



ROYAL  
COLLEGE OF  
PHYSICIANS  
OF IRELAND

# Policy Group on Ageing

Submission to SAGE Forum on Long-Term Care  
April 2016



## *Background*

1. The Royal College of Physicians of Ireland (RCPI) established a Policy Group on Ageing in 2015 which had its first meeting in 2016. This group comprises representation from a range of medical specialities, nursing, and professional bodies relevant to medicine for the older person. Also included in the membership is a lay member from RCPI council. The group was convened with the overall aim of influencing national policy on a range of healthcare issues for older people using evidence-based research and best practice from Ireland and internationally. The group will publish formal recommendations in the form of a policy statement in due course.
2. This submission highlights relevant information on the subject of long-term care, drawn from documentation selected by the Policy Group members based on their individual areas of expertise.
3. While there is consensus across the professions that there is an imminent need to formalise guidelines that address the care of the ageing population, the ICGP, while represented on the Policy Group, cannot sign or endorse this present document on the basis that wider consultation is required to better understand and jointly address the multifactorial issues that arise in the provision of care to the ageing population. The ICGP is keen to engage in a process that progresses these developments in a consultative and timely manner.
4. This submission is largely focussed on medical and health care in long-term care in the nursing home sector, as this is a specific area of expertise of many members of this group, represents the most frail and disabled group of older people in our communities<sup>1</sup>, and has been subject to a degree of scrutiny and research in the last decade. This care displays ongoing deficits in a number of areas, and the quality, appropriateness and gerontological attuning of the care provided is a useful basis for considering these aspects of long-term care of older people in their own homes and other settings which have not yet been scrutinized to the same extent. This focus in no way detracts from the Policy Group's support for long-standing government policy and the clearly stated wish of older Irish people to remain supported in their own homes to the greatest extent possible: indeed, the content of this submission should provide insights which have relevance for appropriate and equitable support in these settings, as yet unregulated, as well.

## *Context*

5. A high percentage of patients in nursing homes have multiple chronic conditions, frailty and disability which require gerontological expertise in care<sup>1</sup>.
6. A concern has been expressed in the literature that only a tiny minority of European states (not including Ireland) recognize a need for specific gerontological training and guidelines (including dementia care and palliative care<sup>2</sup>) for medical care of nursing home residents<sup>3</sup>.
7. There is growing interest among OECD countries in monitoring quality of care in nursing homes<sup>4</sup>.
8. Although the Irish Society of Physicians in Geriatric Medicine articulated a need for a gerontologically-attuned approach to nursing home care in 2001<sup>5</sup>, the review of deaths at Leas Cross Nursing Home in 2006 indicated that no other professional body or arm of the Irish health services provided evidence in the public domain at that time of incorporating this key principle of care provision to frail older people in nursing homes<sup>6</sup>.

