



# Care of Older Adults

*One in a series of curriculum statements produced by the Royal College of General Practitioners:*

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# Acknowledgements

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## Key messages

- The United Kingdom has an ageing population.
- The care of older people will make up a higher proportion of the general practitioner's workload.
- Co-morbidity, difficulties in communicating, the problems of polypharmacy and the need for additional support for the increasingly dependent patients are important issues in the care of older people.
- General practitioners with the primary healthcare teams have an important role to play in the delivery of improvements in the care of older people.

# Introduction

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The United Kingdom has an ageing population. Since the 1930s the number of people aged over 65 has more than doubled. Today a fifth of the population of the UK is aged over 60. Between 1995 and 2025, the number of people aged over 80 is set to increase by almost a half and the number over aged 90 will double.<sup>1</sup>

## Rationale for this curriculum statement

General practitioners (GPs) and primary healthcare teams are likely to play an increasing role in addressing the health problems that we will face with the ageing population, which will make up a higher proportion of the GP's workload.

It is one of the greatest privileges of being a GP to be able to practise longitudinal care – caring for patients through a large part of their lives and involving several generations of the same family and their relatives. The GP is put in the position of trust and confidence in the care of elderly people and the dying relative. It is therefore important that the general practitioner understands not only the clinical care of this group of patients, but also how that care interacts with family, carers and the multidisciplinary team.

While the underlying pathology will also be commonly found in the rest of the population, there are some specific issues that pertain to the care of older people. These include the increasing prevalence of co-morbidity, difficulties in communicating, the problems of polypharmacy and the need for additional support for the increasingly dependent patients.

The Joint Working Party of the Royal College of General Practitioners and the British Geriatric Society published a report in 1978<sup>2</sup> that highlighted the limited teaching in geriatric medicine that was available at the undergraduate level. It emphasised that training in geriatric medicine should begin at this level and should be reinforced throughout the postgraduate phases. In addition to the report, they published a booklet *General Practitioner Vocational Training in Geriatric Medicine*.<sup>3</sup> The booklet provided essential guidelines for specialty registrars (GP) and trainers in both the hospital and the general practice phases of GP vocational training programmes. This curriculum statement aims to update the objectives and provide help for those charged with creating new training programmes and for specialty registrars (GP) and trainers across the UK.

## UK health priorities

In March 2001, the Secretary of State for Health launched the *National Service Framework for Older People* that placed the care of older people at the top of the health agenda. The National Service Framework (NSF) was a result of an extensive consultation with older people, their carers and health professionals.

The NSF set out a programme of action and reform to address the needs of older people and ensure that the quality of services improved for them. It set out national standards and service models together with local action and national underpinning programmes for implementation, a series of national milestones and performance measures.

The standards are:

## **1 Rooting out age discrimination:**

- NHS services should be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.

## **2 Person-centred care:**

- NHS and social care services should treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

## **3 Intermediate care:**

- Older people should have access to a new range of intermediate services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.

## **4 General hospital care:**

- Older people's care in hospital should be delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

## **5 Stroke:**

- The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate
- People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service and subsequently with their carers participate in a multidisciplinary programme of secondary prevention and rehabilitation.

## **6 Falls:**

- The NHS working in partnership with councils should take action to prevent falls and reduce resultant fractures or other injuries in their population of older people
- Older people who have fallen should receive effective treatment and with their carers receive advice on prevention through a specialised falls service.

## **7 Mental health in older people:**

- Older people who have mental health problems should have access to integrated mental health services provided by the NHS and councils to ensure effective diagnosis, treatment and support for them and their carers.

## **8 The promotion of health and active life in older age:**

- The health and wellbeing of older people should be promoted through a coordinated programme of action led by the NHS with support for their carers.

The NSF standards were accompanied by additional guidance on medicines and older people and papers to support the local delivery; it is clear that GPs with the primary healthcare teams have an important role to play to deliver the improvements in the care of older people that are laid out in the framework documents.

