



FRAILTY, OLDER PEOPLE AND CARE HOMES

CAN WE DO BETTER?

IMPROVING WHAT WE DO

Contents

Foreword	Page 3
Executive Summary	Page 4
Observations and High Level Recommendations	Page 4 – 6
The Current Situation	Page 7
Future Requirements – Delivering Better Outcomes	Page 13
Conclusion	Page 16
Acknowledgements	Page 16
References	Page 17-18
Appendices	Page 19

Appendix 1 – Care Home Medicine – We can do better report

Appendix 2 – NHS Grampian Local Enhanced Service contract for medical care in care homes

Foreword

In February 2008 a one day conference took place titled “Care Home Medicine – Can We Do Better? (Appendix one) Delegate numbers for the event were in excess of 120, with 70% of participants being from a General Practice background with the remaining being from Geriatric Medicine and Old Age Psychiatry with a number of non medical staff. This successful event was opened by the Minister for Public Health and Sport, Ms Shona Robison MSP. The background for this conference was developed through joint working between the Scottish branch of the British Geriatrics Society, the Royal College of General Practitioners Scotland and The Royal College of Physicians and Surgeons of Glasgow, where the event took place. It was clear that much could be done to improve the welfare of care home residents as well as those with the clinical picture of frailty who remain in their own homes.

Following a meeting with the Minister for Public Health and Sport and her officials in February 2009, RCGP Scotland and the British Geriatrics Society (Scotland) were asked to prepare a paper reflecting the present situation and noting recommendations for change. The importance of this area of clinical practice is reflected through relevant advice within respective training curricula and websites of the two organisations.^{1,2}

Whilst the authors of the report have attempted to take into account as many aspects of Government policy as possible, much of which is referenced to Better Health Better Care³, the recommendations are not an exhaustive list, and this document should be seen as a starting point rather than an end point.

The text box statements within the document indicate areas where practice could be improved. Recommendations for improving care and service provision are also suggested.

Dr Ken Lawton
RCGP Scotland (Chair)

Professor Paul Knight (Chair) & Dr William Primrose (Immediate Past Chair)
British Geriatrics Society (Scotland)

October 2009

Executive Summary

This jointly developed paper between the Royal College of General Practitioners (Scotland) and the British Geriatrics Society (Scotland) reflects the present situation with regard to aspects of frailty and the increasing older population within Scotland. Some, who will need higher levels of support, will move into residential or nursing care. Care Homes are the main focus of this report which suggests important opportunities for improvement. There are recommendations relating to primary and secondary care as well as to social work and Care Homes themselves. Implementation will lead to both greater efficacy and efficiency of limited resources, driving up the quality of care, improving patient safety and, most importantly, improving the quality of life for our most vulnerable elders.

Observations and High Level Recommendations

Our observations

- The availability and the skills of Comprehensive Geriatric Assessment are not universal in community and/or hospital settings. Those with frailty-related problems may not be accessing appropriate assessment and rehabilitation opportunities.
- The skill mix of staffing in care homes at times fails to meet the changing needs of individual residents.
- Education and training opportunities for care home staff are often inadequate.
- Prescribing practice, especially for the many with dementia, is often suboptimal with a lack of rigour in relation to medication reviews.
- The ability to up-skill nurse staffing to manage inter-current illness and palliative care requirements is identified as a deficit and results in some inappropriate hospital admissions.
- Sufficient care managers are not always available to support service requirements.
- The processing of Guardianship procedures can take an inordinate amount of time.
- Early multidisciplinary review following placement often fails to question whether a return to the community is possible.
- General practice does not routinely provide structured and proactive support /reviews of residents including detailing anticipatory care plans. The use of the Adults with Incapacity legislation is less than would be expected.
- In urban areas practices may be linked with too many care homes, and conversely care homes supported by too many separate practices.
- Key clinical information and summaries regarding individual residents are often not available at the time of admission and often not held within care homes.
- Allied health professional support both for assessment and therapy are, as yet, insufficiently available through community or outreach services.

- Pharmacy support is not uniform
- There are insufficient educational opportunities for the subspecialty of Care Home medicine.
- Assessment processes are not sufficiently supported by specialist secondary care prior to care home admission.
- Involvement through an integrated specialist service in the support of practices, residents and care homes is limited and in some areas non-existent.
- The specialist support of end of life care is in some areas lacking.
- Consultant community sessions are not routinely available to support practices and care homes and to, when appropriate, prevent inappropriate use of unscheduled care.

