Community matrons’ views of readmission

In this article...

- Results of a small-scale research study of community matrons’ perspectives on reasons for readmission
- Possible reasons why individuals are frequently readmitted
- Suggestions for encouraging care at home

Author

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Abstract


Readmission to hospital is an expensive but common occurrence, estimated to cost the NHS approximately £1.6bn a year. This study analyses the opinions of community matrons who proactively manage NHS service users who are frequently admitted to hospital. The study design was qualitative and used a phenomenological approach. A semi-structured interview was used to collect data, which was then analysed.

Three themes emerged: exacerbation of chronic obstructive pulmonary disease linked to depression and anxiety; poor concordance with medication; and being discharged too early, for example, when not medically fit.

The findings of this study back up evidence that more effective support of psychological and mental health needs of people with long-term conditions can lead to improvements in physical as well as mental health.

Study aim and design

In the light of my findings, I designed a study to explore community matrons’ perspectives of the factors affecting their patients’ readmissions to hospital. The sample was four community matrons from different neighbourhoods in the same borough; they all volunteered to participate and no cost was incurred.

The study was carried out using a qualitative, phenomenological approach to analyse the opinion of the community

5 key points

1 Readmissions cost the NHS around £1.6bn a year
2 There is often a link between long-term physical conditions and mental health problems
3 A phenomenological approach is useful to gain information from a staff perspective
4 Better management of mental health needs in the community can reduce the likelihood of readmission from long-term physical conditions
5 A lack of concordance with medication and being discharged too early can lead to readmissions

The Department of Health defines an emergency readmission as “any unplanned (non-elective) admission to hospital within 28 days of a previous discharge. The two hospital spells need not have the same diagnosis, HRG (healthcare resource group) or specialty” (DH, 2008).

I carried out an exploratory study in one borough after concerns were raised about the high number of patients being readmitted to hospital within 30 days of previous admission. This showed common themes for causes of readmission and variations in this between neighbourhoods. Following analysis of the results, other key themes emerged that could influence readmission rates in the local health economy of service users on the community matron caseload.

Across the borough, 4.5% of service users were readmitted within 30 days of discharge. In the neighbourhood in the most deprived area of the borough and with the highest readmission rate (67.7%, n=21), the main cause was generally directly related to the initial admission and was respiratory in origin.

Anxiety plus COPD leads to admission
matrons who actively case manage service users who are frequently readmitted to hospital. The study examined matrons’ opinions about the causes of readmission. Data was collected in the form of a semi-structured recorded interview, with each interview lasting no longer than 30 minutes.

Results
Analysis of the results revealed three themes highlighted by the matrons:

» Exacerbation of chronic obstructive pulmonary disease linked to depression and anxiety;

» Poor concordance with medication;

» Being discharged too early, not medically fit for discharge (Table 1).

Of the three identified themes, the area that came up the most was COPD exacerbation linked to depression and anxiety.

Discussion
There is strong evidence of a close link between mental health problems and COPD (Naylor et al, 2012). Climpean and Drake (2011) say that at least 30% of people with a long-term condition also have mental health problems; however, given the high prevalence of mental health problems in the general population, this is a conservative estimate.

People with long-term physical health conditions – the most frequent users of health services – commonly experience mental health problems such as depression and anxiety. As a result, the prognosis for their long-term condition and their quality of life can deteriorate markedly (Naylor et al, 2012). Additionally, the cost of providing care to this group increases as a result of less-effective self-care and other complicating factors related to poor mental health (Naylor et al, 2012). Data from the World Health Surveys indicates that people with two or more long-term conditions are seven times more likely to have depression than those without a long-term condition (Moussavi et al, 2007).

The community matrons commented on the impact of anxiety and its influence on patients’ ability to cope with COPD; anxiety leads to breathlessness, which in turn leads to anxiety in a cycle until a full-blown panic attack occurs. This can result in a call to the emergency services and admission (or readmission) to hospital.

Many of the study’s findings had been anticipated. The majority of service users on the community matron caseload had identified mental health problems, generally anxiety and depression.

All patients admitted to these caseloads are assessed for mental health problems as part of their initial assessment and any problems are highlighted with the GP or referred to another health professional. Access and effectiveness of these services was discussed by the community matrons and they described their frustration at service users’ reluctance to engage with different forms of psychological support or to consider alternative methods of coping with their long-term condition. The location of the hospital could have some influence on their readiness to attend the emergency department rather than to opt for early symptom recognition, self-care and accessing GP services, as the most deprived wards in the borough are very close to the emergency department.