There is also a strong political focus on older people in Northern Ireland and Wales. In *Northern Ireland*, the *Investing for Health*<sup>4</sup> and *A Healthier Future*<sup>5</sup> strategies both highlight the needs of older people. In *Wales*, the Welsh Assembly Government began with its 10-year NHS Plan *Improving Health in Wales – a plan for the NHS with its partners*<sup>6</sup> in 2001. It produced a nation-wide strategy for older people *The Strategy for Older People in Wales*.<sup>7</sup>

This document analysed the aspirations and needs of older people in Wales and highlighted the need to work across all government departments in a ‘joined-up’ approach. This strategy led to a draft NSF for Older People in Wales, in 2005 and the final document and implementation framework was launched in spring 2006.<sup>8</sup>

The problem associated with an ageing population is also high on the politicians’ agenda in *Scotland*. The Scottish Health Plan, *Our National Health – a plan for action, a plan for change*,<sup>9</sup> made a commitment to improve the care of older people in NHS acute and primary care services.

An expert group chaired by the Chief Medical Officer subsequently produced a wide-ranging report, *Adding Life to Years*.<sup>10</sup> The report highlighted the health and healthcare needs of older people, and emphasised that their care is the central responsibility of NHSScotland, with good mainstream care as a goal of current and future efforts in health service reform. It recognised that the population of Scotland had already aged significantly and will age still further. It noted that mass survival into older age, along with the baby boom of the 1950s and 1960s, will lead to a rise from 787,000 to 1.2 million over-65s from 2001 to 2031, and a rise from 84,000 to 150,000 in over-85s over the same period. It suggested that the 15% of the population now over age 65 accounted for around 40% of health and social care spending, while over-75s made greatest use of services. Elective surgery, such as hip replacement, mainly benefited older people and has increased in recent decades. Acute admissions were said to be rising most rapidly in older age groups, and again further increases are anticipated.

A series of recommendations were made that covered strategic and operational issues. It proposed that NHSScotland should plan strategically for the health care needs of older people, including: meeting the challenges of changing demography; emerging healthcare technology; increasing research and development of services for older people; increasing expectations amongst patients and carers; addressing workforce training, recruitment, retention and development. A full list is available on its website, listed later in this curriculum statement.

# Learning Outcomes

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The following learning objectives relate specifically to the care of older adults. This RCGP curriculum statement should be used in conjunction with the *core* curriculum statement 1, *Being a General Practitioner*, and the other clinically orientated statements.

## Primary care management

The work of GPs increasingly involves the care of older people in partnership with the wider primary health-care team, both within their own practice, in the local community, and also with specialists in secondary care, using the diagnostic and treatment resources available in hospitals.

Thus primary care education must promote learning that integrates different disciplines within the complex team of the NHS. During their training, specialty registrars must learn the importance of supporting patients' decisions about the management of their health problems and communicating how that care will be delivered by the NHS team as a whole.

### **The GP should have the ability:**

#### **To manage primary contact with older patients, dealing with unselected problems.**

This requires:

- Knowledge of the epidemiology of older people's problems presenting in primary care
- Understanding of the theories of ageing
- Understanding of the physical, psychological and social changes that may occur with age and relating them to the adaptations that an older person makes, and to the breakdown of these adaptations
- Understanding of the special factors associated with drug treatment, e.g. the physiology of absorption, metabolism and excretion of drugs, the hazards posed by multiple prescribing, non-compliance and iatrogenic disease
- Understanding of physical factors, particularly diet, exercise temperature and sleep that affect the health of older people
- Understanding of the management of the conditions and problems commonly associated with old age such as Parkinson's disease, falls, gait disorders, stroke, confusion, etc.
- Mastering an approach that allows easy access to the primary healthcare team for older people, appropriate timing of appointments and an organisational approach to the management of chronic conditions and co-morbidities.

