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Older people in care homes and the primary care nursing contribution: a review of relevant research

Claire Goodman and **Rosemary J Woolley** Primary Care Nursing Research Unit, University and King's Colleges, London, UK

In the UK, older people who are resident in care homes because of their needs for social support and personal care receive their health care from primary health care. Although there is increasing input from district nurses in care homes (Audit Commission, 1999), there is little knowledge or recognition of the primary care nursing contribution. This paper reviews two types of research literature: studies that consider the health care needs of older people in residential care homes that could inform nursing support and interventions in care homes, and research that describes the nursing involvement with these settings. The paper argues that on the basis of the research reviewed many of the health problems older people in care homes experience could be avoided or improved by primary care nursing support and intervention. A reassessment is needed of how the interface between community and residential care is managed so that older people in care homes have access to appropriate health care support.

Key words: care homes; district nurses; older people; primary care nursing; primary health care; residential homes

Introduction

In the UK, older people who are resident in care homes because of their needs for social support and personal care receive their health care from primary health care. There is evidence that the impact of providing general practitioner (GP) services to older people in institutional settings is greater than providing for older people in their own homes (Jacobs, 2003; Kavanagh and Knapp, 1998; Pell and Williams, 1999). However, there is little discussion of the contribution of other primary care based NHS practitioners who regularly work with care homes and what kind of interventions they undertake for older people in these settings. This is despite an increasing policy expectation that NHS staff will work closely with other providers of care for older people and that care homes will offer intermediate care and rehabilitation services alongside their long term care provision (Department of Health, 2001a). The aim of this paper is twofold. To review evidence of the health needs of older people in care homes that could benefit from primary care nursing interventions and support, and to establish what is already known about the nursing contribution in these settings.

Care home provision for older people

In England, care homes provide for older people who have been assessed as needing ongoing help with personal and/or nursing care. Some care homes can provide both types of care, but the majority differentiate between residential (personal/social care) and nursing care. Most care homes in England (71%) offer residential and personal care only, and the independent sector is the main provider of 90% of these homes. In 2000 there were

Address for correspondence: Dr Claire Goodman, Primary Care Nursing Research Unit, University and Kings College's London, UCL Archway Campus, Holborn Union Building Level 2, Highgate Hill, London N19 3UA, UK. Email: c.goodman@pcps.ucl.ac.uk

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341 200 places in homes offering residential care (Department of Health, 2000). Of the total population who are over 65, 4% are resident in care homes and from age 75 this progressively rises with 30% of people aged over 90 resident in care homes (Wanless, 2001).

In April 2002, the Care Standards Act (Department of Health, 2001a) replaced the Registered Homes Act 1984 as the legal framework for regulation of care services. The Care Standards Act led to changes in the definition of and regulatory arrangements for care homes for older people in England and Wales. The Act makes no distinction in registration between residential and nursing homes, stating that an establishment is a care home if it provides accommodation together with nursing and/or personal care. For the purposes of this review, the definition of care home, unless otherwise stated, applies to those who largely provide personal rather than nursing care to residents.

The review

The review located studies on the health needs of older people in care homes that could arguably inform nursing intervention and support for this population, and research that considered specifically the primary care nursing contribution to care homes. Databases included were: CINAHL, MEDLINE, BIDS, AgeInfo, the Cochrane Library and British Nursing Index. Variations and combinations of key words used included residential homes, long-term care, older people, health needs assessment, nursing, and primary health care. Studies were excluded if the two reviewers independently considered the research focus unlikely to inform nursing work in care home settings (e.g. specific medical conditions or therapy regimes). The research literature was organized into three areas: research on physical and mental health needs, research on the experience of being a resident and research into the nursing contribution. Studies that included both residential and nursing homes were included. Literature was reviewed from 1990, as the NHS and Community Care Act (Department of Health, 1990) was the last significant change in the organization and funding of support for care homes (residential) up until the implementation of the National Minimum Care Standards Act in 2002 (Department of Health, 2001a).

The research evidence: older people in residential homes

Research into health care needs

In the wake of the reforms of the NHS and Care in the Community Act (Department of Health, 1990), a series of research studies looked at dependency levels in relation to costs and quality of life (Personal Social Services Research Unit (PSSRU), 2001). A longitudinal survey of 2544 people admitted to publicly-funded residential and nursing home care in 1995 and a cross-sectional survey of residents ($n = 11\,899$) was carried out in 1996. The results showed that residents are considerably more dependent than a decade ago, particularly with regard to cognitive impairment and inability to perform self-care tasks such as washing. In private or voluntary residential homes the proportion of people who are highly dependent had risen by 28%. Crosby *et al*. (2000) in a separate survey of 468 residents found that 20% of residents in the residential and dual-registered homes were classified in the highest dependency category. Like the Personal Social Services Research Unit (PSSRU) research, they found that although nursing homes have the highest dependency levels, there is a band of overlap between the dependency ratings of residents in residential and nursing homes.

