Care of the elderly, quo vadis?

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Donaldson and colleagues have sought to understand variation in the provision of acute and community elderly care services across Scotland.[1] Their traditional approach of relating geriatrician numbers to the over 65 years of age population harks back to a time when geriatricians managed an extensive number of long-term care beds where, once over 65 years of age, patients irrespective of need were often defined as geriatric and allocated by locality to a geriatrician and their team.

Geriatric services have evolved from curating long-term care to actively managing patients and realising their rehabilitative potential. Subsequently, the mantra 'medicine delayed is medicine denied' has driven equitable access to modern medicine for older people, a real National Health Service (NHS) triumph. Now, older patients dominate the clinical practice of many organ/system specialist physicians and many physicians specialising in the medicine of later life provide sophisticated clinics for common presentations in older people, such as falls, fractures, movement disorders, stroke, the dementias and a range of liaison services.

Donaldson et al.[1] rightly highlight the importance of comprehensive geriatric assessment (CGA) being applied to older people on hospital admission. But CGA is not a panacea, illustrated by the older person who on contacting their local authority seeking a grab rail by their front door is told that they really need a CGA by the multidisciplinary team (MDT). By the time the MDT arrive to do this a fall at the front door, hip fracture and hospital stay have been completed. The CGA determines a front door grab rail is all that is necessary. CGA carried out thoroughly is a significant commitment that requires appropriate triggers.

Isaacs et al.'s 1972 study[2] of geriatric patients in Glasgow identified a 'geriatric hard core' – people who survive into advanced old age with dwindling economic and social resources, dwindling strength of their bodies and clarity of their minds casting a shadow over health services.

A vignette of their experience was of a Mrs McGoldrick, a frail 86-year-old widow, living alone in a tenement house in Glasgow. One night she fell and was unable to rise. She lay all night; cold, frightened and untended until her Home Help found her the following day and hospitalisation occurred. With personal alarms Mrs McGoldrick could reasonably be expected to avoid such an indignity in 2019.

My observation from a recent personal sojourn of several nights in a medical admissions unit was that the majority of patients were very elderly and generally unlikely to benefit from hospitalisation, but had been referred 'just in case' or because no one attending them in the community 'was able' to make a decision not to admit and/or provide in situ care. I believe this to be commonplace. Many of these patients were from care homes. Avoidable admissions from care homes are not a new phenomenon,[3] but the NHS still has no coherent programme or strategy in this regard.

Most initiatives have been short term and at least one bellwether indicator, the prescription of antipsychotics, remains a serious concern.[4]

NHS Scotland has 13,000 acute hospital beds for all specialties,[5] whilst some 31,000 older people are resident in Scottish care homes for long-term care and nearly 1,500 for short-term admissions.[6] These relative bed volumes are not unique to Scotland, but care home resident profiles vary on a range of local factors, such as deprivation-linked endemic ill health or geographical isolation. Care home residents do not fit well into established models of social care or

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acute medicine with their medical complexity, progressive dependency and limited capability to benefit from treatment.[7]

It is probable if Isaacs were repeating his 1972 study now he would suggest the care home population is casting a much deeper shadow over the NHS.

There is increasing evidence that a systematic proactive approach to the care of care home residents is beneficial, one well-conducted study was able to report a 50% reduction of hospitalisations.[8]

It is remarkable that care homes do not warrant a mention in the Donaldson et al. paper,[1] has geriatric medicine become so alienated from its traditional core constituency?

Though there is evidence that NHS teams can facilitate care home outcomes,[9] maintaining relationships with care homes on an informal or ad hoc basis will always be vulnerable, especially with the predictable shortages and churn of professional staff. In care homes with nursing in Scotland, as elsewhere, there are thousands of nurses whose role is poorly defined.[10] In reality their day-to-day work is often indistinguishable from care assistants. A systematic fresh approach for care homes beyond the simplistic managerial integration of health and care is overdue. I believe the professional nurse's role should evolve as the responsible professional for an individual's CGA with medical support and case manager for the individual. A defined caseload, technology to share information with colleagues 24/7 would facilitate this. The capability of the precious resource of expert nursing could provide continuity, an improvement of experience and outcome, and reduction of medical futility.

Donaldson and her colleagues in viewing the future through the lens of the past help crystallise the need for a bold new strategic vision that includes care homes. The declaration 'there's no such thing as geriatric medicine – and its here to stay' will continue to stand the test of time, though the patients and practice may continue to change.[11]

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