Family Medicine and Community Health
COMMENTARY

The Community Hub: a proposal to change the role of Residential Aged Care Facilities (RACFs)

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Introduction

In Australia, as in most parts of the world, the increasing number of aged persons and the proportion of the population represented by aged persons is a cause of concern that will require changes in many areas of community life, including aged care [1]. This paper draws on Australia's experience to propose a new model for residential aged care with potential international application.

The health care needs of the aged are also changing everywhere. More aged persons have chronic diseases needing regular supervision and management, and there are more aged persons with dementia. We must anticipate elderly populations seeking more health care at a time when families and authorities are less able to afford health care [2].

These Barriers Limit Effective Aged Care

1. Attitudinal Barriers
   a) *Attitudes in Bureaucracies*
      Residential aged care in Australia is heavily regulated, regimented, and change is generally imposed through compliance-based legislation demanding considerable paper work, which limits staff satisfaction and time with patients.
   b) *Community Attitudes*
      The common stereotype of older people is associated with decline, dependency, and dementia. Residential Aged Care Facilities (RACFs) suffer a poor reputation, and the prospect of placement in a RACF fills many older people with dread [3].
   c) *Staff Attitudes*
      The culture of the RACF focuses on disease and the maintenance of comfort, which encourages resident inactivity and both physical and social decline. A pervasive concern about 'duty of care' induces an anxiety to avoid responsibility and mistakes. Staff-to-patient ratios are low, work must be rushed, and residents have to adapt to set times for hygiene, meals, and sleep, which are a cause for dissatisfaction amongst residents and family members. More emphasis on activity and encouragement for patients to fend for themselves reduces the number needing major assistance and compresses the stage of decline that precedes death, thus allowing more time to attend to individual needs [4].
2. Structural Barriers
   RACFs are a complex mix; specifically, RACFs are large and small, public and private, and for-profit and not-for-profit. The multiple agencies

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involved embody a wide variety of histories, values, managements, and associations. Common to most is a relative isolation from the communities in which they are located.

Ways of incorporating RACFs into the community around them will be particularly important if more aged persons are to be managed in homes. The RACFs need to be in a position to offer support for local home care, with respite opportunities, particularly for dementia care [4]. If the RACFs offer clinical supervision of home care, symptom crises can also be managed in the home, avoiding transfers to acute hospital care.

3. Staffing Barriers
   a) *Medical*

   Many primary care practitioners (commonly called general practitioners [GPs] in Australia) are reluctant to undertake visits to homes or RACFs, regarding fees for such consultations as inadequate. Increasingly, locum services provide medical advice in those areas, with the attendant risk of inappropriate overprescribing, and unnecessary hospital admission for acute illness episodes [5–7].

   Lack of medical interest in aged care partly reflects a lack of training. A comprehensive preparation in psycho-geriatrics, chronic disease, and palliative care is needed, but has not been part of existing medical curricula.

   b) *Nursing*

   Funding for RACFs means that the sometimes solitary registered nurse finds that much time is taken up with completion of administrative duties and paper work. Enrolled nurses commonly supervise medications and provide support for the less-qualified carers who are the major work force.

   c) *Caretakers*

   RACF caretaker staffing increasingly relies on relatively young persons recruited from overseas and trained in a short intensive program after arrival. There are communication difficulties and cultural misunderstandings. Many hope for further education and alternative employment opportunities. The caretakers have not done this kind of work before, many having relied on servants at home [8].

   Most elderly persons wish for care in their own home. This places significant demands on those who provide care in the home. The elderly persons need regular support from visiting physicians, nurse practitioners, other health workers, and volunteers, plus access to respite care.

   d) *Other Staff*

   The many discomforts of very elderly persons benefit from the available support of allied health expertise, including psychology, podiatry, dietetics, speech pathology, physiotherapy, pharmacy, occupational therapy, speech therapy, and social work. These services need to be accessible both to RACF residents and those receiving care at home.

4. Clinical Management Barriers

   RACF staff often feel that support is inadequate and they are overburdened by responsibility. Transfer of RACF residents to acute hospital care is a common response to any significant acute clinical need if only a locum service, unfamiliar with the case in question, is available. This creates an issue for emergency departments whose staff see the arrival of an aged person with a sometime minor deterioration in health status as a distraction from their main work [9, 10].

   Hospitalization encourages unnecessary investigation, futile treatment, and not infrequently, deterioration and death of an elderly person in an unfamiliar and inappropriate environment [11].

AN ALTERNATIVE MODEL

The Community Aged Care Hub is proposed as a development of the RACF that will offer coordination and management of all matters affecting the health and well-being of elderly persons at the community level. The Community Hub would continue to provide comprehensive aged care for its RACF residents, but also participate in social support, preventive care, dementia care, and palliative care for aged persons in the homes of the local community (Figure 1).