The matrons described referring to mental health services as a lengthy process and consequently they felt service users tended to disengage. Alternatively, when service users were seen by a mental health professional, their community matron was given advice on how to deal with their problems. The opinion of that community

### Table 1. Community Matrons’ Comments

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<th>Evidence statement 1</th>
<th>Evidence statement 2</th>
<th>Evidence statement 3</th>
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<td>Exacerbation of COPD associated with depression and/or anxiety</td>
<td>“The patient gets breathless and then becomes anxious and all the advice I give them goes out of the window, they panic and dial 999.”</td>
<td>“I have encouraged some of my patients to use the ‘relax and breathe’ CD when they feel an attack coming on, but they don’t and when I ask why they say ‘it’s the last thing I think of doing when I need an ambulance’.”</td>
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<td>Poor concordance with medication</td>
<td>“Concordance with medication is a big issue, especially when the patient starts to exacerbate.”</td>
<td>“The number of times I have gone through inhaler technique and what to do during an exacerbation... the patient does what they want to do in the end.”</td>
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<td>Early discharge from secondary care</td>
<td>“You wouldn’t believe the state some of my patients come home in... high temps, no medication, no communication with primary care to discuss discharge planning - no wonder they go straight back in.”</td>
<td>“I really struggle with some of my patients to get them to take their medication properly, especially their inhalers. When I check what they are taking, the cupboards are full of inhalers which they wouldn’t have if they took them properly.”</td>
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<td>“The discharge planning from secondary care is poor, I call almost every day, speak to a different nurse, who doesn’t know the patient, has just come back from leave, takes my number for the fourth time and then discharges someone with complex health and social needs with no contact with primary care services and wonders why the patient is readmitted.”</td>
<td>“Some of the patients are discharged far too early; they need time to stabilise and recover, which they can’t always do at home.”</td>
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matron was “if I knew how to deal with it, I wouldn’t have referred in the first place”.

Service users were also offered relaxation CDs and instruction in a controlled breathing technique but these are often “not used consistently enough to help change learned behaviour”.

The matrons openly discussed scenarios and described how many service users did not feel going to hospital repeatedly was a problem. They expressed some frustration that once a service user with COPD became breathless, anxiety was the next step in the “cycle of dyspnoea” and admission was “almost inevitable”.

Service users admitted to the matrons’ caseloads have had two or more admissions in the previous 12 months related to their long-term conditions, and the majority (80%) have COPD. Following initial assessment, service users agree aims and goals and receive support with self-care, are reviewed regularly and encouraged to contact the community matron between visits if they start to feel unwell.

The service users also have access to 24-hour nursing support outside normal working hours from the out-of-hours community nursing service. I found evidence of frustration from the community matrons that, despite having access to nursing and medical services that could prevent readmission, service users “choose to go to hospital”. Perhaps the reason for this is that it is the “easiest option”, easier than finding the folder containing the different telephone numbers and deciding which one to dial for that specific time of day. It is also possible that the rotation between home, hospital and home is almost a culture.

Struggling to breathe must be terrifying, not only for service users to experience but also for family members or carers to witness. The matrons noted that once service users start to have difficulty in breathing, all the advice provided and relaxation techniques taught are not used and the only thing they can think of doing is getting to hospital as soon as possible. A cause for concern is that, should a health professional advise against readmission and something catastrophic happens, then not only has the service user been put at risk but also the health professional will be held accountable for their actions or perceived lack of them.

Comorbid mental health problems can reduce people’s ability to actively manage their physical condition and are associated with unhealthy behaviours, such as smoking; this could be an alternative yet significant explanation for readmission to hospital with an exacerbation of COPD with depression and anxiety.

DiMatteo et al (2000) believe self-management is the core of effective treatments for long-term conditions. However, if poor mental health reduces the motivation and energy needed for self-management, it will lead to poorer adherence to treatment plans and non-engagement with non-pharmacological interventions such as pulmonary rehabilitation.

Limitations of the study
Despite being small-scale and qualitative, the study has identified some important issues. The views and perceptions gained from community matrons suggest that the phenomenological approach was particularly useful when exploring this subject. In retrospect, I may have considered a larger sample size across a broader geographical location. However, the study has highlighted some important issues that will form the basis of future research.

Conclusion
The findings of this study concur with growing evidence that supporting the psychological and mental health needs of people with long-term conditions more effectively improve both physical and mental health (Naylor et al, 2012). Felker et al (2010) say mental health has a major impact on symptoms and outcomes for COPD and there is some evidence that depression increases mortality rates from COPD (Wilson, 2006).

It is estimated that depression is associated with a 50% increase in the costs of long-term medical care; these costs are associated with the effects of depression on health risk behaviours such as smoking, poor diet and a lack of exercise, along with the lack of adherence with self-management regimens (Katon, 2003).

It can be argued that better management of depression could significantly improve health and service delivery, which could reduce the demand for a range of specialist and acute services (DH, 2006). Depression, as a cause or consequence of physical illness, could exacerbate the perceived severity of symptoms and distress, and increase reliance on services. Existing provision of healthcare appears to separate two areas that should be addressed together; physical and mental health care should be linked to allow mental health problems to be recognised and service users supported early on.

With investment in the recognition and the treatment of depression, it is highly likely that the perceived burden of illness for the service user would be reduced, avoiding hospital readmission.

References