High quality long-term care for elderly people

A SUMMARY OF A REPORT OF THE ROYAL COLLEGE OF PHYSICIANS AND THE BRITISH GERIATRICS SOCIETY

Aims

This report contains guidelines on the management of common challenges encountered in long-term care for elderly people, and is intended to enhance its quality. Long-term care includes residential homes, nursing homes and hospital wards in the NHS, local authority, private and voluntary sectors. The guidelines are intended to be implemented through audit using an audit package developed for the purpose—the Royal College of Physicians CARE scheme (Continuous Assessment, Review and Evaluation). Clinical audit and quality assurance schemes, involving peer review, change and re-evaluation of change, are more likely to foster high quality long-term care than a punitive regulatory approach.

Although many of the frailest of elderly residents live in NHS long-term care establishments, the types of disability and problems encountered in their care occur in other sectors, all of which should find these guidelines useful.

The report will have educational value for people learning about long-term care, and may also stimulate research into the gaps in knowledge that it highlights.

Background

The report was written in response to the continuing difficulties in ensuring high quality long-term care and the failure of previous initiatives. Long-term care has changed dramatically in organisation, quantity and approach since the specialty of geriatric medicine was born 40 years ago. Organisational changes include: (i) the introduction of ‘part III’ local authority homes (1948); (ii) more recently, modification of supplementary benefit to fund private care; and (iii) the opening of some NHS nursing homes. Very large numbers of elderly people live in long-term care, with many more now in the private sector. The inadequate assessment of their needs constitutes a modern day neglect of elderly people. Demographic changes imply future expansion in long-term care and, despite the provisions being made for community care, a proportion of elderly people will probably always need long-term care. The cost of long-term care has risen rapidly to about £3-4 billion or more annually, with social security support alone costing about £1 billion in 1989. The ‘psycho-social’ model of care has emerged to replace the old ‘institutional model’ of care (which was characterised by control over residents through routines etc). The psycho-social model aims for flexible personal care through choice and for a better quality of life for residents.

There is ample evidence of poor long-term care in all sectors. This may reflect the fact that long-term care is difficult and is often delegated to the least trained, least skilled and least well paid staff. Moreover, there is a lack of agreed standards of care.

There is also a difficulty in assessing the quality of long-term care. The goal of such care should be high quality of life for residents, but this is difficult to define and elusive to measure, particularly amongst the more frail long-term care residents, and alternative measures are therefore needed. This report has adopted eight ‘key indicators’ all of which are believed to reflect the quality of care, although some also cover adverse events. The bias towards health-related key indicators reflects a presumed association of health with quality of life and the importance of high quality health care in long-term care. However, the report recognises the importance of merging health and social aspects of care by providing guidelines for many non-clinical aspects of long-term care.

Findings and recommendations

The report presents three main components for each key indicator: a descriptive review, a set of guidelines, and the CARE scheme questions. It is intended that the guidelines can be used as a framework to develop high quality care and that they may be copied for use by staff. The CARE scheme questions reflect the guidelines and are intended as a tool to be used for audit activities within long-term care facilities. A summary of the key indicators is presented below.

Preserving autonomy

Although autonomy, the right to self determination, should be central to high quality long-term care, loss of autonomy is common. Freedom of choice, privacy, and dignity can be achieved through individually planned care negotiated with the resident. Moreover, long-term care should aim to simulate ordinary life at home through an agreed flexible programme for each resident to ensure that an agreed form of address is used, personal clothes are worn, meals are provided according to preference, and an appropriately organi-
ised programme of recreational and cultural activities is available if desired. Long-term care facilities should attempt to integrate with their local community. Other important areas covered by the guidelines are advocacy, key workers, the input of residents to policy, and training.

Promoting urinary continence

Urinary incontinence is common amongst long-term care residents and may provoke great distress. Most (about 80%) of those in long-term care will have an unstable neurogenic bladder, which by its very nature is particularly difficult to manage. The onset or worsening of urinary incontinence should prompt a search for an underlying reason, such as the functional effect of a new illness, urinary tract infection, faecal impaction, bladder abnormalities, the adverse effects of medication, and the aids and lavatories provided. Thereafter, successful promotion of urinary continence should include an attractive, homely environment and a relaxed holistic approach. So that residents can have confidence, they should have a dependable toileting regime tailored to their needs, and staffing levels should ensure that someone will always be available to help them go to the lavatory. The discomfort of incontinence can be reduced by good quality pads which make the patient feel dry. Urinary catheters have a limited role in long-term care; they are usually not useful for patients with unstable bladders as leakage commonly occurs. Occasionally, a catheter may be necessary for a resident with a particularly large residual volume of urine, or who cannot be adequately helped by pads, or who prefers one. A policy on the promotion of urinary continence should be created to ensure that all members of staff understand the nature and causes of incontinence. A multidisciplinary group concerned with the promotion of continence may facilitate this process and foster good practice. The district continence nurse adviser should be available to all long-term care residents. The guidelines also cover the purchasing of pads, and monitoring the impact of urinary incontinence.