#### **To cover the full range of health conditions.**

This requires:

- Skills in acute, chronic, preventative, palliative and emergency care
- Skills in history-taking, physical examination and use of ancillary tests to diagnose conditions presented by

patients in primary care

- Skills in therapeutics, including drug and non-drug approaches to treatment of these conditions, the importance of medication reviews and an understanding that medication issues account for many acute admissions to hospital for older patients.

### **To coordinate care with other professionals in primary care, and with other specialists.**

This requires:

- Knowledge of local primary care resources including those organised by the primary care organisation
- Skills to effectively liaise and cooperate with the many different disciplines and persons in primary, intermediate and secondary care
- Knowledge of the locally agreed protocols for preventing and managing stroke.

### **To master effective and appropriate care provision and health service utilisation.**

This requires:

- Knowledge of the structure of the local and national healthcare system and the role of primary care within the wider NHS
- Understanding of the management of the transfer from the system of care to another, the complications that can arise and how they can be prevented and managed.
- Knowledge of how to access support services for older patients, e.g. podiatry, visual and hearing aids, immobility and walking aids, meals on wheels, home care services, etc.
- Knowledge of the different forms of daycare and residential accommodation available and the ability to advise patients about them
- Knowledge of how to use the various statutory and voluntary organisations for support of older people in the community.

### **To make available to the older patient the appropriate services within the health and social care systems.**

This requires:

- Appropriate communication skills for counselling, teaching and treating patients, their families and carers, recognising the difficulties of communicating with older patients including the slower tempo, possible unreliability and the evidence of third parties
- Skills to develop policies for the primary care team so as to ensure effective management of repeat prescriptions, the appropriate use of screening and case-finding programmes and auditing the quality of care of elderly people in all forms of residential accommodation.

### **To act as an advocate for the patient.**

This requires:

- The ability to develop and maintain a relationship, and a style of communication that treats the patient with respect, as an equal and does not patronise the patient
- Skills in effective leadership, negotiation and compromise
- Ensuring that the provision of care promotes the patient's sense of identity and personal dignity, and that the patient is not discriminated against as a result of their age
- An understanding of legal issues that may arise, e.g. confidentiality, Mental Health Act, power of attorney, court of protection, guardianship, living wills, death certification and cremation.

## Person-centred care

The GP has an important role in ensuring that the older person is treated as an individual and that he or she receives timely packages of care that meet his or her need as an individual.

**The GP should have the ability:**

**To adopt a person-centred approach in dealing with older patients and their problems, both in the context of patient's circumstances.**

This requires an understanding of:

- The theories of ageing
- The basic scientific knowledge and understanding of the individual, together with their aims and expectations in life
- The development of a frame of reference to understand and deal with the family, community, social and cultural dimensions in a person's attitudes, values and beliefs
- The special features of prognosis of diseases in old age and how to use the knowledge to produce an appropriate plan for further investigation and management
- The way in which the management of disease processes in old age is influenced by the psychological state and the social situation of the old person.

**To use the general practice consultation to bring about an effective doctor-patient relationship, always respecting the patient's autonomy.**

This requires:

- Adopting a patient-centred consultation model that explores the patient's ideas, concerns and expectations, integrates the doctor's agenda, finds common ground and negotiates a mutual plan for the future
- Communicating findings in a comprehensible way, helping patients to reflect on their own concepts and finding common ground for further decision-making
- Making decisions that respect the patient's autonomy and dignity
- Being aware of subjectivity in the medical relationship, from both the patient's side (feelings, values and preferences) and from the doctor's side (self-awareness of values, attitudes and feelings).

**To communicate, to set priorities and to act in partnership.**

This requires:

- Appropriate skills and attitudes to establish a partnership with the patient
- The skills and attitude to achieve a balance between emotional distance and proximity to the patient.

**To provide long-term continuity of care as determined by the needs of the patient, referring to continuing and coordinated care management.**

This requires:

- Understanding and mastering the three aspects of continuity: personal continuity; episodic continuity (making the appropriate medical information available for each patient contact); and continuity of care.