High Level Recommendations

- The delivery of Comprehensive Geriatric Assessment is supported by responsive specialist services with the ability of elderly medicine and old age psychiatry teams to deliver prompt community-focused assessments.
- The opportunities for rehabilitation should be maximised through appropriate levels of community and secondary care support.
- Local care home capacity should meet present and future population requirements. Detailed projections to inform health and social services of the 5, 10 and 15 year needs for Care Home care or equivalent alternatives are required.
- The care manager co-ordinates a multidisciplinary assessment with appropriate primary and secondary care involvement, achieving the goals within Comprehensive Geriatric Assessment and ensuring that access to rehabilitation is optimised for any potential care home resident prior to any final decision making. National targets for the times for referral and assessment processes must be achieved.
- Pre-admission assessment should include consideration of Guardianship and Adults with Incapacity Legislation. When Guardianship procedures are required, then acknowledgement of a lengthier timescale is accepted, though again targets for such processes must be achieved.
- The early review (at 4-6 weeks) should include the opportunity of a return to alternative care arrangements, should these be seen as feasible.
- Access to community and allied health professional support should be available to care home residents if the clinical need is evident.
- Pharmacy input should be routine for all care homes and should link in with regular medication reviews, also involving primary care input.

- When the staffing establishment includes fully registered nursing support there should be the ability to manage higher levels of care including the provision of subcutaneous fluids and parenteral antibiotics. Community nursing teams will be required to provide similar support to care homes which do not have the staffing expertise. Consideration should be given to training senior care home nursing staff in prescribing a limited range of medications, dressings and appliances.
- Education of staff in care homes must be more proactive and gauged towards the care population concerned
- Patients in care homes are best served by skilled proactive support from a local general practice. Practices should be aligned to individual care homes to facilitate communication with a single practice and allow for structured proactive visits and the supporting of regular reviews for individual residents. Such review processes will allow for anticipatory care plans and opportunities to communicate with key family members. Wider use of appropriate sections of the Adults with Incapacity legislation should become routine.
- Communication of case record summaries should take place following any move to a care home, with a summary being kept in the care home to inform staff and out of hours services.
- Secondary care input to care homes should be part of an integrated service to the community in general and allow linkages to other specialty areas such as day hospital and out patient clinics. Community based specialist secondary care teams should support care home residents, these being based within local Old Age Psychiatry and Medicine for the Elderly services. Service redesign and an appropriate level of community sessions will reflect availability through the job planning process. Local palliative care teams may contribute to end of life care when required, as an adjunct to General Practice input.
- Hospital admission, whether planned or unscheduled, will be available to care home residents when indicated, the secondary care support being appropriate to the needs of the resident. The limited requirements for NHS continuing care should be met through local secondary care services for those individuals meeting the criteria for such care. Regular reviews of such individuals will confirm the continuing need for such care.

The Current Situation

Introduction: Frailty in the Community and the Care Home

The majority of older people, even those in their 80s and 90s continue to live in their own homes. Many with multiple and often complex medical conditions, including cognitive decline, continue to live in their own homes with the appropriate support of family, carers and members of the multidisciplinary primary health care team.

Defining frailty is a challenge, though most would feel able to recognise the older person who has become frail. Causation is usually multi-factorial, and correlates to disability, co-morbidity and self-related health issues and these individuals are vulnerable to adverse outcomes.⁴ Such a population has limited reserve, and minor illnesses or events can precipitate crises which require prompt and skilled interventions, if we wish to prevent further deterioration in their conditions. These may include higher levels of support, but also and more importantly skilled assessments by the Primary Health Care Team and at times Secondary Care. Clinical interventions often lead to polypharmacy and the need for a rational approach in terms of prescribing practice is required.

There is a need to make more widespread the methodology of the Comprehensive Geriatric Assessment which is less available than indicated and which delivers real benefits to frail older people.^{5,6} An integrated approach has been a policy objective for many years, but progress is slow.⁷

The institutionalisation rate for the population aged 65 and over has stayed remarkably consistent at around 4% for many decades. This may reflect changes in health and social care policy and/or an improvement in the general health of the population. This is in the middle of the range for European countries.⁸ With the increasing age and frailty in older age groups, the rate of requirement for residential care does increase, and for the over 85s the rate currently exceeds 16%. This rate has decreased in recent years though changes in designation of accommodation from care home to supported housing make trend analysis more complex. Most cognitive and physical decline is seen within the “older old” people, and these aspects of frailty are often the background to a potential move into care.^{9,10} Although this report’s focus is on older people, an important minority of the population in care homes is under the age of 65, and the needs of these individuals also need fuller consideration.

