The Elderly in Family Practice: An Evaluation of the Geriatric Visiting Nurse

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The Geriatric Visiting Nurse (GVN) is a health-care professional who, assisted by a checklist, screens patients in their homes, carries out basic tests, and facilitates effective follow-up of patients. Utilization of the GVN in a rural Well-Elderly Clinic associated with the University of Iowa Department of Family Practice is described, and the GVN's participation in the clinic is compared with the screening services provided for physicians by geriatric nurses in advanced communities in various countries. Subject to careful planning, the GVN can play an important role in case-finding, and can, when incorporated into the family practice team, promote efficient utilization of the physician's time.

It may be suggested at the outset that tardiness in working out an adequate measure of care for the aged is not so much a lack of sympathy as a lack of *awareness*. The tendency to devote attention to the needs of younger age groups, coupled with an enthusiasm for the work ethic, may be factors that delay construction of an optimal care system for the elderly. One serious consequence is that growing old is often associated with an empty and inferior quality of life.

Physicians do continue to serve those elderly patients who are brought to their attention. But, it should be noted that the inevitably heavy requirements of older patients create a dilemma. Almost 200 Iowa family physicians responded to a survey that their greatest difficulty in coping with their elderly patients is a lack of time. Three perplexing obstacles on the road to optimal geriatric care are: (1) how can contact be established between the reticent elderly patient[1,2] and the physician? (2) how can these patients then be handled efficiently and well (ie, without exhausting the energies of the physician)? and (3) how, at this time, can a system be planned for the delivery of optimal health care to the increasing numbers of elderly people?

It needs to be stressed that this branch of medicine is at a rudimentary stage and that more vigorous efforts should be made to augment and improve geriatric care in family practice. There is an immediate need to explore ways in which logistic problems associated with contacting and screening elderly patients may be overcome, and a beginning must be made in planning the comprehensive care system needed in this society.

Since it is frequently the case that lack of contact between older patients and family physicians precludes initiation of necessary care or treatment, a manifest effort must be directed towards establishing effective communication between these two parties. The present report focuses on the Geriatric Visiting Nurse and the various contributions which that nurse can make, all of which can promote effective and efficient interactions between patient and physician. It will be helpful to consider first how the Geriatric Visiting Nurse participates both in the health-care process in Iowa and in other advanced communities. A careful look at the merits of using a nurse in those innovative programs has influenced the attempt to incorporate such a person into one of the model practices of the University of Iowa's Department of Family Practice.

The Geriatric Visiting Nurse as a Participant in Some Experimental Innovative Programs

*Iowa County Experiment**

To initiate the program a specially trained nurse made home visits to people over sixty who responded to an advertised invitation to use the facilities of a Well-Elderly Clinic. The publicity was directed towards those who did not receive regular medical care. (One woman who responded had not consulted a physician for thirty years.)

At the first home visit, the nurse completes a questionnaire designed to elicit information about medical, social, and psychological problems. The nurse also carries out urinalysis, hematocrit estimation, and simple vision and hearing tests. Temperature, pulse, blood pressure, weight, and height are recorded. The data generated are reviewed by the physician and nurse together at regular conferences. When the initial screening has

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*The Iowa State Department of Health also supports five other Well-Elderly Clinics in Iowa. These are organized differently and run by specially trained Public Health Nurses.

uncovered possible problems, the patients are examined by the physician at a weekly clinic session. No standardized battery of screening tests is applied to every patient. Instead, after careful physical examination, the relevant investigations are carried out. To provide control, routine physicals are carried out on every tenth patient whose questionnaire reveals no health problem.

Patients found to be needing treatment are either referred to the physicians of their choice or the required community service is alerted, eg, Meals-on-Wheels, Congregate Meals, Social Services, or a Public Health Nurse. One month later, the nurse who made the first home visit makes a follow-up visit to determine whether or not recommendations are being followed and to evaluate both the program's effectiveness and the patient's attitudes. In some cases additional visits by the nurse are called for in order to carry out blood pressure checks, collect pathology specimens, and assess patient compliance with medication, dietary modifications, or recommendations to increase socialization. Merits of home visits include gains in patient confidence, and the elicitation of more specific information about social needs, loneliness, and other facets of the patient's life-style.

