RACGP

CO16 Care of older people contextual unit

Rationale

Australia has an ageing population. The number of people aged 65 and over has increased from 11.6% of the population (or 2.1 million people) in 1993 to 14.4% (or 3.3 million people) in 2013.[1] In the next two decades, the number of people aged 65 and over is projected to rise by 91%, and the number aged 85 and over to more than double.[2]

Around 34% of general practice patient encounters are with adults aged 65 years and over, and general practitioners (GPs) are seeing an increasing proportion of older patients, particularly those aged 75 years or over.[3] This presents significant challenges for clinical care, population health and the economics of healthcare.

Although ageing is associated with increasing levels of complexity and disability, most older people have a positive view of their own health. The majority of Australians aged 65 years or older (66%) rate their health as either good, very good or excellent, while 34% report their health as being fair or poor.[4]

Aboriginal and Torres Strait Islander peoples have a lower life expectancy than the non-Indigenous population and are therefore likely to need aged care services earlier. The gap in life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians reduces with age. For example, life expectancy at age 65 years is estimated to be 10.7 years and 12.0 years for Aboriginal and Torres Strait Islander males and females respectively, or around six years less for men and eight years less for women than for non-Indigenous Australian males and females.[1] In 2006, 11% of Aboriginal and Torres Strait Islander Australians were aged 50 years and over.[1]

High-quality general practice care of older people is about integrating more than the principles of geriatric care. It is about providing continuity of care for patients as they get older and making clinical judgements about the most appropriate care for the individual – care that integrates the wishes of the patient and, where appropriate, those of their family and carers.

As it is in other population groups, preventive care is an important priority for those in aged care. There is a need to continue with age- and ethnicity-specific guidelines to screen for prevention of chronic disease, cardiovascular and metabolic risk factors, and cancer. There are additional needs to focus on immunisations, screening for falls risk, memory, vision and hearing impairments, and assessment of continence for those at risk.

There are particular health issues that occur more frequently in this population group and it is important for GPs to be mindful of the need to distinguish normal ageing from pathological processes requiring intervention. Higher rates of undifferentiated and complex, multisystem pathology, sensory impairment and consequent difficulties with communication and/or cognition in the context of decreased physiological, psychological and financial reserves often combine to enhance the need for holistic assessment and supportive continuity of care.

Quality general practice care integrates:

- recognition and safe management of health conditions (including rational prescribing and mindfulness of the risks of poly-pharmacy)
- assessment of the functional impacts on the individual and recognition of consequences for their accommodation and care needs
- identification of impacts on family and/or carers, in particular recognition of the need for respite care, identification of indicators of carer stress and potential for risk of elder abuse.

Capacity to provide informed consent may be impaired in the elderly. The care of aged patients may involve regular communication with their carers, consideration of requirements for medical power of attorney and involvement of regulatory administrative bodies such as guardianship boards. The role of advanced care directives is very important in this population, with discussion, formulation and documentation of decisions concerning end-of-life care ideally in place prior to the individual's capacity to consent being impaired.

Older patients may require assessment for fitness to drive and laws may affect their licence eligibility. Other legal requirements, which may require general practice involvement, include pension eligibility, taxi concessions, and death and cremation certificates, including coronial obligations.

Older patients are especially at risk of adverse patient safety outcomes, particularly in relation to the inappropriate use of physical or pharmacological restraint, missed diagnoses due to failure to evaluate vague or unclearly expressed symptoms, and adverse pharmaceutical events due to poly-pharmacy and/or failure to understand management instructions.

Related contextual units

RC16 Residential care

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Useful care of older people resources and tools

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Glossary

Carer stress
Can be defined as a condition of exhaustion, anger, rage, or guilt that results from unrelieved caring for a chronically ill dependent.

Common presentations in aged care
May present as undifferentiated illness or with different symptoms to those found in younger patients. These presentations include, but are not limited to:

- degenerative diseases (osteoarthritis, joint pain, Parkinson's disease)
- cardiovascular diseases (cardiac insufficiency, ischaemic heart disease)
- metabolic diseases (diabetes, hypothyroidism)
- urogenital (incontinence, vaginal prolapse, lower urinary tract symptoms)
- neuropsychiatric/cognitive (delirium, dementia).

Elder abuse
'A single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person' (World Health Organization. Ageing and life-course: Elder abuse. Geneva: WHO [date unknown]. Available at www.who.int/ageing/projects/elder_abuse/en [Accessed 1 December 2014]).

Elder abuse can take various forms, such as physical, psychological or emotional, sexual and financial abuse. It can also be the result of intentional or unintentional neglect.