## Specific problem-solving skills

Problem-solving in general practice is highly context-specific. The skills required relate to the context in which the problems are encountered, the natural history of the problems themselves, the personal characteristics of patients, the personal characteristics of the doctors who manage them, and the resources they have at their disposal.

Focusing on problem-solving is a crucial part of GP training, because family doctors need to adopt a

problem-based approach rather than a disease-based approach. This is particularly true when working with older people who often have complex physical, psychological and social problems.

**The GP should have the ability to:**

**Relate specific decision-making processes to the prevalence and incidence of illness in the community.**

This requires:

- Knowledge of the prevalence and incidence of disease in the elderly population
- Knowledge of the practice community (number of elderly patients, prevalence of chronic diseases)
- Skills to apply specific decision-making (using tools such as clinical reasoning and decision rules).

**To selectively gather and interpret information from history-taking, physical examination and investigations, and apply it to an appropriate management plan in collaboration with the patient.**

This requires:

- Knowledge of relevant questions in the history and items in the physical examination relevant to the problem presented
- Knowledge of the patient's relevant context, including family and social factors
- Knowledge of available investigations and treatment resources
- History-taking and physical examination skills, and skills in interpreting data
- Skills of taking a mental health assessment from an old person, including how to assess brain function (e.g. using short mental-state questionnaires) and mood, and how to evaluate the testimony of third parties
- A willingness to involve the patient and if appropriate their carer and family in the management plan.

**To make effective and efficient use of diagnostic and therapeutic interventions.**

This requires:

- Understanding of the changes in the normal range of laboratory values that are found in older people.

## **A comprehensive approach**

GPs need to be able to address *multiple complaints and co-morbidity* in the older patients for whom they care. The challenge of addressing the multiple health issues in each individual is important, and it requires GPs to develop the skill of *interpreting* the issues *and prioritising* them in consultation with the patient.

The GP should also use an evidence-based approach to the care of patients. The family doctor should aim at a holistic approach to the patient where the main focus would be in promoting their *health* and *general well-being*. Reducing risk factors by promoting self-care and empowering patients is an important task of the GP. The GP should aim to minimise the impact of patient's symptoms on his or her wellbeing by taking into account the patient's age, personality, family, daily life, and physical and social surroundings.

*Coordination of care* also means that the GP is skilled not only in managing disease and prevention, but also in caring for the patient, providing rehabilitation and providing palliative care in the end phases of a patient's life. The physician must be able to coordinate patient care provided by other healthcare professionals and care provided by other agencies.

**This competence is concerned with the ability:**

**To simultaneously manage multiple complaints and pathologies, both acute and chronic health problems.**

This requires:

- Understanding of the concept of co-morbidity in an elderly patient
- Skills to manage the concurrent health problems experienced by an older patient through identification, exploration, negotiation, acceptance and prioritisation

- Understanding the special features of psychiatric diseases in old age, including an appreciation of the features of dementia, and the effects of physical function on the mental state.

**To promote health and wellbeing by applying health promotion and disease prevention strategies appropriately.**

This requires an understanding of:

- The concept of health and the ability to promote health on an individual basis as part of the consultation
- The ability to promote health through a health promotion or disease prevention programme within the primary care setting
- The role of the GP in health promotion activities in the community
- The importance of ethical tensions between the needs of the individual and the community, and acting appropriately, e.g. driving and the DVLA regulations
- Knowledge of preventative strategies required in the care of older people.

**To manage and coordinate health promotion, prevention, cure, care, rehabilitation and palliation.**

This requires:

- Understanding the complex nature of health problems of older patients
- Understanding the variety of possible approaches
- The ability to use different approaches in an individual patient and to modify these according to an individual's needs
- The ability to coordinate teamwork in primary care including involvement of family members nearby, or at a distance
- Understanding moral, ethical and emotional issues at the end of life as well as after death.

