Australian Society for Geriatric Medicine
Position Statement No. 9
Medical Care for People in Residential Aged Care Services

1. People are rarely admitted to residential care facilities for social reasons alone. Dementia, chronic illness and physical disability are the major determinants of admission, and compulsory pre-admission assessments ensure that this is so. Many among the 140,000 people currently living in Commonwealth subsidised residential aged care facilities have complex medical service needs, and augmentation of the current medical service model is required if these needs are to be met.
2. Two decades of separate reform processes in residential aged care and general practice in Australia have resulted in significant advances in both fields, but the medical service needs of people in residential care have largely been neglected by policy makers from both the residential care and general practice sectors.
3. For the physical and mental health of residents there is a need for access to a broad range of integrated high quality health services including, but not limited to, gerontic nursing, primary care medicine, geriatric medicine; psychiatry of old age; palliative care medicine; dentistry; optometry and ophthalmology; physiotherapy; occupational therapy; speech pathology; podiatry; audiology; dietetics; and psychology.
4. Many common conditions of residents including behavioural symptoms of dementia; chronic pain; depressive disorders; urinary incontinence; hip fractures risk; skin ulcers; cardiorespiratory conditions and palliative care needs; require the development, institution and adherence to multidisciplinary clinical practice guidelines and valid outcome indicators. Therefore a collaborative inter-professional mechanism for integrated guideline development must be established for this population.
5. People resident in Commonwealth subsidised facilities should retain access to regional State and Territory-funded services. Specialist multidisciplinary services should establish supportive relationships with residential facilities in their regions, and provide individual consultations (on site if necessary), on referral by general practitioners. Aged care and aged psychiatry assessment and treatment services; memory clinics; regional continence services; falls and balance clinics; movement disorder clinics; pain management services; wound management services; and community health centres; all have expertise pertinent to the needs of facilities and residents.
6. At the level of the facility some form of organisation of medical service is required. Doctors are otherwise unable to conduct peer review activities and participate in multidisciplinary policy and procedure development. If this is economically impractical in each facility, it should be achievable under the auspices of local Divisions of General Practice.
7. At the sector level there is a need for the establishment of a medical special interest group, dedicated to promoting high quality medical care for the resident population, in which the Australian Society for Geriatric Medicine should have a major role. This body could progressively establish education and training requirements for recognition of competency in residential care medicine. This recognition could become an entitlement to a remuneration margin, thereby exposing the sector to a competitive market of interested and skilled medical providers.
8. The Australian Society for Geriatric Medicine believes that the matter of medical service provision in residential aged care requires urgent collaboration between Commonwealth, State and Territory ministerial portfolios and sections of the bureaucracy that are responsible for primary care; specialist medical services, and residential aged care, in order to establish to whom the reform mandate belongs; and to bring the medical and sectoral stakeholders together to begin the process of reform.

This Position Statement represents the views of the Australian Society for Geriatric Medicine. This Statement was approved by the Federal Council of the ASGM on 8 October 2001.

The preparation of this paper was coordinated by Dr Sam Scherer.

BACKGROUND PAPER

Introduction

The practice of medicine in the complex circumstances of a residential aged care facility requires a doctor with particular skills, interests, and attitudes [1], and competence in geriatric medicine, preferably acquired through dedicated post-graduate training [2]. Recently there have been adverse events suffered by nursing home residents when treated sub-optimally [3]. These types of unfortunate incidents are sentinel events which expose treatments that do not conform to existing evidenced-based clinical practice guidelines [4] [5]. Such events may be isolated incidents or could be indicative of a widespread lack of adherence to contemporary evidence-based clinical practice for this population. Disturbingly, there are no data on which to base an informed answer to this question, and the lack of data is in itself a cause for alarm.

Medical characteristics of residential aged care populations

Predictors of admission to residential care are overwhelmingly health-related, rather than social. Of the 134,000 Australians diagnosed with dementia in 1996, about 50% were housed in residential care [6]. Dementia is the only condition that has been the subject of a major local prevalence study [7], and this revealed that 28% of hostel ("low level residential care") residents and 60% of nursing home ("high level residential care") residents had this diagnosis. The prevalence of "cognitive impairment" (which in this setting usually indicates delirium or dementia) was much higher at 54% in hostels and 90% in nursing homes.

After dementia, walking difficulty, and poor self-rated health are the strongest predictors of nursing home admission in Australia [8]. The characteristics of the hostel population are progressively becoming more like the nursing home population. In 1990 only 54% of hostel residents required assistance with personal care, whereas 80% of residents required such assistance by 1997 [9], and this trend is now entrenched with the single classification funding scale and "ageing in place" policy introduced with the Aged Care Act 1997 [10].