Findings from the Care Commission and Mental Welfare Commission joint report ‘Remember I’m still me’ state, ‘Around 70% of people living in care homes have varying degrees and types of dementia. There is evidence of care homes not recording adequate records of life histories and personal preferences.’¹¹

Scottish Government published National Care Standards - Care Homes for Older People in 2001, and updated these in 2006. This document defines standards of care against which care homes will be assessed. They cover moving in, settling in, day to day life and moving on.¹²

As stated above an integrated approach has been a policy objective for many years and this paper indicates some benefits if implementation follows these recommendations.

- Availability and the skills of Comprehensive Geriatric Assessment are not universal in community and/or hospital settings. Those with frailty related problems may not be accessing appropriate assessment and rehabilitation opportunities.

Future Demography

In the coming decades the number of older people will increase, with the most rapid rate of change noted for those aged 85 and over. In March 2008 the over 65 population comprised 16.5% of a Scottish population of 5 168 500, with estimates suggesting this rises in 2028 to 23.9% of 5 370 234. For the over 85s the proportionate increase is far greater, rising from 1.9% in 2008 to 3.9% in 2028.¹³

If age specific rates of care home provision do not alter significantly, then the number of places required in Scotland is estimated to increase from a current 33 000 to over 57 000 residents by 2028. The implication of such an increase in care home places by 2028 will mean that the care home institutionalisation rate in the over 65s rises from a present 3.9% to 4.8%. Clearly there may be developments in relation to extra care housing and the use of new technologies such as telecare. Despite these developments when high levels of frailty predominate “people need people” and it is generally seen as being more efficient and cost effective for this to be within care homes.

These demographic changes in the elderly population have to be seen in the context of a smaller population of younger people to provide the necessary care and tax base to support the health and social care programs.

Care Managers

The responsibility for assessment for admission to a care home, and receipt of the free personal care allowance, rests with care managers. In some Health Boards there are recruitment problems leading to gaps in service delivery, resulting in delays in assessment and transfer of patients.

A comprehensive multidisciplinary assessment should underpin any move into a care home whether the individual is in hospital or a community setting. There is good evidence that with appropriate treatment people may move out of a state of frailty and regain a level of independence. Unfortunately this does not always happen, and the opportunity to provide rehabilitation is missed in some Health Boards.

All other options should be explored sensitively, but frequently the only realistic option that meets the individual's needs is a move into care. Most residents within care homes have a lesser or greater degree of dementia and appropriate use of the Adults with Incapacity legislation¹⁴ is often lacking. Where there is a need to pursue Welfare Guardianship arrangements there may be considerable delays.¹⁵

There have been substantial improvements in many Health Board Areas in delayed discharges but the problem has not been totally eradicated this may in part be due to inappropriate placements. The initial review of the care home placement should take place early on, at about six weeks following admission, and thereafter at regular intervals. There is often insufficient debate at the early review as to whether care home placement is the only option, or if the older person may be able to return to more individualised care at home. A Scottish study indicated that a significant proportion of new residents to nursing homes on review had very low dependency and could possibly have returned to their own homes.¹⁶

- Sufficient care managers are not always available to support service requirements.
- Early multi-disciplinary review following placement often fails to question whether a return to the community is possible.

Care Homes

There were recently (March 2008) approximately 33,000 residents in 942 care homes in Scotland.¹⁷ Size ranges from 1 to 240, with an average of 40 residents per care home. The mean age at admission was 82.5 years, and average duration of stay 2.4 years in 2007.¹⁸

Since 2003 there have been no significant changes in the mean age at admission or average length of stay. However the reduction in NHS continuing care beds means that more complex care has to be delivered in care homes.

Care Home Managers or Matrons need to be involved in the individual assessment of the potential resident and must feel that they can meet their assessed needs. The initial weeks of stay should be seen as a period of assessment on both sides.