9. Recently published research indicates that age-specific incidence of dementia may be declining in high income countries<sup>7</sup>, however, Ireland's future demographic outlook means that there will be high numbers of older people who will require residential care in the coming decades and beyond.
10. The stated aim of the Irish Health Services since *The Years Ahead* (1988)<sup>8</sup> has been to enable care at home to the greatest extent possible. It has been reported that 25% of nursing home residents might be able to age in place in the community if adapted homes are provided<sup>9</sup>. A UK Department of Health funded evaluation of 19 "extra care" housing schemes found "similar or lower costs" than residential care but better outcomes, supporting extra care housing as an alternative to residential care<sup>10</sup>. In Ireland, "sheltered housing" was previously provided mainly by the public sector, but now non-profit organisations play a significant role. The recent Cluid report<sup>11</sup> into housing needs for older people clearly demonstrated that older tenants wanted to remain in their current social or sheltered housing, despite their increasing care needs, and indeed there was a widespread "fear" of nursing homes in this group. The report recommended flexible schemes with varied house types, and the careful design of homes which would allow for multiple uses as the person's needs change over time. The Centre for Excellence in Universal Design has similarly outlined key principles for the design of housing for dementia that may facilitate ageing in place<sup>12</sup>.
11. It is likely that less than 5% of older people reside in nursing homes. It is likely given the compression of morbidity seen in Western populations that the absolute numbers will not rise in proportion to the increasing numbers of older people: in the UK this population has remained almost stable since 2001 with an increase of just 0.3%, despite growth of 11% in the overall population aged over 65<sup>13</sup>. In 2014, there were 20,325 older people (65+) resident in long-stay care in the ROI<sup>14</sup>. According to the most recent estimates 29,274 older people will require long-term care in 2021<sup>15</sup>. This estimate corresponds to an increase of 44% or 8,949 between 2014 and 2021.
12. A marked shift has occurred towards the private sector, and to a much lesser extent the voluntary sector, in the provision of nursing home care, with a correspondingly smaller proportion in public (state provided) nursing homes. In 2008, public long-stay had accounted for 29% of long-stay beds<sup>16</sup>: In 2013, 66.8% of all beds were provided by the private sector, 10% by the voluntary sector, and only 23.1% by the public sector<sup>17</sup>. The majority of all places are majority-funded by the state, regardless of the sector<sup>18</sup>.
13. This shift has occurred without any public debate or clear statement of policy, although a 2013 presentation by a Health Service Executive (HSE) manager revealed that the Department of Health wished to maintain 20% of nursing home beds in the public sector<sup>19</sup>. This is of significance because of a reasonably consistent finding of a differential in quality between the for-profit and not-for-profit sector in the international literature<sup>20 1</sup>. In addition, there has been a long period of neglect of the physical fabric of public nursing homes<sup>21</sup>. There is also concern that there is limited availability of nursing home beds for people whose behaviour is outside accepted norms, whether they have cognitive dysexecutive disorders or severe enduring mental illness.
14. The Nursing Home Subvention Scheme (also known as the 'Fair Deal' scheme) did not clarify access to equipment, supplies such as continence pads, transport for health needs, therapies or social work. Many community HSE services do not provide a service to private nursing homes, for example Occupational Therapy and dietetics, which disadvantages these patients. Although the Health Information and Quality Authority (HIQA) regulations state that residents should be referred to care services, they do not specify how these should be provided. The Irish National Audit of Stroke Care indicated a low level of provision of such services to residents with stroke<sup>22</sup>. In addition, the scheme particularly emphasizes physical disability and disadvantages access to residential care for those who experience mental health and cognitive problems but retain physical functioning.

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<sup>1</sup> No data currently available from HIQA on compliance with standards between for-profit and not-for-profit sector

15. Much of the recent growth in the private nursing home sector has been in the form of relatively large units at the periphery of urban areas, distant from the localities where the residents formerly lived. In addition, there is a marked variability in the provision of nursing home beds, with relatively larger proportions in rural areas, and bed numbers well below the national average at 1.9 and 2.2 per 100 older people in Dublin South-West and Dublin North Central respectively<sup>23</sup>.
16. Current regulations for constructing nursing homes do not specifically incorporate modern concepts in nursing home care, such as the Green House<sup>24</sup> or Eden Alternative<sup>25</sup>, and it is not clear to what extent enforcement is carried out of design elements such as those contained in section 25 of the HIQA regulations (i.e., regularly spaced seating areas, areas of interest and diversion). HIQA's 2014 Overview Report on Regulation of Designated Centres for Older People found that only 29% of inspections showed compliance with Outcome 12 'Safe and Suitable Premises'<sup>26</sup>.
17. There are currently no national policies to provide a mix of diverse long-term care residences to include duplex units for sharing with spouse/partner or assisted living accommodation where people who are socially isolated and lonely can be accommodated without having 'care needs'. These are only available for those who can afford to personally finance them or who can avail of the very limited availability through voluntary initiatives<sup>18</sup>.
18. There is limited availability in nursing home care for couples/spouses/siblings/friends to share appropriately configured rooms.
19. Formal advocacy is an important development in health and social care settings. For older people it presents complex challenges<sup>27</sup> and with people living with dementia 'often tests some of the advocacy principles to extremes'<sup>28</sup>. It is important that such services in nursing homes are based on as solid a basis of contemporary research and scholarship as possible; manage the complex task of combining independence with due liaison with other sources of advocacy within the care setting (family and care staff where the resident so desires); and have a strategic vision for appropriate response to the deficits in provision of professional services (such as access to social work and therapists) and resources within the sector. It is also important that the advocacy service is appropriately resourced.

## *General principles for medical care in nursing homes*

The RCPI Policy Group on Ageing endorses a number of national and international position statements and recommendations on healthcare in nursing homes. These include:

20. The European Union Geriatric Medicine Society (EUGMS) in 2015 published a paper setting out seven key elements of standard of medical care for physicians working in nursing homes<sup>29</sup>. The seven principles proposed are:
  - All patients under consideration for admission to nursing home care should have an assessment by a specialist in geriatric medicine or old age psychiatry or both, prior to admission.
  - Given the complexity of care associated with older people in nursing homes, physicians providing medical care to nursing homes should have a formal competence in geriatric medicine and old age psychiatry.
  - The medical care needs to be supported in the nursing home by nurses who have gerontological training, including training in dementia and palliative care and care attendants who have due training in the care of older people.

