

An evaluation of in-patient respite care at St. Vincent de Paul Residence

Joseph Dimech, Daniela Agius, Annette Attard, Lorraine Bonnici, Helen Fiorini, Joseph Grixti, Vincent Muscat, Louise Schembri, Dorianne Sultana

Abstract

Aim: To identify the multi-dimensional characteristics and need for inter-disciplinary input associated with in-patient respite care.

Methods: During the period January-December 2007, 91 in-patient respite users, aged ≥ 60 years, were assessed on admission for respite care at St. Vincent de Paule Residence. Assessment instruments used included the Barthel Index, the Mini-Mental State Examination, a Caregiver Strain Index, the Functional Oral Intake Scale and the Communicative Effectiveness Index.

Findings: Of the study group ($n=91$), 65% of respite users were found to be suffering from moderate to severe dementia (Mini-Mental State Examination score 0-20). High dependency on the Barthel Index (0-7/20) was found in 52% of cases whilst 45% had low dependency (13-20/20). Carer strain was reported in 60% of care-givers (carers). Interdisciplinary input requirements in the group studied included nursing in 85%, dental (83%), speech language pathology (70%), physiotherapy (39%), occupational therapy (38%), medical (33%) and social worker assistance (24%).

Conclusion: Elderly respite users are a mixed group with multiple and diverse needs. In their own homes, these care needs are principally met by informal helpers who are frequently under stress. The expansion of in-patient respite services will reinforce the informal community care network and will help avoid or postpone long-term institutionalisation.

Keywords

Carers, community, elderly, respite

Joseph Dimech* MD, MGer

St Vincent de Paul, Residence for the Elderly, Luqa, Malta
Email: dimechjoseph@gmail.com

Daniela Agius BA(Hons) (Soc Work)

St Vincent de Paul, Residence for the Elderly, Luqa, Malta

Annette Attard BSc(Hons) (Physio), Dip Ger

St Vincent de Paul, Residence for the Elderly, Luqa, Malta

Lorraine Bonnici Dip HSc(OT)

St Vincent de Paul, Residence for the Elderly, Luqa, Malta

Helen Fiorini BSc(Hons) (Comm Ther)

Joseph Grixti Reg (Nursing), DipGer

St Vincent de Paul, Residence for the Elderly, Luqa, Malta

Vincent Muscat BChD(Hons), Dip Ger

St Vincent de Paul, Residence for the Elderly, Luqa, Malta

Louise Schembri

St Vincent de Paul, Residence for the Elderly, Luqa, Malta

Dorianne Sultana Cert (Nursing)

St Vincent de Paul, Residence for the Elderly, Luqa, Malta

Introduction

It is widely recognised that in order to retain maximum independence and individuality, elderly people would benefit mostly by continuing to live in their own environment.¹ With advancing age, elderly people are more prone to develop health-related problems, which lead to disability and increased dependency.² Support from the family is crucial to maintain care in the community.³

As a result of demographic and socio-economic change, Maltese families have become smaller, leading to role conflict in carers which may result in economic, social and psychological stress.⁴⁻⁶ Home support services aim to provide a personalised support network to help elderly people remain living in their own homes and could lead to a decline in the need for nursing home placements.^{7,8}

In-patient respite care (respite care), also known as relief or holiday admissions, is a service that is widely accepted as being an integral part of the community support package.⁹ The aim of respite care is to temporarily alleviate the burden on carers of elderly people who are living within the community. This gives carers time to recuperate physically, mentally and psychologically, hence enabling them to continue coping with the care of their dependent elderly. The main reasons behind requests for respite include:

- Periodical relief from care;
- Temporary failure of provision of carer support. This includes remediable health problems in carers and transitory situations of conflict in social roles;

* corresponding author

- Holiday admissions, where carers ask for temporary relief of the caring role, in order to go on holiday.

High quality community care entails proper multi-dimensional assessment to discover and address needs, thus leading to good care management.¹⁰ To this aim, respite care not only provides relief to carers, but it also presents an excellent opportunity to expose dependent elderly to a multi-dimensional assessment.¹¹ The process for such assessment entails an inter-disciplinary approach with the objective to evaluate problems arising between the elderly person and their carers.¹² A typical inter-disciplinary geriatric assessment team is composed of a geriatrician, a nurse, a social worker, a welfare worker, a physiotherapist, an occupational therapist and a speech therapist.^{13,14}

St. Vincent de Paul Residence (SVPR) is a residential complex for elderly people that provides a range of services, including long-term care and respite care.¹⁵ It currently provides respite care in a consultant led, 7-bedded unit, which provides an inter-disciplinary approach to care. Booking for respite is on a first come first serve basis. Requests for respite care need to satisfy the following criteria in order to be given a booking for admission:

- a request for temporary relief of the burden of care by informal carers;
- care is being provided to a dependent elderly person (≥ 60 years);
- the elderly person is residing in the community;
- informal carers need to declare in writing their intention to pursue care in the community once their period of booked respite expires.

