# Intensive home nursing

## An innovation in old age psychiatry

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**This paper describes the establishment of a team of four nurses to provide a service in old age psychiatry along the lines of "Hospital At Home". Its aim was to treat and nurse patients at home who otherwise would have to be admitted to hospital. An integral part of this initiative is the use of a problem orientated approach with integrated records. The work of the team over six years is reviewed and how it has evolved to provide a rapid response to difficult and fraught situations.**

In 1971 a new psychogeriatric assessment unit was established at Cefn Coed Hospital, Swansea. From that time the local old age psychiatry (OAP) department has continued to evolve and develop. In the early 1980s we became interested in the concept of 'The Hospital At Home' (Clarke, 1984). We were conscious that a tranche of patients could be managed effectively at home if only the community psychiatric nursing component could be generously expanded. For this reason a specialised intensive home nursing team, was proposed. This was referred to as the Task Force, consisting of a team leader – sister grade (FH), two staff nurses, and a nursing assistant. The essential idea was that this small team could provide intensive home nursing to a small number of patients who would otherwise require hospital admission. The team would focus on patients in whom it was felt a short period of intensive treatment would bring about rapid improvement. With development money from the Welsh Office, this proposal was implemented and the Task Force became operational in October 1988.

### Referral and pattern of working

Referrals to the team are made by the senior psychiatrists. The patients primarily targeted are those in whom it is considered that intensive home nursing over 4–8 weeks would bring about substantial improvement. Initially priority was given to patients with mild/moderate dementia who were resistant to accepting structured help at home. The Task Force would be used to introduce and establish services. However, we soon learnt that several patients in this category could not be managed as we had hoped. The introduction of help had to be more gradual and once achieved tailing off could be difficult. Sometimes, despite considerable effort little was achieved. On the other hand, we found that the team could be used more effectively in treating patients with major depressive disorder and paranoid states.

The use of problem orientated care planning (Williams & Owen, 1988) has been found invaluable in providing comprehensive management. The problems are clearly defined together with the treatment strategy. The initial plan is set out at the time of referral but this is regularly revised, modified and up-dated. This technique is regarded as a key element in the Task Force's style of working. This example of how the work is organised relates to the second vignette, Mr J L.

*Review of problem list and care plan by the Task Force team (Mr J L, aged 72): 16.02.90*

1. *Endogenous depression*

Mildy depressed in 1984, worse at present with paranoid delusions relating to money and the stairs (difficult access to flat). Refusing to take diet and difficult with medication.
Flupenthixol injection given by GP on 07.02.90.
Current medication pericyazine 7.5 mg and imipramine 50 mg twice daily, now crushed and given in jam.

Plan
(a) Task Force to continue visiting three times daily to give Mr J L medication and diet.
(b) To monitor mental and physical state.
(c) To give supportive counselling to wife.

2. *Lack of volition, and poor concentration*

Neglects personal hygiene.
Conversation and movement are slow and retarded.

Plan
(a) To give practical assistance with personal care, e.g. oral hygiene, bathing and dressing.
(b) To engage him in light activities e.g., newspaper, reading, games.

3. *Weight loss*

Marked weight loss from 9st 6lb to 8st 7lb within 6 weeks.
(a) Weight to be checked weekly.

4. *Constipation*

Refusing to take prescribed Fybogel.
(a) To give him bran sprinkled over his foods.
(b) To encourage fluids.

The work is facilitated by the use of an integrated single record shared by all members of the department. The Task Force has established close links with other disciplines, particularly family doctors, social workers and care managers. The work of the team is reviewed in a regular structured way. In addition to frequent *ad hoc* contact with the referring psychiatrist, there is a monthly meeting when the patients are discussed and reviewed carefully. Decisions about discharge are also made at this time.

### *Review of work 1988–1994*

This covers the period from 18 October 1988 to 17 October 1994. It has not been possible to review the work in a systematic and precise way but we can give a clinical impression of its contribution to a comprehensive old age psychiatry service (see Table 1).

## Comment

Very quickly the staff of the OAP Department gained the impression that this was a helpful innovation. Initially priority had been given to patients with mild/moderate dementia who required the tactful introduction of structured help. However, these patients did not respond in the way we had hoped. In fact, more progress was made by introducing help in a gradual unhurried way. In addition, it was difficult to phase out the task force. The first vignette is an example of how difficult some of the patients in this category were. It soon transpired that the Task Force was most effective in treating major depressive disorders and paranoid states where symptom relief with medication was the key target. Mr J L, the second vignette, is an example of a very favourable outcome.

The Task Force was used to aid the successful discharge of patients precariously balanced both from general and psychiatric hospitals. Conversely the Team was deployed to provide intensive support in fraught circumstances when admission seemed essential. Because of the amount of help provided, admission of a patient on a compulsory basis could be avoided.

Soon new uses for its deployment became obvious. Community psychiatric nurse (CPN) colleagues realised that the Task Force could become involved when one of their patients relapsed. Short-term help from the Task Force could prevent admission and once recovered, CPN supervision could continue.