Promoting faecal continence

Faecal incontinence is common amongst long-term residents and is often mismanaged. It should be possible to control virtually all cases of faecal incontinence. First, the cause of faecal incontinence should be sought—the commonest cause being constipation and faecal impaction (with paradoxical diarrhoea). It is helpful to review medication (especially of laxatives and drugs causing diarrhoea or constipation), and to assess mental status and mobility. Faecal impaction should be treated with small volume enemas coupled with stimulant or osmotic laxative once disimpaction has occurred. Manual evacuation is only occasionally required and should only be carried out by specially trained staff. Thereafter, recurrence can be tackled using a number of measures such as dietary fibre, the encouragement of exercise (even for the chair fast), the promotion of functional independence, adequate fluid intake, regular and carefully supervised oral laxatives, suppositories, or enemas. Residents with uninhibited defaecation may respond to ‘bowel training’. If these methods fail, a constipating/stimulation regime can be used. The guidelines also cover the development of written policies concerned with the promotion of faecal continence, and a grading scheme for faecal incontinence is presented.

Optimising drug use

There are high levels of prescribing in long-term care and standards may be poor. Therapeutic objectives in long-term care should lay greater emphasis on conservation of function, and the promotion of autonomy and quality of life. Regular review of therapy and its objectives, with a view to discontinuing unnecessary medication is an important part of good practice to reduce inappropriate polypharmacy andiatrogenesis. Non-pharmacological approaches to particular problems may be more appropriate than medication in long-term care. The guidelines also cover formularies, and continuing education.

Managing falls and accidents

Most accidents in hospitals and institutions are falls and most of the remainder are injuries associated with using equipment (such as wheelchairs or commodes). Falls and accidents may be caused by both intrinsic factors (such as neuromuscular disease, joint disease, visual impairment, cognitive impairment and drug effects) and extrinsic factors (such as poor lighting, stairs, furniture and equipment, polished floors and the incorrect use of walking aids). Following a fall or accident, both the resident and the environment should be reviewed. Since falls may warn of other developing problems, it is especially important to search carefully for new remediable problems. Overall, any strategy should strike a balance between the risks of activity and the unacceptability of restraint. The guidelines also cover policy development, and a new model incident form is presented.

Preventing pressure sores

Pressure sores are expensive and can be avoided by an active prevention plan. They are multifactorial in origin and residents should be assessed for risk of developing pressure sores. Repeated re-assessment of risk is essential, not only because circumstances alter but also because changes in risk score may pressage the development of pressure sores. An active prevention plan should involve staff of all disciplines. Low pressure surfaces and any specialised equipment must be easily
available and well maintained. Attention should be given to worn mattresses on solid-based beds and pressure relief on trolleys, radiography and theatre tables. Pressure relieving devices should be easily available, not forgetting low pressure cushions for chairs. Equipment now thought to be ineffective or dangerous, such as air rings or sorbo rings, should be discarded. The guidelines also cover the formation of a pressure sore group, education, classification of pressure sores, and two pressure sore risk assessment scales are presented.

Optimising the environment, equipment and aids

The ordinary standards that we would all expect in our own homes should be the aim of long-term care. A homely environment with privacy ranks second highest behind the quality of staff in the eyes of long-term care residents. Since preferences vary, a choice between single and shared accommodation should be offered. Rooms should be personalised and private by being accessible to residents at all times, being identified with the resident’s name, having lockable doors and by ensuring that staff knock before entering. Residents should have their own personal possessions including small items of furniture, photographs and ornaments. There should be easy access to a personal basin, toilet and bath. In shared rooms, screens or curtains should be available. Ideally, each resident should have a personal toilet; in practice this is rare. There should at least be an adequate number of toilets within easy reach of bedrooms and day rooms. Residents should have freedom from unwanted noise such as communal radio and television. Private telephones should be available. There is good evidence of shortcomings concerning aids and appliances. Wheelchairs in particular are often in a poor state of repair. Since aids and appliances may be crucial to independence, they should not be neglected.

