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WHITE PAPER

Loneliness and isolation in older people: everyone's problem

Introduction

"An older lady came to our Covid vaccination centre. When someone spoke to her she burst into tears. She said: 'It's the first time I've spoken to somebody in months'. The pandemic has been very difficult for older people. They've felt abandoned."

Linda Nazarko, a consultant nurse in older people's care, and a consultant nurse in physical health, west London, is describing an experience that is all too common — the devastating impact of loneliness on older people, made so much worse by the Covid-19 pandemic.

The scale of the problem is immense. Older people's charity Age UK estimates the number of over-50s experiencing loneliness is set to reach two million by 2025/6.[1] This compares to around 1.4 million in 2016/7 – a 49% increase in 10 years.[1]

"This reflects the growing numbers of older people in our society, rather than evidence showing definitively that loneliness is becoming more prevalent," says Caroline Abrahams, charity director at Age UK.

Impact of loneliness on older people's mental and physical wellbeing

Loneliness is a problem with major health consequences, increasing your chance of dying by 26%.[2] Research has shown loneliness has the same impact on mortality as smoking 15 cigarettes a day, making it even more dangerous than obesity.[3]

The impact of that loneliness on the older population is evident in our communities, GP surgeries, and hospitals. Dr Dan Furmedge, a consultant geriatrician at Guy's and St Thomas' NHS Foundation Trust, says loneliness plays "a significant role in impacting on the wellbeing of older people".

He says being lonely and socially isolated contributes to low mood, and overall frailty, contributing to "a significant number of hospital admissions and community healthcare contacts".

Impact of the pandemic

Loneliness can be eased by support from families. As we get older and frailer we rely on our families even more. Just how much we need them has been highlighted during the pandemic, when families have been unable to visit or have close contact with relatives due to infection control and social distancing measures. The impact of severing face-to-face communication between older people and their loved ones has been extremely damaging.

Age UK has documented the impact of the pandemic on older people.[4] "Notably there has been a deterioration in some older people's physical and mental health," says Ms Abrahams. "There is a combination of reasons for this, but certainly reduced social connections have had an impact on loneliness and mental health.

"In addition, reduced contact and touchpoints with friends, family and the health and care system has meant that for some older people, mental and physical health symptoms and signs will not have been noticed and addressed.

"Many families have expressed concerns for older loved ones since they have seen them again, with many noticing a significant decline in mobility, cognitive ability and confidence since the start of the pandemic," she says.

Keeping everyone informed

At a time when older people and their families are unable to have their usual contact in hospital settings due to Covid restrictions, it is more important than ever that there are clear communication systems and procedures in place to keep people informed about their loved ones' health and care.

Ms Abrahams of Age UK says professionals should "always try to involve and share decisions with the person receiving care, even if this might mean providing additional support or time to do this properly".

"However, some older people may find it helpful or necessary to directly involve family, friends or unpaid carers in the support and care they are receiving. We would expect this to happen when it is in the best interest of the person and/or where there is permission, which should be noted on someone's record," she says.

The General Medical Council produces guidance to protect patients on what and under which circumstances medical information can be shared.[5] Ms Abrahams advises that it is the responsibility of the GP practice to make sure that family and friends involved in supporting an older person have access to important information.

"There should also be a clear and accessible way for them to contact the practice when their needs change or there is a non-emergency care need. In recent years, some areas have adopted care coordinator roles that can help with this, sometimes delivered by local Age UKs," she says.

Ms Abrahams says Covid-19 has sometimes meant that older people who would like a carer or family member to attend appointments with them are no longer able to do so, which has caused some people distress if they wish to have support in an appointment.

"While Covid-19 measures are important to protect people, carers should be allowed into appointments where this is required," she says.

No-one's problem

Practitioners in both primary and secondary care told *GM Journal* that they were not aware of any formal systems in place to help ensure effective communication between health and social care professionals, older people, and their families.

