Attitudes and practices of the primary health care team towards assessing the very elderly

JILL TREMELLEN

DEE A. JONES

SUMMARY. This paper investigates the attitudes and practices of members of the primary care team towards assessing the very elderly in the community. Using self-completion questionnaires 47 general practitioners, 24 health visitors and 22 community nurses in the Bath health district were asked if they felt over 75 year olds should be assessed, and if so who should do it, and what the assessment should include.

A majority of all three groups of professionals considered it important to assess the over 75 year olds and that this should be done at home. They felt that such an assessment should be functionally oriented, that is, should concentrate on the activities of daily living rather than medical problems. None of the groups felt assessment was their sole responsibility but should be undertaken by a combination of members of the primary health care team with the health visitor playing a prominent role. Although 89% of all the respondents felt that health visitors should be involved in assessing the elderly, half of the health visitors felt their work should be mainly concerned with 0–5 year olds. In the absence of any general policy few assessment schemes exist in the district. An overall policy is required and this should be reflected in the training of each of the professional groups.

Introduction

ACCORDING to demographic forecasts, between 1981 and 2001 the proportion of the UK population aged 75 plus years will increase by 27.6% and those aged 85 plus years by 79%.[1] In west Wiltshire, the population of over 75 year olds will have increased between 1981 and 1991 by 45% to 8605 and the population aged 85 plus years will have grown by 94% to 1933 (West Wiltshire County Council revised population projection, 1988). Although the majority of elderly people are active and healthy these demographic changes have implications for primary health care teams.

These implications are reflected in the government's recently published white paper which encourages general practitioners to undertake regular and frequent assessment of elderly people.[2] The importance of anticipatory care is also stressed by Age Concern, who maintain that preventive work is an integral part of any comprehensive package of care for older people but that variations between different areas of the country make it difficult to recommend any one method or policy.

Since 1964, when Williamson first published his survey identifying the extent of unreported disease in the elderly,[3] there has been considerable discussion about the appropriateness and benefits of assessing the elderly.[4-8] One of the major influences on the development of assessment programmes has been the assumption that the elderly are underconsulters. Taylor and Ford, however, found that although the elderly undoubtedly suffer from more illness they consult their general practitioner in the same proportion as younger age groups.[9] They suggested that future developments should involve a combination of self referral and multi-tiered screening for low contact and high risk groups.

Others favour opportunistic assessment with doctors carrying out case finding within routine consultations[7,10] but the majority of doctors do not do so, largely owing to lack of time. Williamson suggested that general practitioners are not good at case finding, because they are too specialized and their professional expectations are rarely satisfied by the apparently mundane nature of the work.[11] He suggested that health visitors must be the first choice in undertaking elderly assessments. Nevertheless, when faced with the prospect of case finding, health visitors also see lack of time as a reason for avoiding it. Luker suggested that the health visitors' reluctance to undertake case finding is due in part to personal preference and in part because they lack an appropriate agenda and frame of reference for dealing with this age group.[12]

In March 1986 a national workshop on preventive care for the elderly examined leading national schemes, concluding that future schemes would be based on case finding and opportunistic screening which would have to be achieved within existing resources.[13]

This study sought to investigate the practices and attitudes of general practitioners, health visitors and community nurses towards assessing the elderly; whether they felt it should be done at all, what it should involve and who should do it.

Method

Each health visitor, community nurse and general practitioner within the five major towns in west Wiltshire was included in the study. These covered one health centre, eight group practices and one single-handed practice. The largest group practice had eight doctors and the smallest three. Nurses and health visitors were practice attached.

Self-completion questionnaires were devised for each group, with questions in four sections: age, length of time since qualifying and years worked in the present practice; practice type, size, location, number of patients and percentage of patients aged over 75 years; visiting patterns of doctors and nurses, including current assessment practices for the over 75 year olds, whether a policy on assessment existed and if so who did the assessment and how often; and finally, attitudes towards assessment. For the last of these the question 'Do you think assessing the elderly is necessary?' was classified as unnecessary, necessary, important or vital. Attitudes towards areas to be included in assessment were classified as agree, strongly agree, disagree strongly and disagree. A specific question asked who should do assessments: the practice nurse, community nurse, general practitioner, health visitor or a combination of members of the primary health care team. Questions also sought to discover if the length of time respondents had been qualified affected their attitudes towards work with the elderly. Although some of the basic questions were adapted to each group, the important attitudinal and current practice questions were identical in all three questionnaires.