The location of care homes within the country reflects somewhat haphazard market force influences and lacks any realistic planning. There is unfortunately no direct relationship with the number of care homes and the surrounding population. Hence in some parts of Scotland the available places per thousand over 65 is relatively high (eg South Lanarkshire) and in others low (e.g. East Dunbartonshire).¹⁸

The distinction between “residential” and “nursing” homes was abolished by statute in 2002. However care homes can choose staffing structures that may or may not include trained nursing staff, so the distinction between “residential” and “nursing” homes continues with considerable implications on the care and support they are able to provide. Even within homes staffed by nurses there is considerable variation in the ability to provide higher levels of nursing support, for example subcutaneous fluids. The training and educational needs for care home staff need to be further explored.

Findings from the Care Commission and Mental Welfare Commission joint report ‘Remember I’m still me’ state, ‘Evidence shows that only a third of care home managers have undergone a recognised training course about caring for people with dementia. The majority of care staff are generally unaware of best practice guidance, some felt their knowledge was insufficient or that they didn’t have enough time to give adequate care.’¹¹

Polypharmacy is common in the care home population and regular review of prescribing and medicines management, particularly for those with cognitive impairment, is a priority.

- The skill-mix of staffing in care homes at times fails to meet the changing needs of individual residents.
- Local care home capacity should meet present and future population requirements, detailed projections to inform health and social services of the 5, 10 and 15 year needs for Care Home care or equivalent alternatives are required.
- Education and training opportunities for care home staff are often inadequate and require more active regional support.
- Prescribing practice, especially for the many with dementia, is often suboptimal with a lack of rigour in relation to medication reviews.
- The ability to up-skill nurse staffing to manage intercurrent illness and palliative care requirements is identified as a deficit and results in some inappropriate hospital admissions.

Primary Care Involvement

The General Practitioners' contribution to the health of the care home population varies widely across Health Board areas. Most Boards have agreed a payment to General Practitioners for the provision of an enhanced level of service through locally enhanced service contracts (appendix two). The amount received per individual care home resident is approximately £100 per year; local contracts stipulate certain standards that have to be met. Although there is a wide take up of this payment, delivery of support to individual care homes remains variable. Too often the care and support provided is reactive rather than proactive and the move towards structured reviews and anticipatory care plans needs to become embedded as part of routine care.

Findings from the Care Commission and Mental Welfare Commission joint report 'Remember I'm still me' state, 'Most people received a good assessment on or before admission to the care home. There appears to be good input from GPs and Allied Health Professionals (AHP), such as dieticians, when the care home requested it. Care of residents needs to be regularly reviewed, at least once a year for most people, but the quality of the reviews varied. Rarely do they involve the person, with most reviews being carried out by care home staff and a relative or friend. There is also little involvement from a social worker, GP or other professionals.

Medication needs to be reviewed regularly, and GP health checks need to be annually. 75% of people in care homes are taking one or more psychoactive medicines, 33% were taking antipsychotic medicines and 6% are taking olanzapine or risperidone, despite specific warnings in place about the use of these drugs. There is evidence of inappropriate and multiple prescribing, many residents have been on the same medication for some time without a regular review.¹¹

Clinical input from pharmacists would help ensure that care homes had a system for recording medicines that would help to provide a complete up-to-date record of all medicines ordered, whether they were taken or not, and what was disposed of.¹²

The new RCGP curriculum 'Care of Older Adults'¹⁹ has clear learning outcomes for care of older people, but there may be additional training needs required by General Practitioners and the GP with Special Interest may provide a model for this.

Within Scotland there are in broad terms three patterns of primary care support to the care home population. For some, a single Practice may look after all, or the vast majority of, residents. This will be the case in most rural settings, when there is no alternative practice in the locality. It may also be a pattern seen in some urban settings when a care home is aligned to a specific Practice. Such arrangements encourage continuity of care (this being enhanced by one GP from the practice taking a lead in supporting a particular home). There may also be issues of patient choice, which have to be addressed, to develop this model as a. As patients in the community have a right to choose their general practitioner. We may have to accept a more utilitarian model to drive up standards of care. where the element of choice is narrower than presently.

A contrasting arrangement is where a large number of practices share the care of patients in a particular home, each having a few residents to look after.

A third arrangement, unique to Glasgow, is where there is a specialist Nursing Home Medical Practice, concentrating on the care of nursing home residents, and having links with other practices who also take a share in the nursing home population.