## Community orientation

GPs have a responsibility for the community in which they work, which extends *beyond the consultation with an individual patient*. The work of family doctors is determined by the makeup of their local community. They understand the potentials and limitations of the community in which they work, and its character in terms of socio-economic and health features.

The GP is in a position to consider many of the issues and how they interrelate, and the importance of this within the community.

**This GP should have the ability:**

**To reconcile the health needs of individual patients and the health needs of the community in which they live, balancing these with available resources.**

This requires an:

- Understanding of the health needs of communities through the epidemiological characteristics of their population
- Understanding of the interrelationships between health and social care
- Understanding of the impact of poverty, ethnicity and local epidemiology on a local community's health
- Awareness of inequalities in healthcare provision
- Understanding of the structure of the healthcare system and its economic limitations
- Understanding the roles of the other professionals involved in community policy relating to health
- Understanding of the importance of practice- and community-based information in the quality assurance of each doctor's practice
- Understanding of how the healthcare system can be used by the patient and the doctor (referral procedure,

co-payments, sick leave, legal issues, etc.) in their own context

- The ability to reconcile the needs of the individual with the needs of the community in which they live.

## A holistic approach

Kemper described holism as involving ‘caring for the whole person in the context of the person’s values, their family beliefs, their family system, and their culture in the larger community, and considering a range of therapies based on the evidence of their benefits and cost’.<sup>11</sup> Or, as Pietroni put it, holism involves a ‘willingness to use a wide range of interventions ... an emphasis on a more participatory relationship between doctor and patient; and an awareness of the impact of the “health” of the practitioner on the patient’.<sup>12</sup> The holistic view acknowledges objective scientific explanations of physiology, but also admits that people have inner experiences that are subjective, mystical (and, for some, religious), which may affect their health and health beliefs.<sup>13</sup>

**The GP should have the ability:**

**To use bio-psycho-social models, taking into account cultural and existential dimensions.**

This requires:

- Knowledge of the holistic concept and its implications for the patient’s care
- An ability to understand a patient as a bio-psycho-social ‘whole’
- Skills to transform holistic understanding into practical measures
- Knowledge of the cultural background and beliefs of the patient, in so far as they are relevant to health care
- Tolerance and understanding towards patients’ experiences, beliefs, values and expectations, as they affect healthcare delivery.

## Contextual aspects

- Understand the key government policy documents that influence healthcare provision for older people.
- Recognise how geographical distance influences the treatment of older people.

## Attitudinal aspects

- Ensure that personal opinions regarding risk factors for cardiovascular problems (e.g. smoking, obesity, exercise, alcohol, age, race) do not influence management decisions.

## Scientific aspects

- Understand and implement the key national guidelines that influence healthcare provision for older people.
- Describe the key research findings that influence management of older people.

## Further Reading

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### Examples of relevant texts and resources

- BENNETT GCJ AND EBRAHIM S. *The Essentials of Health Care of the Elderly* London: Hodder Arnold, 1992
- BRITISH MEDICAL ASSOCIATION AND ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN. *The British National Formulary 50* London: BMJ Books, 2005
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- WILLIAMS I. *Caring for Older People in the Community* Oxford: Radcliffe Medical Press, 1995

### Web resources

#### Age Concern

Age Concern is the UK's largest organisation working with and for older people. The website is an excellent resource for patients and carers. Their mission is to promote the wellbeing of all older people and to help make later life a fulfilling and enjoyable experience. GPs will find it full of useful facts and information.

[www.ageconcern.org.uk/](http://www.ageconcern.org.uk/)

#### Alzheimer's Disease Society

The Society has expertise in information and education for carers and professionals. It provides helplines and support for carers, runs quality day and home care, funds medical and scientific research, and gives financial help to families in need. It campaigns for improved health and social services, and greater public understanding of all aspects of dementia.