Admission to the Respite Unit is broadly guided by 3 weekly admission slots: the actual length of booked stay varying according to assessed need. Each admission slot is subsequently allocated to different users of this service. Respite care is free of charge. Carers can apply and utilise the respite service more than once in each year.

Method

All applicants ($n=206$) for respite at SVPR that were received between January-December 2007 (the Annual Group), were assessed to determine the reason for applying for respite care. Of these 206 applicants, 158 applicants were given a booking as they satisfied the criteria for admission for respite. By the date of admission, 51/158 approved applicants ended up not honouring their booking. Seven of these 51 approved applicants had passed away prior to admission whilst the remaining 45 applicants ended up cancelling their booking. Of the remaining 107 approved respite applicants that were eventually admitted for respite, the 91 subjects (the Study Group) that were admitted by the end of December 2007 were investigated by a multi-disciplinary assessment team. The Respite Study Team was made up of a doctor, nurse, occupational therapist, physiotherapist, social worker, dentist and speech language pathologist. All cases were assessed for the need of inter-disciplinary intervention.

The Study Group was assessed for cognitive function using the Mini-Mental State Examination (MMSE). The MMSE, although not diagnostic of dementia, is useful for assessing cognitive function.¹⁶ Performance on the MMSE varies with the patient's age and education, however a score higher than 23 is generally considered normal.¹⁷

The Barthel Index (score range: 0 to 20), was utilised in the Study Group to assess self care and mobility.¹⁸ The Barthel Index is widely used in geriatric assessment settings, it is considered to be reliable and a good measure of Activities of Daily Living.¹⁹

The Communicative Effectiveness Index (CETI), is a 16-item questionnaire developed to measure change in aphasic individual's performance in 4 communication categories related to basic need, life skill, social need and health.²⁰ Furthermore, this index has been found to be an indicator of severity of communication disability in dysphasic individuals.²¹

The Functional Oral Index Scale (FOIS) is a 7-point ordinal scale of proven reliability and validity.²² The FOIS has been developed to document the functional level of oral intake of food and liquid in stroke survivors. The scale was found to be significantly associated to severity of dysphagia.

Carer strain was measured using a Caregiver Strain Index.²³ This 13-item score is a simple index that is useful in an assessment package that examines intergenerational relations involving dependency and care.

Subjects in the Study Group were re-contacted, 3 months after discharge from the respite unit, to assess outcome.

Results

During the year 2007, 206 applications were received at the Medical Records Office at SVPR. The mean age of the Annual Group was 77.9 years (95%CI: 66.7-89.1), with 139 being females (67%) whilst 67 were males (33%). Of the 206 applicants, 67 had previously also applied for permanent admission to long-term care (32%).

Of the Annual Group ($n=206$), 117 of carers applied for respite to avail of a break in care (57%) (Table 1). Care conflict - namely work pressures, pursuing academic studies and relief during preparation for major family functions including weddings - was found in 15 of applicants (7%). On the other hand, 11 had admitted to having misguidedly applied for respite care, with no intention to take their elderly back home (5%).

On the basis of their application, 107 applicants of the Annual Group ($n=206$), were subsequently admitted for respite care. Thus, each of the 7 beds in the respite unit was able to support 15.3 clients in one year. This gave a through-put of 1 client per bed every 24 days. The total bed occupancy during 2007 was 92%.

Morbidity in the Study Group ($n=91$) included cardiovascular disease in 65% of subjects, a history of depression in 42%, diabetes in 30%, Parkinson's disease in 13% and a history of stroke in 25%. On the other hand, 27% suffered from recurrent falls, 12% had a history of fracture femur whilst 8% had pressure sores.

An analysis of the cognitive function of the Study Group (Table 2), showed that 21 scored 24+ on the MMSE score (23%). Moderate to severe dementia (MMSE score of 0-20) was found in 59 of respite users (65%).

An assessment of the Barthel Index in the Study Group on admission, showed an average score of 10.5/20 (Table 3). High to very high dependency (<8/20) on the Barthel Index was found in 47 of respite users (52%), whilst 21 subjects were fully independent with a Barthel Index of 20/20 (22%).

