



Australian and New Zealand Society for Geriatric Medicine

Position Statement No's 9 and 10

The Geriatricians' Perspective on Medical Services to  
Residential Aged Care Facilities (RCFs) in Australia.

Revised August 2011

*Companion paper regarding the NZ perspective to follow.*

1. The demand for residential aged care in Australia continues to grow as the population ages.
2. Dementia, chronic illness, and physical disability are the major determinants of admission to residential care. Many people currently living in 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.
3. Decades of separate reform processes in residential aged care and general practice in Australia have resulted in significant advances. Whilst the medical needs of people in residential care have received some attention from policy makers in relation to general practice, there is still a need for substantial policy changes to address the major shortcomings in provision of medical care to residents.
4. There is a need for access to a broad range of integrated high quality health services including general practice, allied health and medical, dental and surgical specialists. These services should be accessible on site at the residential care facility when it is impractical for the patient to travel to an outpatient clinic.
5. Many common conditions occurring in residential aged care require the collaborative development, institution and adherence to multidisciplinary clinical practice guidelines and valid quality outcome indicators. Whilst significant progress has been made in recent years with evidence-based guidelines, work in developing sustainable implementation strategies and valid outcome indicators for these guidelines are urgently needed.
6. Remuneration schedules recognising the time-consuming and complex nature of comprehensive assessments undertaken by Geriatricians are needed to encourage Geriatricians to work in RCFs. RCFs will require appropriate resources and expertise

to undertake multidisciplinary management plans.

7. Existing 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, continence services, falls and balance clinics, movement disorder clinics, pain management services, wound management services, palliative care services and community health centres all have expertise pertinent to the needs of facilities and residents.
8. At the level of the residential care 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.
9. There is a need for the establishment of a medical special interest group, dedicated to promoting high quality research and medical care for the residential care population, in which the Australian and New Zealand 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 creating a competitive market of interested and skilled medical providers.

10. International comparative studies in residential care have paved the way for high quality local research into the health status and outcomes of people in residential care. Strategic alliances need to be formed to establish what currently accepted best practice is and where investment should be made in targeted research within residential care facilities.

11. Funding and accreditation systems should be managed by one organization to avoid the duplication of assessment and documentation. Adoption of a well evaluated tool such as the Resident Assessment Instrument (RAI) as an outcome driven national assessment and funding system would be a welcome step forward.

The Australian and New Zealand Society for Geriatric Medicine believes that the matter of medical service provision to residential care facilities requires further collaboration between the sections of the bureaucracy that are responsible for primary medical, nursing and allied health care, specialist medical services, and residential aged care, in order to establish to whom the reform mandate belongs, and to bring stakeholders together to further the process of reform. Aged Care Trainees and Geriatricians in Australia and New Zealand must continue to prioritize residential care as one of their essential community roles from both a clinical and strategic perspective.

**This Position Statement represents the views of the Australian and New Zealand Society for Geriatric Medicine. This**

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BACKGROUND

PAPER

### **Introduction**

The practice of medicine in the complex circumstances of a RCF requires a doctor with particular skills, interests, attitudes [1] and competence in aged care, preferably acquired through dedicated post-graduate training [2]. Adverse events suffered by aged care residents when treated sub-optimally are regularly reported in the media [3,4,5,6]. These types of unfortunate incidents are sentinel events which expose treatments and processes that do not conform to existing evidenced-based clinical practice guidelines [7] and may be indicative of a widespread lack of adherence to contemporary evidence-based clinical practice. Despite recommendations for a comprehensive data repository including quality and financial performance data, there is still no structure for collection of an adequate and meaningful clinical dataset or of any objective valid and reliable quality indicators in the residential aged care sector.

In Australia the current residential care funding system and the accreditation system are managed independently and report through separate channels, leading to inefficiencies and duplication of assessment and documentation. Neither of these

systems is evidence-based and both are unlikely to result in a beneficial health care outcome for the residents. The Resident Assessment Instrument (RAI ) was introduced in the USA in 1990 and has been utilised as an international benchmark for practice and research in quality health care for long term care settings. The RAI attempts to link regulation and funding with quality care processes and outcomes and has in the US been demonstrated to reduce the use of psychotropic drugs, restraints, indwelling catheters as well as increasing continence, documented advance directives and behaviour management. [8, 9,10,11,12] Local research studies into the use of RAI or similar tools could be a first step towards adoption of an alternative, outcome driven national assessment and funding system.