- The medical care needs to be supported by associated disciplines; and in particular physiotherapy, occupational therapy, speech and language therapy,(including skills in dysphagia assessment and management), clinical nutrition and pharmacy at a minimum and access to other professions- dentistry, social work and psychology- as required.
  - The medical care needs to be supported by specialist gerontology services, including geriatricians, old age psychiatry, gerodontology and clinical nurse specialists as required.
  - The process of maintaining patient medical and nursing records should be gerontologically attuned so as to reflect the needs of this patient group and support clinical decision making
  - Appropriate schedules should be maintained for preventive interventions (such as vaccination, monitoring of chronic diseases and regular clinical review and medication review). All staff providing care to people in residential facilities should also receive an annual influenza vaccine. There is an onus on the employer to facilitate staff vaccination and on staff to avail of the vaccine to reduce their risk of influenza and of transmission to family and friends, as well as to residents.
21. Many of these principles are also reflected in an earlier position statement (2001) from the Irish Society of Physicians in Geriatric Medicine<sup>5</sup>. The position statement outlines four basic principles and standards:
- Gateways to care- Appropriate assessment and remediation.
  - Equity and financial access- financial criteria for access to long-term care should parallel those of other forms of healthcare.<sup>2</sup>
  - To respond to ongoing health needs, where the package of long-term care is not provided by the patient's own family doctor, it should be delivered by a family doctor with a certified competence in the care of older people <sup>3</sup>. Nurses also should have adequate training (where possible a higher diploma in Specialist Care of Older People), and there should be full and appropriate access to all members of the multidisciplinary team. In addition standards of good practice should be clearly detailed in new legislation and ongoing audit of standards of care will require an independent inspectorate.
  - Environment- standards of accommodation are specified (own room, en-suite bathroom, physical and social environment to fulfil recreation, social interaction and stimulation needs).
22. The 2006 Leas Cross Report contains a number of recommendations<sup>6</sup>. Some of these have been partly implemented, but many recommendations still require action:
- Recommendation 1 called for clear and formal articulation (by the Department of Health and Children and the Health Services) of the complex health and social care needs of older people requiring long-term care. The HSE response indicates that this was being addressed in various ways; through a National Steering Group overseeing the standardised development of all services for older people; a working group on residential services, addressing nursing homes Inspections, standards of care and dementia specific care; an interdepartmental working group report on funding of long-term care; and a national forum with HSE and nursing homes working on quality initiatives including service level agreements.

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<sup>2</sup> This should include diverse forms of long-term care and not simply nursing home care.

<sup>3</sup> The ISPGM does not intend to specify which college or higher academic institution should provide this.

- Recommendation 2 sought formal clarification of the provision of the care in terms of adequate numbers of adequately trained nursing and healthcare assistant staff, recommending that at least half of nursing staff should have diploma in Gerontological Nursing, that Directors of nursing should have diploma in Gerontological Nursing or equivalent and all Health Care Assistants (HCAs) should have FETAC level 5 or equivalent training. The HSE accepted the recommendation to use a workload analysis tool and had begun work on this. Their response indicated that it would be difficult in the short term to reach a situation where at least half of nursing staff have a diploma in Gerontological Nursing, and instead proposed an approach where a certain proportion of staff would have a post graduate course completed and a regular programme of clinical updates for all staff would be instituted. They also noted that Directors of Nursing in nursing homes who do not have a diploma in Gerontological Nursing may have other relevant third level qualifications.
- Electronic version of Minimum Data Set made mandatory to assist in development of individual care plans, quality monitoring and provision of national statistics. The HSE indicated that work had begun on this, and had selected the interRAI as the Single Assessment Tool for older people<sup>30</sup> but this has not yet been advanced in nursing homes.
- Funding arrangements should be reviewed by the Department of Health and Children and the Health Services to ensure that they are matched to high quality care. Again, the HSE response indicated this was a work in progress.
- Nursing homes legislation needs to be updated.
- Pending introduction of a Social Services Inspectorate, nursing home inspection teams to be immediately developed.
- Irish Health Services Accreditation Board process for long-term care to be reviewed to reflect realities of long-term care in Ireland- not only to include training but appropriate numbers of nursing and HCA proportionate to case-mix of residents.
- For those not looked after by their GP who provided their care at home, medical cover must be specified in terms of relevant training (at least diploma in Medicine for the Elderly, responsibilities and support from HSE). The HSE response was that a working group between the HSE and ICGP was proposed to review the role of general/practitioner/medical officer in nursing homes, with a view to describing best practice and make recommendations regarding the way forward. This group was never established, and should be implemented as soon as possible.
- Multidisciplinary team support to be clearly specified – at a minimum to include physiotherapy, occupational therapy, speech and language therapy, clinical nutrition and social work. The HSE response agreed a need for review of access to multidisciplinary team members in the primary and continuing care teams for clients in nursing homes, the result being an action plan addressing gaps and based on need regardless of location. No action plan has been developed, and this should be a high priority area for the Social Care Programme and National Clinical Programme for Older People.
- Specialist medical support needs to be developed (geriatric medicine and psychiatry of old age) - also in terms of development of guidelines and therapy. The HSE response acknowledged this as a key element of future older persons care.
- Professional bodies representing healthcare workers should clarify the specialised needs of older people in residential care in guidance to its members.
- Public Health Overview of residential care must be strengthened- HSE to coordinate data nationwide. There was at the time little data available on length of stay, quality of care, levels of dependency, equipment needs and therapist input, all of which help to better formulate policy and practice.

