

Age-friendly principles and practices

Managing older people in the health service environment

Developed on behalf of the Australian Health Ministers' Advisory Council (AHMAC)
by the AHMAC Care of Older Australians Working Group.

Endorsed by Australian Health Ministers, July 2004

Developed on behalf of the Australian Health Ministers' Advisory Council (AHMAC) by the Care of Older Australians Working Group. Endorsed by Australian Health Ministers, July 2004.

Published by the Victorian Government Department of Human Services, Melbourne, Victoria, Australia.

April 2005

Copies of this document can be obtained from:

The COAWG Secretariat
Department of Health and Ageing
MDP 126
GPO Box 9848
Canberra City ACT 2601

Or

The COAWG Secretariat
Metropolitan Health Care and Aged Care Services Division
Department of Human Services
GPO Box 4057
Melbourne Victoria 3000

This document may be downloaded from the Department of Human Services website at
www.health.vic.gov.au/acute-agedcare

ISBN 0711 6217X

Foreword

The treatment and care of older people can present health service providers with a mix of complex medical care and psychosocial challenges. If poorly managed, an older person's stay in a health care facility might result in adverse outcomes ranging from rapid physical and cognitive deterioration to increased length of hospitalisation, premature entry to residential aged care and increased mortality.

People aged 65 years and older are significant users of public hospitals, representing 34 per cent of all public hospital separations and 48 per cent of all public hospital bed days in 2002–03.¹ Although much has been achieved in recent years, the hospital environment with its absence of familiar surroundings and support, the practice of confining patients to bed, reduced activity and the likelihood of higher than average risks of complications associated with the medical and diagnostic procedures, means the older person's stay in hospital can result in poorer outcomes than would occur in younger people.

Given the current demographic trends, health services need to adopt policies and procedures that address the diverse needs of older patients and their carers. It is no longer appropriate for age-friendly care to be delivered only in 'geriatric' or 'general medical units' within a hospital.

Older people receive treatment and care across the entire health service. It is therefore important that health services review their underlying principles and practices to ensure they:

- adopt principles and practices that enable older people to access appropriate forms of care treatment and support as indicated
- optimise older people's health outcomes and their functional independence
- take the older person's wishes into account where possible
- provide a supportive environment during decline and end of life.

The Australian Health Ministers' Advisory Council's Care of Older Australians Working Group developed the following health service principles and practices with the support of its Clinical Reference Group. Australian health ministers endorsed the principles and practices in July 2004.

This report establishes an overarching national framework for health services and their management of older people. It is consistent with state and territory policy directions and should be implemented in conjunction with these.

¹ Australian hospital statistics 2002–03 from the Australian Institute of Health and Welfare.

Contents

Principle 1	6
Principle 2	7
Principle 3	8
Principle 4	9
Principle 5	10
Principle 6	11
Principle 7	13
Appendix 1: Robust protocols and agreements	14

Principle 1

Health treatment and care delivered to older people will be based on strong evidence and have a focus on maintaining, improving and preventing deterioration in their health and quality of life.

Practices:

1. An holistic approach is adopted in caring for the older person, which takes into consideration their overall physical, psychological and social needs despite the person having presented with an acute condition.
2. Health services apply practice based on the best evidence available in caring for older people. This should include specific attention to maintaining functional mobility:
 - avoiding falls
 - avoiding the loss of skin integrity
 - improving nutrition
 - managing delirium and dementia
 - managing depression and isolation
 - improving medication management
 - managing incontinence
 - promoting self-sufficiency and self-management.

Principle 2

Health services will recognise and address older people's complex needs.

Practices:

1. Appropriate screening is undertaken to identify older people at risk of adverse health outcomes.
2. Older people with a positive risk screen have a comprehensive interdisciplinary assessment which builds on existing information and identifies:
 - functional ability
 - physical health
 - cognitive and mental health
 - availability of carers or services
 - socio-environmental situation.
3. Older people at risk of adverse health outcomes have an interdisciplinary care plan developed early in their admission which takes into account their pre-existing health issues, care plan or community health service support.
4. The assessment outcomes inform the development of the interdisciplinary care plan, which is founded on evidence-based care pathways where available.
5. Development of the interdisciplinary care plan involves input from:
 - a range of health professionals
 - the primary care service provider
 - the older person where possible
 - the older person's carer or family
 - community support providers where appropriate.
6. Treatment and care provided to older people link to the interdisciplinary care plan and to any pre-existing care plans.

Principle 3

Health treatment and care are respectful and recognise individual differences and specific needs, such as cultural, religious and sexual differences.

Practices:

1. Older people and, where appropriate, their carers are involved in planning their care and treatment.
2. Health services are responsive to older people with special needs, including those from diverse language and cultural backgrounds, such as Aboriginal and Torres Strait Islander people, people living in rural and remote areas, and people on low incomes. This might include:
 - providing information on accommodation and advocacy services for carers and families
 - giving access to accredited translators and translated information
 - considering dietary needs, religious beliefs and customs.
3. Older people with complex co-morbidities have their condition and treatment explained to them and to their carers and families and there is confirmation of understanding.
4. Elderly patients and their carers and families are actively involved in setting goals and developing their care plans so that self-management is encouraged and seen as a valued contribution to the ongoing care.
5. Health care services are sensitive to the needs and abilities of families and carers.

Principle 4

Health treatment and care are delivered in a coordinated and timely manner across care settings.