### **Medical characteristics of residential aged care populations**

Predictors of admission to residential care are overwhelmingly health-related, rather than social. Because dementia is one of the most disabling health conditions, a large proportion of people with advanced dementia need residential aged care. The number of people with a severe activity restriction with dementia is predicted to reach 180 000 in Australia in 2020. The majority of permanent aged care residents in Australia with probable dementia have high level care needs. The RCF length of stay for people with dementia is on average longer

than for residents without dementia. [13] Dementia is the only condition that has been the subject of a major local prevalence study [14], and this revealed that 28% of hostel ("low level residential care" or low care) residents and 60% of nursing home ("high level residential care" or high 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 low care settings and 90% in high care settings. People with dementia in residential care tend to be older than those with dementia living in private households, and have more severe dementia (91% of those with moderate or severe dementia were in residential aged care) [15]. In 2008, people living with dementia made up more than 50% of the total residential care population, with 80% of people living with dementia requiring high level care. More than 70% of residents had either dementia or another mental illness on data collected by the Aged Care Funding Instrument in 2008. [16]

The characteristics of the low care population are progressively becoming more like the high care population. In 1990 only 54% of hostel residents required assistance with personal care, whereas 80% of residents required such assistance by 1997 [17], and this trend is now entrenched with the single classification funding scale and "ageing in place" policy introduced with the Aged Care Act 1997 [18]. The residential aged care population is becoming progressively older and increasingly

dependent. At June 30th 2008, there were 160,250 residents of aged care facilities in Australia compared with 156 549 at 30<sup>th</sup> June 2007 and 135,991 at 30<sup>th</sup> June 2000. [16] The majority (98%) were permanent residents. Of these, 55% were aged 85 years or older and 23% were 90 years and over. 70% of residents were assessed as needing high care compared to 63% in 2006 and 58% of residents in 1998. [19] Internationally, 45 to 80% of nursing home residents suffer from chronic pain [20]. Clinically significant depression is suffered by around 40% of residents. [21]. More than 80% of residents of nursing homes experience significant vision or hearing difficulties [22] and 45% of nursing home residents suffer from a major sleep disorder [23]. Half of the nursing home population suffers from urinary incontinence [24]. Falls, often recurrent, affect 30% of nursing home residents. [25]. Osteoporosis is almost universal in the nursing home [26]. 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 [27], and 38% of the 15,000 hip fractures in Australia in 1996, occurred among older people living in hostels and nursing homes [28]. Annual hip fracture risk for residents who fall repeatedly is as high as 14% to 41% [29], and 40% of a nursing home cohort who were taking psychotropic medication and had ongoing falls, suffered a hip fracture within six months [30]. Pressure ulcer risk can also be stratified and definable individuals are at very high risk

[31].

Multiple medical co-morbidities, especially contributed to by the weight of neurodegenerative disorders [33], 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 [30].

### **Organisation of medical care in RCFs**

The 2004-2005 AIHW report on residential aged care in Australia showed that over a third of permanent residents will die within a year of admission to an RCF, and in response to this, national palliative care guidelines were developed for use in RCFs [34]. The impact of these guidelines on patient outcomes has not been evaluated. Palliative care planning and timely access to palliative care specialists is clearly important to ensure symptom control and quality provision of palliative care to this large cohort of residents.

The Royal College of Physicians and the British Geriatrics Society [2] recommend that doctors working in long-term care should have a Diploma of Geriatric Medicine, and that their role in long-term care should embrace more than occasional medical intervention for intercurrent illness: it 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 [35]. Dr Peter Ford, Chairman of the Australian Medical Association (AMA) committee on care of older-aged people, in a 2008 commentary to the AMA, placed some responsibility on the Aged Care Accreditation Agency for the difficulties encountered in attracting GPs to care for residents in RCFs. [36] He commented that the 44 criteria currently in place do not impose a requirement for the provision of adequate medical care, and suggests a review of the decade old criteria. He makes a number of suggestions for improved medical care for this population, including adequate remuneration that acknowledges the high proportion of non face to face work involved, improved recruitment of registered nurses, improved IT infrastructure including remote access and electronic prescribing, improved examination rooms and medication imprest systems, better advanced care planning and improved teaching and Geriatrician attendance.

