

How the Dutch Do It: The Role of the Nursing Home in the Netherlands

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Abstract

Providing care in nursing homes is challenging for family physicians. The Netherlands has developed the specialty of nursing home medicine. In this article we describe our visit to the Netherlands and potentially new and exciting ideas for Canadian physicians providing care in nursing homes.

Key words

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Physicians
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It is our belief the delivery of medical care to our long-term care facilities is in need of renewal and fundamental change. This is based in part on the following observations: increasing resident medical complexity, lack of training for these complicated issues, inadequate support services, outdated physical environments, and inappropriate fees for service remuneration models. Family doctors are withdrawing from active care in nursing homes based on these realities, not because of a lack of interest in this patient population. This is evidenced by the largest nursing home facility in the Maritimes, with over 500 beds, having a 50 per cent reduction in family doctor services, with the majority of care falling to about 10 per cent of family physicians.

As a small group of community family doctors with Care of the Elderly Training (COE), we will attempt to identify these deficiencies, and review other existing care models. We envision this information could lead to new models of care, thereby unlocking nursing homes for new roles, and giving new opportunities for family doctors. This article focuses on the Dutch models of care, describing our onsite review of academic nursing homes and the Department of Nursing Home Medicine, Vrije University, Amsterdam. The Netherlands is the only country in the world to have a university department dedicated to nursing home medicine, including teaching, research and clinical care.¹⁻⁵ The Nursing Home Medicine program is a two-year training program that began in 1989 after much lobbying to the Royal Dutch Medical Association (RDMA). At that time, about 700 physicians already practicing in nursing homes were grandfathered in, with the condition the two-year program would be implemented, thus starting a new medical specialty—nursing home medicine. There are now three university training centres for nursing home medicine located in Amsterdam, Nijmegen and Leiden. The Vrije University is the principle academic centre. There are 168 physicians-in-training located

across 200 teaching nursing homes in the Netherlands. Presently, there are 1000 qualified nursing home physicians practicing in 333 nursing homes (57,500 beds).¹ The usual ratio is one full-time equivalent nursing home physician to 100 residents. The Netherlands has approximately 80 clinical geriatricians (five-year specialty training program) with 120 residents in training. The population of the Netherlands is approximately 16 million, about one-half of Canada's. The clinical geriatrician is trained and practices mainly in hospitals, whereas the nursing home physician is trained and practices in nursing homes and the community. A more detailed rationale for the reasons behind the creation of this new specialty was articulated in an article by Hoek, which in many respects inspired our travel to review the model in the Netherlands.³

The Department of Nursing Home Medicine has six main functions: 1) nursing home physician training; 2) undergraduate medical school training; 3) postgraduate training for nursing home physicians for maintenance of certification; 4) research in nursing home medicine; 5) international collaboration exemplified by RAI (resident assessment instrument); and 6) development of an academic nursing home network. Our time was limited to an examination of the training of nursing home physicians and specific examples of academic nursing homes. We did, however, meet with several researchers who described 18 major nursing home research projects, emphasizing their strong focus on progressive clinical ideas in the medical practice of nursing home medicine.

The general outline of the teaching of nursing home physicians was quite advanced and intricate. The training was structured around problem-based learning, and the final examination centred around competence in 55 tasks. The teaching of trainees is divided into practical and theoretical. Four days of every week are spent in a teaching nursing home (a teaching nursing home is selected based on the experience of the senior nursing home physician, the quality of the medical records, the composition of the resident population, including somatic, psychogeriatric, rehabilitation, day hospital etc.).

The theoretical training is one day per week where 12 trainees meet at the university with a psychologist and a nursing home physician. The teaching is broken down into five cornerstones of teaching: 1) 50 per cent patient care (e.g. geriatric syndromes, dementia, rehabilitation, palliative care); 2) 29 per cent communication and attitude (e.g. communication and collaboration, ethics and law); (3) eight per cent methodology of care; 4) eight per cent management (e.g. basic business management skills and extramural nursing home care systems); and 5) research.