Of the Study Group, 41% had a moderate to severe communication deficit, whilst 51% of subjects had problems with oral intake of food and liquid, which would necessitate a special preparation or compensatory strategies to manage a total oral diet with multiple consistencies.²⁴

Eighty-five carers of the Study Group voluntarily answered the Carer Strain Index ($n=85$). Fifty-one had a score of 7-13 indicating carer strain (60%), while 34 had a score less than 7 indicating a situation of lesser stress (40%). The 85 respondents indicated that 30 elderly respite users were living with relatives/friends, whilst the remaining 55 subjects were living in their own home. The main carers of these 55 elderly respite users that were living in their own home (multiples possible), included a spouse in 24 of subjects, children (22), a sibling (4), friend/neighbour (2), other relationship (4), whilst 6 subjects claimed poorly identifiable or no carers. In 61% of the Study Group, there was only one identified carer who was regularly involved in care.

Following a multi-disciplinary assessment of the Study Group ($n=91$) after admission, inter-disciplinary intervention was identified for nursing in 85% of subjects, dental (83%), speech language pathology (70%), physiotherapy (39%), occupational therapy (38%), medical (33%) and social worker assistance (24%).

Of the Study Group ($n=91$), 86 of subjects were discharged back to the community as planned at the point of booking (94%). The remaining 5 subjects either passed away during the respite stay (1) or were failed discharges (4). At the 3 month follow up, 12 of the Study Group had been admitted to long-term care (13%).

Table 1: Reasons given by carers for applying for respite care ($n=206$)

	No.	(%)
Break in care	117	(57)
To go on holiday	49	(24)
Poor carer health	20	(10)
Care conflict	15	(7)
To admit permanently	11	(5)
Rehabilitation of the elderly dependent	5	(2)
Convalescence after illness of dependent elderly	4	(2)
To have a trial in a Home	2	(1)

Table 2: Assessment for Dementia (MMSE Score) in the Study Group ($n=91$) on admission

MMSE Score	No.	(%)
24-30 (cognitively preserved)	21	(23)
21-23 (mild dementia)	10	(11)
10-20 (moderate dementia)	33	(36)
0-09 (severe dementia)	26	(29)
Ungradeable	1	(1)

Table 3: The Barthel Index of the Study Group ($n=91$) on admission

Barthel Score	Total	(%)
20 (independent)	20	(22)
13-19 (low dependency)	21	(23)
8-12 (medium dependency)	3	(3)
4-7 (high dependency)	21	(23)
0-3 (very high dependency)	26	(29)

Discussion

Informal carers in the community are a slowly dwindling, yet important resource that play a crucial role to help keep elderly people living in their own home.⁵ Frequently under-rated and unskilled in care, carers are expected to shoulder on, many times alone²⁵, the burden of care of elderly dependents who suffer from a wide spectrum of needs. The study results show that such needs, range from simple social support, to care of highly dependent elders. Such high dependency often requires the need for highly complex care and considerable knowledge in nursing and rehabilitative skills.²⁶

Comparison of dependency in the Study Group with that found in admissions to nursing care showed that 52% of those admitted for respite had high to very high dependency, this compared to the 67% of admissions to nursing care having similar dependency.²⁷ In addition, 30% of respite users suffered from diabetes whilst 25% had a stroke. This morbidity closely follows that found in admissions to nursing care (40% diabetes; 27% stroke). Furthermore, 76% of the Study Group had an MMSE score of 23 or less, which is the usual cut-off score for diagnosing cognitive impairment, whilst 41% of subjects had a moderate to severe communication deficit.

Nearly half (51%) of respite users presented with some form of dysphagia. This placed them at risk of aspiration, more so if fed by untrained carers.²⁴ Dysphagia not only creates physical and medical problems for the individual affected, but also social and psychological ones, thus adversely affecting the quality of the person's life and the relationship with their carers.²⁸

This high level of morbidity and dependency clearly justifies the need for a multi-disciplinary team approach in respite care. Such team input is necessary to identify the needs and the

development of an appropriate, personalised support package for the elderly prior to returning home.

To provide a holistic approach to care, this care plan, must not only target the needs of the dependent elderly, but also has to give due attention to the physical, social, psychological and economic needs of the carer involved. Caregivers, that are frequently inundated with worries related to care and are frequently exposed to an unacceptable high level of carer stress. To be truly effective, such inter-disciplinary team approach at the Respite Unit needs to be followed up in the community, after discharge, by suitable home support and multi-disciplinary team input by primary health services.

In the face of such high level of dependency, respite care can help to address important physical and psychological needs in carers, to help them cope with the continuous and at times strenuous care they provide.⁵ Such relief is frequently reviving to the extent, that carers opt to persist with care at home, and thus postponing requests for admission to long term care.

Conclusion

The results of this study show that respite care can be an important link in the community support package that may help assist carers to continue to provide informal family orientated care to their elderly dependents. The study also indicates that the inter-disciplinary approach in respite, serves to prepare an appropriate package of care that can be implemented before and after discharge of the elderly respite user back to the community.