These studies claim that residential homes are supporting residents with greater disability than previous surveys indicate. However, it is acknowledged that comparison of studies is difficult when different measures of dependency have been employed. These include the DHSS classification of dependency (Davies and Knapp, 1978), the Barthel Activities of Daily Living Index (Mahoney and Barthel, 1965), the Clifton Assessment Procedures for the Elderly (Pattie and Gilleard, 1979) and the modified Crichton Royal Behavioural Rating Scales (Wilkin and Jolley, 1979). The concept of dependency has also been unclear (Dant, 1988; Darton, 1994). Challis *et al*. (2000) in their survey ($n = 308$) provide evidence that admission is as influenced by economic factors as by health or social need, and defined the majority (71%) of new admissions to residential homes as having low dependency needs. Nevertheless, the evidence suggests that new admissions to residential care are increasingly old (aged 80 or over) and that a minority are severely dependent (Challis *et al*., 2000; Crosby *et al*., 2000).

Specific health needs: identification and management

It is argued that older people resident in care homes feature many clinical diagnoses, including nonstroke cardiovascular disorder, rheumatological diseases, dementia, stroke and neurodegenerative disease (Challis *et al*., 2000; Royal College of Physicians *et al*., 2000). More research, however, has focused on the prevalence and management of specific health needs such as continence (Peet *et al*., 1995; 1996; Roe and Shiels, 2000), infection (Yates *et al*., 1999), pressure sores (Shiels and Roe, 1999), hip fracture (Butler *et al*., 1996; Norton *et al*., 1999), dental health (Lall, 1999), diabetes (Taylor and Hendra, 2000), visual problems (Sturgess, 1994), hearing impairment (Stumer *et al*., 1996), and terminal care (Komaromy *et al*., 2000) – all of which are relevant to nursing. It is difficult to generalize from these studies which have been few, of a small sample size, have not all been carried out in the UK or do not differentiate between residential and nursing home populations. Nevertheless, they indicate prevailing health needs that are inconsistently managed and that could be improved through nursing support collaboration with unqualified staff. For example, two separate surveys by Peet *et al*. (1995) (n = 6079) and Roe and Shiels (2000) (n = 652) found that around a third of residents from residential homes had a continence problem. Eighty seven per cent of homes in the Peet *et al*. (1996) survey reported using aids and appliances. Both studies claimed that in only two-thirds of the homes was promotion or management of continence adequate. Komaromy *et al*. (2000) found that although care staff were committed to providing quality terminal care for residents, barriers to good practice included staff shortages, a lack of knowledge of palliative care and the physical layout of the home.

Mental health needs

High levels and comorbidity of cognitive impairment, depression, dementia and behavioural problems have been identified by several studies in care homes (Godlove Mozley *et al*., 2000; Jagger and Lindesay, 1997; Medical Research Council Cognitive Function and Ageing Study, 1999). Jagger and Lindesay (1997) found that in a population of 6079 living in different types of residential facilities, 38% were moderately or severely cognitively impaired and behavioural problems were present in 11.5%. The research conducted by Challis and colleagues (Godlove Mozley *et al*., 2000) identified clinically significant cognitive impairment in 61% of new admissions to the 18 residential homes in their sample, and nearly 45% were classified as 'depression cases'. Comorbidity of cognitive impairment and depression was found in 24% of the residents and positive associations were found between cognitive impairment and dependency, depression and reduced mobility, and depression and social class. Depression in particular has been identified as a major health threat for older people in residential homes (Ames, 1990). However, it has been argued that an awareness of depressive disorders in this population is poor and symptoms of depression often go unrecognized by care staff (Bagley *et al*., 2000). The available evidence suggests that mental health conditions are common, that they may mask other physical problems such as pain, are a challenge for assessment and indicate a need for specialist expertise for this population (Godlove Mozley *et al*., 2000).

Intervention-based studies

A few intervention studies have targeted the specific needs of older people living in residential homes with varying success. These have included the introduction of specialist outreach teams for care homes to improve the quality of resident staff interaction, and resident mental health (Proctor *et al*., 1999; Reeves *et al*., 1998). Two randomized controlled trials in residential care homes that had exercise promotion and falls prevention interventions, were both able to show improvement in their intervention groups in the short term (McMurdo and Rennie, 1993; McMurdo *et al*., 2000). One study described the introduction of an oral health training programme for care staff and concluded that despite evidence of need and an increase in care staff knowledge, actual oral care did not improve one week or one year after the intervention (Simons *et al*., 2000). In contrast to experimental and before and after evaluation designs, other intervention studies have focused on specific conditions such as depression or behavioural difficulties and raised staff awareness, but have not involved nurses. For example, Ames (1990) attempted to treat depression among older residents of 12 residential homes. Psychiatric interventions proved to be difficult to implement and

there was no evidence to suggest efficacy of the interventions at three months, or after one year. More recently, the randomized-controlled trial by Llewellyn-Jones *et al*. (1999) evaluated the effectiveness of a population-based multifaceted shared-care intervention for late life depression in residential care. Although their methods have been criticized (Cameron *et al*., 2000; Deeks and Juszczak; 1999; Haynes, 1999), they claim there was significantly more movement to 'less depressed' levels of depression at follow-up in the intervention group than in the control group.