A pilot study was undertaken with one group practice in Bath in order to test the validity of the questionnaire. Ninety-seven

J. Tremellen, HV, health visitor manager for the elderly, Warminster Clinic, Wiltshire; D.A. Jones, PhD, deputy director, Research Team for the Care of the Elderly, University of Wales College of Medicine, Cardiff.

© *Journal of the Royal College of General Practitioners*, 1989, 39, 142-144.

questionnaires were then delivered to the sample and collected personally over a period of two months. This personal contact enabled a 100% response rate of nurses and health visitors to be achieved. General practitioners were approached personally where possible, or through practice managers, or their own community nurses.

Results

Forty seven of the 51 general practitioners, all 24 health visitors and all 22 community nurses completed their questionnaires (total of 96% response).

None of the general practitioners, health visitors or community nurses had a policy of regular visiting of the elderly in their area (apart from one health visitor who had just started doing so). However, three-quarters of all three professions (35 general practitioners, 18 health visitors and 16 community nurses) did visit some people aged over 75 years regularly (Table 1). Fifteen general practitioners and seven community nurses visited more than 20 patients regularly, whereas only four of the health visitors visited this many patients on a regular basis — considerably fewer than their colleagues.

Table 1. Number of patients aged 75 plus years regularly visited by each health professional group.

Number of elderly patients regularly visited	Number of respondents: General practitioners (*n* = 47)	Health visitors (*n* = 24)	Community nurses (*n* = 22)
None	12	6	6
<10	12	11	4
10–19	8	3	5
20–29	8	1	3
30–39	2	1	3
40–49	5	2	1

n = total number of respondents.

Thirty six general practitioners, all 24 health visitors and 18 of the community nurses felt routine assessment of over 75 year olds to be either necessary, important or vital. Only 14 respondents out of a total of 93, thought it unnecessary. When asked if it were necessary for an assessment to be carried out in the home, over three-quarters of the three professions felt it was either necessary or important that the assessment be home based (Table 2).

Despite the fact that so many of the respondents were in favour of an assessment scheme, 15 of the health visitors said they had no time to spare to carry out such an assessment. Twelve of the community nurses also said they did not have the time although 10 felt that they should be involved with assessment but only in conjunction with other members of the team. Twenty six general practitioners, however, said their 'at risk' patients were already known to them. Twelve of the respondents (eight general practitioners, two health visitors and two community nurses) stressed that in conducting any assessment it was important to respect the privacy and independence of the elderly people. The length of time since qualification appeared to have no significant effect on the attitudes towards routine assessment in any group.

Table 2. Number of each profession favouring home assessments for the 75 plus years age group.

Opinion of home assessment of the elderly	Number of respondents: General practitioners (*n* = 47)	Health visitors (*n* = 24)	Community nurses (*n* = 22)
Unnecessary	11	4	3
Necessary	30	7	8
Important	6	13	11

n = total number of respondents.

The general practitioners, community nurses and health visitors who were in favour of assessment did not necessarily feel they should do the work themselves. Twenty nine general practitioners, 19 health visitors and 17 community nurses felt assessments should be carried out by a combination of the primary health care team members; no community nurses saw the work as theirs alone. Of the 93 respondents 83 said the health visitor should be involved and 18 (12 general practitioners, three health visitors and three community nurses) saw it as the health visitor's responsibility alone. Half (12) of the health visitors, however, felt their work should be mainly concerned with 0–5 year olds, whereas over three quarters (17) of the community nurses felt the work of health visitors should be more widely spread.