Internationally, 45 to 80% of nursing home residents suffer from chronic pain [11]. Thirty to 40% of residents of elderly care homes suffer from clinically significant depression [12]. More than 80% of residents of nursing homes experience significant vision or hearing difficulties [13]. Forty-five percent of nursing home residents suffer from a major sleep disorder [14]. About 50% of a nursing home population suffers from urinary incontinence [15].

About 30% of people in nursing homes suffer from falls that are often recurrent [16]. Osteoporosis is almost universal in the nursing home [17]. Long term care residents in New Zealand have a 10.5 fold increase in risk of hip fracture compared with age-matched people living in private homes [18]; and 38% of the 15,000 hip fractures in Australia in 1996, occurred among older people living in hostels and nursing homes [19]. Annual hip fracture risk for residents who fall repeatedly is as high as 14% to 41% [20]; and 40% of a nursing home cohort, who were taking psychotropic medication and had ongoing falls, suffered a hip fracture within six months [21].

Pressure ulcer risk can also be stratified and definable individuals are at very high risk [22]. Stroke; Parkinson's disease; cardiovascular disease; obstructive lung disease; degenerative arthritis; cancer; diabetes mellitus; peripheral vascular disease and renal failure are also common in nursing homes [23].

Multiple medical comorbidities, especially contributed to by the weight of neurodegenerative disorders [24], result in this population having particularly complex health care needs. Failure to meet these care needs is the strongest predictor of depression among people in residential care settings [12].

Organisation of medical care in Australian residential aged care

A 1996 survey of general practitioners in Sydney [1] indicated that 54% visited at least 1 nursing home, and that the 35 facilities surveyed had a mean size of 56 beds, with a mean of 23 attending general practitioners per facility. These general practitioners averaged 2 to 3 patients per facility; a

median of just over 1 nursing home visit per week, and had no other involvement with the facility. North American studies suggest that high quality medical care in residential facilities is associated with larger numbers of residents being managed by smaller numbers of doctors [25]; as well as with the number of hours of medical coverage per week; and accreditation of doctors to the facility [26].

The Royal College of Physicians and the British Geriatrics Society [2] recommend that doctors working in long-term care should have at least the English Diploma of Geriatric Medicine, and that the medical role in long-term care should embrace more than occasional medical intervention for intercurrent illness: but should include responsibility for high quality care standards; regular review and reassessment; and participation in audit, education, and staff training. The American Medical Directors Association takes a similar position and oversees certification of competency in these aspects of the medical role in long-term care [27].

Evidence based medicine in residential aged care facilities

The Royal Australian College of General Practitioners publishes a handbook titled: "Medical Care of Older Persons in Residential Aged Care Facilities", and the 3rd Edition [28] is endorsed by the Australian Society for Geriatric Medicine and the Australian Medical Association. Early editions carried the title of "Guidelines" but this word has been removed as an acknowledged that this would imply evidence-based guidelines, which would be a much high order undertaking. This handbook is clearly a most welcome publication, but according to a recent Cochrane review: "the effects of printed educational materials compared with no active intervention appear, at best, small, and of uncertain clinical significance" [29].

The American Health Care Association and American Medical Directors' Association jointly publish comprehensive guidelines for the multidisciplinary management of the common medical conditions in long-term care populations, including a guideline on implementation of their series of clinical practice guidelines [30]. The Royal College of Physicians and the British Geriatrics Society publishes an outline for a process of quality enhancement based on objective audit criteria for nursing home residents [2].

Neither the USA or British guidelines are widely read in this country, but even the circulation of practice guidelines is often ineffective in changing general practitioners' clinical practices [31]; unless the guideline is embedded in a comprehensive education program with active participation of doctors, preferably in their own practice settings [32].

Australian residential aged care reform and medical service provision

In 1962 an amendment to the National Health Act 1953, granted a daily benefit (originally $2) for all residents in approved nursing homes [10]. Subsequently the 1960's & 1970's saw a rapid nation-wide growth of what was in large part a nursing home "cottage industry". From the early 1980's reviews were commissioned by successive Governments [33] addressing the need for more rational policy and planning. Major reform has been achieved in all dimensions of the sector except medical care.

A "psycho-social" model of care has replaced the "institutional model" [2]. The current primary community care medical service model leaves the medical care of each resident to his or her independent general practitioner, and there is no structural inter-relationship of the medical service to the facility or sector. How well the medical care needs of residents are being met by this service model has never been considered from the perspective of the sector.