Meehan *et al*. (2002) describe the preliminary findings of a partnership project where a project nurse (not primary care based) using an action research approach, was able to work with nursing and residential care homes to review training and development needs and inform the commissioning of education and services The authors described a range of new intitiatives because of the partnership approach but did not discuss the implications of the changes for the older people. All the intervention studies reviewed relied on extra researchers/specialists to implement the intervention, did not discuss how existing community services could be used to sustain change, and followed up their interventions for a year or less.

The move into residential care

Considerable evidence suggests that admission to residential care is often precipitated by a sudden crisis or psychological factors such as loneliness, grief or the lack of companionship that might follow bereavement (Allen *et al*., 1992; Burholt, 1998; Lee *et al*., 2002; Warburton, 1994). In particular, the fear of moving into an 'institution' or the lack of involvement older people have had in the decision-making process can constitute a threat to an older person's sense of individuality (Peace *et al*., 1997). Morgan *et al*. (1997) suggest that older people who perceive relocating to a care home as stressful, are at risk of developing either physical illness or negative psychosocial states. The focus of nursing research in this area, therefore, has been on the importance of involving and providing continuity of care for the patient and their carer(s) during the transition period and on the maintenance of their sense of self. Hunter *et al*. (1993) suggested that district nurses and community psychiatric nurses might be best placed to engage older people and their carers in discussions about their care options. Reed and Morgan (1999) interviewed 20 older people and 17 of their family members following discharge from hospital to a care home. They found that few people had been offered opportunities to discuss their move with nurses and that older people tended to adopt a stoical attitude. Nolan *et al*. (1996) and Reed and colleagues (1996; 1999) suggest how nurses might facilitate such discussion, as well as support older people and their carers through the process of adapting to their new environment. Lee *et al*. (2002) reviewed 30 years' research into older people's experiences of residential care placement and concluded that although there was evidence on older people's transition to care, less was known about how older people, and particularly those from different ethnic backgrounds, come to terms with residential life. This area of research draws attention to the issues that might face older people prior to, during or following a move to residential care and suggests that nurses could be appropriately placed to undertake sensitive interventions.

Involvement of primary care services

Primary care nursing involvement: issues of access and demand

A national survey of access to NHS services by care homes for older people in England (Jacobs *et al*., 2001) found that almost all care homes had access to district nursing services, but access to specialist nursing support was limited and the frequency of contact care homes had with nursing services was variable. Since 1992, the number of district nursing contacts in care homes offering residential care has risen by 13%, even though actual numbers of older people in residential care are not increasing at an equivalent rate. Older people in care homes consistently account for about 7% of all district nurse contacts, and the proportion of this population being seen by district nurses is rising as the average age of the resident rises (Audit Commission, 1999). Little is known about the kind of nursing support that residential care homes receive from generalist and specialist community based nursing services. Donald *et al*. (2002a; 2002b) undertook a census in one county of district nursing involvement in care homes and suggested their work was primarily concerned with wound care and the management of continence.

However, the census was based on care home managers' responses choosing from a range of six predetermined nursing interventions. This could have meant only a partial account of the range of district nursing work in care homes was achieved. In a study that asked district nurses about working in residential care homes, practitioners described it as a significant part of their work often shaped by factors unrelated to patient need such as, GP attachment, availability of other resources and confusion around their role and responsibilities (Goodman *et al*., 2003). They acknowledged this was a demanding aspect of their work, but they felt ambivalent about their increasing involvement. The only other study found that has considered nursing involvement surveyed 730 palliative care nursing specialists' work in both types of homes. The authors concluded the work was reactive, intermittent and task specific. There were only a few examples provided where practitioners had adopted a more proactive approach in these settings (Froggatt *et al*., 2002).

