A STUDY TO DETERMINE IF A GERIATRIC WARD SHOULD BE ESTABLISHED AT BROOKE GENERAL HOSPITAL

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A BRIEF HISTORY OF
BROOKE GENERAL HOSPITAL

The present hospital evolved from the "old" Post Hospital at Fort Sam Houston, coming into existence in a temporary building on Staff Post in 1881. The Post Hospital was rebuilt once in 1885 on its original site and again in 1908 on Artillery Post. Its name changed in 1915 to Base Hospital and to Station Hospital in 1920. Although need for a larger and more modern building was felt as early as 1921, plans were not laid nor approved for the new building until 1933. The main hospital finally completed in 1938 then became known as the "new" Station Hospital.

In September of 1942, the hospital was named Brooke General Hospital, in honor of Brigadier General Roger Brooke, MC, USA, and in recognition of the outstanding manner in which he identified himself with community interest while in command of the "old" Station Hospital from 1929 to 1933.

During World War II, expanding through the annexing of a number of permanent and temporary buildings, the hospital played an important role in caring for the sick and wounded. In 1945, the Brooke Hospital Center was established and later that year more

than 10,000 patients were hospitalized in its two components. The Center reverted to Brooke General Hospital in 1946 when Brooke Army Medical Center was organized. The hospital was designated Brooke Army Hospital in July 1950 and was renamed Brooke General Hospital in January 1960.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

In this second half of the twentieth century, health care for the aged has received more attention than at any time in history. In recognition of the increased longevity of a large segment of our population and the consequent requirement for additional hospital facilities, the health care field is adjusting itself to meet the problems of the geriatric patient.

Public concern for the health of the aging is illustrated by the federal legislation passed in July 1965.[1] This act will make possible medical care for elderly persons who previously could not afford to be hospitalized or reside in a nursing home.

New emphasis is being placed on gerontology in the medical school curriculum and geriatrics may emerge as a new medical specialty.

As the civilian hospitals brace for the impact of the Medical Care for the Aged Act, military hospitals are also being

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[1]U. S. Congress, Public Law 89-98, Health Insurance for the Aged and Medical Assistance Act, 89th Congress, 30 July 1965.

affected by the geriatric problem. The increasing number of retired personnel and their dependents has resulted in an increased hospital census of persons in the geriatric category.

The designation of Brooke General Hospital to provide care for Veterans Administration beneficiaries in the San Antonio area has contributed to the number of elderly patients in this hospital. One hundred twenty beds have been designated for Veterans Administration patients, most of whom require geriatric care.

The consensus of medical personnel interviewed was that the geriatric patient should be cared for in the appropriate specialty care area during the acute phase of his illness.

As expressed by one author:

> Out of 100 typically geriatric patients we doubt if more than 10-20 really need hospital resources which even approximate the needs of the average acute patient.[2]

In the effort to provide the best possible care for all patients at Brooke General Hospital, the administrative and professional staffs are facing the geriatric challenge.

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[2]"Geriatric Crossroads in Britain," Hospital and Health Management, XXIII (May, 1961), pp. 152-153.

CHAPTER II

THE PROBLEM

Statement of the Problem

To evaluate the care provided elderly patients at Brooke General Hospital and to determine if the segregation of selected patients by age and condition would result in better patient care and more effective use of the professional staff, the administrative staff, and the hospital's facilities.

Reasons for the Study

The geriatric patient census at Brooke General Hospital has, on occasion, exceeded fifty per cent of the total patient census. During his recovery, the geriatric patient usually achieves a state of health that no longer requires specialty care although continued hospitalization is indicated. At the time of discharge the elderly patient often becomes a problem because he has no home, or because his relatives cannot or will not provide the required care. It was also recognized that the geriatric patient is often unsteady on his feet and is subject to falls with subsequent injury while he is in the patient status.

Definition of Terms

Geriatric is a term pertaining to the treatment of the aged. (For the purpose of this study, persons sixty years of age and over are considered to be in the geriatric category.)