"With a lot of services it feels like it's everybody's problem, therefore it's no-one's problem. But it is everyone's issue," says Tom Rose, an Admiral Nurse clinical lead based at St Barnabas Hospice, Lincolnshire.

What is in place, he says, "depends on the commissioning landscape". "In a lot of places, individual services do go out of their way to make communication better. But a lot of the time we communicate 'our bit' but not in a joined up way."

While communication processes may be ad hoc and variable, the pandemic has shone a light on the need to improve them. Dr Furmedge is finding that the whole healthcare team now takes a more proactive approach to communication. "With patients not being able to see visitors there's been a more concerted effort to communicate with families, with charts to show if they've been updated in the past couple of days."

However, a shortage of staff, with some shielding or working from home, is making the liaison process more difficult, he says. "We'd like to do much more but we're limited with the amount of communication that can be done."

Reduced capacity: 'minefield for communication'

Another challenge to effective communication is the issue of older people with reduced capacity.

Ms Abrahams advises: "It's an important principle that we assume that someone has capacity to make a decision until it's proved otherwise." However, many older people have reduced capacity, but do not qualify for advocates.

This situation is "a minefield for miscommunication" says Helen Lewis, an advanced nurse practitioner (ANP) in a practice based in Wales. She warns the issue of reduced capacity could be a growing problem that may not be identified in individuals, as a lack of face-to-face contact during the pandemic means signs of changes in behaviour are going unnoticed.

Older people without a support system

Then there are older people who have no family connections, but equally important communication needs. Ms Abrahams says there are some organisations, including Age UK, and NHS Responders, which are available to support older people who are isolated and without a support system.

For people with reduced capacity who do not have family and friends to support them, Ms Abraham advises that, in theory, there are systems in place, and adult social care services should provide an independent advocate for people where they struggle to understand or remember information or have difficulty communicating their views.

However, in practice, she says "there is often very little advocacy available, so many people are going without. And while there are "some great organisations" which can also support in this way, "their services are often oversubscribed", she says (see resources box).

Practitioners suggest many older people without family or friends could be "slipping through the net" because if they don't present to their GP, or at the hospital their needs may go unnoticed.

Resources

- Age UK helpline: 0800 678 1602 (8am-7pm, Mon-Sun)
- Admiral Nurse Dementia Helpline for advice on finding local support networks: 0800 888 6678
- Dementia UK: Tips for better communication: https://www.dementiauk.org/get-support/understanding-changes-in-behaviour/tips-for-better-communication/
- Dementia UK: How to handle communication challenges: https://www.dementiauk.org/how-to-handle-communication-challenges/
- NHS Responders: 0808 196 3646 (8am-8pm, Mon-Sun)

Improving communication and tackling isolation

Effective solutions are available that can help to improve communication between older people and their families, and tackle the isolation of those without family connections.

Digital systems are being used by practitioners not only to consult with patients, but also to help improve communication with older individuals and their loved ones. Video calls have ensured families can see each other on screen when they have been unable to have face-to-face contact, while hospital volunteers have helped older people to use ipads to keep in touch with their families.

However, technology is not a cure-all for communication difficulties. "It's important to think about people with a disability, or who are restricted by, say, a sensory impairment. We have to make sure our response meets their individual needs," says Dr Jennifer Burns, president of the British Geriatrics Society and a consultant geriatrician.

To help address isolation in those living alone, Dr Michael Dixon, chair of the College of Medicine and co-chair National Social Prescribing Network, says that through social prescribing, individuals can be referred to a link worker who "can get under their skin and understand their culture, history, hopes, beliefs and challenges. And then refer them to something appropriate – often physically taking them – to a knit and natter group or an artistic or outdoor group and thus provide the foundations of a sustainable solution to their loneliness".

During the pandemic, the social prescribing link worker role has become more proactive going beyond simply receiving referrals to making direct contact with those who were shielded or vulnerable, says Dr Dixon. They have been supported by "an army of volunteers offering services such as shopping and maintaining social contact by telephone".

Charities, such as Age UK's befriending service, Dementia UK's Admiral Nurses, and the Red Cross, offer valuable support to older individuals. But even before the pandemic that support was stretched to the limit.