Involvement with the community nursing team may be required for homes staffed by carers but not trained nurses, i.e. those previously designated as “residential” homes. Community nursing teams may be reluctant to become involved with homes that have a trained nursing work force, as the basic nursing care should be provided by the staff of the home. However, specialist nurses e.g. stoma, tissue viability, continence practitioners or specialist palliative care nurses should be available in all settings. Other Allied Health Professionals - AHP’s (e.g. physiotherapists or speech and language therapists) should provide support to the care home residents if a need is identified. Residents should expect a level of input that is similar to that of the surrounding community.

Of particular importance is the need to have access to key clinical information, with summaries for individual residents to be more readily available. Difficulties occur when there are delays in receiving hospital discharge summaries or when there are changes of practice.

With the development of nurse prescribing, consideration should be given to training senior care home nursing staff in prescribing a limited range of medications, dressings and appliances.

Pharmacy input is variable with opportunities for support, advice and medication review being evident in some but not all local arrangements. Where practices have practice-based pharmacists many use this expertise in the delivery of care to residents of care homes. Occasionally in the locality there is a multidisciplinary Nursing Home Support Team (eg The Deeside Support Scheme) with medical, nursing and AHP support and this provides a higher level of support to the care homes in that locality.²⁰

Where homes have built up a relationship with a local community pharmacist, it is appropriate that the medication reviews are undertaken with their input. This will help ensure patient safety and lead to more effective prescribing.

One of the issues that is seen in many care homes, is where there is a mixture of funding streams for care. Some patients may be partly funding their care themselves, whilst others may be entirely funded by the local authority. This can be a problem when additional services may be purchased by the former group.

- General practice does not routinely provide structured and proactive support /reviews of residents including detailing anticipatory care plans. The use of the Adults with Incapacity legislation is less than would be expected.
- In urban areas practices may be linked with too many care homes, the converse also being seen
- Key clinical information and summaries regarding individual residents are often not available at the time of admission and often not held within care homes.
- Allied health professional support both for assessment and therapy are, as yet, insufficiently available through community or outreach services.
- Pharmacy support is patchy and should contribute regularly to care homes, as well as to GP led medication reviews, which should specifically review psychoactive medication.
- There are insufficient educational opportunities for the subspecialty of Care Home medicine.
- With the development of nurse prescribing, consideration should be given to training senior care home nursing staff in prescribing a limited range of medications, dressings and appliances.

Secondary Care Support

Community-focused input from secondary care services relates mostly to three areas – Palliative, Geriatric Medicine and Old Age Psychiatry. In different localities the support and involvement from these services will often reflect historical patterns of culture and practice rather than need.

For Palliative care, some but not all teams will demonstrate proactive outreach to the Care Home population. Many palliative care services deal with all aspects of end of life care, including end stage renal, neurological and cardiac disease, not just cancer.

Within Geriatric Medicine there are widely different approaches evident, with some local services being closely involved with primary care and related care homes, but for others there is little such interaction or focus.

Old Age Psychiatry teams are generally more community-focused and have Community Mental Health Nurse (CMHN) and Psychiatrist resources which can, and do, in many settings provide valued support to the care home population.

However, often the main interaction between secondary care and the care home resident relates through unscheduled care and the emergency admission, these being frequently “out of hours.” In many clinical situations the admission is entirely justified and to do otherwise would be a departure from good clinical practice (and a demonstration of ageism). Other admissions will be seen, on review, to be less justifiable and a higher level of proactivity and engagement might have allowed the resident to stay safely and appropriately within the care home. Clearly the greater the degree of primary and secondary care support for the care home the more likely the individual resident can be looked after in what is seen as their home. Though whether this can be extended to the management of frank delirium is perhaps more debateable.

- Assessment processes are not sufficiently supported by specialist secondary care prior to care home admission.
- Involvement through an integrated specialist service in the support of practices, residents and care homes is limited and in some areas non-existent.
- The specialist support of end of life care is in some areas lacking.
- Community sessions are not routinely available to support practices and care homes and to, when appropriate, prevent inappropriate use of unscheduled care.

Future Requirements – Delivering Better Outcomes

Assessment/Admission Procedures to Care Homes

The care manager led assessment process should occur without delay and have skilled multidisciplinary input, whether the potential resident is in hospital or the community. Maximum opportunities for rehabilitation should be provided in all settings and the individual should have access to Comprehensive Geriatric Assessment. This will require input from Medicine for the Elderly or Old Age Psychiatry services as well as information from primary care. When there are complex capacity issues for an older person there may require to be use of Guardianship legislation, Adults with Incapacity Act or involvement of Mental Health Officers and others.