Geriatrics is the branch of medicine which treats all the problems of aging and old age, including the clinical problems of senescence and senility.

Gerontology is the scientific study of the problems of aging, whether clinical, biological, historical, or sociological.

Selected Patients refers to those patients designated by a physician who could benefit from a concentration of care and services in one treatment area that is directed toward patient rehabilitation.

Criteria

The elderly patient should receive more comprehensive professional care in a geriatric treatment area than he is presently receiving.

The number of patients at Brooke General Hospital in the geriatric category should be sufficient to justify a separate treatment area.

More extensive use of the hospital's paramedical personnel should be realized.

A geriatric treatment area should provide better use of existing equipment and facilities throughout the hospital.

The patient should be better able to contribute to his individual and community needs at the time of discharge.

A safer hospital facility should be realized for the elderly patient.

Facts Bearing on the Problem

The following facts bearing on the problem were noted.

1. The main hospital building and the Beach Pavilion are separated by nine-tenths of a mile.

2. Medical and surgical care are provided in both facilities.

3. Safety devices, such as hand rails, are not installed in halls and patient latrines.

4. The total patient census is extremely high because of patients returning from the Vietnam conflict.

5. Staff personnel are minimal to support the heavy patient census.

6. San Antonio has a large concentration of retired military personnel and their dependents.

7. Brooke General Hospital has 120 beds designated for Veterans Administration beneficiaries.

Assumptions

The Medicare Bill proposed by Representative F. Edward Hebert of Louisiana, which includes dependents of active duty

military and retired personnel and their dependents, will be passed into law.

If the Medicare Bill is passed, most retired personnel and their dependents will elect to continue receiving medical care in military facilities.

The proposal to include beds for retired personnel in military hospital construction planning will be passed into law.

Personnel and funds will be available to support the recommendations of the study.

Approach to the Problem

The general descriptive method of research was used to gather the data on which the final conclusions and recommendations were based. A thorough review of the literature pertinent to the subject was accomplished. A complete tour was made of the Main Hospital and Beach Pavilion, with special attention paid to all areas where geriatric patients were located. Tours of the Grace Lutheran Hospital and the convalescent geriatric wards at Santa Rosa, San Antonio, Texas, were also conducted.

In order to determine the approximate number of patients who would benefit from a geriatric treatment area at Brooke General Hospital, the ages and diagnoses of all inpatients and admissions for the period from 24 March 1966 through 30 April 1966 were reviewed. This information was retrieved from the computer

produced alphabetical roster of patients and was not available elsewhere. The computer was not programmed for retrieval of information by age of the patient; therefore, accurate figures could not be obtained except for this short period of time.

Personal interviews were held with the commanding general, department chiefs, ward officers, and ward nurses at Brooke General Hospital; the assistant administrator, Santa Rosa Medical Center, San Antonio, Texas; the administrator and director of nursing, Grace Lutheran Hospital, San Antonio, Texas, and Dr. E. T. Xemenes, geriatrician and representative on the President's Council for the Aged. These persons were interviewed to determine their views regarding the advantages and disadvantages of a geriatric treatment area and any special problems that might be encountered in establishing such an area.

CHAPTER III

DISCUSSION AND FINDINGS

The Registrar, Brooke General Hospital, stated that geriatric patients often exceeded fifty per cent of the total inpatient census prior to the patient buildup caused by casualties returning from Vietnam.

Returning casualties during the first four months of 1966 raised the average patient census and occupied beds to 1,059.5 and 865, respectively, as opposed to 875 and 705.2, respectively, for calendar year 1965.[3] On 24 March 1966, there were 167 geriatric inpatients and 944 occupied beds, indicating that 17.69 per cent of the patients occupying beds were over sixty years of age.[4] From 24 March to 30 April 1966, there were 1,789 direct admissions, of which 265 were patients in the geriatric category. This represented 14.8 per cent of the total direct admissions, or 7.16 geriatric admissions per day.[5]

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[3]Statistical Records, Budget and Fiscal Branch, Office of the Comptroller, Brooke Army Medical Center, Fort Sam Houston, Texas (in the files of the Branch).

