Geriatric screening and care in group practice

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A SCREENING programme (Hodes 1968, 1969) was introduced into the practice in 1966, and a logical development of this was geriatric care. The approach was one of identification of patients at risk by the screening programme, and to develop from this a method of meeting the needs of the elderly, in association with health visitors and district nurses attached to the group practice.

The care is of three types:

1. *Screening.* Patients for this are selected from registers compiled by the computer, and they are sent letters offering them examination at a screening clinic. Results of these clinics determine future care of the patient. The screening is carried out at home if the patient is unable to attend the surgery.

2. *Episodes.* The patient may be seen at home or in the surgery. The result of this contact will lead to health visitor, district nurse and social worker services. The total result of this determines whether the patient should go on surveillance.

3. *Residential accommodation.* Patients here may be permanent residents, short stay or attend for day care. Assessment, treatment and management of these groups is by the general-practitioner team assisted by voluntary workers.

Method

Screening was considered the best starting point as it deals with the preventive aspects and allows the computer file to be developed. Patients were examined both in the home and at the surgery but patients over 80 were visited at home if they did not attend after the first invitation. The examinations were carried out by a nurse and consisted of—height, weight, abdominal measurement, blood pressure, visual acuity using a Snellen's test card, tonometry, and haemoglobin. Urine testing for diabetes was done after taking 25g or 50g glucose. The results were then examined by the general practitioner and if positive, the patient was seen again by either health visitor or general practitioner who arranged further investigation or any service required. After this assessment, if mobile, the patient would be asked to call at the surgery at regular intervals. If confined to home routine visits are made by a doctor, health visitor or nurse, often in rotation. At any stage the patient can be seen by a geriatrician.

This work of routine visiting in the home and routine attendance by the patient to the surgery was done by different teams. One doctor would be responsible for the routine home visits, to be shared with a health visitor and nurse; patients attending the surgery would see the doctor of their choice; and finally the patient would come back in to the general file for re-screening, the date depending on the initial report, and the screening examination carried out by another team.

Episodes are dealt with either in the home or surgery, by all the doctors and health visitors. If necessary the patient is put in the surveillance group as described earlier. The health visitor can arrange home help and holidays, advise about supplementary pensions, obtain appliances and advise about diet. She holds weekly 'obesity clinics' for groups of not more than eight patients. When a spouse has died a visit is made by the health visitor within a few days and regularly after that.

The district nurse has daily treatment clinics and for domiciliary care she is assisted by the home nurse and a male nurse. She holds three clinics weekly and makes home visits for the taking of pathological specimens which are collected by the group laboratory.

Social workers also provide additional services and psychiatric support, and advise and organize the admission of patients to county residential accommodation. In a recently established home in the area 12 of the 60 beds have been allocated for use by short stay residents. The community health team treats the patient in the atmosphere of residential care which, for the geriatric patient is his own home. An essential part of this treatment is the participation of the superintendent, matron and staff who in effect become members of the community team. Short stay patients are usually admitted for several weeks, either because of some crisis or when a relative goes on holiday or into hospital. This presents an opportunity for assessment and initiation of medical care. All patients are seen by a doctor and health visitor shortly after admission for assessment and then at regular intervals alternately by the doctor and health visitor. There is also the support of the district nurse, physiotherapist (two sessions per week) and the chiropodist.

TABLE I

THE PARTICIPATION IN SCREENING OF THE DIFFERENT AGE GROUPS

	No. of letters sent	*No. attended clinic*	*Percent*
Women 60—64	257	89	*35*
Men 60—64	273	86	*32*
Women 65—69	179	64	*36*
Men 65—69	150	48	*32*
Total	859	287	
Women 70—79	228	130	*57*
Men 70—79	113	68	*60*
Total	341	198	
Women over 80	77	71	*92*
Men over 80	35	30	*86*
Total	112	101	

TABLE II

MEAN SYSTOLIC AND DIATOLIC BLOOD PRESSURE, HAEMOGLOBIN, NUMBER OF PATIENTS WITH INCREASED INTRAOCULAR TENSION

WOMEN	*Mean SBP*	*Mean DBP*	*Mean Hb. percent 14.5 g/100 ml*	*No. of patients with Intraocular tension 22mm and over*
60—65 years	155	86	90	0
65—69 years	166	89	89	3
70—79 years	165	87	88	6
Over 80s.	170	89	82	3
MEN				
60—65 years	145	82	91	0
65—69 years	145	81	88	2
70—79 years	153	82	87	7
Over 80s.	148	78	86	0

Results

Table I shows the participation in screening of the different age groups. In the 60 to 69 year group the invitation to screening was accepted by one patient in three; second

invitations have not been given and home visits not made. In the 70 to 79 year group the response was one patient in two and one home visit was made to every three attendances at the screening clinic. In the over-eighties there was a 90 per cent response and two home visits were made to every one attendance.

Table II shows the mean systolic and diastolic blood pressures. Numbers of patients with a diastolic pressure of over 100 mm Hg are shown in table III.

TABLE III

NUMBER OF PATIENTS WITH A DIASTOLIC BLOOD PRESSURE OVER 100MM HG

	60—64	*65—69*	*70—79*	*80*
Men.. ..	10 *10*	2 *3*	3 *4*	0
Women ..	14 *15*	18 *18*	16 *12*	11 *17*

TABLE IV

HAEMOGLOBIN LEVELS BELOW 80 PER CENT

	60—64	*65—69*	*70—79*	*80*
Men.. ..	3 *3*	8 *15*	2 *19*	6 *33*
Women ..	5 *6*	8 *9*	7 *20*	5 *21*

The haemoglobin levels were generally high and those below 80 per cent were as shown in table IV.

All cases with an intraocular tension of 22mm Hg or over were referred to the glaucoma clinic at the Institute of Ophthalmology and seven of the 21 cases were confirmed as chronic simple glaucoma. Further treatment is arranged at local clinic and relatives of the patient are advised and offered examination.

Discussion

The need for early geriatric care has already been demonstrated by Anderson and Cowan (1955) and Williamson *et al.* (1964). Lowther *et al.* (1970) concentrated on 'high risk' groups of patients and also noted that 'after a short time family doctors had difficulty in changing from the usual patient-inititated approach'. The development of a primary health team giving comprehensive care in the community means that total medical care can be extended without great difficulty or cost.

The screening of the geriatric patient is often restricted by lack of mobility but the development of transport systems for this should not be difficult. Most old people welcome help from their family doctor and in this context include the health visitor and nurse working with him. The treatment of episodes of ill-health is much easier if a baseline has been established for the patient. All this requires sharing of the medical record by the team and a high standard of recording. The geriatrician, using domiciliary visits, becomes the link between the patient and the hospital.

It is intended to have day care patients coming to the residential home. Even one day a week can relieve the pressure on a difficult domestic situation. The mixing of day care, short stay and permanent stay patients in groups organized by social workers and voluntary workers in this atmosphere will provide a therapeutic community. This will serve as an introduction to residential care for non-residents and relieve the isolation of the residents. The pressure for beds in Part 3 accommodation should also be eased.

The primary care team can therefore offer all geriatric patients organized care as part of one community of which they form part, but from which, by so much fragmentation of the health service, they have been separated.

Summary

A method of identifying the elderly at risk in a group practice and the programme of community geriatric care which is being developed is described. The work is being carried out in a group practice of 16,000 patients with seven principals and fully inte-

grated health visitors and nurses. Care is of three types—screening, episodes and surveillance, and Part 3 residential accommodation. The bulk of the data on each patient is stored in a computer file.

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