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Care home medicine

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This conference was organised as a joint venture between the Royal College of Physicians (RCP) and the British Geriatrics Society (BGS) as an acknowledgement of the changing role of care homes in today's NHS. It is becoming increasingly evident that new ways of working are vital to ensure that those who live in these facilities are able to receive the best treatments, therapies and services from health and social care, and that neither age nor disability are a barrier to access.

Background and services

Care of the elderly and infirm in the Middle Ages took place in monasteries and equal emphasis was placed on both medical and custodial care. Following the decommissioning of these institutions by Henry VIII, care over the next few hundred years took place in almshouses, workhouses, NHS long-stay wards and the care homes we know today. One in four of the population will enter a care home at some stage of their life with most admissions occurring directly from hospital, raising concerns of whether maximal rehabilitation potential has always been achieved. The most common reason for admission to long-term care is dementia, followed by stroke.

Due to changes in structure, the NHS is becoming increasingly reliant on care homes and the services they are expected to provide are changing. Current service commissioning must be improved to ensure that residents, both short and long term, have adequate access to therapy support and clinical skills. The existence of multiple care home regulators, together with the lack of an effective single assessment process, makes organisation and management challenging, and there is still a wide range in the quality of institutions. Capital investment in staff and staffing is essential in continuing to improve standards.

In the Netherlands, nursing home medicine is a well established specialty with a three-year postgraduate training programme. The demographics of the Dutch care home population are very similar to that of the UK, with dementia the predominant reason for admission to long-term care. Their nursing homes offer a full spectrum of services, from rehabilitation through to palliative care, and it is normal for the homes to employ their own multidisciplinary teams, including physicians, physiotherapists and speech and occupational therapists, and also to have arrangements with consulting hospital specialists, such as geriatricians and psychiatrists.

Registered nurses (RNs) in care homes are an invaluable source, combining personal knowledge of long-term residents with broad clinical experience. They deal with emergencies and are involved in anticipatory and preventive care as well as rehabilitation and health promotion. Residents value the presence of 24-hour nursing care and are reassured by having trained staff present. In the development of care homes it is vital that the RNs:

- are supported
- have their skills further developed in specialist nursing roles
- share their expertise with staff in other care homes.

Influenza in care homes

Seasonal influenza is a major killer of frail older people, with variations in death rates correlating with influenza infections, and so pandemic flu is a major threat. Flu causes death in older people via secondary processes such as bacterial pneumonia and worsening of pre-existing chronic diseases. Influenza vaccination during an active flu season, among healthcare workers with an uptake rate of over 50%, has been shown to significantly reduce patient mortality. Young healthy adults have a better response rate to the vaccine (as high as 90%) compared to 20% in the elderly.

In the event of a severe pandemic, hospital capacity may not be able to meet demand resulting in a substantial proportion of sick older people in care homes receiving their treatment in situ. Good general care requires hydration and oxygen with early recognition and treatment of complications, and symptomatic treatment with paracetamol. Viral spread within individual care homes could be rapid and basic infection control procedures will be vital. There is a role for neuraminidase inhibitors, such as Tamiflu®, even in this cohort.

Clinical syndromes in care home residents

Delirium has high prevalence in care homes and is associated with increased morbidity, mortality and re-hospitalisation. The 'Stop delirium!' project in Leeds involves the administration of a training package to care home staff and the establishment of collaborative working between staff in different homes. Staff became more confident in delirium recognition, and also had improved knowledge of prevention and management of the condition. Delirium prevention focuses on good nursing care, for example hydration and prevention of constipation, and thus also can prevent falls and other complications. This project was

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This conference took place at the Royal College of Physicians (RCP) on 30 June 2009 and was organised by the RCP and the British Geriatrics Society

viewed as a way of education on many conditions under the auspices of just one.

Falls rates in care home residents are three times those of people living at home, and although the main concern is often a fractured hip, significant head injury is also an important consequence of falling. Calcium and vitamin D may be helpful in preventing hip fractures although more trials are needed. Medication reviews seem to lead to an increase in prescribed drugs rather than a reduction, possibly due to the addition of calcium and vitamin D supplements. Staff education and 'falls diaries' can produce a reduction in falling.

