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Focus

Is your practice elder-friendly?

Introduction

Older patients constitute an increasing proportion of the general practice "list" and workload, and GPs need the clinical knowledge and skills to provide a competent service to the elderly. An "elder-friendly" practice will complement this care by improving quality, detecting gaps, and helping to avoid under or over-servicing and inappropriate investigation, medication or referral.

The elderly are in the main loyal to their GP, and appreciative of thorough care in a comfortable and friendly environment. Their GP's clinical skills perhaps become less important than the interpersonal ones. They have time to talk with their friends and family, and are not averse to voting with their feet if the practice management, environment or staff are considered below standard, even in seemingly small details.

This article provides ideas and checklists as an aid and incentive for practices to audit themselves for "elder-friendliness". Most of the structural and process items listed are common to all ages, but those of particular relevance to the elderly are emphasised. The recently developed RNZCGP practice standards document Aiming for Excellence1 includes a number of indicators and criteria of direct relevance to the elderly. These are referenced to the indicator number in the document (eg, A.1.8). Another resource likely to be of assistance in reviewing a practice is the RNZCGP publication Care of Older People.2 This covers common health problems and monitoring.

KEY POINTS

- An "elder-friendly" practice improves quality, detects gaps, helps to avoid under or over-servicing, and inappropriate investigation, medication or referral
- The elderly may appreciate their GP's interpersonal skills at least as much as their clinical ones
- Practices need systems to flag, recall, screen and monitor problems in the elderly as well as screening and health promotion
- A practice philosophy and consultation style centering on the person and their needs rather than on pathology or pharmacology is important
- Holistic care includes cultural issues, appropriate greetings, family involvement and issues like acknowledging geographical or tribal origin and links with the past
- Practice standards for the elderly need special scrutiny

Elder-friendly principles and attitudes

Age should be considered by the practice to be part of the normal lifecycle rather than a chronic, fatal condition. Many of the basic principles of good general practice apply particularly to older people (see Checklist 1). Those measured in the practice standards document are covered in more detail in the next section.

Anticipatory care

Looking ahead and planning for possible future scenarios is not at odds with supporting patient independence; rather it is designed to preserve it. Most non-demented elderly comply with a clearly explained and understood regimen of treatment and surveillance and seldom miss appointments. However, any change needs monitoring and reinforcement.

The practice needs systems to flag and recall non-attenders and people who do not pick up

repeat prescriptions. Also to screen for and monitor patients needing regular review or home visits, such as diabetics and the chronically disabled. Checklists at times of patient contact (eg, Checklist 2) can assist in forestalling deterioration. Regular structured assessment of older patients allows practitioners to move from a crisis intervention mode, to anticipatory health care.3-5

As a disease or disability progresses, aids and supports need to be predicted before a crisis occurs, and options for management discussed with the patient and/or carer. A management plan is useful but should be reviewed regularly and not set in stone, as elderly patients tend to continue a treatment even if the need for it has passed. Proposed or expected contacts with the health system, and the next visit to the practice, need to be agreed upon and noted at the end of each consultation.

It is helpful if the patient (and carer/family) are aware of the likely natural history and any possible complications of the condition(s), so that any departure from expected can be notified.

Health promotion and preventive care

Screening and health promotion is not wasted on older people. The cost-effectiveness of intervention in some conditions is greater in the elderly than younger adults. Thus, treating a blood pressure over 160/95 prevents four times more cardiovascular events over five years in men aged 70 than in those aged 40 6 (see also Practice systems below).

Patient-centredness

For the elderly, a critical quality is a practice philosophy and consultation style centring on the person and their needs, rather than on pathology or pharmacology. Elderly patients welcome a chance to give feedback and complete an appropriate patient-satisfaction survey.

Holistic care, family involvement and context

Careful attention to all aspects of the elderly person – body, mind and spirit – is an essential part of being patient-centred. Holistic care for the elderly includes cultural issues, familiar rituals and traditions such as respect and appropriate greetings, avoiding over-familiarity; family involvement; and issues like acknowledging geographical or tribal origin and links with the past.

With the elderly more than younger adults, the "patient" includes the context, and a practice culture and organisation encouraging home visits, and involving carers and family members (with due care about trust and confidentiality) is in everyone's interests. Carers of the elderly and disabled are at higher risk of morbidity and mortality, and need special attention.7

Continuity and teamwork

Continuity of care with one primary doctor and a small team of familiar staff, another core value of general practice, is the ideal for older patients.8 This is reassuring for one or two-doctor practices, but should also be possible in larger practices. This team is complemented by integration with other health professionals and agencies relevant to the elderly.