[4]Alphabetical Roster of Hospital Patients, February 24, 1966, Registrar Division, Brooke General Hospital, Fort Sam Houston, Texas.

[5]Admission Rosters, March 24, 1966 through April 30, 1966, Registrar Division, Brooke General Hospital, Fort Sam Houston, Texas.

To evaluate geriatric care, the attitude and position of the physician, the characteristics of geriatric nursing, the benefits of physical and social rehabilitation, and patient safety were extensively explored.

Position of the Physician

To first determine the position of physicians at Brooke General Hospital, the hospital commanding general, chiefs of departments and services, and ward officers were interviewed. To better understand the position taken by some of the department and service chiefs, it is necessary to explain that the medical staff is a closed one (physicians practice within their designated or chosen area and do not have their patients throughout the hospital plant).

The chief of medicine expressed the position that military hospitals are by tradition and by Army regulation acute treatment facilities.[6] He expressed further concern that such a treatment area would create a greater workload because:

1. Patients would have to be transferred from one ward to another.

2. The attending physician would be required to travel from ward to ward to care for his patients.[7]

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[6]Department of the Army Regulation 40-3, with Changes, "Medical, Dental and Veterinary Care.

[7]Interview with Colonel R. H. Forrester, Chief, Department of Medicine, Brooke General Hospital, 1 February 1966.

The Chief of Urology Service explained that most of his patients were short-term surgical cases and once the primary acute care was terminated the patient was discharged.[8]

During tours of the various wards, several geriatric urology patients receiving nursing care were found on other wards because they had not recuperated sufficiently to be discharged.

The Chief of the Neurology Department was most receptive to the possibility of a geriatric ward. He felt that many of his elderly patients with neurological problems could benefit from concentrated rehabilitation and social services. The social service was considered extremely important because many patients with neurological disorders cannot return to their homes. Discharge planning is essential to proper placement in a nursing home or hospital for care of chronic illness as indicated by the case.[9]

The Chief of the Physical Medicine Department recognized the need of the geriatric patient for concentrated occupational therapy and physical therapy treatment. He felt that such a treatment area would benefit the geriatric patient, but considered his staff of Physical Medicine Specialists (physiatrists) insufficient to

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[8]Interview with Lieutenant Colonel Prince D. Beach, Chief, Urology Service, Brooke General Hospital, 31 January 1966.

[9]Interview with Lieutenant Colonel Eugene W. Ebberlin, Chief, Department of Neurology, Brooke General Hospital, 1 February 1966.

operate such a ward or treatment area.[10] The physiatrist coordinates the activities of the physical therapist and the occupational therapist, and is usually aware of a patient's nutritional problems or any conditions requiring the assistance of the Social Service.

The general consensus of the ward officers interviewed was that such a convalescence or rehabilitation ward for the geriatric patient would be worthwhile. They felt that both the acutely ill patient and the designated geriatric patient would benefit by establishing such an area. The geriatric patient requiring primarily nursing care takes valuable nursing time from the acutely ill patient when the two categories are integrated.[11]

One ward officer expressed concern that the patient admitted to such a ward might be difficult to discharge. This point was well taken, but the efforts of the entire team should insure discharge when the maximum expected benefits have been obtained. An understanding of the purpose of such a treatment area and an effective utilization review should preclude the area's becoming a chronic long-term care facility.[12]

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[10]Interview with Lieutenant Colonel Walter H. Moore, Chief, Department of Physical Medicine, Brooke General Hospital, 10 May 1966.

[11]Interviews with Captains William F. Eastley, Ralph C. Bobbitt, and Joseph F. Norato, Ward Officers, Brooke General Hospital, 11 May 1966.

[12]Interview with Captain Robert Noble, Ward Officer, Brooke General Hospital, 12 May 1966.

