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.²³ The Oakden case in Adelaide⁴ has recently attracted particular scrutiny, but it is only one of many major episodes of abuse in Australian residential aged care homes.⁴⁵

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 that the 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

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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