Where individuals are housebound, the home-visit approach opens doors that thus far have been ignored. Of the 121 patients screened in the first six months of the Clinic's operation, 23.5 percent were found to be in need of immediate medical attention. Thirty previously undiagnosed conditions were identified. The most frequent disorders uncovered were urinary tract infections, cardiac arrhythmias, significantly elevated blood pressures, and cardiac failures. Of those screened, 16.7 percent were suffering from unmet social needs. By tapping into such community-sponsored simple services as Meals-on-Wheels, the confidence and gratitude of many patients was gained.

Families incapable of handling older relatives were better able to deal with that problem after the visiting geriatric nurse mustered community resources. Certain problems were ameliorated by the application of the nurse's training. For example, an 84-year-old man who lived with his brother, a chronic schizophrenic, had severe chronic obstructive lung disease with cor pulmonale and malnutrition. Medical treatment was organized, his physical condition improved, and nocturnal dyspnea became less of a problem when he could be propped up in a surplus hospital bed discovered by the nurse. The Public Health Nurse now visits the brothers regularly. A 91-year-old retired professional man who was unable to care adequately for his confused 89-year-old wife now benefits from regular visits by the nurse, and medication has made a major contribution in improving his wife's organic brain syndrome. These two families were not being reached by the medical and social help available before the Well-Elderly Clinic nurse made a positive effort to search out elderly individuals who were in need of care.

Manhattan Experiment

In the St. Vincent's Hospital Manhattan program,[3] the stated objectives are to keep patients in the best possible state of health in their own homes, to keep patients out of institutions, and to keep them as independent as possible. Regular screening visits are made by the program nurse while local organizations and community residents act as case finders. The nurse plays a key role in the program and works closely with the physicians and social workers of the health-care team who volunteer their services to bring health supervision and care to the patients' homes. The nurse screens patients, evaluates referrals, and functions as a nurse practitioner for those patients who do not need further medical care. Aside from advantages that stem from patients' desire to remain in their own homes, it was estimated that, in the first 12 months, 70 people had been maintained at home who would otherwise have needed nursing home care at three to five times the cost. Without the visiting nurse, such an emphasis on home care could not be constructed with these economic advantages.

Petah Tikva, Israel Experiment

In Israel, a Geriatric Outpatient Clinic was introduced in association with a polyclinic of 12 general practitioners.[4] Weekly visits were made by a geriatrician, and daily care was supervised by a nurse trained in public health and geriatrics. Care provided by the general practitioner was supplemented by the clinic. The nurse gathered information about the patient's family and environment, carried out assessments and follow-up visits, and conducted group sessions. New knowledge about the patient, including social insights gleaned by the geriatric nurse, proved invaluable to the doctor when making an overall medical evaluation. A valuable part of the nurse's role proved to include the psychological support that the nurse extended to the family. Also valued by families was the nurse's experience in making arrangements for elderly relatives to be admitted to a home when that became necessary. Ideas being considered for future action include the addition of a social worker, introduction of health screening in addition to treatment of referrals, and use of the clinical facilities for health education programs.

Experiment at Boreham Wood, England

An English group practice with seven physicians and 16,000 patients[5] offered screening examinations to their elderly patients. These were performed by a district nurse attached to the practice, and it was routine to carry out the examination in the home if the patient was over 80 years old. Parameters evaluated included height, weight, girth, blood pressure, visual acuity, tonometry, and hemoglobin level. Urinalysis for glucose was also performed, after 25 gm or 50 gm glucose orally. Results were studied by the physician and further examination or investigations arranged if required. Patients thus identified as being at risk were thereafter seen routinely, either in the office, or at home if nonmobile. Follow-up home visits were performed either by the physician, health visitor, or nurse, and careful notes were made on the patient's office chart by each.