Furthermore, from a logistic point of view, the investment in such beds to assist informal carers makes considerable economic sense, as one single bed, detailed for respite, has a high annual through-put that serves and supports multiple carers during the same year.

References

1. Venn NJ, Jones DE, Victor CR. A health visitor affects the problems others do not reach. *The Lancet*. 1986 Jul;5:30–
2. Our Healthier Nation. BGS Newsletter. 1998 Jun; Suppl 10.
3. Brody SJ, Poulshock SW, Masciocchi CF. The family caring unit: a major consideration in the long-term support system. *The Gerontologist*. 1978;18(6):556–61.
4. Williamson J. Health problems of the elderly. Department of Health (Malta). 1980.
5. Tinker A. *Older people in modern society*. 4th ed. London: Longman; 1997.
6. Troisi J. The Maltese elderly: from institutionalization to active participation in the community. In: Sultana RG, Baldacchino G, editors. *Maltese society: a sociological inquiry*. Malta: Minerva Publications; 1994. p. 655– 68.
7. Growing older. Department of Health and Social Security. London: HMSO; 1981. CMND8172.
8. Rubenstein LZ, Rubenstein LV. Multidimensional geriatric assessment. In: Brocklehurst J, Tallis RC, Fillit HM, editors. *Textbook of geriatric medicine and gerontology*. London: Churchill Livingstone; 1992. p. 150– 9.
9. Twigg J, Atkin K. *Carers and services: a review of research*. London: HMSO; 1994.
10. Nocks BC, MaxLearner R, Blackman D, Brown TE. The effects of a community-based long term care project on nursing home utilisation. *The Gerontologist*. 1986;26(2):150-157.
11. Steiner A. New care? Reassessing intermediate care. *Geriatric Medicine*. 1997 Oct;
12. Andrews G. Role of primary health care. In Kane RC, editor. *Improving the health of older people*. Oxford: Oxford University Press. WHO; 1990 .
13. Quartararo M, O'Neill TJ, Tang C, MacMaster M. assessing the residential care needs of nursing home applicants. *Australian journal of public health*. 1991;15(3):222-227.
14. Sharma SS, Aldous J, Robinson M. Assessing applicants for Part III accommodation: is a formal clinical assessment worthwhile? *Public health*. 1994;108:91– 97.
15. Dimech J, Fiorini A. A study of admissions to st. vincent de paule residence for the elderly – Malta. *Bold*. 1994;4(3):22–7.
16. Santacruz KS, Swagerty MPH. Early diagnosis of dementia. *American Family Physician* 2001 Feb 15;63(4):703–13.
17. Tangalos EG, Glenn ES, Ivnik RJ, Peterson RC, Kokmen E, Kurland LT, et al. The mini-mental state examination in general medical practice: clinical utility and acceptance. *Mayo Clinic Proceedings*. 1996;71:829–37.
18. Mahoney FI, Barthel D. Functional evaluation: the barthel Index. *Maryland State Medical Journal*. 1965;14:56-61.
19. Collin C, Wade DT, Davies S, Horne V. The barthel ADL Index: a reliability study. *Int. Disability Study*. 1988;10:61–3.
20. Lomas J, Pickard L, Bester S, Elbard H, Finlayson A, Zoghaib C. The communication effectiveness index: development and psychometric evaluation of a functional communication measure for adult aphasia. *Journal of Speech and Hearing Disorders*. 1989 Nov;54;113–124.
21. Backheit AMO, Carrington S, Griffith S, Searle. High scores in the western aphasia battery correlate with good functional communication skills (as measured with the communication effectiveness index) in aphasic stroke patients. *Disability & Rehabilitation*, 2005;27(6):287–291.
22. Crary MA, Giselle D, Carnaby M, Groher ME. Initial psychometric assessment of a functional oral intake scale for dysphagia in stroke patients. *Arch Phys Med Rehabil*. 2005 Aug;8:1516-20.
23. Robinson BC. Validation of a caregiver strain index. *Journal of Gerontology*. 1983;38(2):344–8.
24. Langmore SE, Skarunpk KA, Park PS, Fries BE. Predictors of aspiration pneumonia in nursing home residents. *Dysphagia*. 2002;17(4):298–327.
25. Wynne T. The burden facing women carers today. *Health Visitor*. 1994; 67(7):241-242.
26. Askham J. The need for support. In: Warnes AM, editors. *Human ageing and later life*; London: Edward Arnold; 1989. p. 107-18.
27. Zammit P, Ferry P. Social cases? *Malta Medical Journal*. 2006 Jul;19(2):17–20.
28. Ekberg O, Hemdy S, Woisard V, Wuttge-Lannij A, Ortega P. Social and psychological burden of dysphagia. Its impact on diagnosis and treatment. *Dysphagia*. 2002;17:139-146.