

GERIATRIC CARE IN A WELFARE HOME

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THE HISTORY OF GERIATRIC CARE IN INSTITUTIONS

TOWNSEND (1962) traced the development of the concepts of caring for people in institutions. It goes back to the obedience of early Christians to the commandment of mercy and compassion. Institutions were first established in the East by the Christian Church in the third and fourth centuries. Many were differentiated in their social and medical functions i.e. Gerontochia for the aged, Nosocomia for the care of the sick, Ptochia for the helpless poor. Western Europe followed much more slowly and Noscomia were established in the fifth and sixth centuries in Italy and France. By medieval times, there were infirmary almshouses and houses of pity for the aged, destitute, sick and disabled in England run largely by groups living under monastic rule. In the sixteenth century this system of religious institutions was broken up by the dissolution of the monasteries by the Reformation Parliament. This abolished hospitals in England for the best part of two centuries. Then the edge was taken off distress by a system of public relief administered by the parishes, and this was succeeded by the poor houses established under the Poor Relief Act 1601. This system prevailed till the eighteenth century when the system of voluntary hospitals began to emerge. In 1834 the Poor Law Commissioners was set up and this established the workhouse. England and Wales were divided into 643 "unions" replacing the former 15,500 small authorities and each "union" was administered by a Board of Guardians. Reforms in local government today seem like history repeating itself! Hundreds of workhouses were built between 1830 and 1840, and these gave care to the infirm, aged and chronic sick for over 100 years, but there was a gross neglect of these groups between 1910 and 1946, a period when the population over 65 years doubled.

Although the Welfare State in 1948 decreed that new accommodation of small residential homes be made available, this was not possible because of lack of finance and these groups were a low priority, and so, it was a question of making do with old, large institutions for many years to come, but in 1954 the Ministry of Health began to attach importance to the conversion of large houses and to design smaller homes with single and double bedrooms in order to produce a homely atmosphere, and in 1961, the Ministry stated—"Many now regard 60-bedded homes as too large for the creation of a homely atmosphere and too wearing on staff when the residents are of the more infirm group".

THE RODDENS

The Roddens is an example of such a small purpose-built welfare home built for the County Antrim Welfare Committee and opened in March 1971. It has accommodation for 42 residents, is a two storeyed building sited in its own grounds near a trunk road and near to the public library. It consists of two wings and the bedrooms are either single or double; there are four sitting-rooms, a dining-room, kitchen, staff dining-room, matron's office, doctor's consulting room with a small

waiting-room, which is also used as an interview room for relatives and clergy, an occupational therapy room, and a small laundry. The decor and furnishings are bright and cheerful and show great taste. In one of the bathrooms there is a medicbath and in another there is an ambulift for lifting patients into the bath. There are many other aids to living like hand rails in all corridors, aids in toilets, small slit lights one foot above floor level in corridors and bedrooms. Each person has a wardrobe and a dressing-table unit with one drawer which locks and they adorn these with little private possessions like photographs and pictures. No personal furniture is allowed. The staffing consists of matron, deputy matron, nurse, cook, assistant cook, four full-time and two part-time domestic staff and seven female attendants and one male making a total of 19.

METHOD OF SELECTION

The selection of an old person for admission to the home is controlled by the Welfare Department Headquarters. Residents may be admitted because:

- (1) They are physically so frail that they require supervision and assistance in the activities of daily living.
- (2) They are so confused mentally that they are at risk living at home.
- (3) They suffer from a mental disorder as a result of which it is inadvisable for them to live alone.
- (4) They are difficult personalities and cannot accept help from community resources or have worn out all available local resources.
- (5) They need to maintain improvements secured by hospital treatment, i.e. many old people deteriorate on return home from hospital, and quickly lose any independence they have regained.
- (6) The inability of community services to provide supporting services because of poor or isolated surroundings.
- (7) Inadequate housing.