Glasgow, Scotland Experiment

Reliance on questionnaires administered by health visitors were features of screening programs in two Scottish surveys. In one, based on a group practice,[6] a questionnaire developed for geriatric assessment was completed in the patient's home by a health visitor, and repeated every six months. This method enabled the physician to

review the care of the geriatric patient through comparison of the patient's problem list on the problem-oriented medical record (which was completed by the health visitor) from one assessment to the next. Each assessment was discussed at a meeting, and the problems assigned for follow-up to the most appropriate member of the group practice team.

Edinburgh, Scotland Experiment

Lowther et al[7] organized screening from the Geriatric Unit of a teaching hospital and focused on high-risk patients; specifically those living alone, recently bereaved, or recently discharged from the hospital. Within one week after the health visitor paid a call on the patient, each received a full physical examination and short psychiatric assessment. Clear evidence of improvement was found in 42 percent of the patients who carried out recommendations. This was attributed to earlier diagnosis than would have been achieved without the screening clinics. The criteria used for evaluation were described as strict but not defined, and after the 18 and 30 month follow-ups, it was claimed that 29 percent had been improved by early diagnosis.

Discussion

Innovative health-care programs have been developed in several countries with very different cultures with the overall idea of identifying elderly patients in need, and the objective of treating them efficiently and effectively. Though each program has unique angles, one common feature is interesting and important. The concept of a visiting or screening nurse, who plays a major part in and works in close association with the physicians, appears to be central in each of the endeavors reported. The author feels reasonably sure that this nurse will continue to be an essential resource when comprehensive health care for the elderly is developed. Although the training, job title, and functions of the nurse vary from place to place, the following will outline the training and titles given in different countries to the person who one may fairly call the "Geriatric Visiting Nurse."

A Health Visitor (a term used in some European countries) is a registered nurse who has received extra training in health education, preventive medicine, and domiciliary practice. Geriatric Health Visitors have had further training in geriatric care. The aims of health visiting, as stated in 1962 by the British Council for the training of Health Visitors,[8] are: the prevention of mental, physical, and emotional ill health and its consequences; the early detection of ill health and the surveillance of high-risk groups; the recognition and identification of need and mobilization of appropriate resources where necessary; health teaching; and, the provision of care, including support during periods of stress, and advice and guidance in cases of illness. The Health Visitor cares for people of all ages, including children, but is not engaged in nursing procedures.

In this country, nurses with Public Health Nursing training* and geriatric experience can be very effective in the role of GVN. Extended roles for nurses were recommended by a joint committee of the AMA and the ANA in 1972,[9] and special courses and new, advanced degrees in gerontological and geriatric nursing have also been recently organized. Some of these courses include health care in a variety of community settings, and incorporate subjects such as bladder training programs for incontinent patients, socialization, and "reality orientation." The geriatric nurse is made aware of theories of aging and expected behavioral and physical changes. Active promotion of health among the aged is also stressed.

Geriatric Visiting Nurse (GVN) is suggested as a title to distinguish the nurse who works as a member of a team with a family physician or who may be associated with a group practice. The nurse's skills may be put to better use for the benefit of patients in this setting, rather than having the nurse act as a resource person for an area containing several practices. The latter arrangement renders almost impossible the unification of effort and intellectual cooperation between the physician and GVN. Emphasis needs to be placed on the importance of home-visiting, with the double objective of locating those in need and assuring effective follow-up.

Older people are known to be reticent in the self-reporting of illness.[10] In one study in Scotland, where inability to pay is not a factor, half the individuals over 65 who were identified suffered from some kind of treatable disabling condition unknown to their family physicians.[1] In a different study, 38.5 percent were shown to have needs that were unprovided for.[2] After sampling at random 200 older people from three medical practices, Williamson[1] concluded that family physicians need to make special efforts to keep in touch with their older patients.

The generation of an optional pattern and standard of care for all older people is, in this author's view, practically unworkable and definitely inefficient if effective use is not made of the GVN. Inasmuch as individual physicians may have differing views on the precise extent of the GVN's responsibility or use of tests or questionnaires, these differences of opinion are healthy. What is important is to realize the GVN's optimal utilization and effectiveness.

