

Practical Approaches to Managing Frail, Older People in Community

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Abstract

The numbers of community-dwelling frail, older people are increasing steadily and a dynamic, integrated geriatric medical service should therefore be established in communities, in line with the health need of local older residents. The concept of Interface Geriatric, the direct engagement of secondary care Geriatricians linked with primary care teams, should be applicable in the community. The spectrum of an ideal community integrated geriatric service should include the multi-disciplinary team meetings on a regular basis, domiciliary visits, care home medicines management and Community Geriatric Medicine CME activities. The Integrated Interface Geriatric Service could yield overall benefits not only for older people in the community but also for doctors in training. This service could provide us positive outcomes from the aspect of cost-effectiveness.

Keywords: Community geriatric care; Care approaches; Potential benefits; Frail older people

Background

Growth of community-dwelling older population and its challenges

The numbers of people aged 65 and above are steadily increasing in local communities [1]. For example, the approximate total population in Sandwell community, West Midlands England was about 311,304 persons in 2012 [1]. Among these people 47,623 persons were people aged 65 and above (15% of the total local population) of which 6,333 persons were aged 85 and above (2% of the total local population) [1]. The aging population trend inclines upward year by year and eventually people aged 80 and above will represent about 13% of the local total population in 2020 [1]. Currently, one third of the total community-dwelling people at age 65 plus in Sandwell live on their own [2]. This proportion is slightly greater than that in other communities of the West Midlands where the average percentage of people at age 65 plus living alone across the West Midlands is about 30% [2].

This situation is directly linked with risks of social isolation, depression, poor physical health, malnutrition and recurrent secondary care admissions [2]. From the perspective of elderly care medicine these risks trigger as well as exacerbate recurrent secondary care admissions, falls and frailty [3]. According to the UK Care Homes Directory there are 26 nursing homes in Sandwell and the surrounding local areas [4]. Undoubtedly frail, older people with complex comorbidities take “the lion’s share” of these care home placements. It can be generally justified that most of these institutional-dwelling older people have poly-pharmacies. This circumstance clearly indicates the need for regular medication review and therapeutic rationalizing in this particular group of people.

Common long-term health conditions in older people

The common illnesses in older people are mainly related to chronic, non-communicable diseases. Traditionally these are known as “Geriatric Giants [5].” These include instability (i.e. Idiopathic Parkinson’s disease), immobility (i.e. Stroke/Transient Ischaemic Attack, Falls, and Fragility Fracture), incontinence and impaired cognitive function (i.e. Alzheimer’s, Dementia) [5]. In addition various presentations of an occult malignancy must be recognized as a red-flagged health hazard in the elderly [5].

In these circumstances, providing and establishing an integrated care to these frail older people is vital in the community. In fact, this issue is everyone’s matter. We would like to discuss about the evidence-based key strategy and practical approaches regarding the comprehensive community geriatric care in this review.

Strategy and Approaches

Strategy

The most important and fundamental strategy that we should apply is “Interface Geriatrics”. Interface Geriatrics is defined by a strong link between the secondary care and community geriatric care [6]. It is a harmonious combination of primary and secondary care, aiming to deliver a comprehensive, integrated care to older adults [6]. Getting the support of primary care geriatricians from the acute hospital should be directly involved in providing medical care to older people in the community, especially institutionalized frail, older people [6]. This strategy could minimise recurrent hospitalizations or re-admissions of older, frail people by up to 25% [7].

Approaches

Based on the concept of Interface Geriatric the following approaches should be implemented in the community geriatric service and directly collaborated with secondary care.

Community multidisciplinary team (MDT) meetings or virtual ward rounds

Aim: To assess the patients rapidly for further management, rehabilitation assessment, inter-specialty referrals and prevention of unplanned emergency admissions.

Setting: Either in the hospital or general practitioner (GP) surgery

Focus patients group: Patients at age 75 plus with complex co-morbidities, social situations, recurrent unplanned emergency hospital admissions

Team: A consultant geriatrician, a general practitioner or primary care physician, community nurse practitioners, other members of the community team

Action plan: Integrated care and assessment in the community, referral to secondary care investigations, blood tests, direct assess/referral to the community rehabilitation team (i.e. iCares), and community hospitals could be made.