When asked what factors an assessment should include there was widespread agreement between doctors and nurses that social, environmental, and activities of daily living were the most important factors; clinical assessment was rated less highly (Table 3). Again the length of time since qualifying did not appear to influence their views.

Finally, the health visitors and community nurses were asked about the general nursing policy regarding over 75 year olds in their district. They all reported that no stated and explicit policy existed for assessment of the elderly. The majority could not remember when they had last discussed an elderly client with their nursing officer.

Discussion

Sociodemographic trends indicate clearly the need for the health of the elderly to be a major consideration in primary health care planning. It is clear that there is a growing interest in this field

Table 3. Factors to be included in assessment of the 75 plus years age group.

Factors	Number (%) of respondents: General practitioners (*n* = 40)[a]	Health visitors (*n* = 24)	Community nurses (*n* = 20)[a]	Total (*n* = 84)
Social contacts	40	24	20	84 *(100)*
Mobility	40	24	20	84 *(100)*
Nutrition	40	24	20	84 *(100)*
House safety	38	24	20	82 *(98)*
Awareness of welfare services	38	24	20	82 *(98)*
Availability of supportive carer	38	24	20	82 *(98)*
Continence	37	24	20	81 *(96)*
Housing	38	24	18	80 *(95)*
Awareness of benefits	36	24	20	80 *(95)*
Hearing	38	23	19	80 *(95)*
Personal hygiene	38	23	18	80 *(95)*
Foot care	35	24	20	79 *(94)*
Vision	37	22	18	77 *(92)*
Dentition	30	23	16	69 *(82)*
Urinalysis	32	14	19	65 *(77)*
Blood pressure	30	16	17	63 *(75)*
Weight	27	16	19	62 *(74)*
Haemoglobin	19	15	14	48 *(57)*
Blood count	17	13	14	44 *(52)*
Cervical cytology	9	4	8	21 *(25)*

[a]Seven doctors and two community nurses failed to complete this question.

among general practitioners, health visitors and community nurses. There is a small but growing number of case finding and screening programmes currently being carried out all over the United Kingdom using different protocols and assessment schedules. The aims, however, of the majority of the schemes are similar in that they concentrate on functional assessment rather than the detection of asymptomatic disease. These programmes are initiated and carried out by different members of the primary health care team but in most cases the health visitor plays a prominent role.

The results from this study showed that all three groups felt that assessing the elderly in the community was necessary and important. There was almost total agreement between the professions on what an assessment should involve, agreeing with the national trend towards case finding rather than screening. Similarly they agreed that the best place to carry out an assessment was in the elderly person's home. There was a greater disparity, however, when it came to who should do it; the majority of professionals felt the assessment should be carried out by a combination of primary health care team members and 89% of all the respondents felt that health visitors should be involved and indeed, a quarter of general practitioners felt the health visitors alone should be responsible. As many as half the health visitors questioned, however, felt their work should be mainly concerned with 0–5 year olds and only three health visitors saw assessment of the elderly as their responsibility alone. This difference in perceptions has serious implications for training of health visitors and for future policy.

Health visitor training covers all ages of patients and includes general principles of assessment rather than the specific assessment of one particular age group. Emphasis, however, is still given to child development; indeed a requirement of entry to health visitor training schools is either midwifery training or an approved obstetric qualification (although this is currently under review); no such background in geriatrics is required. Within training courses, lectures on the care of the elderly are often based on geriatric medicine rather than gerontology which would seem a more appropriate framework for a specialist in prevention and health education. The British Geriatric Society and the Health Visitor Association in their joint policy statement pointed out that newly qualified health visitors often have an inadequate knowledge base and insufficient skill for working with the elderly.[14] They make recommendations for improving training which would include in-service training for qualified health visitors.