The applications come from the social workers in the field who are contacted by a variety of agencies i.e. family doctors, health visitors, district nurses, clergy, relatives, neighbours, hospitals, Abbeyfield homes and private homes. Each is screened as to his circumstances by the local social worker who makes a report to headquarters, together with a simple medical questionnaire filled in by the family doctor. This form asks such questions as, previous health, present medical disabilities, present medication, physical and mental state. If there is a vacancy and if the person is suitable, headquarters then notify the matron to receive him. There were 52 people admitted to the Roddens during the first year; 27 (51.9 per cent) from their own homes, 19 (36.5 per cent) from hospital, 5 (9.6 per cent) from other welfare homes, and 1 (2 per cent) from an Abbeyfield home. Of these, there were two who did not settle and were discharged; and there were two transfers to other homes nearer their relatives and friends.

MEDICAL CARE

Every new entrant is subjected to a full physical examination to provide a baseline for future deviations. It speaks well for the screening process and simple medical form that out of 52 entrants in the first year of operation there were only

three surprises; one with a haemoglobin of 6 g/100ml; one with a haemoglobin of 8 g/100ml. and one with an undetected chronic urinary infection. Table I shows the medical conditions on entry.

Old Stroke	4	Hypochromic anaemia	5	Cardiac	2
Arteriosclerosis	4	Psychiatric	6	Glaucoma	2
Parkinson's disease	3	Diabetic	3	Cataract	2
Osteoarthritis of knees	3	Cardiac asthma	1	Congenital syphilis	1
Epileptic	1	Chronic pyelonephritis	2	Pernicious anaemia	1
Hypertension	2	Rheumatoid arthritis	2	Incontinent	1

In this age group the incidence of multiple pathology is highest and Table II sets this out.

1	Epileptic and incontinence of urine
1	Hypochromic anaemia and hypertension
1	Diabetic, cardiac and anaemia
1	Rheumatoid arthritis and cerebro-vascular accident
1	Cardiac and rheumatoid arthritis
1	Hypochromic anaemia and cataract
1	Cardiac and arteriosclerosis
1	Pernicious anaemia and arteriosclerosis
1	Arteriosclerosis, rheumatoid arthritis and cardiac failure
9	TOTAL

Table III gives the age distribution of the community.

64	65-69	70-74	75-79	80-84	85-89	90	TOTAL
2	4	5	13	18	7	3	52

The sex distribution was 11 males and 41 females, and this gives a ratio of 1:3.7. Green and Lodge (1965) in their large survey found the largest number of residents of welfare homes in the 80-84 age group and the sex distribution 1 male to 1.2 females.

The total number of visits which were paid to the home in the first year was 162 of which 5 were after midnight and there were 13 emergencies. The causes of the emergencies were two sudden deaths, one cardiac asthma, two dementia, one broncho-pneumonia, one coronary thrombosis, one terminal, and five cases requiring suturing.

Undoubtedly, the commonest disability to manifest itself is that of dependent oedema of the feet, ankles and legs. This has a great immobilising effect on the

old people and has to be treated enthusiastically. They were treated by diuretics, supporting stockings and keeping the legs elevated when not walking.

DRUG THERAPY

“A great deal of treatment that is given to the young and middle-aged is intended to prevent troubles in the distant future, and some nuisance in the present may be accepted to obtain this end. It is, of course, obvious that old people have no distant future, yet they are often continued on treatment which however correct it might have been, can no longer benefit them” Harman (1971).

Residents are admitted on regular drug therapy which they may have been on for a long period and this regime tends to be accepted and continued as long as the patient is well, active and mentally alert, but in a small community of 32 residents (which was the occupancy rate for the home at this time) this drug therapy, when aggregated, can be quite large. The following tables give the drug therapy for the residents of the home for one day—a grand total of 259 tablets or 8.20 tablets per resident.