Dutch nursing homes have a greater role in their health care system than Canadian homes. Most of our nursing homes simply act as residences for frail elderly. In the Netherlands, nursing homes have a rehabilitation function, offer palliative care, and run day and night centres all covered by government funding. To admit a stroke patient to one of these rehab units, several criteria have to be met, such as medical stability, two weeks post-stroke and clear origin of the stroke. Interestingly, refusing to admit a stroke patient because of an uncertain home situation is not permitted. Psychologists are an integral part of the care team.

Sint Jacob Nursing Home, a rather old-style building in central Amsterdam, has a 16-bed post-stroke rehab unit, six orthopedic rehab beds, 46 somatic beds, 80 psychogeriatric beds, 10 beds for Huntington's sufferers, 10 beds for residents with primarily psychiatric diagnoses, and a separate section with four palliative beds. The length of stay in the rehab unit was usually six to eight weeks, with about 37 per cent being discharged to their

home in the community. The rehab team comprised the nursing home physician, physiotherapist, occupational therapist, nurse, speech therapist and often a regular visit by an orthopedic surgeon.

Rosendaal Nursing Home in Utrecht has 230 beds: 40 rehab, 80 somatic, 90 psychogeriatric and 20 psychiatric, as well as 35 day/night centre beds. The day/night centre program is the largest in the country. In this program there were three groups: one group was for active intervention and goal attainment scales, using such disciplines as physio, speech therapy and OT; a second group was for socialization, but improvement was not a goal; and a third group was the quiet area set aside for those who did not require stimulation. The program had dementia and non-dementia individuals who were seen two to three times per week. Nursing home physicians would be available to help develop care plans. Weekly multidisciplinary rounds would ascertain if the individual was placed in the right group, and whether any diagnostic intervention was needed. Interestingly, although there was no study evidence, the staff were convinced this program kept the frail elderly in their homes longer, as evidenced by length of stays in the program of up to five years.

Polderburen is a modern, progressive nursing home in the fastest growing city in the Netherlands, Almere. This city of 200,000 is 25 years old and was built on land reclaimed from the sea. There are 130 “places” (they attempt to avoid the term beds), which are divided into 10 houses (10 “places” in each). Each house has an address with a door and a street number on a real Almere street. The door opens into a unit that contains 10 bedrooms, a kitchen, bathroom and living room. There are five houses for somatic residents, five for psychogeriatric residents, and two short-stay houses for rehab purposes. All residents, including those with dementia, have an indoor walkway and a huge central garden-like area complete with a pond and playground for visiting children. In 10 years, no resident has climbed the monkey bars or fallen into the pool. No restraints are used, except for Dutch doors, which may be used occasionally. The average length of stay is two years. Overlooking the interior garden is a very inviting dining room. Staff, residents and family use it, as well as visitors from the neighbourhood. Polderburen is dedicated to making the residents’ place as home-like as possible.

Graeme Bethune visited Haarlem to review a nursing home, Anton Pieck Hofje, which inspired the philosophies of dementia care at Polderburen, under director Hans Houwelling. Houwelling’s concept is that most people with advanced dementia are looking for their home or their mother. Anton Pieck Hofje began as a housing initiative in 1989, when 36 residents with dementia were placed in a home-like setting with six residents in a ‘house’ each sharing a central courtyard. The caregiver assists the residents with morning chores such as cleaning up and shopping (if able). The caregiver and the residents prepare meals together and, weather permitting, eat in the courtyard. Visitors may be invited to tea like our visiting author was. This is clearly a serious, well thought-out attempt to comfort the residents with a truly home-like care environment.

Seeing appropriately trained family doctors working in a more progressive care environment encouraged us to think outside the box. In particular, the training and development of community family doctors is something we should consider doing in our own province (perhaps using the Care of the Elderly diploma program). It was our conclusion that not only did it unlock the barriers to family doctors and provide them with the expertise and the time to use it, but it fundamentally shifted the nursing home

paradigm from the far too common “end of the road mentality” to one of progressive, additional models of restorative care, palliative care, respite care, and day/night centre care, which may also allow for the frail elderly to stay at home longer. Clearly, no off-the-shelf model will work in all places. In the coming months, we will examine what we have seen, survey our resources, and suggest new roles and models for our long-term care facilities.

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