A SURVEY OF INTERMITTENT HOSPITAL BASED RESPITE CARE FOR ELDERLY PEOPLE IN THE HUTT VALLEY

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Summary
Many elderly patients prefer to live in the community and the cost of institutionalization is very high. Respite care was considered as one way that could provide support and relief to the carers so that they could continue the stressful caring work. We performed a retrospective evaluation on the intermittent hospital based respite care for the disabled elderly patients in the Hutt Valley, New Zealand. From November 1994 to March 1995, 54 disabled elderly patients and their carers were included in our survey. There were 29 male (54%) and 26 female (46%). Most of the patients were totally dependent on their caregivers (42 of 54; 77.8%). The main indication for the admission to respite care was neurological disease (45 of 54; 83.3%). Dementia was the commonest indication for respite care (22 of 54; 40.7%). Through the intermittent hospital based respite care, all the caregivers could get different forms of relief from their stressful caring work. Therefore, respite care could provide support and relief to the caregivers of frail elderly patients who choose to continue to give care at home as opposed to institutionalization.

Introduction
Only a proportion of elderly in the developed countries is institutionalized. Many elderly people prefer to live in the community rather than in institutions. To live in the community, they should be supported by a network of family, health and social services and voluntary agencies. The availability of supporting carers is recognized as a key factor to determine whether a disabled elderly person can cope at home. However, care of elderly persons can produce physical, emotional, financial and family stress on the carer.

Jones et al and Peters et al had examined the detriment of the caring role upon the quality of life of the caregivers. They suggested services and polices should be oriented towards the needs of carers and their families and not solely to the needs of frail elderly people.

Respite care is one of a wide range of services designed to help maintain the infirm elderly at home by reducing the burden on the caregiver. This type of care is designed to provide the carer with a break and ideally also a holiday for the dependent individual with a change of environment — sometimes in a more protected one. Such respite had been studied concerning what impact they might have on the elderly as well as on the carers.

In addition, in a climate of economic rationalization and in view of the high cost of institutional care, there is increasing pressure for prolonging home care. There was evidence that patients in hospital based respite had fewer admissions for acute medical care. Thus respite care is thought to be one of the interventions that is able to keep more disabled people at their own home.

There are various types of respite cares in different parts of the world. Planned or ‘elective’ respite is probably the true form of what the term stands for. Unplanned or ‘emergency’ respite represents the occurrence of crisis, be it in the carer or in the person being cared for. Such could be due to an intercurrent illness, deterioration of the condition, or a change in the domestic circumstances. An admission to a geriatric ‘assessment and rehabilitation’ unit would then be appropriate course of action, as such crisis could be identified and dealt with accordingly in the appropriate setting.

In New Zealand, one form of respite called ‘alternative care or Aid to Families’ is available to...
caregivers of dependent elderly - funded through the New Zealand Income Support Service; this form of respite may be given in the dependent's home by an alternative caregiver or by short term placement of the dependent older person in a rest home or alternative accommodation up to 28 days per annum. Short term admission of a disabled elderly to a rest home for a certain period can provide a break for the carer and the elderly in a different environment. It is thought that in the case of dealing with very disabled patients, particularly when the carers are the elderly spouse — more provision can be given in the intermittent care setting, when beds of the geriatric unit in the locality can provide frequent planned respite in a hospital setting. Here, not only custodial and nursing care is available, maintenance medical, physical and occupation therapies are given where appropriate and hence further benefit regarding maintaining these patients in the community might be effected.

At the Hutt Hospital, we provide two weeks in-hospital 'intermittent care' for the accepted patients every 6 to 14 weekly. There are 14 beds assigned to this program that serves a population of 130,000; in which 11% of the population is older than 65 years old.

**Subjects and Methods**

The survey was done as clinical evaluation and was retrospective. The form of the respite service provided at the Hutt Hospital geriatric unit is described. All patients already receiving regular intermittent care over the five months from November 1994 to March 1995 were eligible for inclusion in the study. Demographic data of these patients and the carers was obtained. The medical diagnoses and the disability basing on the national SNAP (support need assessment protocol) documentation were recorded. Attempt was made to look at what indications were present when the patient was accepted for the program.

Patients and the carers were interviewed by the social worker. Before the interview, the details of the survey were explained to the patients and carers and the consent was obtained from the carers. Questions regarding whether relief was achieved and in what form — through the program; and any dissatisfaction with the service; and any health problems related to the caring of the patient (optional question) was asked during the interview. In addition, the carers and the patients were asked what other social services besides the intermittent care program they had received in previous month before the interview.

Demographic data of the patients and carers were analyzed. The degree of satisfaction and dissatisfaction with the service was also assessed.

