Care of older people

Approved 2007

Background

Health care issues involving older persons are of concern to the NZMA. With the gradual shift in the age structure of the population, and increasing number and proportion of persons surviving into old age, there is an increased need to focus on the care of these persons.

The United Nations estimates that the number of people in the world over the age of 60 will have increased over 224% between 1975 and the year 2025. In New Zealand it is projected that by 2021 there will be more older people (65+) than young people (under 15 years) and that older people will make up 17.6% of the total population. By 2051, half of all New Zealanders will be older than 45.1 years of age.

This phenomenon creates challenges for the government and policy makers attempting to address the social, economic, political and medical issues raised by a change of this magnitude. As we experience increasing demands on our heavily burdened health care system, we must strive to ensure that the needs of our elderly members of society are addressed.

Principles

1. General

Aging is a normal process and does not, of itself, imply illness, impairment or disability.

Medical practitioners must strive to preserve the dignity of the elderly especially in the face of serious physical and mental morbidity.

Elderly patients have the same rights as any other patient to choose their own general practitioner even though they may now reside in a rest home.

The quality of medical care for older people at home, in hospital and in residential aged care facilities should reflect those principles considered to be optimal medical practice. Standards of care should not be compromised through discrimination on the basis of age, restriction of resources or economic rationalisation.

It is the government's responsibility to ensure access and funding are available for optimum quality care.

Health care and social services, including comprehensive assessment and effective rehabilitation should be directed towards the restoration and maintenance of each person's optimal level of independence.

With the increasing proportion of older people in the population, health care services for older people should be expanded within the community setting, in hospitals and in residential care. The effectiveness of these services must be regularly evaluated to ensure that older peoples' needs are being met.

Health services for older people should specifically acknowledge and meet the special needs of older people and acknowledge cultural values.

2. Patients' rights

Doctors and other health care providers should actively involve elderly patients in discussions regarding their own care including decisions to accept or refuse treatment, consistent with both the NZMA Code of Ethics and the Code of Health and Disability Services Consumers Rights. If the elderly patient is mentally incompetent, doctors should re cognize the responsibility of the family or other guardian to participate in the care decisions on behalf of the elderly patient.

3. Access to health services

Like all people, older persons in all parts of the country should have timely access to medical and supportive health care services that are clinically appropriate and delivered in the appropriate setting. This includes:

- rapid access to primary medical care
- access to a full range of medical, diagnostic, and rehabilitative services
- access to specialised programs designed to address physical and mental problems experienced by older persons.

Access to care should not be denied on the basis of age or disability.

4. Doctors' responsibilities in care for the elderly

The doctor is responsible for providing quality health care within the resources available. This includes:

- recommending health promotion measures that will foster independence and quality of lifestyle
- making an accurate diagnosis based on knowledge of the aging process and disease processes
- providing treatment and ongoing medical evaluation (often for multiple problems)
- ensuring continuity of care and coordination among caregivers
- facilitating good communications with the patient, the family, and other caregivers to clarify issues relating to treatment goals
- Subject to the patient's consent, discussing with the patient and family information regarding the nature and course of the disease and potential treatments
- supporting the patient and their family in informed decision-making regarding treatment; and using life support technology in a manner which is appropriate for the particular patient and their family, and with respect to their medical condition.

5. Involvement of general practitioners

Co-ordination of and responsibility for the health of an older person should remain with the patient's general practitioner. General practitioners must be involved in the decision making process relating to the care of their older patients, including involvement with Aged Care

Assessment Teams, geriatric and rehabilitation services, home and community Care, palliative care services and other community services.

Usually the patient's general practitioner is best placed to assess the outcome of the care, and services provided to that person, and carries the responsibility for doing so. The point(s) of access to regional domiciliary services should be easily identifiable and available to the general practitioner, older persons and their carers.

General Practitioners must be remunerated adequately for their involvement in the coordination of the care of an older person including case referencing, family conferencing and advisory committees.

6. Particular needs of frail elderly persons

The "frail elderly" are those older persons with multiple interactive, acute or chronic health problems compounded with functional and/or cognitive impairments and the need for supportive care. To achieve optimal health outcomes and quality of life and to minimize inappropriate use of resources, these elderly persons should have rapid access to an integrated range of specialized medical and other health care services.

7. The health care team

High quality medical care of older persons requires an integrated system of care that includes, but is not limited to:

- the general practitioner and practice nurses
- medical and geriatric specialists, including geriatric psychiatrists
- community-based health care professionals and support services and
- the patients' families and caregivers.