Demand for services

Counsel and Care (1998) looked at the relationship between health services and care homes. Although the involvement of GPs was central to the study, it is nevertheless remarkable that there is no mention of district nursing services and only very brief discussion of community psychiatric nurse involvement. Crosby *et al*. (2000) monitored the contacts with primary health care services made by residents in 10 nursing homes, 14 residential homes and three dual-registered homes over a 16-week period in 1996. As no other contemporary studies have measured demand for all the primary health care services by residents, it is difficult to compare this study. Contacts with the district nursing service were less than with GPs. However, residents in residential care homes placed a high level of demand on district nursing services. Multiple regression analysis indicated that the interaction of several factors explained 60% of the demand placed on primary care services (Crosby *et al*., 2000). These were: resident numbers, mean dependency of the residents of the home, number of whole time equivalent (WTE) care staff employed by the home, the mean experience of staff in years and the percentage of WTE care staff who had formal qualifications. A positive relationship was found between 20% of residential home patients who used a high proportion of primary care services. Crosby *et al*. (2000) argue that the significant demand on district nursing services from a minority of highly dependent residents raises issues about appropriate placement, the type of care residential home staff are allowed to undertake and the availability of specialist geriatric services.

Discussion: the contribution of primary care nursing

The research reviewed suggests that older people in residential care homes are a vulnerable population who have a spectrum of health needs amenable to nursing support and interventions from primary care. Despite ongoing concern about the health care provided to residents (Black and Bowman, 1997; Counsel and Care, 1998; Royal College of Physicians *et al*., 2000; Turrell *et al*., 1998), the research literature contributes little to an understanding of primary care nursing in residential homes. It appears that although district nurses are the primary care nurses who have regular and increasing contact with older people in residential homes (Audit Commission, 1999; Goodman *et al*., 2003), their role and contribution has consistently been overlooked. Similarly the contribution of community psychiatric nurses, specialist nurses and practice nurses, or the public health role of health visitors in this setting has not been explored in recent research and reports (Counsel and Care, 1998; Crosby *et al*. 2000; Royal College of Physicians *et al*., 2000). The only topic that has been given attention in the nursing literature is that of supporting older people during and after the transition to residential care (Lee *et al*., 2002; Nolan *et al*., 1996; Reed and Morgan, 1999; Reed and Roskell Payton, 1996). Standards for good practice in care homes (Centre for Policy on Ageing, 1996; Department of Health, 2002) have concentrated more on the experiences and quality of everyday life for older people rather than on access to or standards of health care. A justified concern that care homes are not seen as mini hospitals but as homes for living in, may help to explain why there has been minimal discussion of older peoples' need, access and use of nursing support and care in these settings.

Recommendations for the development of intermediate care identify care home settings as service providers, and presuppose a network of support from primary care that is likely to include nursing expertise. Furthermore, the recent NSF (Department of Health, 2001b) on older people indicates that nurses should be involved in providing support and training to care staff. Arguments for specialist gerontological nurses in these settings do not appear to engage with how these practitioners will integrate with existing services nor acknowledge the existing nursing input or potential for development of these services (Royal College of Physicians *et al*., 2000). It is also unclear why the existing involvement of primary care nursing has been so overlooked when there has been discussion of the demands on GP services, and in some situations, additional remuneration to acknowledge the extra work these providers create for primary care services.

Research on nurses in primary care and district nurses in particular consistently identifies their contribution as maintaining continuity in care, coordinating and involving other services, as well as providing direct and specialist care to a predominately older patient group (Audit Commission, 1999; Goodman *et al*., 1998; Griffiths, 1996; McIntosh, 1996; Smith *et al*., 1993). These are attributes that do and could benefit further older people in care homes. The inevitable lack of continuity apparent in intervention-based studies could be addressed by primary care nurses adopting a more proactive role in the management of health care for this population – an approach that reflects a public health dimension of primary care nursing (Department of Health, 2002). It is to be hoped that the introduction of the Single Assessement Process and use of standardized approaches to assessment and review of care (Ford and McCormack, 1999) will encourage a more systematic approach and a greater recognition of the contribution of nursing for this population.

Conclusion

Much of the literature reviewed in this paper does not make a distinction between nursing and residential home populations. From a primary care nursing perspective the absence of nursing staff in the home defines their involvement with older people as the main providers of nursing support and interventions. Very little is known about how much care is provided, in what context and to what effect. However, what research there is strongly suggests that although older people in these settings have a range of health needs that could be helped by nursing support, their access to primary nursing care is variable. Flicker (2002) observes that although there has been considerable progress in the clinical management of disabling problems, such as dementia, osteoporosis, incontinence and falls, the appropriate mix of funding between primary, secondary and tertiary interventions has not been determined. Arguing from an Australian perspective he argues the health care needs of older people in residential care have been totally neglected. In this country, primary care trusts have the opportunity to take a more strategic, proactive approach and work with public, private and voluntary providers of care for this vulnerable population. This review has demonstrated the need to develop what is currently being offered for older people, ensure equity of access to services and ultimately evaluate which models of care and who is best placed to promote and maintain the health of older people in residential care homes.

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