



SPECIAL ARTICLE

The role of the geriatric nurse specialist as a key response in the care of the elderly, chronicity, complex chronicity and its consequences on dependence[☆]



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Abstract Ageing together with multimorbidity, polymedication and various social factors are some of the determinants that lead to increasing complexity of care in the elderly, thus making it difficult for health systems to meet their needs.

To approach this new and growing scenario of care for the elderly, the formal health and social care systems must define specific jobs for geriatric nursing specialists trained to address the needs of older people from a perspective of comprehensive care, both for healthy ageing, and for the different health problems of this population group, characterised by the consequences of ageing and chronicity, towards dependence, and develop the powers established by law in the framework of an interdisciplinary team, for those who have been trained and accredited, thus adding value to the response that health systems have to provide for this growing problem of the 'ageing-chronicity-dependence' triad.

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PALABRAS CLAVE

Enfermería
geriátrica;
Enfermedad crónica;
Anciano frágil

La enfermera especialista en geriatría como respuesta clave en la atención a la persona mayor, la cronicidad, la cronicidad compleja y sus consecuencias en la dependencia

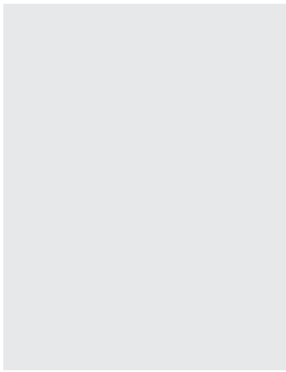
Resumen El envejecimiento unido a la multimorbilidad, la polimedicación y a diversos factores sociales se conforma como uno de los determinantes que conducen a aumentar la complejidad de la atención en las personas mayores y a dificultar, por tanto, el aportar respuestas eficaces desde los sistemas sanitarios a sus necesidades.

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Para afrontar este nuevo y creciente escenario del cuidado a la persona mayor, es necesario que los sistemas formales de atención, sanitario y social, definan puestos de trabajo específicos para que las especialistas en enfermería geriátrica, formadas para abordar las necesidades de las personas mayores desde una perspectiva de la atención integral, tanto en el envejecimiento saludable como en los diferentes problemas de salud de este grupo poblacional, caracterizado por las propias consecuencias del envejecimiento y la cronicidad hacia la dependencia, desarrollen las competencias que la ley establece en el marco de un equipo interdisciplinar, para las que han sido formadas y acreditadas, sumando así valor en la respuesta que los sistemas sanitario y social han de aportar a este creciente problema de la tríada «envejecimiento-cronicidad-dependencia».

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Introduction. The challenge of ageing and its consequences

Ageing and chronicity alone justify a change in the health-care model due to their impact on the sustainability of the social and medical systems.¹

According to the latest data of the National Statistics Institute (INE), in 2018 19.1% of the population was aged over 65 years old, and the projection is that in 50 years time it will stand at 29.4% in 2068. In 2017 life expectancy at birth was 85.7 years for women and 80.4 years for men.² Mortality and disablement in Spain are linked to chronic diseases. In the year 2016 80.5% of deaths occurred in individuals aged over 70 years old, and chronic diseases were the main cause of 92.8% of these deaths.³

In the year 2017 more than half of hospital stays corresponded to elderly people. Moreover, hospital mortality rates increase with age, and this is associated with poorer states of health and chronicity.² Comorbidity alone cannot account for all of the characteristics of elderly patients, as the complexity of treating them also has to be taken into account. This is due to their functional and cognitive states, their social and life circumstances, the degree to which they adhere to therapy or the risk of adverse reactions to medication. Caring for this population sector requires an approach that is holistic, multidimensional and interdisciplinary with the aim of preserving patients' functional status.⁴

The *World Report on Ageing and Health* considers it to be necessary to change perceptions regarding health and ageing, to give a complete response. It is necessary to adapt health systems to elderly people, especially in the case of complex chronicity. A shift is required away from models that centre on curing acute diseases in a fragmented and disconnected way, to care that encourages healthy ageing. Services should be accessible and provide complete care that centres on the elderly, with duly trained staff, including in the gerontological and geriatric fields. This viewpoint encourages healthcare systems to create geriatric units that include new care models to treat this complex patient type.⁵

Geriatrics, the history of a necessary speciality

Marjory Warren, the English nurse and surgeon who is considered to be the mother of modern geriatrics, showed in the 1940s that elderly people with associated chronic disease who were evaluated holistically by a multidisciplinary team, who received high-quality individualised care and early rehabilitation improved, recovered their independence and were discharged into the community.^{6,7} Warren stated that suitable care for chronic elderly patients required that doctors and nurses had specific geriatric knowledge, and she promoted research in this field.⁷

The form of care adopted by Warren gave positive results in terms of mortality, morbidity and recovery. A type of healthcare for elderly adults with chronic multiple pathologies gradually emerged, based on the use of interdisciplinary teams as its working methodology and a holistic approach to medical care for elderly people.⁶

There was already talk of age discrimination (ageism) in the 1960s, together with the bioethical problems arising from care for the elderly; the main geriatric syndromes were defined in the 1970s; and in the 1980s holistic geriatric evaluation (HGE) started to be applied.