While a number of these recommendations have been implemented in part or fully – for example, the development of care standards and inspections for nursing homes by HIQA<sup>31</sup> - significant aspects remain unfulfilled, including the requirement for gerontological training, provision of multi-disciplinary team and geriatrician/old-age psychiatrist support, and the public health overview of residential care through universal application of the Minimum Data Set (the core information set at the heart of the Single Assessment Tool).

23. The value of gerontologically-attuned nursing care in Long-term Care is highlighted in research commissioned by The All Ireland Gerontological Nurses Association.<sup>32,33</sup> Key points include:

- “Research from around the world identifies that staff in residential services are experiencing dilution of staffing mix (with reduced nursing and health professional input)... work that once was carried out by registered nurses (RNs) is done by less qualified staff and RNs have less time to spend with patients.”
- Imperative for establishing value of expertise in nursing in residential care of older people. Value of expert nursing care needs to play more explicit role in discourses within society, policy on residential care and the nursing discipline
- Distinction between RNs and Care Assistants highlighted.
- Consolidation of expert nurse role in residential care needs clarification, particularly in context of skill mix, scope of practice and leadership.
- Potential role development for Nurses- RNs as leaders and coordinators; nurse prescribing, palliative and end of life care.
- Importance of development of Clinical Nurse Specialist and Advanced Nurse Practitioner roles.
- Gerontological Nursing needs greater recognition as a speciality in its own right. Undergraduate curricula need to acknowledge the speciality and post-registration education programmes need to be standardised.

The report(s) highlight a significant deficit in the current position paper from the Irish Nursing and Midwifery Board on nursing older people which makes no mention of Gerontological Nursing or specialist nursing of older people<sup>34</sup>, in stark contrast to the near contemporaneous position paper from the UK Nursing and Midwifery Council<sup>35</sup>.

## Legislation

24. The Law Reform Commission published a 2011 report “Legal Aspects of Professional Home Care”<sup>36</sup> following publication of a consultation paper in 2009 ‘Legal Aspects of Carers’ which looked at delivery methods for home care, both state provided and privately provided; regulation of residential care providers; legislation regulating home care in Ireland; and models in other jurisdictions. The 2011 report made a number of recommendations and included a draft bill -*Health (Professional Home Care) Bill 2011* to implement the recommendations. The draft bill was introduced in the Seanad in 2004 as a private members bill but did not progress beyond that stage.

25. The legal requirements of the Health Act 2007<sup>37</sup> cover all designated centres for older people, whether operated by private, public or voluntary providers. Under this act, the relevant regulations are the Care and Welfare of Residents in Designated Centres for Older People Regulations 2013, which replace the 2009 Regulations and came into operation on 1 July 2014.