The hospital commanding general expressed the opinion that such a ward would be a luxury--in the "nice to have" category. He felt that the elderly patient not requiring specialty care should be separated but not isolated. Continuing this point, General Rhea stated that the Older patients prefer to be together and, in addition, older patients often depress younger ones.[13]

The point that the older patient should be separated but not isolated was supported by a civilian physician prominent in geriatric care. He also stated that eventually all general hospitals will have a separate geriatric department to support the growing population of the aging.[14]

According to Stieglitz, more can be done for the aging than for the aged, his point being that when senility truly equals infirmity maximum rehabilitation has been reached. Although senility is the end point, the consequence of senescence, control, and careful guidance through the period of senescence may retard and diminish the debilitations of aging. A continuing attitude of prophylaxis is essential to the full development potential of the geriatric patient, with the realization that his repair is slow.

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[13]Interview with Brigadier General Robert L. Rhea, Jr., Commanding General, Brooke General Hospital, 14 May 1966.

[14]Interview with Dr. E. T. Xemenes, Geriatrician and Representative on the President's Council for the Aged, 16 May 1966.

Although more time is necessary for convalescence, Dr. Stieglitz makes it clear that long immobilization is not desirable for elderly patients.[15]

Nursing Care for the Geriatric Patient

The attitudes and approaches to nursing the aged are different from those required for nursing the acutely ill.

> The nurse must have attained a good measure of emotional maturity before she can give effective nursing care to the elderly patient.[16]

Norton supports the idea of different nursing requirements with an enumeration of personal qualities, special techniques, and characteristics the geriatric nurse should possess. She was careful to include the fact that in the patient who is quite old many of the classic signs and symptoms of disease are frequently absent or, if present, they vary considerably. Some of the factors and qualities felt to be important in geriatric nursing are sympathetic kindness, thoughtfulness without pity, a sense of humor, and tolerance. The geriatric nurse needs patience, tact, flexibility, warmth, and a genuine interest in people to help the patient overcome the loneliness he so often feels. Geriatric nursing also

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[15]Edward J. Stieglitz, "Principles of Geriatric Medicine," Geriatric Medicine, the Care of the Aging and the Aged (2d ed., Philadelphia, Pennsylvania: W. B. Saunders Company, 1949), pp. 30-33.

[16]Kathleen Newton, Geriatric Nursing (St. Louis: The C. V. Mosby Company, 1950), p. 23.

requires physical energy, the knowledge of how to use it, and the ability to manage the patient without appearing to do so.[17]

Although many of the qualities of the geriatric nurse overlap those of general duty nursing, the literature indicates that special consideration should be used in selecting the nurse for the elderly patient.

Norton divides geriatric nursing into two distinct categories: rehabilitative and irremediable. Her point is that these two categories of the elderly sick have totally conflicting needs.

The rehabilitative or acute category includes those patients who have the potential to regain the ability of basic self care. (This is the category of patient envisioned to benefit from this study.)

The irremediable or chronic category includes those patients who have gone beyond medical reclaim and will need some degree of nursing care for the remainder of their lives.

Norton continued:

> It is also generally appreciated that the good (bedside) nurse is at a great disadvantage when patients reach the stage of being rehabilitated. A new discipline has to be learned, that of gradual withdrawal of nursing care--and this comes hardest of all to those who love to lavish care, and harder still when the patients are old people.[18]

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[17]Doreen Norton, "Nursing in Geriatrics," Gerontologia Clinica, Vol. VII, No. 1 (1965), pp. 53-54.

[18]Norton, op. cit., pp. 53-54.

Physical Rehabilitation and Social Service Support

The elderly patient requires a longer period to repair; therefore, special consideration subsequent to an acute illness is indicated. Longer convalescence places on the hospital the responsibility for rehabilitation. This process may be in the form of restoring the function of a particular muscle or group of muscles, or in assisting the patient to accept and adjust to injuries or limitations created by illness. Social adjustments may also be necessary before the elderly patient returns to his normal routine. It must be determined during the convelscence period whether the patient should return home, be transferred to a hospital which provides long-term care, or be sent to a nursing home. All of these requirements of the rehabilitation process suggest the team approach in restoring the elderly patient to health.