Findings from the Care Commission and Mental Welfare Commission joint report 'Remember I'm still me' state, 'Concerns has been raised with care homes where staff did not understand the legal safeguards in place for patients. It wasn't clear who had the legal powers and often no indication that formal discussion had taken place with a person's welfare guardian about their powers. It has become apparent that the law on medical treatment of patients who lack capacity is not being adhered to. Only a minority of patients have received appropriate assessments of capacity, certificates of incapacity and treatment plans. Some care staff did not know that certificates were needed and some doctors refused to issue them.'¹¹

Admission to a home, when required, should be as local as practical for the individual and family and occur without delay. The early review of the placement should be comprehensive and specifically consider if circumstances have changed for the individual and whether a return to the previous home (or alternative housing) would be appropriate. The whole process of placement and subsequent review must be "needs driven and patient focused", with appropriate risk management taking into account the views of the patient and their family,

Primary Care

Individuals in care homes are best served by skilled proactive support from a local practice. Ideally homes and practices are aligned and there are regular arrangements for visits which allow for thorough initial assessments on admission and regular reviews (at least once a year for most people and more frequently when clinically indicated). Included in the assessments and medication review is the need for discussion and recording. Mental Welfare Commission forms are available for the use of covert medication and use of appropriate sections of the Adults with Incapacity legislation should be routine.

The indications for an urgent review require general agreement. Such reviews allow for anticipatory care planning including consideration of end of life care as well as opportunities to meet family members.

Access to the resident's recent and past medical history should be available at the time of admission and key summary details kept within the care home. Out of Hours services need to have secure access to the emergency care summary. A decision to admit a patient to hospital out of hours needs to be made with as much clinical information as possible.

Some patients within care homes are within the age categories for breast and cervical screening, and local arrangements are required to ensure that those who wish to attend are not routinely excluded because they stay in care homes. The same applies to other screening programmes such as retinal and bowel screening.

The majority of End of Life Care is co-ordinated by general practice, this can be a complex clinical area and specific expertise is required. Support should be available where appropriate from specialist palliative care teams. Consideration should be given to the training needs of care homes' staff in end of life care provision. This will result in fewer unnecessary and distressing admissions to hospital in the final days of a patient's life.

Nursing and Allied Health Professional Support

Care homes which are not staffed by trained nurses will require professional support from practice and community nursing teams to optimise the management of individuals.

If it is seen that the needs of the resident are no longer being met, then the care manager must urgently review the situation and when appropriate facilitate alternative care home accommodation which will meet the residents' new care requirements.

Access to AHP staff both for assessment and therapy should be available in the context of local service delivery. There will be requirements for physiotherapy, occupational therapy, speech and language therapy, dietetics and chiropody support for individuals when indicated. Homes may also have their own separate therapy staff, but additional NHS support may well also be required.

Pharmacy support should be integral to all care homes and support the regular medication review process as well as prescribing governance.

In homes staffed by nursing staff there should be opportunities to care for residents who require additional support due to deterioration in their condition. Resources and skills for the administration of parenteral antibiotics and subcutaneous fluids, both for treatment of intercurrent illness, and for end of life care should be generally available. Such additional support may require input from community nursing teams.

Specific areas of clinical need in relation to diabetes management, stoma care, continence, pressure care may also be required, and the likelihood of depression complicating physical illness should not be overlooked.

Secondary Care

The key community-focused specialist services for the support of the care home population will be available through Medicine for the Elderly and Old Age Psychiatry teams. There should also be support from Palliative Care teams when required.

Involvement with Geriatric Medical and Psychiatry of Old Age teams can be at any stage of the resident's journey – from contributing to the assessment of need for care and the potential for rehabilitation, to advice and support throughout the resident's stay, which may include contributing to terminal care. With aligned practices the opportunity to link with specific Community Geriatricians and Old Age Psychiatrists, who themselves should function in an integrated fashion, is facilitated. Communication and advice can be by 'phone, ad hoc contacts or through planned visits.

For residents with challenging behaviour, or on long term psychotropic medication, review by Old Age Psychiatry teams is particularly important. In the provision of complex end of life care involvement with local specialist Palliative Care services would be expected.