26. There are significant concerns arising from the 2013 amendment, which not only fails to mandate a post-registration qualification in gerontology for the ‘person-in-charge’ but also which gave an opt-out clause for nursing homes to provide 24-hour nursing cover and require a post-graduate qualification of any sort from the person-in-charge if the nursing home is deemed by the Chief Inspector to have no resident who needs full-time nursing care. While diverse types of residential accommodation should be provided, ideally to allow progression from assisted living through light to heavy dependency (see point 16, page 3), there is concern that the amendment may not recognize either this progression or the high levels of morbidity and disability in sheltered housing<sup>38</sup>.
27. The Assisted Decision-Making (Capacity) Act 2015 was enacted in December 2015. It provides a statutory framework for the making of Advance Healthcare Directives. The Act takes into account Ireland’s obligations under the UN Convention on the Rights of People with Disabilities and the Council of Europe Recommendation CM/REC (2009)11 on *Principles Concerning continuing powers of attorney and advance directives for incapacity*.
28. Prior to enactment of the Act, a small working group convened by RCPI produced a submission<sup>39</sup> on Advance Care planning in the context of a 2014 Public Consultation on Advance Healthcare Directives. This submission was supportive of advance care planning, consistent with the Medical Council 2009 Ethics guidelines, highly relevant for residents of nursing homes, but expressed concerns regarding legally binding advance healthcare directives refusing treatment as a general response to planning for end-of-life care. Taking this and other issues into consideration, it would be helpful to have input to the development of the codes of practice for the Act to make them practical for the situations clinicians see daily.

## National Strategy, Standards and Models of Care

The following national strategy documents, standards and models of care are relevant in relation to long-term care for older people.

29. National Positive Ageing Strategy<sup>40</sup>- National Goal 2 focuses on supporting people as they age to maintain, improve or manage their physical and mental health and wellbeing. The document refers to recent long-stay activity statistics compiled by the Department of Health which showed that 13% of long-stay care residents are classified as low dependency, with a further 21% classified as medium dependence. It is noted that this suggests scope to further reduce demand on residential care. There needs to be a clear strategy around planning levels of supportive accommodation going forward (see points 10 and 16, page 2 and 3): many currently supported accommodation facilities are quick to move people on when they start to display symptoms and behaviours of dementia. The continuum from home to nursing home needs to be more closely examined and planned for. The National Dementia Strategy 2014<sup>41</sup> includes a number of relevant actions and objectives:
- The need for an integrated care pathway across all services for people with dementia was identified. (HSE to develop and implement a dementia and delirium care pathway).
  - In planning future long-term residential care, the HSE will take appropriate account of the potential of new residential models, including housing with care, for people with dementia.
  - Anti-psychotic drugs should only be used when all other non-pharmacological interventions have first been tried and exhausted.<sup>4</sup>
  - The HSE will work to maximise the implementation of the national policy on restraint: Towards a Restraint Free Environment in nursing homes. Legislation is required to set out principles/procedural

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<sup>4</sup> Anti-psychotic drugs should only be used if there is a therapeutic reason for doing so and not to control behaviour.

rules with regard to the use of restraint, in compliance with the European Convention on Human Rights.

- HSE to review health and personal social services for people with dementia to identify gaps in existing provision, and prioritise areas for action.
- The HSE will consider how best to configure resources currently invested in home care packages and respite care so as to facilitate people with dementia to continue living in their own homes and communities for as long as possible and to improve the supports available for carers.
- The HSE will evaluate the potential of assistive technology to provide flexible support both to carers and to people with dementia.
- In line with the health promoting health service model, the HSE will ensure that information on how to access advocacy services, voluntary organisations and other support services is routinely given to people with dementia and their families/carers.

In 2016, new research projects, aligned with the National Dementia Strategy were announced. The research will look at the best ways to provide care for people living with dementia based on choice rather than just relying on the traditional residential care model, and will examine personalised, non-pharmacological approaches to care such as physical exercise and the beneficial effects of non-pharmacological interventions.<sup>42</sup>

30. HIQA was established by The Health Act 2007 as an independent inspectorate with strong power to assess the extent to which standards and regulations of the health act are met. HIQA has published National Quality Standards for Residential Care Settings for Older People in Ireland (2009) and a 2014 consultation was conducted to update the 2009 standards, but a final report has not yet been published. A 2014 Annual overview report on the regulation of designated centres for older people from HIQA found<sup>26</sup>:

- Overall there was an acceptable level of compliance with regulation and National Standards, but many needed to improve their approach to individualised person-centred planning and risk assessment and management.
- The report notes significant improvement to the physical environment of centres since 2009.
- Levels of compliance against outcomes of 'Health and Safety Risk Management' (compliance in 21% of inspections) and 'Health and Social Care Needs' (compliance in 29% of inspections) were the lowest of all outcomes. Health and Social Care Needs relate to the standard of care in nursing, medical and allied health and individual care plans based on assessed needs and with involvement of the resident.
- Outcome 9- Medication Management. In 43% of inspections the centre was found to be fully compliant.

