Residential aged care: there is no single optimal model

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The needs of aged care residents are as diverse as when they were younger

Notwithstanding the remarkable and unique achievement of the innovative, complex and detailed investigation by Dyer and colleagues,[1] we should examine the findings and their implications carefully. The study is timely, as Australia's aged care sector is under intense scrutiny, with major concerns about quality of care and governance.[2-5] The Oakden case in Adelaide[2] has recently attracted particular scrutiny, but it is only one of many major episodes of abuse in Australian residential aged care homes.[4,5]

The overall purpose of a residential aged care facility (RACF) is rarely, if ever, explicitly stated, perhaps because the community, professional bodies and policy makers each have a clear sense of what a RACF should do: provide care and accommodation for older people unable to live independently at home. This aligns with the common perception that an older person enters an RACF when they are no longer safe at home.[6]

A contemporary definition of the role of the RACF should be positively framed and anchored in the perspective of the people who live there, and consider their desired outcomes. The RACF should provide opportunities for its residents to thrive. This requires a major shift from prevailing views of RACFs as places of last resort, where our frail elders wait to die. The change in perspective is especially important given the ongoing transition to a more competitive and market-based aged care system.

The concept of smaller home-like environments accommodating up to 15 people is a step toward meeting the expectations of baby boomers. It conveys a sense that care will be personalised and rejects the model of large institutional housing. There now also appears to be empirical evidence for the benefits of this model in Australia.[1] While readers might conclude that all RACFs should therefore be designed as small residential clusters, this is not the case. The inherent challenges of the study by Dyer and her co-authors resulted in their examining a moderate proportion of all residents (541 of 1323 potential participants [41%] consented), already highly selected by including only people who had been "a permanent resident in their RACF for at least 12 months" and excluding those with "complex medical or family problems that would impede participation". This causes significant doubt about whether the participants were representative of the overall RACF population in Australia.

Assessments of different housing models must consider both the individual's course from entry to exit and the different subpopulations in RACFs. The peak periods for clinical care are likely to be at the time of entry to the RACF and during end-of-life palliative care. The RACF must also accommodate subpopulations with differing trajectories, including people likely to stay for less than 12 months and those who require residential respite care. Further, a significant number of residents die within 6 months of entry.[7]

Taking these subpopulations into account when assessing quality of life and economic costs is important, as their care needs and preferred accommodation models may also be quite different. Further metrics are needed to broaden our evaluation. Surrogate measures, such as the number of general practitioner visits and hospital admissions, describe episodes of service delivery. Greater nuance is required in assessing causal links between health care needs and housing model. Finally, measures of harm or adverse events[8] would round out a global evaluation.

Firm conclusions about the efficacy of the clustered residential aged care accommodation model are not possible because of inherent design limitations in the study by Dyer and colleagues. The notion of smaller scale housing is appealing, and it may indeed achieve a better quality of life for residents, but there are still many unknowns. Our challenge is to unravel the factors pertinent to different types of housing and to health and quality of life outcomes.

Obvious questions include whether cluster-style housing produces a different social environment and culture of care, or, conversely, whether it attracts people (staff and residents) already seeking social connectedness and a communal living space. Less obvious questions include that of whether differences in outcomes are less related to the housing model than to the organisational characteristics of the provider, their philosophy, leadership, staffing profile, team dynamic, workplace culture, and financial viability. Perhaps the success of cluster-style housing reflects the fact that its providers are innovators, and it is this factor that actually makes the difference.

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RACFs must serve the needs and wants of their residents, and this encompasses enabling those who want to go skydiving to do so, as well as providing optimal quality care for people nearing the ends of their lives. This requires re-thinking every aspect of the RACF, including continuing the move towards increased respect for the human rights of residents, and supporting their decision making and social connectedness. We need approaches that are more proactive in satisfying the individual needs of a diverse range of residents, and must be uncompromising in guaranteeing optimal care and eradicating abuse of this highly vulnerable population.

These changes will be a new experience for health professionals familiar with designing services to meet the needs of patients with illnesses; it also challenges aged care providers, who are traditionally concerned with meeting the lifestyle wants of their clients.

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1 Dyer SM, Liu E, Gnanamanickam ES, et al. Clustered domestic residential aged care in Australia: fewer hospitalisations and better quality of life. *Med J Aust* 2018; 208: 433-438.

2 Lander B. Oakden: a shameful chapter in South Australia's history. Adelaide: Independent Commission Against Corruption, 2018. https://icac.sa.gov.au/content/oakden (viewed Apr 2018).

3 Carnell K, Paterson R. Review of national aged care quality regulatory processes [report to Australian Minister for Aged Care]. Oct 2017. https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/10_2017/review_report_final_23_october_2017.pdf (viewed Apr 2018).

4 Standing Committee on Health, Aged Care and Sport, House of Representatives. Inquiry into the quality of care in residential aged care facilities. Undated. https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/AgedCareFacilities (viewed Apr 2018).

5 Ibrahim JE, Ranson DL. Policy development and regulation of aged care. *J Law Med* 2018; 25: 320-323.

6 McLennon SM, Habermann B, Davis LL. Deciding to institutionalize: why do family members cease caregiving at home? *J Neurosci Nurs* 2010; 42: 95-103.

7 Ferrah N, Ibrahim JE, Kipsaina C, Bugeja L: Death following recent admission into nursing home from community living: a systematic review into the transition process. *J Aging Health* 2018; 30: 584-604.

8 Ibrahim JE, Bugeja L, Willoughby M, et al. Premature deaths of nursing home residents: an epidemiological analysis. *Med J Aust* 2017; 206: 442-447. https://www.mja.com.au/journal/2017/206/10/premature-deaths-nursing-home-residents-epidemiological-analysis ■