TABLE IV

Psychiatric	47
Diuretics	71
Hypnotics	25
Cardiac	14
Parkinson's disease	11
Miscellaneous	91
TOTAL	259

It can be seen that the commonest conditions are psychiatric, dependent oedema of feet, ankles and legs, insomnia and cardiac. Then after this there is a wide spectrum of conditions ranging from Parkinson's disease to mild diabetes which are supervised. Examining the drug list for one day might seem to be an example of over-prescribing and in order to test this, the drug therapy of 32 unselected patients of 65 years and over were noted as they appeared in the Health Centre or were visited in their homes by the author (so that the same doctor was prescribing for the two groups of geriatrics). Their drug therapy was 166 or 5.18 tablets per patient. The average age of the residents was 80.2 years and the control group 71.9 years.

The following table gives the drug therapy for the patients outside the welfare home.

TABLE V

Psychiatric	6
Diuretics	15
Hypnotics	4
Cardiac	19
Hypertension	23
Rheumatism	42
Miscellaneous	57
TOTAL	166

The difference in the daily drug therapy between the two groups was 93 tablets (259-166=93) and this was accounted for by two groups of drugs, psychiatric and diuretics.

The reason for more psychiatric problems in the home than in the community is probably due to the change in environment and to learning to live as a community for the first time; and the reason for the great increase in the use of diuretics is probably explained by the older age group in the home. Apart from these two groups of drugs, the remainder seem similarly prescribed in the home and in the community.

FACILITIES FOR MEDICAL CARE

The facilities for medical care consist of a medical officer, three qualified nurses, a chiropodist, a physiotherapist, occupational therapist and a local dentist. The chiropodist and the physiotherapist visit when required, and the occupational therapist weekly to give instruction and give out work for the week ahead. The author is aided in his work by being on the staff of the Health Centre and the local Cottage Hospital and thus is able to admit patients for the treatment of acute illnesses. The residents are, therefore, still being cared for by the same doctor and this provides a sense of security. During the year there were nine deaths. When a resident dies the body is transferred immediately to the small chapel of the hospital and there is little disturbance in the home.

FURTHER ASPECTS OF GERIATRIC CARE IN A WELFARE HOME

Occupational therapy has been mentioned, but a variety of other activities take place. The local library is on the same site and can provide large print books; a short Sunday morning service is conducted by the local clergy; entertainment groups give shows, and the local Evergreen Club meets weekly, and there the residents meet other members of the local geriatric community. Special efforts are made to inculcate a feeling of security and this is done in a number of ways. For instance, when a resident is admitted, his home or flat is not given up immediately and this prevents the new resident feeling he has made an irrevocable decision. Equally, when a resident is admitted to hospital his room is kept for him for a minimum period of six weeks. All efforts are made to combat "the effects of living in a Home" as described by Townsend (1962) which are: —

- (i) Loss of occupation.
- (ii) Isolation from family, friends and community.
- (iii) Tenuousness of new relationships.
- (iv) Loneliness.
- (v) Loss of privacy and identity.
- (vi) Collapse of determination.

DISCUSSION

A welfare home is a place where old people who are ambulatory in one form or another (i.e. they are not bedfast), and who can no longer care for themselves, are admitted. While a great many are physically and mentally fit, nevertheless,

they all suffer in different degrees from the degenerative diseases. One can subsequently follow the slow progress of this as time goes on, they move to the phase of being mentally duller, physically slower, becoming more dependent on the staff until they are chairbound, or some sudden terminal illness strikes. "Geriatric care means (in whatever setting) much more than treating the acute episodes and the terminal illnesses that occur in this group. It means the slowing down, where possible of the process of ageing; and the provision of various medical and welfare aids to enable them to retain their independence" (Burns, 1969). While it is imperative to provide good medical and para-medical care it is equally important not to allow the residents to become too dependent on the staff. It is this field that the staff have a very important part to play, for they also have to recognise when the resident is becoming less and less independent mentally and physically and to act sympathetically and compassionately. A welfare home should be small enough to provide the homely atmosphere and to give a sense of security to the residents. Its occupants should be encouraged to integrate with the local community as much as possible so that they do not become institutionalised. By keeping residents occupied and providing good regular medical facilities and interest in life both inside and outside the home their lives are being prolonged in an active state. These should be the ideals of geriatric care in a welfare home.

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