

Responding to the needs of older people in care homes

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Reflections on the CCC 2006 Census
Physicians' Perspective

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Summary

- Key findings from the census
- The features of good medical practice
- What are the doctoring tasks
- Where are the necessary skills
- What is the optimum service model

Points from the census

- Diagnoses don't explain differences in dependency patterns
- High prevalence of potentially distressing issues
- Care home residents are different from usual research subjects
- Probable under diagnosis of dementia and depression

Diagnoses related to dependency

	CCC Census	Research Literature
Dementia	~ 35%	74% non EMI home (Macdonald et al Age Ageing 2002)
Depression	20-25%	>30%
Stroke	~20%	
PD		but also and PD plus conditions
<i>and also</i>		
Osteoporosis (particularly hip fracture)		
Cardio - Respiratory disease		
Osteo-arthritis		

almost always in combination

Good medicine is easier when.....

- The patient can describe symptoms and discuss preferences etc
- The goals of treatment are agreed and have been researched as trial outcomes
- The patient resembles the research case-mix in treatment efficacy and adverse effects
- A facilitative service model exists

What are the goals of care ?

Consider the mortality rates

- Nursing Homes: 50% per year
- Residential Homes: 25% per year
- Total 65+population: 5% per year

Therefore quality of each day becomes paramount

What are the key medical tasks ?

Specialist pre-admission assessment (*evidence suggests benefit*)

Early care planning

Long term conditions management eg. vascular risk factors, osteoporosis, PD, COPD (*evidence based prescribing*)

Managing acute illness, pain and sleep problems

Support (as part of the multi-disciplinary team)

risk assessment, eg falls and pressure sores

promotion of continence

care plans for residents with complex disability

residents dying "at home"

rehabilitation

What knowledge and skills are needed ?

- Comprehensive geriatric assessment
- Ameliorating the common distressing problems eg incontinence and pain
- Tailoring the management of LTC in an evidence sparse zone
- Working through care staff and proxies

Who has these skills ?

- Primary care teams ?
- Acute care geriatricians?
- District nurses?
- Nurse practitioners ?
- “Evercare” case managers ?

Joint Working Party of the Royal College of Physicians, Royal College of Nursing and British Geriatrics Society (2000)

recommended a standardised interdisciplinary approach to assessment, care planning, and care delivery, with specific suggestions to:

- introduce a gerontological nurse specialist for homes;
- introduce a specialist GP service for homes;
- introduce a specialist pharmacist service for homes;
- increase inputs from the professions allied to medicine (PAMs);
- introduce regular multidisciplinary consultant sessions and consultant visits to homes;

Our local experience in a specialist team suggests some of this is possible and may work