According to Freeman:

> The team concept is one of the most significant contributions to geriatric care today. . . . Only when we learn to use our combined efforts wisely and effectively can we secure the best for the most important team member of all--the patient and his family.[19]

In addition to the physician and nurse, the team may consist of physical therapists, occupational therapists, social workers, dietitians, chaplains, aids, and corpsmen.

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[19]Ruth Freeman, "Planning Care for the Geriatric Patient," Journal of the American Geriatric Society, Vol. I, No. 2 (February, 1961), p. 93.

It is not being suggested that rehabilitation should not begin until the acute phase of treatment is complete. As Newton states:

> Rehabilitation must be thought of as a constructive process beginning as soon as the disease is discovered.[20]

Weakness of the muscles is one of the reasons physical rehabilitation should be started early in the treatment process.

This position is supported by Riccitelli who reports that inactivity has a disintegrative action on the body, illustrating that the body must expend energy to remain health. He explained that when the muscles undergo disease atrophy and become shorter, weaker, and stiffer, there is a decrease in functional ability.[21]

Not all physical exercise must be robust to be meaningful. One author suggests that elderly patients be encouraged to use a rocking chair for its therapeutic value.[22]

The value of physical rehabilitation for the elderly patient in the geriatric setting is that one patient often encourages another with resulting benefit to both

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[20] Newton, op. cit., p. 35.

[21] M. L. Riccitelli, "The Therapeutic Value of Exercise in the Aged and Infirmed," The Journal of the American Geriatric Society, Vol. XI, No. 4 (April, 1963), p. 299.

[22] "A Community Hospital Rehabilitation Unit," Nursing Outlook (February, 1965), p. 41.

Occupational therapy, like physical therapy, plays a significant role in restoring the geriatric patient to normal, or as nearly normal as possible.

According to Kovacs, the objective of occupational therapy is to restore function and work habit primarily through two forms: diversional or recreational and functional activities. In treating traumatic conditions, such therapy together with corrective exercises can prevent muscle atrophy and a loss of muscle power and will contribute to a return to normal activities.[23]

Occupational therapy at Brooke General Hospital is provided by the Occupational Therapy Service and the Recreation Specialist of the American Red Cross.

The Social Work Service at Brooke General Hospital assists in patient rehabilitation by attempting to understand the social and emotional factors of the illness and by establishing a patient discharge plan.

Difficulty in adjusting to an illness, a limited social environment, or a handicap or incapacity are some of the social and emotional problems which may impede normal recovery. When a personal or family problem seems to be a significant factor in an illness, referral of the patient for social evaluation is often indicated.

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[23]Richard Kovacs, "Principles of Physical Therapy for the Aged," Geriatric Medicine, the Care of the Aging and Aged, Edward J. Stieglitz (Philadelphia: W. B. Saunders Company, 1949), p. 179.

The clinical social worker contributes to the medical program by:

1. Securing background information pertaining to the patient.

2. Evaluating the patient's personal and emotional problems affecting his illness and recovery.

3. Helping the patient and his family deal with the problems affecting their ability to use medical care.

4. Sharing with the physician his understanding of social implications affecting the medical plan.

5. Arranging environmental changes, when possible, to meet the recommendations of the medical staff.

In addition to the above, the Social Work Service is quite active in planning for the patient's discharge. Consultations are conducted with both the patient and his relatives regarding future employment, continuation of the rehabilitation program, financial assistance, and nursing home placement when necessary. Often a patient's acceptance of future limitations resulting from an injury or illness depends on the concentrated effort of the social worker's discharge plan.[24]

The value of group counseling in the geriatric rehabilitation program is expressed by Barton:

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[24] "Social Work Services for Patients at Brooke General Hospital," Brooke Army Medical Center, Fort Sam Houston, Texas, Unnumbered Pamphlet, pp. 2-5, May 1966.

> Participating in a patient peer-group realistically focused on constructive adjustments to aging and illness can substantially assist the older hospital patient in arriving at the best adjustment for his individual situation.[25]

The Army health nurse provides followup of the hospital's rehabilitation program through home visits after discharge.