Dementia is the only medical condition of this population that has been of sufficient interest to policy makers to be studied. Rosewarne [7] found that although people with severe behavioural symptoms of dementia were being supported in residential facilities, care practices were inadequate; and he recommended more specialist support. Burdekin [34] found that general practitioners often failed to recognise and treat mental disorders in elderly institutionalised people. In the mid 1990's the percentage of residents in Sydney nursing homes who were taking psychotropic drugs was among the highest reported from any geriatric institutions around the world, and many of these prescriptions were considered to

be inappropriate [35]. General practitioners acknowledge that they have educational needs in dementia [36].

Even in the light of the concerns raised by these reports consideration of medical care continues to be excluded from residential care accreditation requirements and the terms of reference sector reviews [10].

Australian general practice reform and residential aged care

Australian general practice has also been the subject of two decades of review and reform, resulting in enhancements in virtually all areas of general practice except residential aged care medicine.

Recently Medicare rebates for general practitioner residential care visits were brought into line with home visits and the Enhanced Primary Care (EPC) program has introduced remuneration for general practitioner involvement in care planning, multidisciplinary case conferences, and comprehensive annual health assessments for people over 75 [37]. These initiatives bring welcome potential benefits for medical practice in residential care, but the lack of dedicated policy for this population is demonstrated by people residing in residential facilities initially being excluded from Medicare reimbursement for all 3 groups of EPC items, and continuing to be excluded from comprehensive annual health assessments. The residential care population, having been regarded as homogeneous with community-dwelling elderly people in their appropriateness for a primary medical care service, becomes differentiated from community-dwelling elderly people for the purpose of exclusion from a primary medical care enhancement.

There is actually no evidence that routine screening of older people who live in their own homes is of any benefit [38]; whilst comprehensive assessment of older people who are known to have significant health problems and disabilities is beneficial; provided it is performed according to the established principles and with the knowledge-base of geriatric medicine [39].

Nurses and doctors

The sector has an increasingly poor record of retention and attraction of nurses, with shortages now reaching critical proportions [40]. Caring for elderly people, especially those with behavioural and psychological symptoms of dementia, is a psychologically stressful occupation, and the level of aggression from residents over the previous week is the strongest predictor of the level of staff psychological disturbance [41]. Systematic clinical supervision and high quality individually planned care, primarily designed to benefit patients, also has a positive effect on nurses, decreasing their level of stress [42]; and particularly their sense of burden in caring for people with dementia [43].

These data may suggest that collaboration with regularly present skilled and committed doctors may help provide the support required to reduce levels of psychological burden among nurses working in residential care. However even if such doctors were available in residential care facilities, collaboration between nurses and doctors, which improve professional relationships, or provide benefits for patients, may be difficult to achieve [44], without the necessary training of medical staff in coordination of multidisciplinary teams.

Multidisciplinary practice models that include a geriatrician, nurses, and allied health therapists, are the cornerstone of hospital and ambulatory geriatric medicine, and there is good evidence for the effectiveness of this model in achieving positive outcomes for patients in those settings [45].

General practitioners also report high levels of work-related stress, with more than one-third of general practitioners considering leaving the field because of occupational stress [46]. The causes of general practitioner dissatisfaction and frustration include corporatisation of general practice (a phenomenon which they share with the residential aged care sector); a perception of being undervalued by Government; a dislike of increasing interference by bureaucracy; and disquiet about reform and change [47]. General practitioners place high value on their autonomy-economic and clinical [47], and perceive a pressure from blurring of professional boundaries with nurses, pharmacists and other health care professionals ‘encroaching’ on areas that were previously their exclusive province [48]. These negative perceptions of involvement in multidisciplinary teams can only be dispelled by appropriate education and training.

Conclusion

The neglect of the medical care of patients in long-term care wards in Britain in the 1940s stimulated the emergence of a new specialty – geriatric medicine [49]. The current generation of Australian geriatricians, through the processes of development of this Position Paper, has attempted to systematically consider the current status of medical services for people in Australian residential aged care from several perspectives. We can only conclude that medical services for people in Australian residential aged care has been a neglected field from all perspectives including Government and Departmental policy development; general practice initiatives; data collection; research; and clinical guideline development.

There is only a decade before the first of the baby boomers begin to swell the ranks of the residential aged care population, and there are long-time lines involved in establishing the review; research; policy; funding; governance; professional development; and medical organisation initiatives which appear to be among the necessary components of reform.

The infrastructure and expertise is available so as to develop a high quality medical service for people in residential aged care. As a matter of urgency, we now need to develop the processes to achieve better outcomes for frail older Australians housed in residential care facilities.

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