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Audit in practice

High Elms: a hostel ward which closed after four years

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Long stay patients who continue to require 24-hour nursing care can be divided into two main groups: those who need to remain in hospital and those who could receive their care outside hospital. The Hostel Ward, with a multidisciplinary team providing input to individualised rehabilitation programmes, has been conceived as a possible solution to providing care for the second group. Some of its clinical, social and economic benefits have been reported (e.g. Hyde *et al*, 1987) and there now seems to be increasing agreement about its potential value within the range of rehabilitation services needed by a health district for people with chronic psychiatric illnesses (Abrams, 1988). However, it is still a relatively new concept and as the experience of this type of service may vary from one district to another, further reports of its utility and limitations are still needed (Garety *et al*, 1988).

Three community-based hostel wards have been opened by our department: High Elms and the Anson Road Project. These buildings are located in an inner-city area about ten minutes walk from Manchester Royal Infirmary. The health district has a multiracial population of about 125,000, a poor housing stock and high unemployment, and covers areas assessed by the Jarman Index to be some of the worst in the country in terms of social deprivation.

High Elms was opened in November 1985. It used to be a residence for nurses working at the infirmary. Unfortunately, it proved to be an inappropriate building for this form of care. It was too large and it was impossible to make the living environment pleasantly domestic. After four years it was closed and residents who continued to need this form of care were transferred to the Anson Road Project when this was opened in November 1989. This is near to High Elms and consists of two new purpose-built 10 bedded units which were initially intended to be for old long-stay patients returning to Central Manchester as part of a closure policy of a regional mental hospital.

This paper describes the progress of patients who were admitted to High Elms during its four years' existence.

Characteristic of patients admitted

During this period 27 patients were admitted to High Elms; 17 males and 10 females. On admission male patients were younger than females (mean years, standard deviation and range; males = 32.4 ± 10.7, 19.6–57.0; females = 43.6 ± 9.1, 29.5–55.5; $P = 0.01$). They also tended to have shorter illness careers although our analysis excluded admissions to hospitals outside the health district (mean years since first hospital admission, standard deviation and range; males = 8.7 ± 8.8, 0.6–34.9; females = 15.5 ± 10.5, 4.8–36.5; $P = 0.06$). Admissions were not restricted to in-patients of our department's acute admission wards if at the time of referral it was thought a person needed this form of rehabilitation: three came from their family home, two from local authority hostels, one from a Salvation Army hostel and one from bed and breakfast accommodation. One patient had a very disabling affective disorder; 26 patients had schizophrenia (three also had alcohol or cannibis problems).

Progress following admission

The outcome of patients when High Elms closed is summarised in Table I.

(a) Need for hospital-based services

Twelve patients had to be transferred to acute wards because of a deterioration in their clinical state which could not be managed in the Hostel Ward. Eight patients needed only temporary admissions and of these two needed more than one transfer. One patient was thought to have committed suicide soon after his transfer to the main hospital: he was a young man with schizophrenia who was found dead in a local river after he had secretly slipped out from his ward one night and had been missing for a week. Three patients had to be transferred to hospital on a permanent basis: a 26-year-old male for attempted arson, a 37-year-old female because of unprectictable and vicious physical attacks on young nursing staff, and a 26-year-old male who without any warning stabbed

TABLE I
Outcome of 27 patients when High Elms closed

	Number
Death	2
Permanent transfer to hospital	3
Transfer to Anson Road Project	6
Discharge to other community setting	
(1) *Accommodation*	
Own flat	8
Group home	4
Family home	3
Bed & breakfast	1
(2) *Support provided**	
CPN services	12
Social services	9
High Elms staff	12
Other	8

*An individual person usually had support from more than one service.

another patient in the abdomen with a knife. Fortunately, the victim was saved by her obesity although she required surgery. The following is a brief vignette of the first of these patients.

> A 26-year-old man with chronic schizophrenia characterised by prominent catatonic features and a marked deterioration of personality. His behavioural problems included smearing faeces on walls when stressed, alcohol abuse, stealing clothes from other residents, and inappropriate sexual activity in the centre of the city. For about 15 months the staff tried to engage him in realistic care plans with little success. During his admission he needed three transfers back to the main hospital of which the last was permanent after he made several attempts to set fire to the hostel ward.

Another resident died from a cardiac arrest following a small number of myocardial infarctions.

> She had been at High Elms for about a year and was progressing well with her rehabilitation. She was 50 years old. Before her admission into hospital she had spent over 20 years in her bedroom at her parents' house, apparently floridly psychotic most of the time and without any awareness of what was going on in the world outside. She came to public attention when she attacked a visiting district nurse who was attending to her dying father. After her florid symptoms remitted following treatment with medication in hospital she turned out to be a very gentle, warm but very shy and nervous person who had very poor self-management skills and no knowledge of the decimalisation of our currency.