Population Trends

In analyzing need, some consideration of geriatric populations is pertinent. Twenty-five years ago, 8.2 percent of the population of the United States was over 65. By 1974, the sector over 65 had increased to 10.3 percent, with certain states, eg, Florida. 15.4 percent, and Nebraska, 12.3 percent, exceeding the national average, which continues to rise. An important parameter affecting these increasing numbers is the rapid rise in average life expectancy from 47.3 years in 1900 to 69.6 years in 1954-1955, to 72 years in 1971. The fastest growing sector is the very old (those over 75), many of whom have to cope with serious disabilities. It is estimated that while only five percent of older people live in institutions, ten percent are confined within their homes,[11] totally dependent on others for their needs. For the latter group, food, companionship, and health care must be brought to the home. The problem of identifying and dealing with the present need is probably much more than can be met by existing medical resources. Even though the unmet need cannot at present be defined or exactly measured, there is strong evidence that the standards of care for older people need

*The District Nurse in British literature is the equivalent of the American Public Health Nurse.

Table 1. Excerpt from Checklist Used in Well-Elderly Clinic*

		First Visit	Follow-Up
Nervous system			
Frequent headaches	2 44		
Difficulty with balance when walking	2 45		
Dizziness or giddiness	2 46		
Faints or blackouts	2 47		
Falls (in past year)	2 48		
Memory loss			
Knows date (day, month, year)	2 49		
Knows name of next street or town	2 50		
Others complain of patient's memory	2 51		
Patient complains of memory	2 52		
Remembers last 5 presidents	2 53		
Remembers test name and address after 5 minutes	2 54		
Alcohol			
Do you drink alcoholic beverages	2 55		
If yes, approximate amount/week _____			
Any social consequences of drinking	2 56		
Others think patient drinks too much	2 57		
Patient thinks he drinks too much	2 58		
Medical consequences of drinking (injury, blackouts, shakes, liver trouble)	2 59		
Past history of excessive alcohol use	2 60		
Depression			
Tiredness/loss of energy	2 61		
Low mood (discouraged, blue, sad, low spirits, unhappy, pessimistic)	2 62		
Loss of interest in things usually enjoyed (social, hobbies, sex)	2 63		
Feel you would be better off if you were dead	2 64		
Feel guilty or feel you have let yourself or others down	2 65		
Sleep disturbance	2 66		
Tense or nervous; can't relax	2 67		
Miscellaneous			
Past history of nervous problems or treatment	2 68		
Have you ever smoked	2 69		
Do you smoke now	2 70		
Drug problem (specify)	2 71		

An unlimited number of follow-up columns can be added.
The numbers refer to the computer card column number.

*Copies of the complete checklist are available from the author.

to be improved and that the greater numbers of older people need to be looked after with greater consistency by this society.

Advantages and Possible Problems of the Physician-GVN Team

The benefits identified in the Well-Elderly Clinic to the family physician working with a practice-attached nurse were considerable, and the GVN may be incorporated with advantage in many family practices. Although the total number of patients increases, the case load carried by the nurse eases the load of the physician and makes more effective use of limited medical personnel. The nurse helps reduce pressures on the physician's time, helps him/her make the best decisions, checks on medications, puts the patients into contact with such social and community services as are necessary or beneficial, performs follow-up work, and acts overall as a professional ally. A checklist or review form may materially help the GVN identify problems. The checklist (Table 1) needs to be comprehensive enough to provide an adequate view of the patient, and to promote consistency in case reviews with the physician. The checklist or questionnaire will also elicit data useful for planning community geriatric care.[6]

The GVN has also reportedly enabled some physicians to communicate more clearly, as noted by Spitzer et al.[12] By explaining transactions and concerns to their nurses in a teaching situation, the physicians' own clarity of thought can be enhanced.

The physician-patient relationship need not suffer through the addition of a nurse to the team. In fact, Andrews et al considered that the attachment of a nurse or health visitor to a practice strengthens the physician-patient bond.[2]

Before setting up the team, possible difficulties should be considered carefully. This team is unique only in the way in which it is linked to the requirement to extend care to a particular sector of the population.