The Task Force has played a major part in extending the hospice function of the department. Relatives and family doctors have been particularly appreciative of the Task Force's contribution in nursing terminally ill difficult and demented patients at home.

The nature of the work and what has been achieved is best conveyed by a series of vignettes.

### *Mrs E B*

A widow aged 80 living on her own had a history of gradual memory loss and personal neglect. She was a stubborn individual with no insight, well supported by close relatives. A diagnosis of Alzheimer type senile dementia of moderate severity was made.

The Task Force was involved in September 1993, visiting once or twice a week with the idea of building up to daily visits. The aim was to help in the preparation of food and to improve hygiene. This would be a prelude to the introduction of regular Home Care provided by the Social Services Department. Regular visits were kept up until February 1994. No progress was made despite close links with relatives and district nurse who called regularly to instil eye drops following cataract surgery. As no progress was achieved her care was transferred to the local CPN for monitoring.

In February 1995 she was referred again to the Intensive Home Nursing Team. This time a

Table 1. Workload 1988–1994

| | New referrals | Total visits | Hospital admissions | Deaths | Active patients monthly average |
|---|---|---|---|---|---|
| 1988–1989 | 80 | 2485 | 18 | 1 | 20 |
| 1989–1990 | 64 | 2701 | 4 | 6 | 28 |
| 1990–1991 | 70 | 3704 | 17 | 5 | 45 |
| 1991–1992 | 98 | 4463 | 28 | 6 | 55 |
| 1992–1993 | 103 | 4358 | 32 | 15 | 59 |
| 1993–1994 | 69 | 4153 | 34 | 10 | 50 |
| Average | 81 | 3644 | 23 | 7 | 43 |



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different tactic was pursued. Working in partnership with the district nurses, the Task Force took over the installation of the eye drops. These were alternated weekly from morning to afternoon. Despite good cooperation with the treatment for her eye condition, this did not generalise to the acceptance of other help.

In May 1995, she sustained a fractured wrist and remaining at home became untenable. The Task Force were able to prevail on Mrs B to visit the EMI Ward where she was encouraged to stay. However, she resisted the idea and was taken back to her own home. The following day she was admitted under Section 2 of the Mental Health Act 1983. In August 1995 she was discharged to a nursing home.

### *Mr J L*

Mr L, 72, was a retired salesman. He was referred and seen at home in February 1990 with a history of depressive symptoms since retirement. For a month he was worse and was worried about money. He had anorexia, anergia and weight loss. He looked ill. He was indecisive, depressed and agitated. A diagnosis of major depressive disorder was made and he was started on imipramine and pericyazine. After a week he was worse, not taking medication and pre-occupied with his bowels. His wife was getting fed up. The Task Force were involved. They were able to visit three times a day to administer medication, supervise diet, provide practical help with hygiene and basic care and provide moral support for his wife. After a week there were signs of early improvement. After a month he was eating and sleeping much better and hardly mentioning his old worries.

Apart from a mild episode of hypomania and the unsuccessful use of lithium due to severe oedema of the lower limbs he made a good recovery and was discharged from follow-up at the end of the year.

### *Mrs D S D*

Mrs D was 91, a retired nursing sister living with her daughter and her family. She had been declining slowly but until 6 weeks earlier had been mobile, eating a little and toileting herself. At referral in September 1991 she was refusing food and drink. She was very uncooperative, she took to her bed and was hostile, abusive and resistive.

She had always been a difficult person and these traits had been aggravated by ageing. She reacted badly to her daughter going on holiday and a vicious cycle was established with physical deterioration aggravating her mental state. Her condition appeared irreversible and the family accepted her terminal condition. The idea of intensive home nursing using the hospice approach was welcomed.

The Task Force became involved. Mrs D regarded FH as a friend of her daughter and accepted basic care from her. She would drink a little but wanted to sleep all the time. After a week she was much weaker. On the 17 September 1991 she was started on morphine and died peacefully four days later.

## Conclusions

Our experience during 6 years has convinced us of the advantages of the Task Force. It is a small team which provides intensive home nursing over a short period of time. It is ideal for treating major depressive disorder and paranoid states, frequently as an alternative to hospital admission. It is also an asset in situations which are precariously balanced, requiring intensive tactful management. In some ways it could be described as a mobile rapid response team. We see it as a necessary integral component of our old age psychiatry service.

As the very elderly fraction of the population continues to increase, realistic alternatives to hospital admission become more important. We have been impressed with the Task Force's role in providing hospice care for patients with severe psychiatric illness at the end of their lives. It is also invaluable when patients with terminal illness develop behavioural problems and insist on remaining at home. It is possible that with the increasing use of advance directives, more individuals will dictate for less intervention and to be looked after at home. Such a development would increase the demand on services such as the Task Force.

General practitioners are impressed with the nature of the service. They have commented on its advantages and on occasion have suggested its immediate deployment at the time of referral.

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