Better support means being proactive

Clearly much more needs to be done to improve communication between isolated older people and their families, and for those living alone without connections. Ms Lewis wants to see more "joined up thinking from both a medical and social care point of view", and open lines of communication between all practitioners "to establish care that supports our older generation".

Dr Dixon predicts "a digital revolution" will be a growing solution and envisages secondary school children teaching the over 70s digital skills.

And he says social prescribing is gaining pace, with between one and three link workers now in every Primary Care Network. "The wider its reach, the greater its impact on everyone, especially including the elderly, isolated and lonely," he says.

Better support for older people and their families involves being proactive, practitioners say. This could be passing on the names of those patients you feel are vulnerable to your social prescribing link worker. Or recognising that when a patient is getting frailer and more confused, and their relatives, who live far away, are becoming anxious, that it's time to get consent, so you can share information.

Being proactive could also involve encouraging older people to talk about their wishes and what's important to them, including end of life care, and the importance of having this discussion with their families.

Dr Burns says: "As a society we need to be more open around topics associated with illness and people's personal wishes so that we don't face situations where people

Use of a DNACPR order

Caroline Abrahams, charity director at Age UK, says: "When Do Not Attempt Cardio-Pulmonary Resuscitation orders (DNACPR) are well managed, they are appropriate advanced planning tools for people who want to limit invasive medical treatment at the end of their lives.

"However, even before the Covid-19 pandemic, decisions to apply DNACPR notices to people's records, particularly in care homes, were too often issued unilaterally and sometimes without individual assessment. During the pandemic, there were stories of GP practices approaching people to update records with DNACPR notices, often causing severe distress and not taking sufficient account of their actual circumstances.

"The CQC reported last year that 'do not attempt resuscitation' (DNAR) decisions were being made without discussion with the person or their family. Covid-19 brought with it significant pressures and a number of decisions were taken without considering the full consequences or the impact on patients.

"However, there needs to be a much more person-centred and standardised approach to having these discussions within the context of improving wider advance care planning processes. Such an approach will take full account of a person's needs and capabilities and absolutely ensure that age alone never justifies the application of a DNACPR."

become unwell and family members are not clear what their relatives want. The British Geriatric Society is keen to promote good, healthy, open discussions between family members about what their wishes are."

Dr Burns says the NHS Ageing Well Programme[6] wants to allow time for healthcare professionals to start having discussions with people about what their wishes are and what is important to them. And she says geriatric special interest groups are looking at particular areas of communication, such as end of life and palliative care, and guidance as to what could and should be done.

Crucially, communication with both older people and their families needs to be "high quality", says Dr Burns. "As healthcare professionals, we need to always be aware of the importance of trying to make sure we have communicated well with patients and offered them the option of supporting their family as well."

Practitioners should encourage older people's families "to work in partnership with us", says Ms Nazarko. "They've known the patient all their lives, they know what works for them, and we should recognise their expertise, working with them, not shutting them out," she says.

It is important, where possible, for practitioners to invest time in really listening to patients and families to learn about their needs. Mr Rose says home visits should be more than just about the clinical or practical, but about having a chat, making a connection, and understanding what is important to that individual.

This past two winters for older people and their families, the pandemic left "a legacy of trauma and grief," says Mr Rose. This year needs to be better, and effective communication with individuals and their loved ones will be vital to helping achieve this.

To help address loneliness, and ensure it becomes everybody's rather than no-one's problem, Mr Rose suggests practitioners can start with a simple question. "Ask the patient: 'How often do you feel lonely?' If it's on a regular basis that's an indication that something needs to be done. It's not ok to say 'that's just what happens in old age'. This shouldn't be the case. We shouldn't accept this."

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Improving communication between doctors and patients' next of kin: an audit

Introduction

Communicating with older adults can sometimes be challenging for a number of reasons. Therefore, involving next of kin in decision-making is extremely important. The aim of this audit was to evaluate the quality of communication between doctors and a patient's next of kin in a community hospital.