### **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", [37] which has been 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

acknowledgement that this would imply evidence-based guidelines, which would be a much higher 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” in terms of changing clinical practice [38]. The circulation of practice guidelines is often ineffective in changing clinical practices, unless the guideline is embedded in a comprehensive education program with active participation of clinicians preferably in their own practice settings [41]. The Northwest Melbourne Division of General Practice developed a manual including evidence based guidelines intended for use by General Practitioners and residential aged care staff in the management of common conditions. The manual is comprehensive and was developed in consultation with a broad range of clinicians and other consultants, however substantial funding and effort would be required to keep the information up to date, and although disseminated widely there has been no formal education associated with its publication [39]. A Palliative Approach in Aged Care (APAC) guidelines developed in 2003 were supported by an initial training program, but without additional resources and ongoing support, may not have had the impact in residential aged care that was hoped for [40].

### **Australian residential aged care reform and medical service provision**

The RCF industry has grown rapidly in Australasia since the early 1960s and successive reviews have occurred by Government in the last few decades [42], leading to major reforms within the sector with positive outcomes for residents. However, the adoption of the primary care model for medical service provision left the medical care of each resident to his or her independent general practitioner, with no inter-relationship of the medical service to the facility or sector. How well the medical care needs of the residents are being met by this unstructured service model was for several decades not considered by the RCF sector.

### **Australian general practice and residential aged care**

A 2007 literature review of GP services to RCFs in Australia revealed that an average of 12.8 GP services were provided per occupied bed per year, with the majority being standard consultations (96.5%), amounting to an average cost of \$570 per occupied bed per year. This is more than twice the average number of GP services provided annually to non-RCF patients. The authors reported a growing concern that GP services to RCFs do not meet demand, and indicated that GPs providing services to RCFs tend to be older males who may be

approaching retirement, with the potential for a widening gap between service supply and demand. They described barriers to GP involvement in RCFs including low levels of reimbursement and more complex and time consuming work compared to clinical work in a surgery. [43]

A substantial change in the last decade was the federal Aged Care Panel funding through the Divisions of General Practice. This initiative aimed to bring together stakeholders as a special interest group to promote best practice initiatives and was successful in establishing networks and research agendas between senior RCF staff, geriatricians, general practitioners and pharmacists with an interest in aged care. Unfortunately, funding was withdrawn from the program after a change in federal Government and so the opportunity to build on early work has been lost.

Whilst there is little evidence that routine screening of older people who live in their own homes (“case finding”) is of any benefit [46], 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 [47].

The residential care intervention program in the elderly “RECIPE” demonstrated that it is feasible to review residents in their facilities after discharge from hospital, and that staff, residents and their carers had high levels of satisfaction with such a program [48]. Through comprehensive geriatric

assessment and hospital substitution, intercurrent illness was managed in the facility, avoiding a prolonged hospital stay. This study also demonstrated the high mortality rate for residents discharged from an acute hospital admission: 38% of participants died within 6 months of initial hospital discharge. A huge gap in palliative care service provision was uncovered as a consequence, and the RECIPE service has been reconfigured to provide palliative support in addition to comprehensive assessment and advance care planning. Whilst similar medical outreach models have been piloted by a number of other health services, the absence of a national model for funding higher levels of clinical care when needed within facilities remains a major impediment to the widespread implementation of these programs.

### **The RCF workforce**

The sector has an increasingly poor record of recruitment and retention of nurses, with shortages now reaching critical proportions [49]. Caring for elderly people, especially those with behavioural and psychological symptoms of dementia is a stressful occupation, and the level of aggression from residents over the previous week is the strongest predictor of the level of staff psychological disturbance [50]. 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

[51], and particularly their sense of burden in caring for people living with dementia [52]. 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 [53], without the necessary training of medical staff in coordination of multidisciplinary teams. There are also the issues of role substitution, nurse champions, nurse practitioners, GP clinic nurses: with such roles potentially supporting GPs in completing Comprehensive Medical Assessments and Care Plans and assisting them with access to the multidisciplinary team enhancements and allied health funding.

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 efficacy of this model in reducing decline in physical functioning. [54].

