The population of the United Kingdom is expected to increase over the next 25 years, with most of the increase in those older than 50 years. The largest percentage area of growth will be in the oldest age group (85 and older) and in males more than females. (J Am Med Dir Assoc 2009; 10: 223–225)

**Keywords:** Quality of care; institutionalized elderly; geriatric syndromes

---

The population of the United Kingdom is expected to increase over the next 25 years, with most of the increase in those older than 50 years. The largest percentage area of growth will be in the oldest age group (85 and older) and in males more than females.1

Currently, 12% of men and 23% of women in the 85 and older age group live in communal residential establishments but overall numbers of the institutionalized elderly are likely to increase. With this change in demography comes the increasing need for appropriate and cost-effective medical care. Although medical care has improved in the past few years, it is still far from ideal for this frail vulnerable group.

Currently there are 2 main care home settings in the United Kingdom: (1) residential homes where patients have minor degrees of disability and some health and social care needs; these residents are fairly independent, and (2) nursing homes, which provide 24-hour nursing care. Many care homes run dual facilities allowing transfer of patients from residential to nursing care should patients deteriorate.

Traditionally, medical care of residents has been overseen by primary care physicians on a needs basis. More recently, however, other models are emerging that provide more comprehensive care tailored to the residents’ needs. Community geriatricians, for example, provide support to nurse specialists, primary care physicians, and all therapy teams.2

The National Service Framework (NSF) was designed to be a turning point for care of elderly patients in the United Kingdom. This document outlines the main geriatric syndromes and the best evidence with the actions required.3 It stresses the importance of treating older people as individuals and enabling them to make choices about their own care. Although it highlights some of the crucial issues affecting older people in a modern health care system, the recommendations were not properly funded and implementation was fragmentary.

Recommendations have also been published by the British Geriatrics Society in 1997 (revised 2003, 2007) for standards of medical care for older people.4 This document outlines the key elements of specialist services for older people and for those people working in the services. It includes the specialist health needs of older people outside an acute hospital setting and the importance of comprehensive geriatric assessment (CGA), a multidimensional evaluative process previously found to improve survival and function,5 but insufficiently progressed within British geriatric medical practice until fairly recently.

The government has taken on board that regulation and improving the lives of elderly people in institutional care is important. The National Minimum Standards document6 set out the core standards expected from care homes. This was published after the Care Standards Act 2000 from which the Commission for Social Care Inspection (CSCI) was formed. This body has been successful in regulating, inspecting, and reviewing care homes. The report “The State of Social Care in England 2006–2007” published by CSCI stated that care homes for older people met on average 80% of the national minimum standards—a 21% improvement since 2003.

**HIGHLIGHTING ISSUES**

Different models of care have been tried. For a model of care to be successful certain factors seem to be important. Doherty et al7 found that a specialist care homes support team had an impact by empowering care home staff, promoting rapid access to services, improving quality of life for
residents, promoting changes in organizational culture, and supporting staff in management of long-term conditions.

However, medical care is just one aspect of the holistic care when considering the needs of care home residents. In a report, “My Home Life,” the charity, Help the Aged, aimed to highlight factors that influence the quality of life of the older person. These included maintaining a sense of identity and creating opportunities for recreation, social, and community activities; shared decision making; and end-of-life care.

One of the fundamental problems of delivering high-quality medical care in British care homes is that services are not joined up. However, in areas such as end-of-life care the government has pushed forward with initiatives such as the End-of-Life Care Strategy. This shares good practice and engages users and carers, commissioning, knowledge, and skills. The challenge, however, is implementing these initiatives into practice.

Urinary incontinence is another area often given low priority even though 24% of older adults suffer from the condition and 30% to 60% are those who reside in long-term care settings. The Audit of Continence Care by the Royal College of Physicians showed a failure to diagnose and treat continence problems effectively.

Support for patients with dementia also seems to be lacking. Up to 75% of residents in care homes have dementia. The National Dementia strategy suggests a specialist mental health assessment on admission and regular review with support from pharmacists, dentists, optometrists, and geriatricians. This, however, has huge resource implications and is implemented infrequently.

Prevalence of illnesses is often grossly underestimated. Aspray et al found the prevalence of diabetes in care home residents to be 11.5% versus 3.5% according to the diabetes register, whereas a study in Birmingham care homes using the oral glucose tolerance test found a prevalence of diabetes approaching 27%. These patients are often very frail and vulnerable, and many have high dependency levels and comorbidities. It is known that diabetic residents have higher levels of arterial disease, foot ulceration, and dementia. A well-structured program of coordinated care is essential. The National Service Framework for diabetes set out standards for patient-centered medical homes.

EMERGING AREAS

New models of improved care provided to homes are emerging. In South Yorkshire, a dedicated specialist care homes team was set up to provide intensive support to staff and residents with an aim to avoid unnecessary admission to the hospital. This multiprofessional team demonstrated a new way of working to provide services in homes that could in the long-term be cost effective.

In contrast, in the United States, the National Committee for Quality Assurance has set new standards for patient-centered medical homes. The medical home is a model of care where each patient has a link with a physician and the physician’s team to provide all their health care needs. There is open scheduling, extended hours, and communication between physicians and staff.

With the increasing technology and easy access, eHealth Web sites (ie, WebMD.com) have been analyzed as a reference resource in nursing homes in the United States and abroad giving justification for their introduction as an adjunct to current resources.

Palliative care link nurses have shown the potential to improved palliative care in UK nursing homes. In the United States, special programs and specially trained staff (SPTS) are prevalent for hospice or palliative/end-of-life care.

Systematic and regular reviews of medications by a multidisciplinary team of general practitioners (GPs), pharmacists, and nursing home staff have been shown to be effective.
Time constraints on already hard-pressed GPs, however, make this a difficult option.

In Ontario, Canada, nurse practitioners working in long-term care homes were found to prevent 39% to 43% of hospital admissions and had a positive impact on improving staff confidence. In the United Kingdom, nurse consultants are increasingly providing this link between primary and secondary care.

In order to progress, local and social care backing is needed and at a higher level commitment from the government to enhance funding. Certainly local services can be developed, and with the support of local health care trusts a fully integrated comprehensive service could be provided with a consultant and a multiprofessional team dedicated to care home residents.

Evidence-based practice for long-term conditions needs to be put into practice, and with that, the appropriate ongoing education and training for people working in the homes. Standard regular assessments of practice would improve the overall care. Where residents are able to make their own decisions, this should be actively encouraged in all aspects of their care. Finally, if geriatricians play a more active role in bringing about change, then the quality of care delivered will improve and others will be encouraged to be involved.

REFERENCES

2. British Geriatrics Society Compendium. The specialist needs of older people outside an acute hospital setting. 4.31.