Components of Community Aged Care Hub

1. Improved Medical Supervision and Support

   A primary care practice on-site, with medical staff trained in aged care, psycho-geriatrics, and palliative care provides in-house clinical leadership while continuing to offer care in the local community.

   On admission, each resident receives, in consultation with family members, a comprehensive assessment embracing a full medical and social history, risk assessment, medication review, and the preparation of an advance directive document [12, 13]. This routine will reduce unnecessary hospital transfers. Hospital-type treatment in RACFs is a viable alternative for many hospital transfers if regular medical review of residents and better on-site management of the complex, multiple medical needs of aged persons is available [14, 15].

2. A New Positive Culture of Healthy Ageing

   Aged individuals will be encouraged by the Hub to take a more informed and positive ownership of their own health. Staff at all levels will affirm ownership of the same positive approach to their own health. Emphasis on graded exercises, improved nutrition, and more interaction in social settings will reduce the need for staff intervention in matters of mobility, hygiene, and feeding. A gymnasium, staffed by a personal trainer, can make an enormous contribution and be relevant to all but the most dependent residents [4].

   Flexibility in management should allow trials of innovative practices in clinical care, staff deployment, and opportunity to offer admissions from local homes for respite or emergency situations rather than transfer to emergency or acute hospital care.

   Medical leadership, based in-house, will bring a new confidence to staff, a heightened morale as they engage with the new paradigm of healthy ageing and confidence in the available back-up and skilled review. Allied health services available on a full-time or sessional basis will enhance the cultural shift required.

   The medical presence will be augmented by nurse practitioners with expertise in psycho-geriatrics and palliative care. The nurse practitioners will support care in the RACF and those community health care staff visiting local homes (GPs, district nurses, caregivers, and family members). The nurse practitioners will undertake in-service education and support of caregivers and volunteer helpers, help devise imaginative and proactive care routines, and facilitate an increased opportunity for death being managed in the home.

3. A Better-Trained Workforce

   Medical graduates taking up work in a Community Hub need confidence in geriatrics, psycho-geriatrics, and palliative care. A wide-ranging program that embraces all three areas at the diploma level should be open to graduates in all health disciplines, not just medicine, and would attract graduates in nursing, psychology, social work, physiotherapy, and pharmacy. Such a diploma, whether offered through a college or university, will be available by distance study.

   GPs or staff from other health disciplines who complete the diploma need recognition as elderly care practitioners, equipped to undertake leadership and teaching roles in aged care situations.

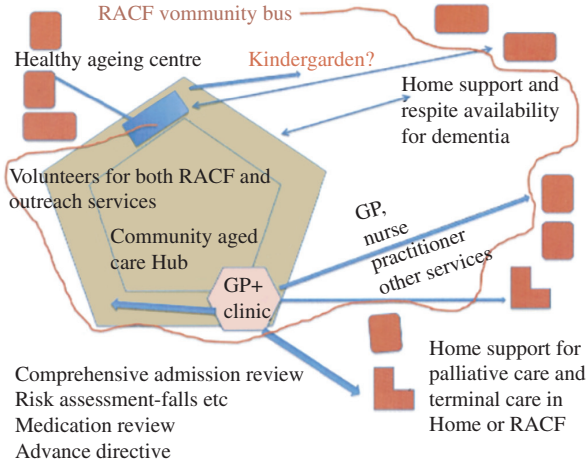

Figure 1. Map/diagram of the proposed components of the Community Aged Care Hub.

4. A Centre for Education and Training

   Forming close links to tertiary and technical training institutions, the Hub will offer on-site undergraduate and post-graduate placements for students of aged care in all disciplines, learning through participation in care delivery, case-studies, tutorials, and discussions. When undergraduates meet the realities of aged care through encounters with feisty elderly RACF residents and others in home placements, they find a new interest in aged care as a career opportunity [16].

5. Integration into the Local Community

   The Aged Care Community Hub will become a part of the local community by providing services into local homes and bringing community members into the facilities.

   Home visits will make the local aged familiar with the RACF and its staff, and comfortable to accept admission there when necessary. IT services, linking homes and the Hub, can expand the range of clinical contact, particularly when both parties already know one another.

   Relevant RACT services may include the following:

   Club facilities for aged persons living in the local community will encourage mobility, strength, and intellect through regular use of the gymnasium, exercise classes, games (bridge and billiards) and discussion groups (e.g., book club and lecture series).

   A community bus service to undertake regular pick-up and set-down runs for access to the Hub by home-based patients and Club participants.

   General social support with a midday hot meal for elderly persons from the local community, plus an opportunity to have laundry done, or a regular assisted shower can be considered. These services will supplement home-visiting services, such as district nurses, visiting meal services, or home care clinical packages.