In a study of nurses working in British general practice attachment schemes[13] over a two-year period, the few problems that emerged were administrative, due to problems of geographical distribution and staff shortages. As may be expected, inter-

personal relationships were also cited, such as misunderstandings between nurses and physicians. Sometimes, when the nurse failed to satisfy the physician's criteria, it was through the physician's lack of knowledge of the nurse's role and unrealistic expectations. Lack of sufficient planning beforehand can also cause trouble. For example, confusion can result when a secretary is not educated about proposed changes in routine, or a patient is not prepared for the team approach to medicine. Thinking through the concept and details of daily routine beforehand is most important. At the onset, some fundamental and very positive assertions about what the GVN can and cannot do, coupled with good checklists, should be outlined.

Most nurses have traditionally received little training in the detection of psychiatric disorders; this was borne out in the geriatric survey by Currie et al,[14] who reported that nurses had difficulty in eliciting signs of masked depression or incipient dementia. However, a geriatrician has suggested that "feebleness of mind and body is often treated best by nonphysicians."[15] Interestingly, it has been claimed that the ability of a nurse practitioner to perform physical examinations and identify problems in nursing home patients is comparable with that of moonlighting residents.[16]

Considerable extra work may be generated in a practice when screening of geriatric patients is undertaken, as their unreported medical and social needs are uncovered.[6,14] This may call for changes in long-established work habits. The family physicians in Lowther's study sometimes experienced difficulty in changing from the usual patient-initiated approach.[7]

Benefits for the Patient

Some patients attending the Iowa County Well-Elderly Clinic commented during a survey that it is easier and less intimidating to talk to a nurse, and that physicians have less time to listen. It is noteworthy that, in the same area, family physicians mentioned lack of time as their biggest problem in dealing with their elderly patients. One 90-year-old, after a house call by the nurse, said she was relieved to be spared the effort of going to a doctor. Making an appointment, arranging transportation, and sitting in the waiting room were more than the nonagenarian could cope with.

In a clinic at the University of Kansas that expanded the involvement of nurses with outpatients from the Department of Medicine, the patients showed a reduction, after one year, in the frequency of complaints and in the tendency to seek physicians for minor complaints. Another response was the development of a preference for nurses to explain test results, diagnoses, and medication instructions.[17]

The nurse who is practice-attached can gain an intimate knowledge of the elderly on his/her list, and can become a friendly and familiar figure who is easily accessible to the elderly.[18] Hodes[5] found that older people welcomed help from their family physician, and in this context included the health visitor and nurse working with him/her. The patient's evaluation of the visiting nurse's contribution to the health-care process may be strikingly different from the self-evaluation made by the nurse. The latter, in a midwest community, gave herself a much lower rating than the patient did, with reference to her value and need.[19]

Conclusion

Family physicians who rely on the older patients in their community to report their illnesses at an early stage will be taking the risk that much disease will be overlooked[1,7,10] due to limited awareness and drive and decreased mobility of many elderly people. Screening older patients can uncover remediable diseases. Serendipitous results include a sense of well-being[10] for the patients following a physical check-up.

The increasing numbers of elderly people necessitate a new approach to their care in family practice. Nurses trained in geriatric nursing are increasing in numbers, and practice-attached nurses could become excellent professional colleagues. The Geriatric Visiting Nurse is an instrument for health education and, ultimately, for an improved quality of life through medical care. When the GVN is widely used, the remediable diseases of the elderly will not be unmentioned, undiagnosed, and untreated.

Acknowledgements

Funds for the Well-Elderly Clinic were provided by the Iowa State Department of Health, Grant No. W-012-76. The author acknowledges her debt to Drs. Remi Cadoret, William Clements, and Reuben Widmer for advice and encouragement in the Well-Elderly Clinic project, and her thanks to Richard Redman for the computer analysis of results. Margaret Schumacher, RN, Marlys Goedken, and Jerilyn McCarty provided skilled assistance.

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