Emergency (or at times elective) hospital admission will prove necessary when clinically indicated in a small number of situations. Care home residents must not be denied access to secondary care when this is required. At times liaison with the Medicine for the Elderly or Old Age Psychiatry departments will contribute to the assessment of need for admission which should normally be arranged by residents' own General Practitioners rather than through out of hours services.

On occasion the care needs of the resident may be more than can be provided in a nursing home, even with additional support. In such circumstances the resident may require NHS continuing care support through Geriatric or Old Age Psychiatry services.²¹ Such individuals will clearly meet the criteria for such care which may prove to be required for a limited or longer period and Care Manager involvement in this process maybe appropriate.

Conclusion

As the observations and high level recommendations demonstrate there are a number of key areas that need to be addressed within the Care Home Community; this in turn would ensure that a uniform standard of health care is offered both through primary and secondary care to the increasing older population in Scotland.

It is hoped that, through establishing good working practices with the many organisations involved in frailty care, positive steps can be taken to standardise and improve care across the country.

Better health and better care will improve the twilight years of our elderly population. This will ensure that we look after our ageing population in a safe, healthy and caring environment.

Acknowledgements

Thanks to those who have contributed to this report, Dr Gary Morrison, Old Age Psychiatrist, Dr David Findlay Old Age Psychiatrist, Dr Jean Hannah Clinical Director of the Nursing Homes Medical Practice (NHMP), Greater Glasgow and Clyde, and the invaluable support and assistance from Diane Rich, RCGP Scotland.

References

1. RCGP website/curriculum <http://www.rcgp.org.uk/> <http://www.rcgp-curriculum.org.uk/>
2. British Geriatrics Society www.bgs.org.uk
3. Better Health, Better Care
<http://www.scotland.gov.uk/Publications/2007/12/11103453/0>
4. Rockwood K. Age and Ageing 2005; 34 :432-434 What would make a definition of frailty successful?
5. Ellis and Langhorne Br Med Bull.2005; 71: 45-59 Comprehensive geriatric assessment for older hospital patients.
6. Stuck AE et al. JAMA 2002; 287: 1022–8. Home visits to prevent nursing home admission and functional decline in elderly people: systematic review and meta-regression analysis.
7. Building a Health Service fit for the future. Kerr D (2005)
8. Long term recipients:society at a glance:OECD Social indicators (2006).ISBN 92-64-02818-8
9. Fried et al. Frailty in Older Adults: Evidence for a Phenotype. J Gerontol A Biol Sci Med Sci 2001;56: M146–56.
10. Gill et al. Transitions Between Frailty States Among Community-Living Older Persons Arch Intern Med. 2006;166:418-423
11. ‘Remember I’m still me’ Care commission and mental welfare commission joint report on the quality of care for people with dementia living in care homes in Scotland.
12. National Care Standards - Care Homes for Older People in 2001, and updated these in 2006 – Scottish Government
13. Registrar General population estimates,2007
14. The Adults with Incapacity (Scotland) Act 2000 sets out the system to help and protect adults who lack the capacity to make decisions on some aspects of their lives http://www.opsi.gov.uk/legislation/scotland/acts2000/asp_20000004_en_1
15. Guardianship Order is a court appointment which authorises a person to take action or make decisions on behalf of an adult with incapacity. A guardianship order can be in relation to property and financial matters, personal welfare or a combination of these. http://www.publicguardian-scotland.gov.uk/whatwedo/guardianship_order.asp
16. DM Newnham et al. Self-funding and Community Care Admissions to Nursing Homes in Aberdeen. Health Bulletin.1996;54:301-306.
17. Statistical Bulletin: Health Services: Care Homes, Scotland, 2008. ISBN 9780755974405 [web only]
18. Scottish Care Home Census, Scottish Government,2003-2007.

19. The RCGP - GP Curriculum Statements – Care of Older Adults http://www.rcgp-curriculum.org.uk/rcgp - gp_curriculum_documents/gp_curriculum_statements.aspx
20. Deeside Care Home Support Scheme, South Aberdeenshire LCH, NHS Grampian
21. NHS Continuing Healthcare; CEL 6 07/02/2008

Appendices

1. Care Home Medicine – We can do better report
2. NHS Grampian Local Enhanced Service contract for medical care in care homes