(b) Need to remain in a hostel ward

Six people continued to need 24-hour nursing care when High Elms was closed. These were therefore transferred to the Anson Road Project. The following vignette is of one of these patients.

> A 55-year-old woman with a 20-year history of paranoid schizophrenia characterised by persistent auditory hallucinations, persecutory delusions, disturbed volition and a marked deterioration of personality. She was often surly, irritable, verbally hostile; and poorly cooperative with treatment regimes. She adopted very serious self-injurious behaviours when under stress or angry such as overdoses, swallowing bleach, and running in front of vehicles. Her hygiene was extremely poor; she urinated and defaecated in her bed and on the floor of her bedroom; she spent most of her time in her bed chain smoking and used somatic complaints as an excuse not to do anything. When out in the street she would walk about in only a nightdress and worn-out slippers.

Her care plan has needed repeated modification in order to reduce the demands on her to a level that she will tolerate. It now focuses on four main areas: personal hygiene, helping her to keep her room reasonably clean, social activities, and exploring other places that she might like to move on to in time as she is keen not to stay in a hostel ward indefinitely. She continues to need a lot of individual attention and although she is still spending much of the day in bed she has made some progress.

> The frequencies of self-injurious behaviour, temper tantrums and inappropriate defaecation have significantly decreased. She helps staff to keep her room reasonably tidy and to wash her clothes and bed linen. She prepares her own drinks and occasionally a light snack. She goes to local shops and attends a local health centre for her depot medication, and usually attends dressed rather than just in a dressing gown and slippers. She has been to the city centre to buy clothes, occasionally to a local pub for a drink, and on various excursions to more distant places of interest along with staff including to see a show at a prestigious city theatre. She manages her own money and often has a friendly rapport with staff.

(c) Discharge to other community settings

It was not possible to engage two patients in any meaningful rehabilitation programme because they were ambivalent about being at High Elms in the first place. After a brief admission they took their own discharge – one went home to live with his parents, the other went to a bed and breakfast establishment. Four residents who were engaged in a rehabilitation programme chose to leave High Elms earlier than the staff had wished because each had been offered the tenancy of a flat. All of these, however, remained very dependent on staff for help and support. Two other residents left because they preferred to live at home with their parents.

Eight people had planned discharges as part of their rehabilitation programmes. They moved to either a group home or a flat of their own. The timing of these discharges was usually delayed mainly

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because they were dependent on a place becoming available elsewhere. This was unfortunate as the wait was very frustrating for residents and staff, and the clinical state of some residents seems to regress a little as a consequence. Since their discharge these people have remained dependent on help and support from staff to varying degrees. At first this was provided by staff of the hostel ward but when the unit closed a support team was established in order to continue with this work (Colgan & Bridges, 1990).

Concluding comment

Although High Elms was not an ideal building as a hostel ward, the majority of patients admitted were able to benefit from the form of rehabilitation provided by its staff. Those who moved to the more homely purpose-built Anson Road Project have made further progress. From our experience the hostel ward continues to have an important place within the spectrum of services needed for people with chronic psychiatric disorders. However, it has its limitation, particularly with regards to the management of some behaviourally disturbed people. It has also proved to be an inappropriate form of care for those who are against being there. Unfortunately patients returning to hospital on a permanent basis had to join other long-stay patients on acute admission wards because of the lack of more appropriate hospital-based facilities for them (Wing, 1990).

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Are your casenotes perfect?

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Working for Patients (1989) demonstrates the Government's intention to "encourage all Royal Colleges to make participation in medical audit a condition of a hospital unit being allowed to train doctors", suggesting this may also become a requirement for psychiatric trainees. The Psychiatry Department at Fazakerley Hospital moved into the rather uncharted territory of clinical audit with monthly unit audit meetings in 1989. At each meeting randomly selected cases are reviewed and data presented which are relevant to clinical practice on the unit. The majority of topic audits have been presented by trainees with support from consultants. Most Colleges agree that casenotes should be available for scrutiny (Warden, 1988). Consequently I undertook a casenote audit.

The "perfect casenote" should serve four main functions: informative – containing patient data and chronological details of events; legal – being the only written document recording the doctor's management of an individual case; communicative – enabling transfer of information between and/or within specialties, professionals and other hospitals; and storage – storage of information for future reference.

The study

The audit was carried out in the psychiatric in-patient unit of a district general hospital with 125 acute beds (approximately 15 beds per consultant). Disciplines incorporated were general adult psychiatry and functional psychogeriatrics, reflecting the practice of 20 doctors from consultant to SHO.

Four casenotes were selected blind from each ward by nursing staff. Duration of admission ranged from