Expected outcomes: Emergency secondary care admissions, readmissions could be prevented and minimised. The secondary care level investigations could be assessed more rapidly. The potential untoward effects of polypharmacy could be reduced. The waiting time for secondary care specialty clinic appointments could be reduced. As an overall many positive outcomes including cost-effectiveness could be expected from this service. In addition both Geriatric and GP registrar trainees could have a good opportunity to attain various clinical exposures.

Medicines management in nursing homes

Aim: To minimise poly-pharmacy related harms and establish safe prescribing in care home residents.

Setting: Nursing homes in our community.

Focus patient group: Care home residents aged 75 plus.

Team: A community pharmacist, members of the community team.

Action plans: Every drug chart of care home residents aged 75 and above will be reviewed and long-term medications will be rationalized appropriately based on current health need and existing co-morbidities of the residents. The GP concerned will be informed and communicated appropriately.

Expected outcomes: Poly-pharmacy induced therapeutic risks in frail, older care home residents could be minimised. Emergency secondary care admissions related to poly-pharmacy could be prevented. From the perspective of efficiency savings, a positive outcome could be expected as extra expenses on medicines that do not have actual clinical benefits to the residents could be reduced significantly.

Domiciliary visits

Aim: To deliver an appropriate geriatric assessment and management advice.

Setting: Patients' own residences or care homes.

Focus group: Patients aged 75 and above who could fulfil the essential criteria for a specialist domiciliary visit. These criteria should include.

- A patient who is bed-bound (or) housebound and cannot attend an outpatient speciality clinic.

- He or she has complex long-term co-morbidities requiring optimisation of specific therapeutic management. E.g. Advanced Parkinson's disease with complications.

- He or she must be assessed by the primary care team prior to asking a specialist domiciliary visit.

- The patient's own GP and the community team must agree that potential clinical benefits for the patient can be expected from a specialist domiciliary visit.

The patient and/or the main carer must be informed and consulted regarding the domiciliary visit and the patient or next of kin (if the patient does not have a mental capacity regarding this advice) must agree to accept the visit.

Team: A consultant geriatrician, community nurse practitioners.

Expected outcomes: Optimization of specific therapeutic management, early intervention against secondary care admissions and early crisis interventions, including advanced care plans could be achieved in time.

Continued medical education (CME) and training opportunities

Aim: To deliver CME activities effectively and provide excellent learning opportunities for trainees in Geriatric Medicine and General Practice.

Setting: Community MDT meetings, domiciliary visits, local CME activities.

Focus group: Geriatric medicine and general practice trainees, members of the community team.

Team for CME programs: Consultants in geriatric medicine and other relevant specialties, GPs with a special interest in geriatric medicine, community nurse practitioners and senior community therapists.

Action plan: Geriatric and GP trainees are encouraged to attend the rapid access Geriatric Clinic and Nursing Home medication review visits. Annual CME Meeting for local GPs should be held regularly. For instance, the Shropshire Medicine Conference for GPs has run successfully for years and a similar activity could be applicable in other local communities.

Expected outcomes: Work-based assessment and clinical exposures could be provided to the trainees. Up-to-date knowledge and information related to care of the elderly, including the local clinical guidelines and management pathways, could be conveyed to our local GPs.

Learning exposures for the undergraduate medical students

The Year 3 and 4 medical students should be allocated in the Community Geriatric Medicine Service for about 4-6 weeks. The students should attend the community MDT meetings and join the

Nursing Home visits during this placement. They are expected to learn about principles and practice of community Geriatric Medicine, integrated community care and medicine management for frail, older people in the community. From these learning exposures they will acquire a key concept, “an integrated care meaning a care approach beyond the horizon of beds and benches in the modern healthcare industry.”

Clinical Governance

Audits

Audits and service-evaluations should be conducted on regular basis, aiming to maintain and promote the high quality care of this

service. For example, the clinical audits such as evaluating clinical effectiveness of nursing home medicines review should be conducted.

Clinical research

Good opportunities for clinical research, studies related to community Geriatrics can emerge from these care approaches. For example, community-based observational studies such as comparing the numbers of unplanned secondary cares visits of the care home frail, older residents before and after implementing the integrated community geriatric care” can be conducted in line with local research and development policies. The Geriatric Medicine and GP trainees should be encouraged to engage in these research activities (Figure 1).

