Safe long-term care

As OECD populations are ageing rapidly, demand is increasing on the LTC sector to provide care for more, and older, people with complex conditions and heightened needs for expert care. This has put an enormous strain on LTC systems – a strain that is projected to increase in the coming years as OECD populations continue to age.

The safety risks in LTC have been made evident by the rapid spread of COVID-19 among residents and health workers in LTC settings (see Chapter 2). The advanced age of many residents, lack of sufficient personal protective equipment and poor infection control meant that many LTC facilities experienced outbreaks that spread rapidly (OECD, 2020[4]).

Over half of the harm that occurs in LTC is preventable, and over 40% of admissions to hospitals from LTC are avoidable. Reducing and preventing harm in LTC is an end in itself, but there is also an economic case to be made. The total cost of avoidable admissions to hospital due to safety lapses in LTC facilities was almost USD 18 billion in 2016 across OECD countries. This figure is equivalent to 2.5% of all spending on hospital inpatient care or 4.4% of all spending on LTC (de Bienassis, Llena-Nozal and Klazinga, 2020[5]).

For older people, most guidelines advise complete avoidance (that is, an ideal rate of 0%) of benzodiazepines because of the risk of dizziness, confusion and falls. Even so, benzodiazepines are prescribed for older adults for anxiety and sleep disorders, despite these risks. Long-term use of benzodiazepines can lead to adverse events (overdoses), tolerance, dependence and dose escalation. Long-acting (as opposed to short-acting) benzodiazepines are furthermore discouraged for use in older adults because they take longer for the body to eliminate (OECD, 2017[6]).

Use of benzodiazepines varies greatly, but – on average – has declined between 2009 and 2019 in OECD countries (Figure 10.10). The largest declines in chronic use have occurred in Iceland, Portugal and Denmark. Korea, Iceland and Denmark experienced the largest decline in use of long-acting benzodiazepines. The wide variation is explained in part by different reimbursement and prescribing policies for benzodiazepines, as well as by differences in disease prevalence and treatment guidelines.

Ageing and multimorbidity often require older patients to take multiple medicines (polypharmacy) for long periods of their lives. While polypharmacy is in many cases justified for the management of multiple conditions, inappropriate polypharmacy increases the risk of adverse drug events, medication error and harm – resulting in falls, episodes of confusion and delirium. Adverse drug events cause 8.6 million unplanned hospitalisations in Europe every year (Mair et al, 2017[7]).

Across a selection of 16 countries with broader data coverage, polypharmacy rates among older people varied more than 8-fold in 2019, with Turkey reporting the lowest rates and Luxembourg the reporting highest rates (Figure 10.11). These large variations are explained in part by the establishment of targeted polypharmacy initiatives in some countries, including related reimbursement and prescribing policies. Countries that cannot separate prescription data from primary care and LTC show higher average and larger variation of polypharmacy rates than countries with separate primary care prescription data.

A major concern for health care-acquired infections is the rise of antibiotic-resistant bacteria, which can lead to infections that are difficult or even impossible to treat. Infections can lead to significant increases in patient morbidity, mortality and cost for the health system. These infections are also generally considered to be preventable through standard prevention and hygiene measures. The most commonly occurring hospital acquired infections in LTC facilities include urinary tract infections, lower respiratory tract infections, skin and soft tissue infections.

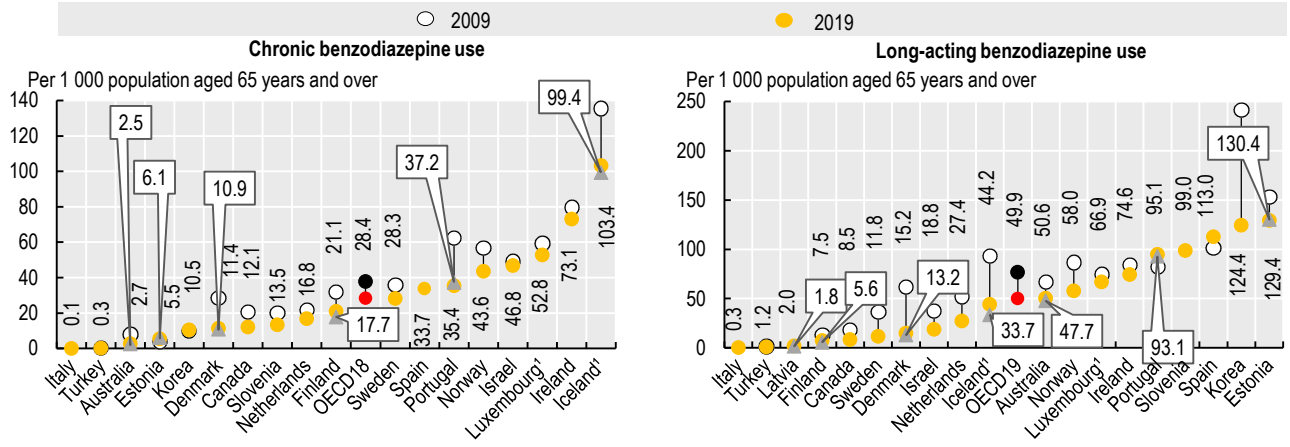
Figure 10.12 shows the proportions of bacteria isolated from LTC residents that are resistant to antibiotics. On average, over one-quarter of isolates were resistant – on a par with levels seen in acute care hospitals.