Advocacy

Also important to older people is the practice's advocacy role: helping them enter, comprehend and exit hospital and specialist services.Fulfilling requirements for practice assessment

The elderly are vulnerable physically, psychologically and socially. They appreciate a safe, secure and familiar environment, with staff (and facilities) helping to preserve their dignity and independence, and doing their best to understand and appreciate their special needs.

The following is a guide to understanding and fulfilling the

Checklist 1

Elder-friendly principles

- anticipatory care
- health
- promotion/prevention
- patient-centredness
- holistic care

indicators and criteria looking specifically at the elderly in the practice standards document Aiming for Excellence in General Practice.1 This may be obtained from the RNZCGP secretariat. The standards are currently undergoing validation in 100 practices.

- consideration of context
- teamwork
- advocacy

PRACTICE STRUCTURE AND FUNCTION

A. Factors affecting patients

Practices might not consciously discriminate on grounds of age, but might provide unintentioned or unrecognised barriers constituting discrimination (A.1.1). Some of these are discussed in this section, eg, privacy for hearing impaired people may be lost if voices have to be raised at reception or in consulting rooms (A.1.3), or the needs of patients with disabilities may not be fully met (A.1.4: criterion 5). Elderly patients rarely complain (A.1.5) and may need to be specifically canvassed to obtain valid feedback with targeted patient satisfaction surveys (A.1.6; A.1.7).

Checklist 2

Anticipatory care (consultations)

- When was the patient last reviewed fully?
- When is the next full review date?
- What is the purpose of this consultation?
- What questions shall I ask now?
- What measurements/assessment should be made?
- Are there any indications to alter management?
- If change is required, what and by how much?
- How well does the patient understand the condition(s) and management?
- Has the patient/caregiver any concerns or questions?
- When is the next consultation necessary?
- How can I become aware if the patient fails to return?

Access and availability

A health problem in an older person is a threat to independence. Anxiety already present can

be worsened if there are difficulties trying to access advice, make appointments or ask for a home visit. So there needs to be easy, direct access to a doctor or nurse (preferably a familiar one) at all hours, without engaged tones, answering machines, electronic voices or complex instructions (A.3.1).
Special arrangements to allow hearing or sight impaired people to communicate with the practice are also helpful (A.3.1: criterion 4). The College standards recommend access to the 24-hour service via a single telephone call (A.2.1: criterion 3). The response to urgent problems, and any phone-back system, needs to be foolproof (A.2.2).
Appointment, home visit and after-hours arrangements need to be clearly displayed and available to take home (A.2.3). Patients need to be listened to and managed empathetically. Understanding needs to be checked, and decision making and informed consent shared (A.2.4). Repeat prescription systems need to be appropriate, accurate and safe, with mechanisms to review medication regularly (A.2.5). An audit of patients on multiple drugs is a good way to start.
When arriving at the practice, elderly people appreciate convenient parking and a drop-off area (undercover), and easy access without steps (A.3.3).

B. Physical factors

The waiting room needs to be comfortable, with appropriate seating and some separation from noisy children (B.4.1). Piped music should be "easy listening" and appropriate for all ages.
All practice facilities, especially consulting rooms and toilet, also need to be comfortable, and designed to accommodate elderly, disabled, and wheelchair patients, with easily read signage (A.3.3; B.4.2). Safety needs to be considered (eg, non-slip floors, railings). To avoid undue pressure on both patients and staff (and the temptation to cut corners in examinations), a

separate room to allow the doctor or nurse to continue working while elderly patients dress or undress is helpful.
Practice equipment of special relevance to older patients includes items used for vision and hearing testing and assistance, ear syringing/suction, ECG, urinary catheter, and appropriate dressings and biopsy/excision instruments (B.5.1).