Dementia, when associated with behavioural problems can be distressing to carers and relatives. Non-pharmacological methods are used to mange difficult behaviour but must be individually tailored to the person, taking into account environmental factors, unmet needs and causes of increased stress. These issues then need to be dealt with appropriately. Anti-psychotic medications are still used to alter behaviour and cause sedation but should be avoided as they are associated with a higher death rate compared to placebo, as well as a multitude of side effects such as falls, hypotension and extra-pyramidal symptoms. Memantine is the only cholinesterase inhibitor which has been shown to improve agitation and aggression as well as delusions and disinhibition when compared to placebo.

Incontinence is more prevalent in care home residents than in community dwelling elders, is associated with falls and fractures and is rarely well managed. Many drugs routinely used in the elderly exacerbate the condition and anti-muscarinic agents used to treat incontinence have been associated with low cognitive performance in community dwelling elderly. A number of conservative interventions can be helpful, but are dependent on the person's cognitive and physical abilities. Prompted voiding, which should be offered to decrease daytime urinary incontinence in care home residents, is effective in the short term and particularly in those who can walk independently and are cognitively intact. Other methods include habit retraining, involving keeping a bladder diary and then establishing a pre-emptive toileting plan, but this is dependent on active caregiver participation. Timed toileting is a passive programme without attempts for re-education or enforcement of certain behaviours.

Diabetes in care home residents is associated with more rapid rates of functional decline than in those without the condition, thus necessitating improvements in diagnosis and treatment. Over treatment resulting in hypoglycaemic episodes is as likely to occur as under treatment and hypoglycaemia. The newly formed Institute of Diabetes for Older People has been established to try to improve care standards and is currently working with the Department of Health. New national guidelines are expected soon from Diabetes UK with specific clinical practice advice for care home residents with diabetes.

Advanced care planning and palliative care

Joint guidelines on advance care planning (ACP) have recently been published.[1] It was noted that once people require 24-hour care, they often no longer have the mental capacity to make an advanced directive. An example currently in use in a nursing home was shown to illustrate that without appropriate knowledge, people can be denied both basic symptomatic care as well as more complex interventions. The guidelines conclude that while ACP has a place, completion on admission to a care home may be too late.

Conference programme

Chair: Professor Graham Mulley, president, British Geriatric Society

CARE HOMES IN SOCIETY
What are care homes and why do we need them?
Professor Graham Mulley

The provider's responsibility
Dr Clive Bowman, BUPA care services

Residents' and carers' needs
Dr Gillian Dalley, Relatives and Residents Association

DEVELOPMENT OF PROFESSIONAL SKILLS
Dental care in care homes
Professor Angus Walls, School of Dental Sciences, Newcastle University

Care home physicians
Professor Jo Schols, University of Maastricht

The enhanced role of the nurse in care homes
Dr Hazel Heath, independent nursing consultant

Delirium
Dr Najma Siddiqi, Leeds Institute of Health Sciences

PANDEMIC FLU IN CARE HOMES
Chair: Dr Finbarr Martin, Guy's and St Thomas' NHS Foundation Trust and president-elect, British Geriatrics Society

Pandemic flu in care homes
Professor David Stott, University of Glasgow

CLINICAL SYNDROMES
Falls
Professor John Young, Bradford Institute for Health Research

Behavioural issues
Professor Roy Jones, The Research Institute for the Care of Older People

Continence
Dr Adrian Wagg, University College London Hospitals and Camden Primary Care Trust

Diabetes
Professor Alan Sinclair, Bedfordshire and Hertfordshire Postgraduate Medical Schools

END-OF-CARE LIFE
Palliative care
Dr Victor Pace, St Christopher's Hospice, London

Advanced care planning
Dr Simon Conroy, University of Leicester School of Medicine

The decrease in numbers of care home beds, combined with the increase in frail elderly, is likely to result in higher numbers dying in hospital, with associated financial implications to the NHS and personal costs to the patient and their family. A Gold Standards Framework nursing home programme has been established resulting in marked reductions in hospital admissions and hospital deaths. Areas covered include distinguishing pathology from inevitable effects of ageing, recognising symptoms in uncommunicative patients and the ability to recognise dying and when someone is entering the terminal phase of their disease. Palliative care in dementia and frailty is very different to that in the end stages of cancer, with multiple low intensity problems occurring over a long time but still with significant symptoms in common. A priority is remembering that for these people life is continuing while drawing to a close, and care must be taken to not turn their home into a hospital.

Summary

Care homes are changing, with improved standards and expanding roles, and it is vital that their residents are not excluded or discriminated against by health and social services. Staff are keen to be educated, and investment of time and money is rewarded with improved outcomes in many areas.

Reference

1 Royal College of Physicians. *Advance care planning*. London: RCP, 2009.

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