   A Volunteer Organization will provide encouragement and support of in-house and Club activities. Volunteers have a special role in befriending elderly persons who have limited family contact. The volunteers can allay, with a quiet presence, the agitation and confusion to which many elderly are prone, and help in the vexed issue of over-medication with psycho-active drugs for resident restraint [17].

   A vibrant facility, busy with community activity, would encourage the involvement of the recently retired as helpers for older aged in-house or in homes, and assist their own healthy ageing. Training and encouragement programs for this essential corps of Hub supporters will involve members of the multidisciplinary team and require the employment of a volunteer coordinator.

   A kindergarden on-site would be a bonus, bringing into the lives of the residents some of the sense of extended family which used to be the setting for aged care, but which has largely disappeared in modern urban societies. Young mothers, whose own parents may face the prospect of old age with trepidation, will become more attuned to the realities and the opportunities of old age. Their small children may find, in both the affection demonstrated by the elderly residents and the stories they can tell, an awareness of age that they might otherwise miss.

Co-Location of Hub Elements is not as Important as Cooperation/Collaboration

The many suggested components for a Community Hub will not easily be added to existing RACFs, though new facilities might consider combining the facilities on one campus. A consortium of RACFs, building a Community Hub by sharing facilities across a region (one having a gym, one a pool, and one a special interest in palliative care) can allow progress to begin. Already, one or more of the changes suggested are being introduced in particular RACFs in Australia. A steady development towards a fuller comprehensive vision will usually have to happen step-by-step, and will require broader encouragement to direct its development.

Establishing Community Hubs

In each country there will be a wide range of existing stakeholders with potential to take up this vision, including government departments, not-for-profit and for-profit organizations managing RACFs, professional organizations, universities, community authorities, and volunteer bodies.

Primary care physicians will need to see an advantage for their future careers in taking up the concept of the Hub and preparing through further education to be part of an exciting development in aged care.

Community health organizations might undertake a coordinating role in the further local development of the proposal.

Government Agencies

All levels of government should recognize the advantage of a model that brings comprehensive aged health care and social welfare support close together in location and management. There are major opportunities for better care and cost savings, for example through the closure of expensive acute hospital beds as RACFs undertake more hospital-type care.

A financial subsidy to GPs who undertake supervision of palliative care in the home has been shown to lead to a far higher proportion of home deaths with further reduction in acute hospital costs.

The central role of the Hub in the health of their communities and should encourage local government authorities to supplement services for its elderly citizens.

Educational Institutions

A single award embracing aged care, psycho-geriatrics, and palliative care with a modular structure, allowing choice and flexible learning by distance study at certificate and diploma levels needs ownership by academic institutions.

Caregiver skills will be enhanced if placement experience at a Hub is incorporated in whatever training is offered to carers.

There is an opportunity for private providers to be involved in developing more comprehensive curricula for other professional or lay caregivers geared to different levels of involvement.

RACFs

Organizations or authorities that manage RACFs need to see the advantages for their residents and staff in the proposed cultural change and closer links with community care. For a RACF to transform into a Community Aged Care Hub offers every probability of becoming engaged with something far more exciting and profitable in every sense than current models of residential aged care.

Design Considerations

Existing RACFs will be constrained by the RACFs already in place; specifically, there will be limited space for expansion, and often only a partial transformation to a Hub will be possible. Incremental steps will be fostered through the consortium concept.

Where structural change can be effected, consideration can be given to matters as follows:

- future uncertainties of climate change, with the risk of higher temperatures and heat stress for elderly persons;
- medical and psychological reasons to incorporate fresh air and light in design; and
- appropriate design and furnishing of wards for dementia care, incorporating a color geography that assists residents to identify one area from another, and brightly-colored materials to life mood for staff and residents [18].

Funding Change

A substantial future increase in demand on health spending for aged care seems inevitable, but the introduction of the Community Hubs can lead to greater coordination of care and reduction in both duplication and bureaucratic oversight of existing services, thus reducing costs.

The pathway for establishing and funding Community Hubs will vary from country-to-country, and the relative place of government funding and private investment cannot be generalized, but the principles underlying the Hub concept have universal application.

Conclusion *A new culture, a new spirit, a new community*

A Community Hub offers a RACF and its community setting a vital spirit engendered among those who work in and support the Hub, and a new culture of caring, not only within the institution, but throughout the local community. As the Community Hub is widely recognized to improve the lives of elderly persons both within the RACF and at home in the community, individuals serving in that setting will be encouraged to consider their work as a privilege.

At the same time, some old-fashioned community responsibility for health costs might be anticipated, the kind that in the past supported a hospital that was 'owned' by the community. As the aged care facility in a community grows in local recognition and status, the aged care facility will attract greater local efforts to raise capital funds for new structures and equipment, or scholarships for further training, and interest in volunteering to be part of an enterprise of which the community is justifiably proud.

Conflict of interest

The author declares no conflict of interest.

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