To serve their older patients, general practitioners require access to a range of acute, rehabilitative, long-term care facilities and palliative care services.

Doctors engaged in caring for the elderly should make reasonable provision for house calls appropriate to the diagnostic, therapeutic, and psychosocial needs of the patient.

8. Home and community care

Community care, including domiciliary services for older people, are of crucial importance. Co-ordination of services is essential and should be matched to the needs of each individual. These services should be comprehensive, regionally based and closely linked to the patient's general practitioner and geriatric services. The person's own general practitioner is usually the best placed to coordinate access to these services. Having said that, this service is usually provided out of the hospital rather than the community, Now that PHOs exist we believe that these community-orientated services should be located within the PHOs (including their funding).

Services for older people should complement and enhance rather than replace the supportive care of family members and should therefore include respite for carers.

The role of voluntary and private organisations in the care of older people is to be recognised and encouraged and not used as substitutes for deficiencies in the provision of Government services.

9. Resident aged care facilities

When an older person is no longer able to remain at home, a range of residential care options, which can cater for their physical, functional and psychosocial needs should be available.

High-level care in a residential aged care facility should be available to any person who is in need of such care irrespective of their financial position.

Application of standards for residential aged care facilities should enhance and improved delivery of resident care, promote efficiency and be practical. The associated documentation should promote face-to-face contact or services by staff and medical practitioners.

Appropriately funded mechanisms of medical audit must be established in residential facilities. These mechanisms should facilitate monitoring by general practitioners of the services provided to residents. Regular discussion of patient care issues between the patient's general practitioner and the other providers of care should be encouraged.

All staff employed in residential aged care facilities should be knowledgeable and skilled in carrying out important components of geriatric care, including, but not limited to, safe medication administration, falls prevention, incontinence care, communication techniques, dementia care, skin care, and able to recognize the changes that can signal acute illness, delirium, and depression.

Residential Aged Cared Facilities have a responsibility to provide complete information to prospective residents to assure that an appropriate match is made between resident and facility.

Residents entering an Aged Care Facility should have a baseline evaluation, completed within 10 days of their admission, of their physical, medical and psycho-social needs, and a detailed review of all medications, prescription, non-prescription, herbal and other remedies, completed by a qualified general practitioner or other medical practitioner experienced in the care of older adults. This culturally sensitive evaluation should be the basis for the development of a care plan that indicates resident physical and psycho-social needs along with resident preferences for treatment and strategies for meeting identified needs. This care plan should be available to the resident and to the Aged Care Facility staff. The Aged Care Facility should clearly indicate, preferably prior to admission, the specific elements of the care plan that the Aged Care Facility will meet and is willing to accommodate as well as the responsibility of the resident/family.

On admission the aged care facility should if possible obtain from the patient, family or person with power of attorney, a signed statement of the patient's wishes for resuscitation in the event of the patient's sudden collapse.

10. Hospital care

General hospitals should provide a designated geriatric medical service with beds for acute care, assessment, treatment and rehabilitation.

Older persons must not be denied access to acute hospitals on the basis of their age or because of their co-morbidities. Medical practitioners with expertise in aged care should be an integral part of each general hospital's services and be available for consultations and advice.

11. Health promotion and illness prevention in the care of older persons

Disability in old age is often influenced by prior lifestyle. Health authorities, hospitals and community based services, should cooperate with general practitioners in developing programmes to promote the optimal health of older people before disabilities develop. Programmes should target high-risk persons.

Health promotion and disease and disability prevention should be integrated into the medical care of older people. Proven preventive measures for specific conditions should be offered at primary, secondary and tertiary levels of care. Strategies demonstrated to promote well being, maximize functional independence and minimize disability and dependency should be emphasized.

Promotion and prevention strategies should also be directed towards family caregivers to enhance their care giving capacity and their quality of life.

12. Dementia and psychogeriatric care

Dementia and psychogeriatric care requires specialised staff and facilities to complement geriatric services. The staff and facilities should be able to provide appropriate assessment and management, whether the older person is at home, in hospital or in residential care. Adequate staff must be able to provide quality care.

13. Elder mistreatment

Elder mistreatment is the umbrella term for a widespread public health problem of elder mistreatment that encompasses physical and sexual abuse, emotional abuse, financial exploitation, as well as neglect by others and self-neglect. Elder mistreatment violates basic legal and human rights. Older people should be able to live in dignity and security and be free of exploitation and physical or mental abuse.

Some types of elder mistreatment can be prevented if carers receive adequate information, education and support. Education and training programmes on the recognition intervention and management of elder mistreatment should be available to all health professionals.