The first chair of Geriatrics was created in Spain in the 1940s, together with the first geriatrics department and the Sociedad Española de Geriatria y Gerontología,⁸ and the medical speciality was recognised in 1978. University studies for nurses started in 1977, and Geriatric Nursing started to be taught as a subject. The nursing speciality was recognised for the first time in 1987⁹ and in the Royal Decree on nursing specialities of 2005¹⁰ it was named as one of the 7 specialities to be developed. In 2009 the Geriatric Nursing training programme was approved and published, containing the following definition: *"The specialist nurse in Geriatric Nursing is the professional who provides attention and nursing care to the elderly population, and they are able to teach, supervise, investigate, manage and leader the care for this group in complex situations, in which they also act as advisors at all levels of the social and health systems"*.¹¹

Nursing roles in the care of complex chronicity

There is the need to respond to the new necessities, which are arising due to the three factors of ageing, chronicity and dependence, together with the complex care situations that are caused by this scenario. Holistic care by a highly qualified interprofessional team, coordinated by case management with the social services, could offer the best responses in terms of quality and efficiency for patients of this type, who intensively consume medical and social resources. Professional profiles and roles have been identified for the care of complex chronicity, including general nurses, specialist family and community nurses who centre on the care of chronic patients within the community,¹² or advanced practice nurses such as case manager nurses,¹³ who are consolidating and stabilising as key players in the management of complex chronicity.

Together with this deployment of professional profiles, the role of specialist geriatric nurses may be that of an independent professional who coordinates the care process for geriatric patients, their family and their environment, intervening to preserve and encourage their independence. They will take into account the consequences of diseases and their complexity, and will often take on the role of leading the interdisciplinary team. They are professionals who have expert knowledge and develop specialised skills in care during the ageing process, the most common pathologies and atypical presentations of diseases. They will undertake a complete geriatric evaluation of patients and treat geriatric symptoms, being of indispensable value in the interdisciplinary team that cares for the elderly.

Caring for geriatric patients in complex situations

We have to distinguish between healthy older adults, sick older adults (healthy adults who suffer an acute illness), frail elderly individuals (with a risk of upset, where frailty is a predictor of disability, dependency and hospitalisation) and geriatric patients. We understand geriatric patients to be individuals of advanced age, with chronic diseases, dependency, cognitive problems or the need for social and medical resources that condition how to care for them.¹⁴ This patient profile will require specific personalised care which takes into account their needs, preferences, values, beliefs, expectations and how they experience and face their health/disease. The care offered will centre on the whole person, requiring a level of professional expertise (knowledge, attitudes and specialised skills) which are not covered by basic training.¹⁰

The systematic review by Ellis et al.¹⁵ on the efficacy of specialised geriatric care for hospitalised elderly patients, found that specialised nurses formed a part of the interdisciplinary team in 16 of the 22 randomised controlled trials that were reviewed.

Given the professional skills of specialist geriatric nurses and the need to add value in meeting care needs in the new demographic and epidemiological scenario described, health and social systems have to make use of the said professionals. They need to be given specific posts that allow them to function together with general and advanced

practice nurses and those of other specialities, together with the rests of the interdisciplinary team. The positions to be occupied by specialist nurses may be located in areas such as the following: the acute geriatric unit, orthogeriatric/convalescent/functional recovery unit, neurogeriatric unit, palliative geriatric care unit, psychogeriatric unit, geriatric hospital, outpatient geriatric surgery, intermediate care/short stay unit, prolonged care/long stay unit, home hospitalisation team, emergency department, geriatric evaluation and care team, support team, social-medical coordination team, old people's home, day and night centre and multiprofessional geriatric teaching unit.^{11,16}

Geriatric research

The research skills of specialist nurses in a field as closely associated with care as geriatrics make it possible to base clinical practice on the best available evidence. This creates scientific knowledge within the field of the speciality itself and spreads knowledge among professionals as well as the population.¹⁷ This in turn makes it possible to progress in the development of good practices and safety within geriatric care. The challenge of ageing offers nurses opportunities for research, development and innovation.¹⁸ Disability, geriatric syndromes, dementia or frailty and common problems in caring for elderly adults all have great research potential for these specialist nurses.¹⁹

Conclusion

The need to respond to ageing, chronicity and complex chronicity, as well as the treatment of dependency all mean that nurses are of greater importance within interdisciplinary teams. By making progress in the treatment of elderly adults, specialist geriatric nurses show themselves to be able to lead a new model of care, one designed for patients in situations of chronicity, complexity and dependence.

Specific training is required for the care of the elderly, given that ageing involves increasing vulnerability and frailty that lead to highly complex situations, of which we can underline new care challenges where geriatric nurses can play a key role, thanks to their capacity and skills. Among others these include protecting the dignity of elderly patients, protecting against their maltreatment (at an individual, relational, community or sociocultural level),²⁰ countering solitude and social isolation and supplying palliative geriatric care.²¹

It is necessary to raise the profile of the more than 7000 geriatric nurses in the whole of Spain, as they work efficiently on caring for the elderly, using the best evidence-based techniques in different areas of care. The status of the category has to be recognised, and work positions must be defined where nurses are able to develop the professional skills they were specially trained and certified in. This step by the medical and social systems will make it possible to respond to the needs of an elderly population, where disability, dependency, frailty, morbidity and social factors increase complexity. It is here that specialist geriatric nurses will be able to offer high-quality care that has a positive

effect in interdisciplinary teams and organisations, as well as on results in terms of health.

Conflict of interests

The authors have no conflict of interests to declare.

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