Definition and comparability

See the “Definition and comparability” box in indicator “Safe prescribing in primary care” in Chapter 6 for more details regarding the definition and comparability of prescription data across countries.

Resistance proportion data are based on a composite antibiotic resistance indicator developed by the European Centre for Disease Prevention and Control (ECDC) (Suetens et al., 2018[8]). Data were obtained from point prevalence surveys conducted between 2016 and 2017 by the ECDC and the US Centers for Disease Control and Prevention (CDC) among participating LTC facilities. Facilities included in the ECDC data were general nursing homes, mixed LTC facilities and residential homes; specialised LTC facilities, as defined by the ECDC, were excluded. Only nursing homes were included in the CDC survey data. Point prevalence surveys currently represent the best tool for collecting internationally comparable data in LTC settings, but they are subject to possible biases due to facility selection, local recording practices and observer training. Countries noted as having poor data representativeness had low participation among LTC facilities, which may lead to wide variance or biased estimates.

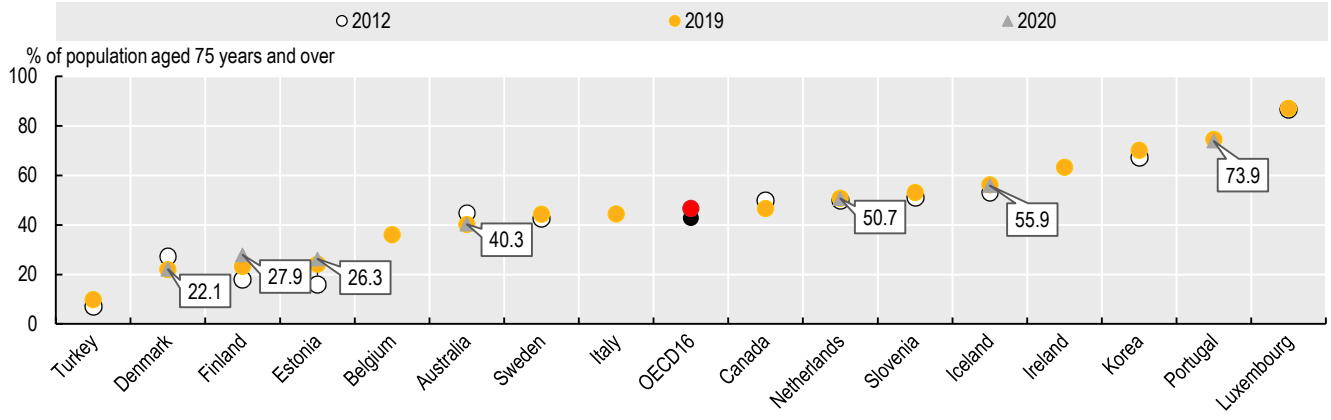
Figure 10.10. **Trends in benzodiazepine use in adults aged 65 and over: Chronic and long-acting use, 2009, 2019 (or nearest years) and 2020**



1. Three-year average.
Source: OECD Health Statistics 2021.

StatLink https://stat.link/r4w7g9

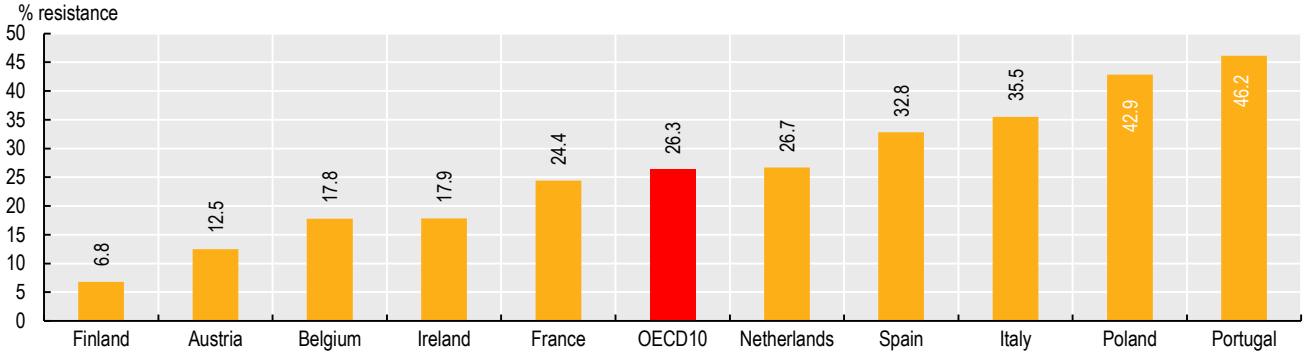
Figure 10.11. **Population at age 75 and over taking more than five medications concurrently, 2012, 2019 (or nearest year) and 2020**



Source: OECD Health Statistics 2021.

StatLink https://stat.link/9mvjon

Figure 10.12. **Proportion of antimicrobial-resistant bacterial isolates from health care-associated infections in long-term care, 2016-17**



Note: Based on composite antibiotic resistance indicator developed by the ECDC. Only countries with over 15 bacterial isolates were included.
Source: ECDC.

StatLink https://stat.link/cnzhk6