Objective:

- To determine if consent was obtained from a patient prior to speaking to next of kin.
- To determine if communication between doctors and next of kin takes place within the first 48 hours of admission on working days.
- To determine if the discussions regarding the ReSPECT (Recommended Summary Plan for Emergency Care) form took place with a patient's next of kin. This is a national patient-held document, completed following an Advance Care Planning conversation between a patient and a healthcare professional.
- Should there be a deterioration in a patient's clinical condition (i.e. new infection, change in cognition, need to transfer to an acute hospital setting), has this been communicated to next of kin?
- To determine if there is regular contact with next of kin of long-stay patients in the community hospital.

Method

We performed a retrospective audit involving 22 patients who have been inpatients on a single geriatric ward at a community hospital for 21 days or more between the period of June and mid-October 2021 with documented next of kin details.

Given that we are a community hospital and most of our patients are here for physical rehabilitation, we looked only at those who had a long stay in hospital, as this was likely due to a chronic medical condition. Following the first cycle, we analysed the data and presented the findings to the team during departmental teaching and recommended areas of improvement.

Following implementation of the recommendations, we completed a second cycle after two months that looked at a total of 12 patients in the same ward who had been inpatients for 21 days or more.

Criteria	Reference
Discussions around ReSPECT form should be discussed with patient's next of kin if patient consents.	GMC (2014) Good practice in decision making[1] CQC Protect, respect, connect: decisions about living and dying well during Covid-19[2] (2021)
Next of kin updated if patients deteriorate clinically, i.e. acute infections, decline in cognition or need for transfer to the acute hospital.	SIGN 139, Care of Deteriorating Patients (May 2014)[3] BCHC (2018) Safe Transfer of Patients and Service Users Policy[4]
Regular contact with patient's next of kin if patient has a long stay in community hospital. No specific guideline regarding how often a family member should be updated during inpatient stay, however, as a team, we believe it is best practice to give a medical update to the patient's next of kin at least once a week.	NICE (2021): Patient experience in adult NHS services: improving the experience of care people using adult NHS services[5]

Results

First cycle

- Mean inpatient stay of patients was 36 days.
- No documentation of consent gained to speak to next of kin from 64% of patients.
- Only 50% of the patients' next of kin were spoken to within 48 hours of admission.
- 55% of the patients had a collateral history taken from next of kin.
- 59% of the patients' next of kin were not been informed of ReSPECT form status.
- Only 5% of the patients' next of kin were updated by a doctor regularly (at least weekly).
- 68% of the patients' next of kin were not informed of any deterioration in their clinical condition.

Recommendations and action plan

- Create a flyer to use as communication checklist.
- Communication whiteboard on the ward.
- Re-audit to check for compliance in two months.

Second cycle results

- Mean inpatient stay of patients: 33.5 days.
- Six patients had consented to sharing information with next of kin, one patient did not want any information shared with next of kin, two patients had no capacity (and this was documented), and two patients had no documentation of consent to update next of kin.
- 72.7% of patients' (eight out of 11) next of kin were spoken to within 48 hours of admission.
- All 11 patients had a collateral history taken from the next of kin.
- Discussions regarding ReSPECT forms were held with three patient's next of kin. Four of the patients' next of kin were already aware and this was documented. Two patients did not consent for this information to be shared. One of them had no ReSPECT form in place.
- 81.8% of patients' next of kin (nine out of 11) were being updated regularly by a doctor (at least weekly).
- Six patients had some form of clinical deterioration during their stay and this was communicated to their next of kin.

Conclusion

Due to Covid-19 and visiting restrictions, meeting patients' relatives on the ward to update them about ongoing treatment/management and escalation plans does not happen very often. The first audit cycle showed that the communication between doctors and next of kin, as well as related documentation, was not up to standards set by GMC's Good Medical Practice. Following the presentation of findings and implementation of recommendations, there has been an improved compliance with the standards set out. This will result in better patient and family satisfaction.

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