The medical role in long-term care

There is an obvious difference in the medical role between NHS long-term care and other sectors. Generally, NHS wards are the responsibility of individual consultants whereas in other sectors individual residents are likely to be under the care of different general practitioners, none of whom may have an overall role in directing the quality of care. However, it is clear that long-term care residents still require access to skilled medical care, and that entry into long-term care should not disbar a resident from access to such care. The unchecked expansion of the private sector in recent years has prompted further interest in the importance of medical assessment before entering long-term care. The multidisciplinary approach is essential with team members having appropriate skills.

The medical role in long-term care should rise above occasional medical intervention for intercurrent illness, to embrace wider responsibility for high quality care, participation in audit, maintenance of high quality records, promotion of education and training, regular review of residents particularly concerning the domains covered in this report, ascertainment of residents wishes regarding all aspects of medical care, and availability to relatives. Medical attendants may have an important role in fostering high morale in long-term care, should be alert to the possibility of elder abuse and should engender discussion and not stifle it.

Implementing the report—The RCP “CARE” scheme

The numerous descriptions of poor long-term care would suggest that the adoption of the very basic measures in the report would transform the care received by many long-term care residents. We suggest that all health and local authorities adopt these guidelines and CARE scheme. The Royal College of Physicians CARE (Continuous Assessment, Review and Evaluation) scheme—has been devised for implementation of this report. The package consists of:

i Questions relating to the facility (ward, unit, or home).

ii Questions relating to the individual resident, based on the recommended guidelines.

Because the final development of the package requires more widespread evaluation than has been possible thus far, those implementing this version will be asked to provide feedback of their experiences of using the package. Ultimately, it may be possible to provide a reading, analysis and comparison service using the standardised package.

Membership of the workshop

Dr John Agate, Retired Consultant Geriatrician, Ipswich; Professor John Brocklehurst, Associate Director, Research Unit, Royal College of Physicians; Mr T. Coman, Member of Public; Dr Joanna Downton, Consultant Geriatrician, St Thomas’ Hospital, Stockport; Dr Edward Dickinson, Senior Lecturer, Royal College of Physicians and University of London Research Group for the Elderly, The Royal London Hospital (Mile End); Professor Shah Ebrahim, Department of Health Care for the Elderly, The Royal London Hospital (Mile End); Dr Carol Foster, Consultant Geriatrician, Queen Mary’s Hospital, Sidcup; Miss Pamela Hibbs, Chief Nursing Officer, City & Hackney Health Authority, St Bartholomew’s Hospital, London; Dr Marion Hildick-Smith, Consultant Geriatrician, Kent & Canterbury Hospital, Canterbury; Dr Anthony Hopkins (Chairman), Director, Research Unit, The Royal College of Physicians, London; Dr Peter Horrocks, Director of Priority Services Development, Yorkshire Regional Health Authority, Harrogate; Dr David Jolley, Consultant Psychiatrist, University Hospital of South Manchester; Professor Brian Livesley, Depart-
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ment of Care of the Elderly, Charing Cross Hospital, London; **Dr Michael Lockwood**, Department of External Affairs, Oxford University; **Dr James Malone-Lee**, Senior Lecturer, Department of Geriatric Medicine, University College and Middlesex School of Medicine, St Pancras Hospital, London; **Dr Peter Mayer**, Consultant Physician, Department of Geriatric Medicine, Selly Oak Hospital, Birmingham; **Dr Doreen Miller**, Chief Medical Officer, Marks and Spencer plc, London; **Dr Bryan Moore-Smith**, Consultant in Geriatric Medicine, Ipswich Hospital; **Professor Graham Mulley**, Department of Medicine for the Elderly, St James' University Hospital, Leeds; **Dr Linda Patterson**, Consultant Physician, Medicine for the Elderly, Rossendale General Hospital, Rossendale; **Dr John Reed**, Senior Medical Officer, Department of Health, London; **Dr Martin Severs**, Director of Clinical Services, Elderly Health Unit, Queen Alexandra Hospital, Portsmouth; **Professor Cameron Swift**, Department of Health Care of the Elderly, King's College School of Medicine and Dentistry, The Dulwich Hospital, London; **Dr Gill Turner**, Consultant in Geriatric Medicine, Lymington Infirmary, Lymington.

The full report is available from the Royal College of Physicians, price £9.50, plus 50p postage and packing (£11.00 overseas including p&pp). The background papers submitted to the working group are also available from the College, on payment of £6.00 for the set to cover costs of photocopying and postage.

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Mr P. Wright, President, College of Ophthalmologists

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