A small number of general practitioners felt that case finding for the elderly was unnecessary because they already knew their patients who were in need of medical support. Vetter and colleagues,[4] however, found that health visitors uncovered needs hitherto unknown to general practitioners, mainly related to problems with hearing, feet and eyesight, mental, social and environmental problems and difficulties concerning carers. This difference in perceptions and possible lack of mutual understanding regarding the work of medical and nursing professions has further implications for training. The Health Visitors Association and British Geriatric Society recommend shared learning opportunities for student health visitors and general practitioner trainees.[14] Lack of enthusiasm for working with the elderly does not appear to be confined to health visitors — although it may be a poor measure, it is noteworthy that less than 2% of general practitioners are members of the British Geriatric Society.[15]

It is significant that there is no community health visiting or nursing policy for the elderly within the district studied here, whereas there are firm guidelines for children from birth to school age. It is also significant that the majority of health visitors and community nurses could not remember when they had last discussed a patient aged over 75 years with their senior nurse. Although community nurse training places increased emphasis on prevention, none of them felt they alone should undertake routine assessment of the elderly. General practitioners did not see themselves as either initiators or chief participants in an organized assessment scheme. It is surprising that with the trend towards greater emphasis on prevention in training the views of the more recently qualified professionals did not significantly differ from their senior colleagues.

The results of this study suggest that a case finding programme for the elderly could be carried out, and carried out in the home. A coordinated approach from nurse managers using all three professions, with the health visitor playing a leading part would seem to relate logically to the attitudes of the primary health care team.

Specific policies need to be developed and, in order for an assessment scheme to succeed within the existing manpower, they would need to be structured and feasible. The next step should be for discussion between professionals to agree roles and responsibilities and build on the mutual aims of all three professions. However, the success of such a scheme will depend on the enthusiasm of the professionals involved, which must reflect a change in training and the attitudes of nurse managers.

References

1. Age Concern. *Elderly people in the United Kingdom: some basic facts.* London: Age Concern, 1986.
2. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health (Cm 249).* London: HMSO, 1987.
3. Williamson J, Stokes IH, Gray S, *et al.* Old people at home: their unreported needs. *Lancet* 1964; **1:** 1117-1120.
4. Vetter NJ, Victor CR, Jones DA. Effects of health visitors working with elderly patients in general practices. A randomised controlled trial. *Br Med J* 1984; **288:** 369-372.
5. Hendriksen C, Lund E, Stomgard E. Consequences of assessment and intervention among elderly people: a three year randomised controlled trial. *Br Med J* 1984; **289:** 1522-1524.
6. Tulloch AJ, Moore V. A randomised controlled trial of geriatric screening and surveillance in general practice. *J R Coll Gen Pract* 1979; **35:** 288-290.
7. Freer CB. Geriatric screening. A reappraisal of preventive strategies in the care of the elderly. *J R Coll Gen Pract* 1985; **35:** 288-290.
8. Pike LA. Early intervention in general practice. London: Croom Helm, 1984.
9. Taylor R, Ford G. The elderly as underconsulters: a critical reappraisal. *J R Coll Gen Pract* 1985; **35:** 244-247.
10. Taylor R, Ford G, Barber H. *The elderly at risk.* London: Age Concern Research Unit, 1983: 7.
11. Williamson JE. Prevention screening and case finding: an overview. In: Taylor RC, Buckley E (eds). *Preventive care of the elderly. Occasional paper 35.* London: Royal College of General Practitioners, 1987.
12. Luker KA. Health visiting and the elderly. *Health Visitor and Community Nurse* 1979; **15:** 457-459.
13. Taylor RC, Buckley EG. *Preventive care of the elderly. Occasional paper 35.* London: Royal College of General Practitioners, 1987.
14. British Geriatric Society and Health Visitors Association. *A joint policy statement.* London: BGS and HVA, 1986: 12.
15. Webster SGP. What is a good GP. *Br Med J* 1986; **293:** 1351-1352.

Acknowledgements

Jill Tremellen would like to thank Johnson and Johnson for funding the pilot study, Georgia Blomley, patient care manager, Bath District Health Authority for allowing her the freedom to undertake this study and we thank Tessa Tremellen and Janice Strom for typing the manuscripts.

Address for correspondence

Jill Tremellen, Warminster Clinic, The Avenue, Warminster, Wiltshire.