31. The National Economic and Social Council (NESC) has published a number of relevant reports which discuss standards in both home care and residential care for older people<sup>43,44</sup>. The most recent of these reports were produced in 2012, including *Home Care for Older People* and *Residential Care for Older People*.<sup>45</sup> Some key points include:

- Two different approaches are noted. Care of older people in residential centres is regulated by mandatory regulations and standards through the Health Act 2007, and with HIQA established to assess the extent to whether standards are met.
- Care at home is unregulated (whether state, private sector or voluntary organisation). A variety of draft standards for home care exist and are being implemented on a voluntary basis (See also Law Reform Commission 2011 report). The report noted that the HSE has awarded tender for organisations to provide new home care packages on its behalf and this requires those awarded to demonstrate quality standards in a range of areas (dubbed 'regulation by the back door' by some).

- The new regulatory regime (refers to the 2009 regulations under the Health Act) has been beneficial in restoring public confidence after scandals. HIQA independence was seen as positive. The inclusion of HSE centres under the regulations was also seen as positive. Transparency was seen as good (i.e. reports on HIQA website) and as a spur for improvement.
- Areas for improvement/change included
  - Sharing of learning based on best practice
  - Supporting culture change to promote person centred care
  - Collecting standardised data to assess quality and costs of different services
  - Coordinating decisions of providers, the Department of Health and HIQA to ensure that services for older people are provided at an optimum level.
- NESC also produced a report on Standards on End of Life Care (2012). The report references the Hospice Friendly Hospitals Programme and its Quality Standards on End-of-Life care in Hospitals as a good example of standards driven from ‘bottom up’.

32. The Irish Edition of the EU Quality Framework for Long- Term Care Services<sup>46</sup> describes quality principles and areas of action, and guidelines for implementation.

33. The National Clinical Programme for Older People (NCPOP) has a model of care for acute care<sup>47</sup>, but one needs to be developed to address services for older people in General Practice, primary and community care which should include long-term care and GP involvement in nursing home care.

## *Guidelines from Professional Bodies*

34. A 2013 ICGP Forum article<sup>48</sup> mentions the absence of agreed guidelines or treatment protocols to guide GPs in caring for patients. This gap may in part have been addressed by a report from the ICGP Quality in Practice Committee, *Dementia, Diagnosis and Management in General Practice* (2014)<sup>49</sup> which details guidelines and clinical evidence in the management of Dementia in General Practice. The report includes a section on advanced dementia in the nursing home and suggests a number of strategies to improve care in nursing homes:

- Senior staff member with lead for quality improvement in care of persons with dementia.
- Local strategy for care and management of persons with dementia.
- Only appropriate use of anti-psychotics<sup>5</sup>.
- Specialist in-reach services from older peoples community health teams.
- Specification and commissions of other in-reach services (primary care, dentistry etc.)

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<sup>5</sup> Education on the distinction between chemical restraint (regarded as inhuman and degrading treatment under the European Convention on Human Rights and not allowed) and the administration of medication for therapeutic reasons, must be made a priority. This appears to be a particular issue in residential centres as highlighted recently by HIQA

- Design features underpinning best practice in dementia care are mentioned.
35. In addition a 2016 series of articles in the ICGP journal *Forum* highlight the many challenges faced by GPs who provide care in nursing homes, and advises GPs on managing those challenges<sup>50,51,52</sup>. Some points raised in the articles are:
- In relation to workload- structured visits to less homes worked better than rushed visits to greater number of homes.
  - Increased workload and reduced remuneration. Current remuneration is not sufficient for what is required to provide appropriate structured care.
  - High levels of administration are required to facilitate remaining registered with HIQA
  - Consulting room in home is advantage; as is a dedicated nurse.
  - The Importance of director of nursing is stated (“who can make decisions and correctly advise on which residents to be seen...”)
  - Importance of effective liaison between GP and the family (especially where there is a degree of cognitive impairment)- to among other things, explain the difference in medical care offered in nursing home and that offered in acute hospital. This includes knowing that GP is not available 24/7 except for emergencies, speaking to one nominated family member only, and family knowing when the GP visits the centre.
  - Changes to medication need to be communicated properly with the patient or their family.
34. Further context to these articles is provided by surveys of the perspectives and experiences of general practitioners on nursing home care published in 2009<sup>53</sup> and 2012<sup>54</sup> in the Irish Medical Journal.

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