[www.alzheimers.org.uk](http://www.alzheimers.org.uk)

### **British Geriatrics Society**

The Society is the only professional association, in the United Kingdom, of doctors practising geriatric medicine. The majority of the 2300 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, GPs and scientists engaged in the research of age-related disease. The Society also has members in the nursing, therapy and pharmacology professions. It was founded in 1947 for ‘the relief of suffering and distress amongst the aged and infirm by the improvement of standards of medical care for such person, the holding of meetings and the publication and distribution of the results of such research’. The website contains useful information, clinical guidelines and links.

[www.bgs.org.uk](http://www.bgs.org.uk)

### **Department of Health Older People’s Services**

The website includes access to the *National Service Framework for Older People* and lots of supporting documentation.

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4003066](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066)

### **National Library for Health**

The aim of the National Library for Health (NLH) is to provide clinicians with access to the best current know-how and knowledge to support health care-related decisions. Patients, carers and the public are also welcome to use the site, because the NLH is open to all. The ultimate aim is for the Library to be a resource for the widest range of people both directly and indirectly.

The main priority for the NLH is to help the NHS achieve its objectives. However, it is also aimed at those healthcare professionals who are working in the private sector where common standards should apply. For example, the National Screening Committee is not only an NHS advisory committee, but its mission is also to promote the health of the whole population and its recommendations are relevant to the private sector. Part of the content of the NLH such as Clinical Evidence and Cochrane Library is licensed from commercial providers.

[www.library.nhs.uk](http://www.library.nhs.uk)

### **NHSScotland: *Adding Life to Years***

Report of the Expert Group on Healthcare of Older People Recommendations.

[www.show.scot.nhs.uk/sehd/publications/alty/alty-10.htm](http://www.show.scot.nhs.uk/sehd/publications/alty/alty-10.htm)

### **The Really Important Questions Group**

A group of over-50-year-olds who want to be involved in the shaping of health and social care. Their interesting website is at [www.tameside.gov.uk/olderpeople/riq](http://www.tameside.gov.uk/olderpeople/riq).

### **Welsh Assembly Government**

*Improving Health in Wales – a plan for the NHS with its partners.*

[www.wales.nhs.uk/Publications/NHSStrategydoc.pdf](http://www.wales.nhs.uk/Publications/NHSStrategydoc.pdf)

# Promoting Learning about the Care of Older Adults

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## Work-based learning – in primary care

The period of time spent in general practice is ideal for gaining a better understanding of the care of older people. The specialty registrar will have the opportunity to care for many elderly patients who have physical and mental illness who live at home or in residential accommodation. Many older patients will experience multiple contacts with secondary care services and will be cared for by different members of the primary healthcare team.

The specialty registrar should be encouraged to look after some of the practice's older patients throughout the placement and follow them along their journey to gain a better understanding of their problems and of the social and medical care that they receive. The specialty registrar should attend case conferences and multiprofessional assessments of his or her older patients to gain a better understanding of the disease process and its functional consequences.

## Work-based learning – in secondary care

Placements in geriatric medicine departments are ideal for doctors training to be GPs. Care must be taken to ensure that the learning is focused on the needs of the specialty registrar who is placed in the department as part of a GP training programme and *not* a geriatric medicine training programme. In addition to working on the wards or medical admissions units, the specialty registrar should have opportunities to attend day hospitals and outpatient clinics, and to see patients in their homes by attending domiciliary visits.

## Non-work-based learning

Older patients often have many complex psychological, social and physical problems that provide rich subjects for tutorials and case-based learning.

## Learning with other healthcare professionals

The discipline of care for older adults involves huge numbers of professionals each with their particular areas of expertise. These include community nurses, physiotherapists, occupational therapists, speech therapists, opticians, audiologists, palliative care nurses and physicians and social workers to name but a few. The specialty registrar should endeavour to spend some time with these colleagues to ensure that he or she understands the breadth of input that can be provided to the older adult, the effectiveness of his or her input and the appropriateness of referral to these agencies. The specialty registrar should take the opportunity to visit patients at their homes with other members of the primary healthcare team and to accompany the occasional patient to hospital clinics to gain a better understanding of the 'patient's journey'.

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