Practices:

1. Coordination encompasses all settings (inpatient and ambulatory) and facilitates the person's admission to hospital and return back to the community. This might include:
 - linking with the older person's current primary care and community services providers to ensure relevant information, including that dealing with health risk factors associated with ageing (for example, social isolation, drug and alcohol abuse, domestic violence (elder abuse)), exercise and nutritional status, and chronic disease self-management, is available to avoid duplication and gaps
 - initiating discharge care planning early in the admission to avoid delays in accessing services
 - involving the primary care service provider in discharge care planning
 - ensuring strong links with the older person's previous community services providers or being aware of the availability of relevant support services
 - being sensitive to the needs and abilities of carers when planning the older person's transition to the community.
2. Older people's care and treatment are managed in a way that minimises delays in receiving allied health and specialist medical services irrespective of whether they are in an inpatient or ambulatory setting.
3. Robust protocols and agreements are developed with primary care and community support providers to ensure older people continue to receive the care and support they require (refer Appendix 1).
4. The treatment and care of people assessed as having complex needs are coordinated from one point.

Principle 5

Unnecessary admission to hospital and extended hospital stays of the frail elderly are avoided.

Primary care/hospital interface

Practices:

1. Primary care and aged care providers are actively involved in ambulatory care programs, such as hospital in the home/nursing home and early discharge programs.
2. Robust protocols and agreements are developed to ensure primary care and aged care providers can continue to meet the ongoing treatment requirements of the older people returning to their care (refer Appendix 1).

Emergency department/hospital interface

Practices:

1. Emergency departments have access to specialist resources to assist them to assess and meet the needs of older people. This might include:
 - risk screening tools to assist them to identify older people with complex co-morbidities and at risk of multiple presentations
 - specialist advice on geriatric conditions
 - separate areas associated or co-located with emergency departments which allow medical, allied and nursing staff to provide safer and more comfortable management of the older person, their families and carers and to facilitate liaison with referring general practitioners, service providers and carers.
2. Emergency departments have systems in place to channel older people into more appropriate treatment and care alternatives where hospitalisation is deemed to be unnecessary. This might include referral to community health services or short stay observation wards with interdisciplinary coordination and input.

Residential aged care facilities/hospital interface

Practices:

1. Robust protocols and agreements are developed with residential aged care providers and visiting general practitioners to ensure older people discharged from hospitals continue to receive the support they require (refer Appendix 1).

Principle 6

The care of older people is a primary focus for all health services.

Practices:

1. The design of the physical environment of health services recognises and takes into account the unique changes associated with ageing:
 - cognitive impairment
 - hearing loss
 - visual deficits
 - mobility problems
 - physical deconditioning
 - declining nutritional status.

This includes providing a safe physical environment, for example by:

 - minimising clutter
 - using non-slip floors
 - using high–low and low–low beds
 - having good access to bathrooms with easy-open taps
 - having a quiet place for assessment
 - providing secure wards for those patients with delirium and dementia who manifest the behavioural problem of ‘wandering’.
2. When planning services or developing policies and procedures, health services incorporate the unique needs of older people. This includes ensuring appropriate patient management practices, such as encouraging independence and activity and avoiding the use of chemical or physical restraints where possible.
3. Health services actively foster a positive approach to caring for older people, including treating the older person with respect and dignity even when they are no longer able to make their own decisions.
4. Inpatient settings are managed in a way that maximises older people's independence and privacy. This includes encouraging everyday activities, such as getting dressed and having meals in a central dining area.

5. Health services ensure that treatment and care are delivered by staff who are proficient in aged care practices.
6. Health services actively strive to raise awareness of aged care issues and the needs of older people among all staff (clinical and administrative).
7. Health care professionals have the opportunity to gain or extend their knowledge, skills and expertise so they can meet the specific needs of older people.

Principle 7

Where safe and cost-effective to do so, older people receive health treatment and care in a setting that best meets their needs and preferences.

Practices:

1. The level of ambulatory services is expanded to enable older people to receive the care they need in the least intrusive setting.
2. The patient's wishes as expressed in advance care directives are understood and implemented within prevailing legal constraints.
3. At the end of life, older people's health care and treatment wishes are respected (which includes ensuring processes for recognising and recording their wishes) within prevailing legal constraints.

Appendix 1

Robust protocols and agreements

The adoption of 'robust protocols and agreements' by health services, primary care providers, community care providers and residential care providers involves understanding and agreeing on the:

- type and breadth of services to be provided
- clear assignment of responsibility
- timeframe and process for client transfer
- waiting lists and resource constraints which might impact on service continuation
- contact point for each service.

Interaction between health services providers and other providers of like services should be coordinated from a single point to ensure a centralised repository of information and knowledge and streamlining of effort. Agreed protocols provide a platform for functional integration between health care providers. Functional integration means agencies will retain their organisational autonomy, while agreeing to share information and to conduct particular functions in an agreed way.

These agreed protocols should be in the areas of:

- the set of client information to be transferred between providers, for example:
 - demographic information
 - client consent and privacy information
 - history of service use (if appropriate and available)
 - care pathways to be used
 - carer information (if appropriate)
 - assessment results
 - care plans
 - future palliation and care wishes
- the process for transferring information between providers, including development of agreed templates
- the transfer of pre-admission information from the primary care and community services providers (either with the older person or on admission)
- the timeframe for transferring discharge summaries to primary and community health care providers (within 24 hours of discharge)
- information security and ownership
- common fee structures.

In addition, protocols and agreements with residential aged care facilities should include:

- a clear outline of the information required by:
 - the health service on admission of the older person
 - the aged care facility on discharge of the patient
- guidelines on communicating patient health updates between the hospital and aged care facility and the visiting general practitioner
- clinical pathways for use by residential aged care staff under the supervision of the visiting general practitioner, in conjunction with hospital medical staff when appropriate
- training in common simple procedures for residential aged care staff.