C. Practice systems

Health checks and screening programmes for the elderly are as important, or more so, than in younger adults, but need to be clearly evidence based as well as appropriate to the age group (C.6.1; C.6.4). Some preventive care and screening guidelines include age as an exclusion criterion (eg, breast and cervical cancer screening);9 others have been shown to be more beneficial in older people (eg, colorectal cancer, osteoporosis,10 incontinence,11 dementia,12 home risk factors). A few are appropriate across the age groups but are more relevant or more prevalent in the elderly (eg, depression, diabetes).13
The College resource for older people contains appropriate screening guidelines and tests.2 The practice needs to be aware of current initiatives targeting the elderly, such as influenza immunisation (C.6.5). In order to carry out such surveillance a practice age-sex register is necessary (C.6.3). Health promotional and educational information appropriate for older patients is important also (C.6.2).

D. Information management

Records systems need to be able to accommodate all past information but at the same time prioritise ongoing problems and allow easy access to current problem and medication lists (D.7.1.1; D.8.3). A system of timely transfer of old records between practices is essential (D.8.4).
Although more difficult in larger practices, careful collaborative teamwork with a GP-nurse-receptionist team, complemented by specialist nurses and other health professionals where necessary, can preserve some continuity of relationship with the patient (D.9.1). A more intensive service to elderly patients with special needs and disabilities requires a register, a monitoring system, and clear instructions on access after-hours for the patient or caregiver (D.9.2).

Conclusion

An elder-friendly practice is one with a culture of patient-centred, holistic, anticipatory and preventive care, promoting continuity of care, and with a practice structure and processes designed for older and disabled people. Quality assurance (E.11.2) should include audit and quality improvement targeted at the specific needs and requirements of the elderly (Checklist 3).

Checklist 3

Suggested indicators for audit of practice "elder-friendliness"

Review a representative sample of older patients (eg, over age 70) using the following checklist of quality indicators:

Anticipatory care	**Access and availability**
• Patients have a mutually agreed, documented and regularly reviewed management plan • All patients are regularly assessed and	• 24-hour medical cover: A.2.1 (especially criterion 3) • Response to urgent problems: A.2.2 (all criteria)

reviewed (with appropriate frequency depending on disease, disability or support structures • The practice has a system for detecting and dealing with missed appointments or prescriptions not collected • The patient and/or caregiver know what situations require medical attention	• Information: A.2.3 (all criteria) • Informed decisions: A.2.4 (all criteria) • Repeat prescriptions: A.2.5 (all criteria) • Telecommunications: A.3.1 (all criteria) • Signs and parking: A.3.3 (all criteria)
Holistic and patient-centred care • At every GP consultation and other patient contacts, the patient is given due consideration as a person, in the following respects: – as a whole person: body, mind and spirit – the cultural and whanau (family) context – respect, trust and confidentiality – family and caregiver involvement and self-care	**Physical factors/facilities** • Waiting room: B.4.1 (all criteria) • Background music (if any) is appropriate for older people • Consultation areas: B.4.2 (all criteria) • Consultation space allows for a separate dressing/undressing area • Floors and corridors are designed to minimise falls (lighting, carpet, obstructions, handrails) • The following equipment is available in the practice (B.5.1.1): – vision/hearing testing – ear syringing – ECG – urinary catheter – appropriate dressings – biopsy/excision equipment
Continuity of care • The practice systems ensure patient contacts are usually with the doctor or other staff member(s) best known to them • Records transfer: D.8.4 (all criteria)	
Teamwork • The practice team structure and process ensure comprehensive care of the elderly without duplication or gaps • Integration of care: D.9.1 (all criteria) • Special needs patients: D.9.2 (all criteria)	**Practice systems** • Clinical guidelines: C.6.1 (all criteria) • Health promotion information: C.6.2 (all criteria) • Age-sex register: C.6.3 (all criteria) • Screening (age specific): C.6.5 (all criteria) • National health targets (age specific): C.6.6 (all criteria)
Advocacy • The practice assists patients to negotiate the state and private health-care systems successfully, intervening when necessary	**Information management** • Medical records: D.7.1.1 (especially section 3: management plan, medication; section 4) • Records access: D.8.3 (all criteria)
Rights and needs of patients	**Quality assurance**

• Human Rights Act: A.1.1 (all criteria) • Privacy: A.1.3 (all criteria) • Code of Health & Disability Services Consumers' Rights: A.1.4 (criterion 5) • Complaints: A.1.5 • Patient involvement: A.1.6 (all criteria) • Patient satisfaction: A.1.7 (all criteria) • Cultural issues: A.1.8 (especially criterion 1); A.1.9	QA and CQI activities (specific to the elderly): E.11.1; E.11.2 **Note:** Indicators taken from College practice standards document1 are referred to by indicator number only

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