**Results**

**Characteristics of Patients**

During the study period, there were 54 patients and their carers included. In these 54 patients, 29 patients were male (54%) and 46 patients were female (46%). All patients were older than 60 years old. The mean age of the patients included in the study was 78.2 years old, and the majority of patients were Caucasians (45 of 54; 83.3%).

Most of our patients depend on their caregivers in daily activities that included dressing, grooming, feeding, bathing, toileting and mobility (42 of 54; 77.8%, Fig. 1). Only 12 patients (12.2%) had independent daily activities. Forty-three out of our 54 patients had problem in mobility (79.6%). Within these 43 patients, 20 of them needed the carers to help for their mobility. Concerning continence problems, 39 of 54 patients (72.2%) had incontinence. Twenty-one patients (38.9% of all patients) had double incontinence.

Elderly patients usually suffer from multiple conditions. In the studied patients accepted for the program, the commonest problem was neurological diseases (45 of 54 patients, 83.3%, Fig. 2). The most frequent neurological indication was dementia (22 of 54, 40.7%) and the second most common indication was stroke (14 of 54, 25.9%). There were other less common causes for respite care. These included Parkinson’s disease, spastic paraparesis, multiple sclerosis, severe congestive heart failure, osteoarthritis, fractured femur, depression, chronic obstructive airway disease and severe peripheral vascular disease.

Initially, many patients received respite care every 14 weeks for two weeks. However, as the time went on, majority of the patients were followed up more frequently (Fig. 3).

Besides receiving respite care, all of our clients received other types of services except 7 patients (what services they received were unknown). The most common service they received was community nurse service (44 of 47 patients, 93.6%). The other services included general practitioners’ consultations (26 of 47, 55.3%), home helper service (23 of 47, 48.9%), alternative care (22 of 47, 46.8%), medical social worker service (20 of 47, 42.6%), podiatrist service (17 of 47, 36.2%) and day care (17 of 47, 36.2%). The least common service they received was meals-on-wheel. Only 3 patients (6.4%) received this type of service.
patients (21 of 29; 72.4%; Fig. 4) and female patients usually had daughters to look after them (12 of 25; 48%; Fig. 4). The other caregivers were sons and friend.

The question of any health problem was asked in the questionnaire. There was no definite medical illness among the caregivers. However, 77.8% (42 of 54) of the carers complained some vague physical discomforts. These included ‘very tired’, neck pain, headache and back pain.

**Satisfaction, Dissatisfaction and Relief of the carers**

Most of the carers were satisfied with our services (40 of 54; 74.1%). Twenty-six of them felt very satisfied with our respite service. All the carers could get some relief when the patients were receiving the service (Fig. 5). They could have their own time (50%); a break or self enjoyment (46.3%); relief from night care (55.6%). However, there was not much relief from work; only 3 of 54 carers (5.6%) got relief from work. Besides the above relief, the carers could have time to spend with other relatives and friends. Also, they could be relieved from

**Characteristics of Carers**

There were 54 carers included in our study. Of these 54 carers, 19 carers were male (35.2%) and 35 carers were female (64.8%). The age range of the carers was 30 to 97 years of age. The mean age was 64.2 years. Most of the carers were between 50 to 79 years old.

Spouses were usually the caregivers of the male
‘mental stress’ in caring of their relatives. After the patients had been admitted to hospital on schedule, some carers felt that they could have more space for themselves and other relatives at home.

Although most of the carers could get relief from the caring of the patients from respite care, one carer still expressed great dissatisfaction of the service during the respite care period. It was because there had been a change of staff and ward for respite care; the change created difficulty in adaptation for the patient. In addition, 5 patients became more confused after discharged from hospital. Besides the adverse effect on patients, the admission for respite care could also cause guilt feeling on the carers. There were 5 carers expressing guilt feeling towards the patients. One carer needed constant counseling on this issue. Another problem is lack of communication. The comments and opinions were shown in Table 1. Nevertheless, most were satisfied with the services. Five of them even thought that they could not continue their caring work without the support of respite care. Some carers wanted their relatives to have more frequent admissions.