Medical practitioners, especially general practitioners, have a pivotal role in the recognition, assessment, understanding and management of elder mistreatment and neglect.

Research and programmes to prevent and alleviate elder mistreatment should be encouraged and supported.

Training in detection of elder mistreatment, and care should be considered an essential curricular element in geriatric and gerontology training programs at all levels of health professional training.

Interdisciplinary geriatric assessment programs should serve as the model for the coordinated response to elder mistreatment issues between health care professionals and those agencies legislatively charged with investigating and responding to elder mistreatment

Comment: Many geriatricians and gerontology professionals regularly treat seniors who match the risk factor profile described for victims of elder mistreatment and who often experience complex social problems in the setting of advanced or chronic disease. Interdisciplinary geriatric assessment and intervention, which is appropriate for both community and institutional settings, is a proven model for the care of frail elders and should be applied to the care of the vulnerable mistreated elder.

14. Making treatment decisions for incapacitated elderly patients

Health professionals and others involved in the lives of older adults are often faced with the problem of making treatment decisions for patients who lack decision making capacity. NZMA has long encouraged the use of oral and written advance directives, the execution of powers of attorney by the elderly while still competent to do so, or the participation of traditional surrogates, such as close family members, to aid in this process. However, many older patients who lack decision making capacity have neither executed an advance directive nor previously discussed their preferences regarding medical treatments. Even when there are traditional surrogates, there may be disagreement among parties, legal or regulatory obstacles, or other problems that impede decision-making.

In the final analysis, decisions about treatment in elderly people who have become incompetent, and in the absence of advance directives, normally rest with the treating doctor. It is the doctor's responsibility, however, to ascertain and take into account the past views of the patient, the views of family or other surrogates, and consult with both medical and other health professional colleagues before making such decisions. Doctors also need to adhere to any legal restrictions that are in place. In situations where the doctor does not believe that he or she can make a decision, application should be made to the Family Court for a determination.

In the absence of an advance directive the following should take place.

- An attempt should always be made to ascertain the patient's ability to participate in the decision-making process, (save of course in cases of obvious and complete incapacity). In particular while a patient's decision making ability may be impaired, it is possible that they are sufficiently competent in regard to particular issues and this should be determined on a case by case basis.
- It should not be assumed that the absence of traditional surrogates (next-of-kin) means the patient lacks an appropriate surrogate decision-maker. A non-traditional surrogate, such as a close friend, a live-in companion who is not married to the

patient, a neighbour, a close member of the clergy, or others who know the patient well, may, in individual cases, be the appropriate surrogate. Doctors should make a conscientious effort to identify such individuals.

- Elderly people may have had Welfare Guardians appointed by the court under the PPPR Act. Such Guardians cannot make decisions to refuse life saving treatment or consent to various forms of treatment, but should have their views taken into account.
- For urgent, life-threatening situations, such as imminent cardiopulmonary arrest, health care providers and institutions should develop methods to make decisions for incapacitated persons without surrogates. These methods might include allowing the attending doctor and a consulting doctor to make certain choices within established protocols subject to retrospective review.

15. Ethical issues in the care of older persons

The ethical principles of respect for a person's autonomy and justice should inform all aspects of medical care of older persons, from systems planning to institutional policies to interactions at the bedside. The special needs of older persons in the following areas should be given particular attention:

- providing the information required for informed consent to medical procedures
- determining competency to make decisions about medical care
- determining an appropriate proxy for those who are not competent to make such decisions
- resolving conflicts between providers of care and those receiving care, or their proxies
- safeguarding privacy and confidentiality
- withholding and withdrawing life-sustaining treatment.

16. Research related to the care of older people

Improvements in care will result from properly designed, analysed and reported biological, clinical and public health research. Resources should be made available by governments, which will ensure the funding of research programmes, which focus on age related issues.

As a matter of urgency, research, especially clinical research into age related issues, should be encouraged and supported.

This research should be multidisciplinary because of the complex interrelationships between genetic, psychosocial environmental and economic factors causing dysfunction from disease, disuse and the effects of biological aging.

17. Effective planning for geriatric services

Those planning for the health care needs of our growing aging population should:

- urgently respond to the changing demography
- address access issues created by rural isolation
- apply the findings of relevant health care research
- ensure that older persons and their families are involved in the planning process

- ensure that caregivers are also involved in the planning process
- pilot new strategies and evaluate and refine them prior to implementation
- continuously evaluate to determine optimal methods of service delivery
- be responsive to cultural diversity
- remain open and flexible to innovation
- ensure that adequate human resources are available to provide medical care to older persons.