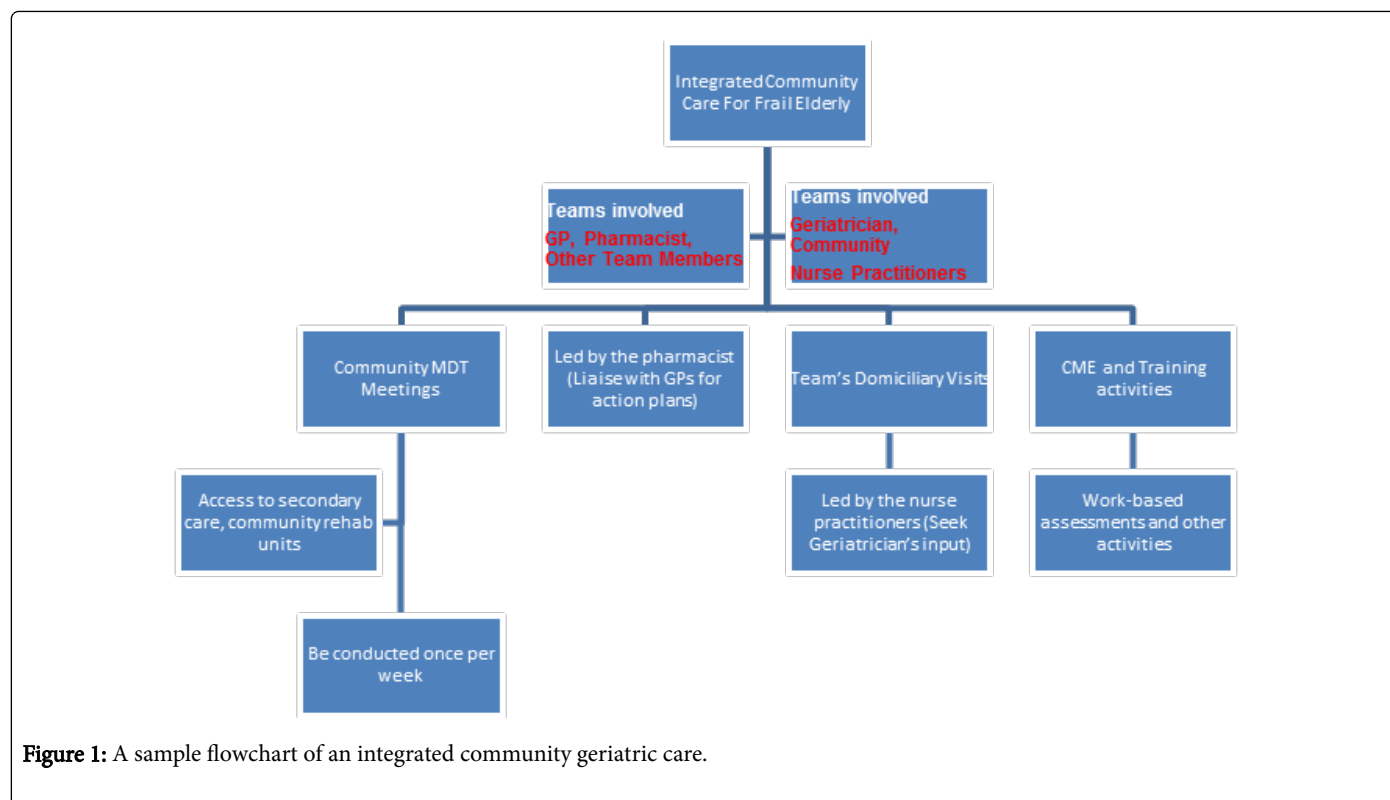


Figure 1: A sample flowchart of an integrated community geriatric care.

Conclusion

These above approaches can be applicable in any community, irrespective of socioeconomic parameters. These can provide many benefits to our senior citizens, healthcare service providers, doctors in training and medical students. As an overall, such a care pathway can minimise the risk of unplanned acute hospital admissions among the community-dwelling frail older people. From the aspect of health-economics, we can generally justify that this care model is cost-effective.

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