Table 1. Comments and Opinions from Carers

<table>
<thead>
<tr>
<th>Comments</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of communication with hospital staff</td>
<td>3</td>
</tr>
<tr>
<td>Lack of information of the patient</td>
<td>2</td>
</tr>
<tr>
<td>Want to have more frequent follow up</td>
<td>3</td>
</tr>
<tr>
<td>Not enough care at hospital</td>
<td>2</td>
</tr>
<tr>
<td>Cause more confusion after return home</td>
<td>2</td>
</tr>
<tr>
<td>Guilt feeling towards the patient</td>
<td>4</td>
</tr>
</tbody>
</table>

Discussion

This is a retrospective evaluation on our respite care or intermittent care program. Most of the elderly patients in the program had physical and mental impairment. They depended on the caregiver to assist their daily activities. Elderly patients often suffer from multiple medical conditions affecting dependency thus leading to the need for respite. The most common indication for the program was neurological disorder. Both dementia and stroke are important diseases that can result in severe physical and mental impairment. However, the admission criteria were not well established and were often not clearly recorded in the studied hospital records. There was increased frequency of admission for respite care as the duration of follow up became longer. As the clients increase in age, their physical and mental state deteriorates. The burden of caring them on their caregivers became heavier and heavier. This might be the reason that caused the more frequent follow-up. However, the definite reason for this change was not clearly defined. A protocol of the respite care programs should be set up in the future and the admission criteria need to be clearly defined. In addition, regular review and assessment of the need of patients and the carers is necessary so that the best caring plan can be offered to the patients and their carers. There was some criticism of the communication between ward staff and the caregiver. This could easily be remedied by ongoing meetings of the multidisciplinary team with patients and their caregivers.

Looking after the disabled elderly patient can be very stressful. The caregivers of these patients need support from others so that they could continue to look after them. The breakdown of the supportive relationship from other community sources may result in institutionalization of the disabled elderly patients. Respite care is considered as a way that can give support and relief to the caregivers. This was clearly shown in our survey. The carers can make use of their free time to maintain their social life. Also they can be relieved from this stressful condition and spend their time with other family members.

Intermittent care, although often beneficial, has several drawbacks. Patients may feel abandoned by their relatives. This may result in the caregivers feeling guilty. Intermittent care may be the beginning of the process of ‘letting go’ by sharing the care and for many caregivers this is difficult. Counseling at this stage and ongoing support can alleviate some of the feelings of guilt. In addition, the change of environment during the admission to hospital may create more confusion to disabled elderly patients.

Nevertheless, many elderly patients prefer to stay at home and the institutional care for disabled elderly patients is very costly. Therefore, from the economical stand point and the patients’ and caregivers’ preference, it is still desirable to maintain the disabled elderly patients in the community. Whether respite care programs can prevent the early institutionalization of the disabled elderly is not known. A controlled trial is required to answer the above question. However, it may be unethical to deprive the patient from this service in a controlled study. In addition, the cost has not been assessed in this study. It is difficult to compare the cost of putting the patients in respite care with those in institution. Besides, calculating the input of the carers is also difficult. The psychological benefit of keeping the patient in the community is also

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difficult to calculate. Therefore, a further study addressing this issue would be useful.

References

TRADITIONAL CHINESE WISDOM
On longevity and health

The teacher, Ch’i Po, answered Huang Ti, the Yellow Emperor of China, “In the most ancient times the teachings of the sages were followed by those beneath them; they said that weakness and noxious influences and injurious winds should be avoided at specific times. They [the sages] were tranquilly content in nothingness and the true vital force accompanied them always; their vital (original) spirit was preserved within; thus, how could illness come to them?

“They exercised restraint of their wills and reduced their desires; their hearts were at peace and without any fear; their bodies toiled and yet did not become weary.

“They followed in harmony and obedience; everything was satisfactory to their wishes and they could achieve whatever they wished. Any kind of food was beautiful (to them); and any kind of clothing was satisfactory. They felt happy under any condition. To them it did not matter whether a man held a high or low position in life. These men can be called pure at heart. No kind of desire can tempt the eyes of those pure people and their mind cannot be misled by excessiveness and evil.

“In such a society no matter whether men are wise or foolish, virtuous or bad, they are without fear of anything: they are in harmony with Tao, the Right Way. Thus they could live more than one hundred years and remain active without becoming decrepit, because their virtue was perfect and never imperiled.”

Huang Ti said: “I have heard that in ancient times there were the so-called Spiritual Men; they mastered the Universe and controlled Yin and Yang [the two principles in nature]. They breathed the essence of life, they were independent in preserving their spirit, and their muscles and flesh remained unchanged. Therefore they could enjoy a long life, just as there is no end for Heaven and Earth. All this was the result of their life in accordance with Tao, the Right Way.”

From The Yellow Emperor’s Classic of Internal Medicine, 2697-2597 B.C.

The Yellow Emperor’s Classic of Internal Medicine describes health and longevity in terms of balance, as a result of following Tao, “the way”, the balance of nature’s duality, yin and yang. It emphasizes on balance and harmony as a means of living a long and healthy life. Following Tao meant living with moderation, equanimity and proper conduct.

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