The chaplain is an important factor in the rehabilitation program for the elderly patient. He provides spiritual guidance and support plus a willingness to listen.

The dietitian, a member of the team often overlooked, provides nutrition planning and guidance during the rehabilitation of the geriatric patient.

In support of this position, it has been reported that nutritional problems for the aged are more difficult than with any other group. This is true because the program must involve more than merely the devising of adequate diets. It has been concluded that proper nutrition is one of the most important problems confronting the physician who is treating the aged.[26]

One hospital administrator reinforced the importance of both the chaplain and the dietitian, and reported that the appetites

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[25] Murray G. Barton, "Group Counseling the Older Hospital Patient," Gerontologist, Vol. II, No. 1 (March, 1962), pp. 51-56.

[26] William H. Sebrell, "Malnutrition," Geriatric Medicine, The Care of the Aging and the Aged, Edward J. Stieglitz. (Philadelphia: W. B. Saunders Company, 1949), p. 187.

of aged patients in his hospital markedly improved when they began eating together in the day room.[27]

Safety

To illustrate the magnitude of accidents involving the elderly, Lawton wrote:

> Of approximately 16 million elderly people age 65 and over in the United States, 25 thousand die from and 3 million are injured by accidents each year. The age group contains less than 10% of the population but one-fourth of the accidents occur to them. Three types of accidents account for 85% of all accidental deaths in elderly people: falls, motor vehicle and fire and explosion. . . . It is generally accepted that accident exposure rates drop with age but that the consequence per event may be increased with age.[28]

Many of these accidents occur in our hospitals. A. H. Lawton, Administrator of the Brooklyn Hebrew Home and Hospital for the Aged, states that the constant threat of injury to the geriatric patient as the result of an accident is the major problem facing homes and hospitals for the aged. In a study of accidents involving the elderly, he found twenty primary causes. He found that accidents happen because elderly patients:

1. Are not sure-footed.
2. Have impaired sight and hearing.

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[27]Interview with Lieutenant Colonel Henry J. Rockstroh (Retired), Administrator, Grace Lutheran Hospital, San Antonio, Texas, May 1966.

[28]Alfred H. Lawton, "Accidental Injuries to the Aged," Gerontologist, Vol. V (June, 1965), p. 97.

3. Receive sedation at night.

4. Awaken suddenly and do not recall their whereabouts.

5. Stumble over objects and furniture that are out of place.

6. Slip on floors which they make wet by incontinence and spillage.

7. Get dizzy in the toilet.

8. Misjudge distances.

9. Try to help one another unsuccessfully.

10. Lean for support upon unstable objects.

11. Climb over bedside rails.

12. Roll off chairs and out of bed.

13. Do not wait for help.

14. Forget where they are

15. Refuse manual assistance.

16. Refuse help when it is offered.

17. Have poor balance.

18. Are impatient.

19. Try to get into their wheelchairs alone.

20. Do not wear shoes when ambulating, especially at night.[29]

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[29]Allen Podell, "20 Causes of Accidents in Older Patients," Hospital Topics, Vol. 38, No. 11 (November, 1960), p. 45.

A survey of safety equipment and devices installed or provided in Brooke General Hospital revealed that:

1. Hand rails are installed only on stairs.
2. No support or pull-up rails are provided in patient latrines or showers.
3. No emergency buttons to alert hospital personnel of patient difficulty are installed in the patient latrines.
4. No seats are installed in patient showers.
5. Showers are not constructed to permit wheelchairs to be rolled into them. (Wheelchair patients must be lifted onto a bedside chair for showering. This is considered a safety hazard.)
6. No mechanical walkers are available on the wards.
7. The primary patient safety device is the bed rail.

The policy that elderly patients are not permitted to go to the shower or latrine alone probably accounts for the excellent safety record. The observed policy, however, appears to be to keep the aging patient either in bed or on his bedside chair to reduce accident exposure.

Plans for the new Brooke General Hospital were reviewed but they have not progressed to the point that safety devices are included.

Summary

Personal interviews and review of the literature indicates that the geriatric patient would benefit from the establishment of a rehabilitative or convalescence treatment area.

