about.

Medical screening

This revealed a number of previously undiagnosed problems, the majority of which were treatable (Table III). No applicant required hospital admission at initial assessment, but six of those who failed to keep their appointment were either dead or in hospital when called for. Eleven (22%) of all applicants assessed were

taking four or more drugs and 24 drugs were discontinued in these applicants because of side effects, drug interaction or lack of indication. The majority of discontinued drugs were either diuretics, or drugs prescribed for 'dizziness' — notably prochlorperazine which is a potent cause of hypotension, Parkinsonism and falls in the elderly.⁷

TABLE III
Medical problems discovered at assessment in 50 applicants for residential accommodation

<i>Diagnosis</i>	<i>Number of subjects</i>
Inappropriate drug therapy	11
Falls due to gait abnormalities	6
Poor vision	4
Anaemia	3
Transient ischaemic attacks	3
Deafness	2
Faecal impaction	2
Biochemical osteomalacia	2
Osteoarthritis	2
Hypothyroidism	1
Carcinoma of the lung	1

Non-referral

It was clear that in a home-based assessment not all applicants for residential accommodation would be assessed. Because geriatric and social services catchment areas are not co-terminous, it was not possible to obtain precise figures. From figures obtained from social services it would appear that around 35% of all applicants for residential homes in our area had not been referred to us for assessment during the study period.

DISCUSSION

In many areas the availability of places in residential accommodation is exceeded by demand.⁸ With increasing numbers of elderly people, especially those over 85 years of age in the community, this situation is likely to worsen. DHSS-recommended norms for places in residential homes and homes for the confused elderly are 24 and three per thousand over 65 years respectively. In our catchment area the actual corresponding figures are 10.8 and 4.5 per thousand. In order to use this limited resource more efficiently there is an urgent need for careful assessment of applicants prior to permanent placement in residential accommodation.

In contrast to other studies,^{2, 3, 4, 5} we assessed thirteen (26%) of our applicants as too fit for residential accommodation. Some otherwise 'fit' elderly people require placement in residential accommodation for important psychological reasons. This figure strongly suggests that people are being referred for residential accommodation without due consideration of alternative means of community support. When an elderly person experiences difficulty in living at home,

residential accommodation should not necessarily be the first response. All applicants in this study were living at home at the time of the initial assessment, whereas in previous studies some or all subjects were already in residential accommodation or in hospital at assessment.^{2, 3, 4, 5} This only partly explains why our group of applicants seemed fitter than those of other studies. Criteria for admission to residential homes can vary according to number of available places, staffing and dependency levels of residents. Unlike other reports this study revealed only one subject who was too dependent for residential accommodation.

There was a significant level of undiagnosed medical illness in applicants, most of which was treatable. Many applicants were on inappropriate drug therapy, confirming findings in previous studies.^{2, 3, 4, 5} Since the reason for non-attendance in three applicants was death and in a further five was emergency admission to hospital or residential accommodation, early assessment may be important to reduce morbidity and mortality. The numbers with dementia in this study were similar to other studies.^{3, 9} The presence of dementia increased the likelihood of need for admission to residential accommodation.

An important finding in this study was that 79% of screened applicants without dementia were unsure how their application had come about or did not understand the implications of a move to residential accommodation — sometimes a relative had taken the decision-making out of the elderly person's hands. This, along with the finding that some applicants were too fit for residential accommodation, points to the need for a careful review of how applications are initiated and processed. Current discussion by the Review Group on Residential Accommodation of the Eastern Health and Social Services Board is therefore timely. Any regular visitor to a residential home will see increasing numbers of frail elderly people. We recommend a change in the philosophy of residential care with a greater nursing input and increased staffing levels to deal with these changes. The alternative is an inappropriate burden of care being placed on the hospital services. Private residential and nursing homes can provide a suitable alternative in some cases, but there is no proper assessment procedure and, despite DHSS supplementation, the cost can be prohibitive.

Placement panels for residential accommodation found the multidisciplinary assessment reports helpful in allocating places although five subjects whom we considered unsuitable were accepted. Around 35% of applicants referred were not assessed by us. There are several reasons for this: those who had emergency admission to residential accommodation or admission from hospital and those referred for residential homes for the confused elderly were not included in our study. Of more immediate concern are applicants who did not wish to be assessed and/or whose general practitioners did not give consent. If multidisciplinary assessment is to be worthwhile it should cover all residential home applicants. For this to happen, assessments might have to be mandatory. Assessments at hospital are stressful so we would recommend home assessment where possible. Good social and medical assessments are important, with referrals to other members of the multidisciplinary team where appropriate. The whole purpose of assessment is to establish a knowledge base which will allow effective, appropriate care which meets the elderly person's real needs.¹⁰ Such assessments should extend to DHSS-supplemented private sector care of the elderly.

In conclusion we recommend:

1. All applicants for residential accommodation should be seen at an early stage by experienced social work staff for discussion and counselling.

2. All applicants should be assessed by medical and social work staff experienced in care of the elderly to avoid inappropriate admissions and reduce morbidity. The main philosophy of this assessment should be to assess the elderly person's needs and to try and maintain them in their own home or other appropriate setting for as long as possible, rather than merely to assess their suitability for residential accommodation.
3. Since occupational therapy assessment provides pertinent information on ability to cope with everyday life it should be part of the assessment process in the majority of applicants.
4. Physiotherapy assessment should be carried out on a more selective basis.
5. Where possible, assessments should be carried out in the applicant's home.
6. All elderly people admitted as an emergency to residential accommodation and being considered for permanent placement should be assessed as soon as possible as they may be suffering from a treatable condition and therefore be inappropriately placed.⁵
7. All DHSS-supplemented applicants for private residential and private nursing homes should be assessed — this will have manpower implications.

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