The Transition Care Program in Australia has allowed for the development of residential aged care facility models in which additional bed-day funding allows more intensive health care for a small group of residents under geriatrician and hospital

non-medical clinician expertise. However, an evaluation of this national program reported in 2008 has revealed high hospital readmission rates of up to 50% and low overall involvement of Geriatricians, General Practitioners and Pharmacists. [55]. Perhaps if this program or other similar models that include additional funding involve Geriatricians and other relevant health professions from planning through to implementation and evaluation, there may be a chance to demonstrate improved patient outcomes. General practitioners have reported high levels of work-related stress, with more than one-third of general practitioners considering leaving the field because of occupational stress [56]. General practitioners place high value on their autonomy both economic and clinical, 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 [58]. These negative perceptions of involvement in multidisciplinary teams can only be dispelled by appropriate education and training. The Brisbane Residential Care Project aimed to increase GP participation and improve resident outcomes by combining a unique assessment tool with promotion of case conferencing and care plan completion [59]. Three month mortality was 20% and they did not demonstrate a reduction in hospitalisation rates. They distributed a survey asking GPs about additional

resources and training that might be required to improve medical care in RCFs. Respondents identified several themes including the need for improved on-site procedures and radiology, improved access to specialists in Geriatrics, palliative care and wound management, improved access to allied health, and increased knowledge of clinical and legal aspects of aged care with access to relevant remuneration. Since 2007, Australian General Practitioners have been able to refer to private Geriatricians for assistance in managing the complex needs of the RCF population. Changes made to Medicare rebates acknowledged the need to spend considerable time in performing a comprehensive assessment and remunerate Geriatricians more appropriately for time taken to visit residents at their aged care facility. This has the potential to improve the outcome for residents and to relieve some of the burden that General Practitioners and facility staff bear, working in comparative isolation in the residential care setting. It is unclear what the uptake has been to date, and this opportunity relies on adequate numbers of privately practicing Geriatricians that are able to attend RCFs in a timely fashion.

### **The emerging role of Nurse Specialists and Nurse Practitioners in RCF**

Specialist nurses and nurse practitioners can contribute greatly to the care of people living in RCF. Their contributions can be wide ranging, including the provision of

education and training to the RCF workforce, prevention strategies and on site management for common Geriatric syndromes, Advance Care Planning and End of Life care and support for people in the RCF, their families, staff and visiting health professionals. Nurse Specialists and/or practitioners could contribute expertise to policy and planning, audit and process improvement in areas such as medication management, infection control, falls and wound prevention programs if funded appropriately. Although some local solutions have been developed for the provision on specialist nursing services to RCF, funding and strategic planning for these positions remains patchy and inadequate. A standardized national program that provided adequate training, integration and financial support for nurse specialists and practitioners could improve quality of care in RCF and ease the burden on GPs and Geriatricians. This is a priority area that needs attention.

### **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 [60]. This position paper has attempted to systematically consider the current status of medical services for people in residential aged care from several perspectives. When this paper was initially published in 2001, the conclusion was that medical services for people in Australian residential aged care

had been a neglected field from all perspectives including government and departmental policy development, general practice initiatives, data collection, research, and clinical guideline development. Encouragingly, a range of initiatives put in place over the past decade have the potential to improve medical service provision for this group of frail, vulnerable elderly. New GP item numbers together with the ground breaking work performed by the now disbanded GP Aged Care Panels are making it more attractive for GPs to provide care to people living in RCFs. However a boost in GP numbers and additional support in terms of nursing assistance and IT infrastructure are needed to improve uptake further.

Thanks to tireless campaigning from the Australian and New Zealand Society for Geriatric Medicine, Geriatricians in Australia now have the opportunity to provide adequately remunerated private practice visits to people in residential aged care facilities, and to facilitate a multidisciplinary management plan for this cohort.

As Geriatricians, it is our responsibility to engage with our primary care, nursing and allied health colleagues to improve medical care provision to this group of people, encouraging leadership, quality activities, research and improved models of care. Geriatricians find the key structural funding and accreditation components to be antithetical to the provision of integrated evidence based multidisciplinary care. A high calibre outcome focused system of

funding and governance requires the attention of policy makers. As the baby boomers start to enter residential care, there is a pressing need to take action to ensure adequate provision for future residential care demand related to the rapid ageing of our population.

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