Information also indicates that better use of rehabilitative type services and facilities would result. As summarized by Rusk and Dacso:

> The majority of the medical profession has long ago abandoned its initial reservation towards rehabilitation, and accepted it as a full partner of the total effort of the service to the sick. If the acceptance could be emphasized in the field of the medical care of the elderly, these often neglected people would enjoy a great many new benefits.[30]

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[30] Howard A. Rusk and Michael M. Dacso, "Rehabilitation in the Aged," Problems of Aging, New York Academy of Medicine, ed. Robert S. Craig, Medicine and Science Books, New York (1955).

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

1. Maximum rehabilitation benefits are not being provided the geriatric patient at Brooke General Hospital. Elderly patients are not routinely included in occupational and physical therapy programs that can better prepare them for leaving the hospital.

2. Geriatric nursing requires different techniques and a different approach to care for the patient than does general duty nursing. The separation of the geriatric patient from the acutely ill patient, when maximum acute treatment benefits have been realized, will result in the use and development of geriatric nursing techniques and improved nursing care for the patient.

3. The geriatric patient who requires only nursing care takes valuable nursing time from the acutely ill patient. The transfer of this type patient to an area designated for geriatric care would result in better service to both categories of patients.

4. Elderly patients often determine their limits and develop new interests by talking with other persons their own age. Therefore, if a geriatric treatment area were established, bringing

elderly patients with varied interests together, more use of peer-group therapy could be realized.

5. A team concept in caring for the elderly patient will result in better and more extensive use of personnel and equipment.

6. There is an urgent requirement to install and provide devices for patient safety throughout Brooke General Hospital.

7. Selected geriatric patients should be transferred to a geriatric ward or treatment area when maximum benefits from the specialty service have been realized.

8. A physician trained in physical medicine could best supervise a treatment area designed to rehabilitate, to the extent possible, the geriatric patient.

Recommendations

1. A separate area should be established for the treatment of selected geriatric patients at Brooke General Hospital.

2. A dining room, or space convertible to a dining room, for group meals should be provided in the area selected for treating the geriatric patient.

3. The geriatric treatment area should be equipped with:

a. Hand rails on at least one side of all corridors.

b. Hand rails and pull-up bars in all latrines and patient showers.

c. Emergency buttons in all patient latrines.

d. Showers that will accommodate a wheelchair.

e. Seats or benches in all showers. Such equipment is considered necessary to insure, to the extent possible, the safety of the patient.

4. Hand rails should be considered for installation throughout the hospital complex.

5. With the approval of the physician, mechanical walkers should be provided elderly patients who are unsteady on their feet.

6. A quantity of rocking chairs should be provided the geriatric treatment area to permit mild exercise and patient enjoyment.

7. Plans for the new Brooke General Hospital should include hand rails on both sides of all corridors. Hand rails and pull-up bars in all latrines, and an emergency button connected to the nursing station installed in all latrines.

8. A geriatric treatment area should be included in the planning for the new Brooke General Hospital.

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FORT SAM HOUSTON, TEXAS

MAJ Gordon K. Dowery

29 Pages August, 1969

ABSTRACT

The study was an evaluation of the requirement for a separate treatment area for geriatric patients at Brooke General Hospital, Fort Sam Houston, Texas.

In the approach to the study, research of pertinent literature was made. Tours were made of the main hospital and Beach Pavilion, Brooke General Hospital, and of two hospitals in San Antonio, Texas, having separate geriatric facilities. Interviews concerning the care of elderly patients were conducted with professional and administrative personnel.

It was found that no requirement exists for separate facilities when the patient requires acute care. However, during the period of recuperation special consideration for the geriatric patient is indicated. The elderly patient requires more time to repair and desires to be with other older patients. Physical rehabilitation, social services support, nutrition, spiritual guidance, and special nursing requirements are important considerations for the geriatric patient that indicate the need for a team approach.

To insure that the geriatric patient receives maximum benefit from their hospital stay, it was recommended that a geriatric treatment area be established.